INTELLECTUAL/ DEVELOPMENTAL DISABILITIES (I/DD) RESIDENT SCREENING SHEET

MCAR 023-080-200 through 023-080-225: To be completed ***by the operator before you accept the resident into your home*** by interviewing the resident in person, and by interviewing the resident's family, caregivers, Service Coordinator, and attending medical personnel. Upon completion of the form, and if the resident is admitted, a copy shall be given to the resident, their legal representative, and a copy shall be placed in the resident record.

☐ Initial screening ☐ Re-Admission

Date of Screening: _____ Date of Entry: _____

Resident's legal name:_____ DOB:_____
Resident's preferred name: _____

Current living situation: ☐ Group Home ☐ ACH ☐ Supported Living ☐ With family
☐ Other _____ Provider/Agency: _____
How long in current situation: _____ Why is resident leaving current living situation?
_____

Who will move the resident into the ACH?_____

Will the resident be bringing their own furniture and belongings? ☐ Yes ☐ No
Will all these items fit in the room? _____

Resident's primary contact person: _____ Relationship:_____
Phone: _____ Other people important to resident: _____
Phone numbers:_____
Important relationships with restricted or no contact orders:_____

Day Support, High School Transitional Program, Employment Program: ☐ Yes ☐ No
Agency:_____
Schedule:_____ Contact:_____

Resident history: Comments:

Does the resident have current legal restrictions?	☐ no	☐ yes	_____
Is the resident a registered sex offender?	☐ no	☐ yes	_____
Does resident have a legal guardian?	☐ no	☐ yes	_____
Does resident have a Health Care Representative?	☐ no	☐ yes	_____

Do you have a release of information signed by the resident or guardian? ☐ no ☐ yes
How many times has the resident moved in the last 5 years? _____

Current Support Needs: ☐ Significant ADL ☐ Medical ☐ Behavior ☐ Social/Community Integration ☐ Legal Issues

Medical:
Primary Care Physician: _____ Phone: _____
Specialist: _____ Phone: _____
Specialist: _____ Phone: _____
Specialist: _____ Phone: _____
Specialist: _____ Phone: _____

Receiving benefits from**:**
☐Medicare #: _____ ☐Medicaid # _____
Home health agency: _____ Phone: _____
Contact: _____Will they remain involved? ☐ Yes ☐ No
Services: _____

Funeral Plan? ☐Yes ☐No Funeral home: _____
Special medical instructions or health care directives (DNR, POLST): ☐ Yes ☐No

Consult with other sources: Remember, it is important to use all resources when evaluating a new resident.

I have consulted with the following sources in making a decision about whether or not to accept this resident into my home.

☐ **Face to face meeting with resident**. Date: _____ Where:_____

☐ **Discussion with Service Coordinator:** Date_____ & Name:_____

☐ Chart review and discussion with hospital staff (CNA,nurse, social worker, etc): Date: _____
Contacts: _____

☐ **Meeting with family member(s)**/legal representative: Date: _____
Contact:_____

☐ Individual Support Plan (ISP) form (available through the resident's Service Coordinator)
☐ Current Functional Assessment and Behavior Support Plan
☐ Referral packet (Available through the DD program)
☐ **Discussion with current provider** (If resident is in another ACH,Group Home, etc.)
☐ RN notes/history & physical form from current home, if applicable
☐ PASR II (Available from case manager for Nursing Facility residents with MH/behavior history)

Medical diagnoses: **Pay close attention to the following diagnoses which range from mild to severe and can require complex medical management: Diabetes, Heart Disease, Seizures, Traumatic Brain Injury, Dementia, PICA**
List all diagnoses:_____
_____
Other medical / physical / mental conditions:
_____

Hearing support needs: ☐ Yes ☐ No, explain: _____
Vision support needs: ☐ Yes ☐ No, explain: _____

