

Ohio Assessment for Immediate Need and Current Need

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| Name of person assessed: | |
| Date of birth: | |
| Address: | |
| County of residence: | |
| Date of interview: | |
| Name of person completing assessment: | |
| Title of person completing assessment: | |
| Names of participants and relationship to person assessed: | |
| In what areas does the person report needing help? | |

Condition [If "No" to any item, stop. This person does not meet the criteria to be added to the Waiting List for Home and Community-Based Services.]

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| Does this person have a condition that is attributable to a mental or physical impairment or combination of mental and physical impairments, other than an impairment caused solely by mental illness? | Yes or No |
| Was the condition present before age 22? | Yes or No |
| Is the condition likely to continue indefinitely? | Yes or No |

Current Living Arrangements [Check one.]

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| <input type="checkbox"/> Lives alone <input type="checkbox"/> Lives with family or other caregivers <input type="checkbox"/> Lives with others who are not caregivers <input type="checkbox"/> Lives in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICFIID) <input type="checkbox"/> Lives in a Nursing Facility <input type="checkbox"/> Other (describe): |
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Currently Used or Available Resources/Services

| | | | |
|--|------------------|--|------------------|
| County Board services/funding | Yes or No | Medicaid State Plan Private Duty Nursing | Yes or No |
| Help Me Grow/Ohio Early Intervention | Yes or No | Ohio Home Care Waiver | Yes or No |
| Bureau for Children with Medical Handicaps | Yes or No | PASSPORT Waiver | Yes or No |
| Family and Children First Council | Yes or No | Assisted Living Waiver | Yes or No |
| Ohio Department of Education | Yes or No | MyCare Waiver | Yes or No |
| Vocational Rehabilitation/ Opportunities for Ohioans with Disabilities | Yes or No | Self-Empowered Life Funding Waiver | Yes or No |
| Children Services | Yes or No | Level One Waiver | Yes or No |
| Medicaid State Plan Home Health Aide | Yes or No | Other (describe): | Yes or No |
| Medicaid State Plan Home Health Nursing | Yes or No | | |

Questionnaire

1 a. Is the individual an adult facing substantial risk of harm due to potential loss of existing caregiver(s) due to caregiver's declining or chronic condition or due to other unforeseen circumstances?

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| <p>(i) Is there evidence that the primary caregiver has a declining or chronic condition or is facing other unforeseen circumstances that will limit his or her ability to care for the individual? [Mark "Yes" if evidence is provided for 1a(i)(a).]</p> <p style="text-align: center;">Yes or No</p> |
| <p>(a) List documentation used to verify presence of declining or chronic condition or unforeseen circumstances.</p> <p>(b) Is action required within the next 30 days due to the caregiver's inability to care for the individual?</p> <p style="text-align: center;">Yes or No</p> <p>Describe required action:</p> <p>[If "Yes" to 1a(i) and 1a(i)(b), the individual has an immediate need. Proceed to Question 2.] [If "Yes" to 1a(i) and "No" to 1a(i)(b), this is a current need area. Proceed to next question.]</p> |

(ii) Is there evidence of declining skills the individual has experienced as a result of either the caregiver's condition or insufficient caregivers to meet the individual's current needs?

Yes or No

(a) List documentation used to verify presence of caregiver's condition, if not already described above.

(b) Describe decline. **[Required field.]**

[If "Yes" to 1a(ii), this is a current need area. Proceed to next question.]

1 b. Does the individual have behavioral, physical care, and/or medical needs that create substantial risk of harm to self/others?

(i) Is the individual a child/adult currently engaging in a pattern of behavior that creates a substantial risk to self/others? **[Mark "Yes" if 1b(i)(a) and 1b(i)(b) are completed.]**

Yes or No

(a) Check all that apply:

- Not applicable; there is currently no pattern of behavior that creates a substantial risk.
- Elopement
- Fire Setting
- Physical Aggression
- Self Injury
- Sexual Offending
- Other

* Describe type, frequency, and intensity of behavioral needs:
[Required if item in 1b(i)(a) is selected.]

(b) Documentation available: **[Only one option is required.]**

- Not applicable; there is currently no pattern of behavior that creates a substantial risk.
- Behavior Tracking Sheets
- Incident Reports
- Police Reports
- Psychological Assessment
- Other (describe):

[Proceed to next question.]

(ii) Is the individual a child/adult with significant physical care needs?

[Mark "Yes" if any one item in 1b(ii)(a) is selected.]

Yes or No

(a) Check all that apply:

- Not applicable; there are no significant physical care needs.
- Frequent hands-on support required with activities of daily living (personal care, mobility/positioning, toileting, etc.) throughout the day and night
- Size/condition of the individual creates a risk of injury during physical care
- Other

* Describe type, frequency, and intensity of physical care needs:
[Required if item in 1b(ii)(a) is selected.]

[Proceed to next question.]

(iii) Is the individual a child/adult with significant or life-threatening medical needs?

[Mark "Yes" if any one item in 1b(iii)(a) is selected.]

Yes or No

(a) Check all that apply:

- Not applicable; there are no significant or life-threatening medical needs.
- Frequent hospitalizations or emergency room visits for life-sustaining treatment

- Ongoing medical care provided by caregivers to prevent hospitalization or emergency room intervention
- Need for specialized training of caregiver to prevent emergency medical intervention
- Other

* Describe type, frequency, and intensity of medical needs:
[Required if item in 1b(iii)(a) is selected.]

[Proceed to next question.]

(iv) Is action required within the next 30 days to reduce the risk presented by the behavioral, physical care, and/or medical needs identified in 1b(i), 1b(ii), and/or 1b(iii)?

Yes or No

[If "Yes," the individual has an immediate need. Proceed to question 2.]

(v) If "No," do the significant behavioral, physical care, and/or medical needs identified above require continuous support to reduce risk?

Yes or No

[If "Yes," this is a current need area. Proceed to next question.]

1 c. Is the individual an adult who has been subjected to abuse, neglect, or exploitation and requires supports to reduce risk? [Mark "Yes" if response to 1c(i) and 1c(ii) is "Yes."]

Yes or No

(i) There is currently an open investigation with: **[Check all that apply.]**

- Not applicable; there is currently no open investigation.
- Adult Protective Services
- County Board
- Law Enforcement
- Other (describe):

* Describe incident under investigation and supports needed to reduce the risk.
[Required if item in 1c(i) is selected.]

(ii) Is action required within the next 30 days to reduce the risk?

Yes or No

[If "Yes" to 1c, the individual has an immediate need. Proceed to question 2.]

[If "No" to 1c, proceed to next question.]

1 d. Is the individual a resident of an ICFIID or Nursing Facility who has either been issued a 30-day notice of intent to discharge or received an adverse Resident Review determination?
[Mark "Yes" if response to 1d(i), 1d(ii), and 1d(iii) is "Yes."]

Yes or No

(i) Is the individual currently a resident of an ICFIID or Nursing Facility?

Yes or No

(ii) Has the individual been issued a 30-day notice of intent to discharge or received an adverse Resident Review determination?

Yes or No

(iii) Is action required within the next 30 days to reduce the risk?

Yes or No

[If "Yes" to 1d, the individual has an immediate need. Proceed to question 2.]

[If "No" to 1d, proceed to next question.]

1 e. Does the individual have an ongoing need for limited/intermittent supports to address behavioral, physical, or medical needs in order to sustain existing caregivers and remain in the current living environment with existing supports? [Mark "Yes" if response to all three questions below is "Yes."]

Yes or No

(i) Does the individual have a need for limited or intermittent supports within the next 12 months?

Yes or No

(ii) Does the individual desire to remain in the current living environment?

Yes or No

(iii) Are existing caregivers willing AND able to continue to provide supports, if some relief were provided?

Yes or No

[If "Yes" to 1e, this is a current need area. Proceed to next question.]