Medications: ☐Insulin ☐Psychotropics ☐Medical marijuana ☐Controlled substances ☐PRN's
List all others: _____
_____
Current pharmacy: _____
Delivery and payment arrangements for meds: _____
Does resident self-administer any meds, treatments, or need support to master skill?
(doctor's order required) ☐ Yes ☐ No, Explain:_____
Do any tasks require delegation? ☐ Yes ☐ No Specify tasks: _____
Which RN will I contact for consultations and delegations? _____
RN who will delegate: _____
RN consultation tasks: _____
RN or Physician responsible for monitoring resident care in the home:
Name: _____ Phone: _____Frequency of visits: _____

Medical equipment /supplies
☐ Incontinence supplies – type: _____
☐ Eye glasses ☐Bedside commode ☐Cane ☐Walker ☐Wheelchair ☐Power chair ☐Oxygen
☐ Hospital bed ☐ G-tube ☐ Other:_____
Medical equipment supplier(s): _____
Delivery and payment arrangements for supplies: _____
Mobility need(s): _____

Are there Protocols in place for these identified risks: ☐Aspiration ☐Dehydration ☐Seizure
☐ Constipation ☐Diabetes ☐Other _____
Missing protocols: _____
Staff needed for medical supports? ☐ Yes ☐No, Please indicate: ☐ Exclusive focus ☐1:1 ☐2:1
Staff needed for ADL care? ☐Yes ☐No, please indicate: ☐ Exclusive focus ☐1:1 ☐2:1

Does the resident have any allergies? ☐Yes ☐No, If yes, what is the resident allergic to?
_____

Behavior Supports: Demonstrated risk supported within the last 5 years
Existing Behavior Support Plan: ☐Yes ☐No Protective Personal Intervention (PPI): ☐Yes ☐No
1:1 Hours for Behavior Supports: _____hrs 2:1 Hours for Behavior Supports: _____hrs
Supervision Requirement: (hearing or visual; hearing and visual, redirecting, independent)
explain :_____

Summary of any At-Risk Behaviors:
_____
_____

Receptive Communication Style: _____
Expressive Communication Style: _____
Speaks English: ☐Yes ☐No Primary language: _____

Night needs: ☐ Wanders ☐ Cueing ☐ Restroom assistance ☐ Medication ☐ Repositioning
☐ Behavioral ☐Other:_____
Awake Staff needed? Yes ☐No, explain: _____

Transportation needs: ☐ Public transit ☐ Family ☐ Medical transport ☐ Tri-Met Lift
Vehicle safety issues: _____
Who will be responsible for setting up transportation? _____

Financial: ☐Representative Payee ☐Manages own finances, Weekly allotted cash on hand: $____
Contact information for Representative Payee: _____
Who will be responsible for making payment to the ACH operator? _____
Who will report any wages to Social Security? _____

Dietary Needs: ☐Diabetic ☐Low sodium ☐Lactose intolerant ☐Low sugar ☐Renal ☐Low fat
☐Vegetarian ☐Vegan ☐Gluten free ☐ Kosher ☐Halal ☐Food allergies: _____
☐Modified diet ☐ Specific food requests, explain: _____

Personal & lifestyle preferences: ☐Sleeps late ☐Stays up late ☐Early riser ☐Prefers privacy
☐Very social ☐Smoker ☐ Drinks alcohol ☐Recreational marijuana
Other:_____
_____

Personal preferences for activities: ☐Gardening ☐ Attends job ☐Arts ☐Enjoys music
☐Reads ☐Cooking/baking ☐Crafts ☐ Attends religious events ☐ Attends day program
☐Wants to be out in the community ☐Plays musical instrument /sings ☐Enjoys outings
☐Cards/board games ☐Belongs to social club ☐Other: _____
_____
Does resident have a pet to bring? ☐ Yes ☐No, Is resident able to care for the pet? ☐ Yes ☐No
Are pet vaccinations current? ☐ Yes ☐No, Who will pay for food, supplies, vet? _____
Responsibilities for pet to remain: _____

Evacuation: Can be evacuated, along with other residents, in 3 minutes or less: ☐ Yes ☐No
Evacuation needs: ☐Cueing ☐Wheelchair ☐Transfer ☐Walker Other: _____
_____

Notes:

ACHP Classification Level Worksheet for Adult Care Home Operators

Resident's Name:_____ Date: _____

Service Needs	Level 1	Level 2B	Level 2M
Assistance with ADLs ● Bathing & Hygiene ● Dressing & Grooming ● Eating ● Elimination (bladder and bowel) ● Mobility (ambulation and transfer) ● Cognition & Behavior (include communication)	☐Mostly independent but may need some assistance with 4 or fewer ADLs	☐Mostly independent but may need ***full*** assistance with less than 3 ADLs. May be full assistance in communication, cognition,	☐Full assistance in all ADLs. Requires one-on-one assist for direct feeding, constant cueing, or to prevent choking or aspiration. Includes nutritional IV or feeding tube set-up by another person*. Needs assistance through all phases, every time.*
Delegated nursing tasks	☐Not allowed in a level 1 home (ACHP is willing to consider exception requests.See page 5 for information on out of class exceptions)	☐May be allowed for routine and stable conditions	☐May be unstable or life threatening conditions. Examples of medical conditions that are serious or may be life threatening: (A) Brittle diabetes or diabetes not controlled through medical or physical interventions; (B) Significant risk of choking or aspiration; (C) Physical, intellectual, or mental limitations that render the individual totally dependent on others for access to food or fluids; (D) Mental health or alcohol or drug problems that are not responsive to treatment interventions; or (E) A terminal illness that requires hospice care.

Protocols Choking or Aspiration; Constipation; Dehydration; Seizure; Unreported pain; Injury due to falling; PICA *or Others*	☐General protocols in place that are not for complex medical conditions (life threatening or unstable)	☐General protocols in place that are not for complex medical conditions (life threatening or unstable)	☐Protocols in place for medical and life threatening conditions.
Behavioral Support Plan A Behavior Support Plan, if needed, must be implemented within 120 days of the individual's placement emphasizing the development of functional, alternative, and positive approaches to behavior intervention; uses the least intervention possible; ensures that abusive or demeaning intervention is never used; and is evaluated by an ISP team.	☐No Behavior Support Plan (BSP) that meet the definitions in 2B homes are allowed in Level 1 homes. ☐BSPs that address personal safety and socialization goals ***are*** acceptable in Level 1 homes.	☐(A) Acts or history of acts that have caused injury to self or others requiring medical treatment; (B) Use of fire or items to threaten injury to persons or damage to property; (C) Acts that cause significant damage to homes, vehicles, or other properties; or (D) Actively searching for opportunities to act out thoughts that involve harm to others. ☐Oregon Intervention System (OIS) required ☐PPI's in current BSP	☐Resident may have informal or formal behavior supports related to medical diagnosis like, Dementia or Alzheimer's. For example; disoriented, confused, sundowner syndrome

Classification:

Residents whose needs are appropriate for Level 1 homes will not need any 2B or 2M services.
*Residents whose needs are appropriate for Level 2B homes will not need any 2M service*s

Potential Resident's Classification: _____

Determination: <u>After taking everything listed above into consideration:</u>
Check the appropriate box(es):

☐ I have determined that the resident's service needs are within the classification of this adult care home and that I can meet the care needs of this resident.

☐ **Exception Request:** I have determined that the resident's needs are **outside** of the classification of this adult care home. I have submitted an exception request to ACHP with evidence that such an exception does not jeopardize the care, health, welfare or safety of any resident. This evidence indicates that all residents' needs can be met and that all occupants can be evacuated within three minutes.

☐If declining placement based on support needs, provide explanation:
_____
_____

Signature of operator: _____ Date: _____

Signature of Resident or Resident Representative acknowledging receipt of a copy of this screening.

Resident/Resident's Representative_____ Date: _____

Resident or Resident's Representative: If you disagree with the screening determination, you may request an administrative conference by contacting the Adult Care Home Program by phone at 503-988-3000, by email at advsd.adult.carehomeprogram@multco.us, or by mail at 600 NE 8th St., Suite 100, Gresham, OR 97030.