1 f. Is the individual reaching the age of majority and being released from the custody of a child protection agency within the next 12 months and has needs that cannot be addressed through alternative services? [Mark "Yes" if response to 1f(i) and 1f(ii) is "Yes."]

Yes or No

(i) Is the individual being released from the custody of a child protection agency within the next 12 months?

Yes or No

If "Yes," indicate anticipated date:

(ii) Does the individual have needs that cannot be addressed through alternative services?

Yes or No

[If "Yes" to 1f, this is a current need area. Proceed to next question.]

1 g. Does the individual require waiver funding for adult day or employment-related supports? [Mark "Yes" if response to all three questions below is "Yes."]

Yes or No

(i) Are the needed services required at a level or frequency that exceeds what is able to be sustained through local County Board resources?

Yes or No

(ii) Are the needed services beyond what is available to the individual through the local school district/Individuals with Disabilities Education Act?

Yes or No

(iii) Are the needed services beyond what is available to the individual through Vocational Rehabilitation/Opportunities for Ohioans with Disabilities or other resources?

Yes or No

[If "Yes" to 1g, this is a current need area. Proceed to next question.]

1 h. Does the individual have a viable discharge plan from the current facility in which he/she resides? [Mark "Yes" if response to all three questions below is "Yes."]

Yes or No

(i) Is the individual currently a resident of an ICFIID or a Nursing Facility?

Yes or No

(ii) Has the individual/guardian expressed an interest in moving to a community-based setting within the next 12 months?

Yes or No

(iii) Is the individual's team developing a discharge plan that addresses barriers to community living, such as housing and availability of providers?

Yes or No

[If "Yes" to 1h, this is a current need area. Proceed to next question.]

2. Is there an immediate need identified that requires an action plan within 30 days to reduce the risk? If "Yes" to any of the following, an immediate need has been identified:

- 1a(i) + 1a(i)(b)
 - 1b(i), 1b(ii), and/or 1b(iii) + 1b(iv)
 - 1c
- or**
- 1d

Yes or No

If "Yes," describe the area of immediate need: **[Required if "Yes."]**

[If "Yes" to 2, proceed to question 4.]

[If "No" to 2, proceed to next question.]

3 a. If "No" to 2, does the individual have a need identified in:

- 1a(i)
 - 1a(ii)
 - 1b(i), 1b(ii), and/or 1b(iii) + 1b(v)
 - 1e
 - 1f
 - 1g
- or
- 1h?

["Yes" is required if any of the criteria listed is "Yes."]

Yes or No

3 b. If "Yes" to 3a, will any of those needs be unmet by existing supports/resources within the next 12 months? ["Yes" or "No" is required if 3a is "Yes."]

Yes or No

If "Yes," describe the unmet need: **[Required if "Yes."]**

4. Will the unmet immediate need or unmet current need require enrollment in a waiver due to the lack of community-based alternative services to address the need?

["Yes" or "No" is required.]

Yes or No

If "No," describe the community-based alternative services that can address the unmet need:
[Required if "No."]

Conclusion [Check one.]

- The individual has unmet needs that require enrollment in a waiver at this time to address circumstances presenting an immediate risk of harm.
- **Requires ALL of the following:**
 - "Yes" to all three condition questions
 - "Yes" to question 2
 - "Yes" to question 4
- The individual has needs that are likely to require waiver-funded supports within the next 12 months and will be placed on the Waiting List for Home and Community-Based Services at this time.
- **Requires ALL of the following:**
 - "Yes" to all three condition questions
 - "Yes" to question 3a
 - "Yes" to question 3b
 - "Yes" to question 4
- The individual does not require waiver enrollment or placement on the Waiting List for Home and Community-Based Services as alternative services are available to meet assessed needs.
- **This is the outcome if one of the other two outcomes above are not met. Requires the following:**
 - "No" to question 4
- The individual is not eligible for waiver enrollment or placement on the Waiting List for Home and Community-Based Services, as he/she has no qualifying condition.
- **This is the outcome if one or more of the three condition questions is "No."**

Name of person determining conclusion:

Title of person determining conclusion:

Date conclusion determined: