

Case Management Comprehensive Assessment

Section A: Consumer Information

Consumer

Name: (First, M.I., Last)		Medicaid State ID#	Date Of Birth:
Current Address:			
County of Residence:		County of Legal Settlement:	
Home Phone:	Work Phone:	Cell Phone:	
E-mail:			

Assessor

Name:		Title:	
Agency:			
Address:			
Phone:		E-Mail:	
Signature			Date

Type of Assessment

- Initial
 Annual
 Special
 Demographic Change Only
 Discharge

Date: _____ Reason: _____

Basis of Case Management Eligibility

- CMI MR DD BI Waiver Elderly Waiver CMH Waiver Habilitation MFP

VERIFICATION OF HCBS WAIVER CONSUMER CHOICE: *Complete this section for consumers applying for HCBS Brain Injury Waiver, Children's Mental Health Waiver, Intellectual Disability Waiver.*

Home- and Community-Based Services (HCBS)

My right to choose a Home- and Community-Based program has been explained to me. I have been advised that I may choose: (1) Home- and Community-Based Services or (2) Medical Institutional Services.

I choose: HCBS Medical Institutional Services

Signature of Consumer or Guardian or Durable Power of Attorney for Health Care		Date
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Case Management Comprehensive Assessment

Consumer Name:

Interdisciplinary team members consulted (including consumer):

Name	Title (if applicable)	Relationship to Consumer

Additional records reviewed:

Consumer Demographics

Gender: Female Male

Language:

	Yes	No
Speaks English	<input type="checkbox"/>	<input type="checkbox"/>
Understands English	<input type="checkbox"/>	<input type="checkbox"/>
Needs interpreter services	<input type="checkbox"/>	<input type="checkbox"/>
Comments:		

Monthly Income: (Please check all that apply)

Source	Amount
<input type="checkbox"/> SSI	\$
<input type="checkbox"/> SSDI	\$
<input type="checkbox"/> Employment	\$
<input type="checkbox"/> Other (specify):	\$
Comments:	

Court Involvement:

<input type="checkbox"/> Involuntary Commitment <input type="checkbox"/> Probation or Parole <input type="checkbox"/> Child in Need of Assistance (CINA) <input type="checkbox"/> Child Protection <input type="checkbox"/> Delinquency <input type="checkbox"/> Foster Care <input type="checkbox"/> Other (Identify) <input type="checkbox"/> None
Comments:

Case Management Comprehensive Assessment

Consumer Name:

Legal decision maker: (Please check all that apply)

None Guardian Attorney-in-fact Other (Specify):

Name: (First, M.I., Last)		
Address:		
Home Phone:	Work Phone:	Cell Phone:
E-mail:		

Co-Decision Maker (if applicable):

Guardian Attorney-in-fact Other (Specify):

Name: (First, M.I., Last)		
Address:		
Home Phone:	Work Phone:	Cell Phone:
E-mail:		

Financial Decision Maker: (e.g. Conservator or Attorney-in-fact) No Yes (complete below)

Name: (First, M.I., Last)		
Address:		
Home Phone:	Work Phone:	Cell Phone:
E-mail:		

Payee: No Yes (complete below)

Name: (First, M.I., Last)		
Address:		
Home Phone:	Work Phone:	Cell Phone:
E-mail:		

Emergency Contacts:

Primary Contact

Name: (First, M.I., Last)	Relationship:	
Address:		
Home Phone:	Work Phone:	Cell Phone:
E-mail:		

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Consumer Name:

Secondary Contact (if applicable):

Name: (First, M.I., Last)		Relationship:
Address:		
Home Phone:	Work Phone:	Cell Phone:
E-mail:		

Complete This Section For Adults (Age 18 and Over)

Veteran: Yes No

Marital Status:

- Never Married
- Married
- Divorced
- Legally Separated
- Widowed
- Unknown or Other – Specify

Spouse's Name:

Comments:

Complete This Section For Children (Age 17 and Under)

With whom does the child live?

(If the child currently lives in a institutional setting, please make note in the comments section below.)

What are the child's parent's names?

Parents marital status: Married Divorced Never married

If the parent's are not living together, what is the non-custodial parent's name and address?

Name:

Street:

City, State, Zip:

Parent's contact information (if different from the child's):

Home Phone:

Work Phone:

Cell Phone:

E-Mail:

Are there siblings in the home? Yes No

Are any siblings receiving waiver services? Yes No

Are there any individuals who are not supposed to have contact with the child? Yes No

If yes, specify:

Other Comments:

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Consumer Name:

Medical Information

Diagnoses:

Medical:

Diagnosis	
Name and credential of professional making diagnosis:	Date of diagnosis:
Comments:	

Mental Health (DSM-IV-TR)

Axis 1:	
Axis 2:	
Axis 3:	
Axis 4:	
Axis 5:	
Name and credential of professional making diagnosis:	Date of diagnosis:
Comments:	

Complete this section for consumers applying for or receiving HCBS Intellectual Disability Waiver.

List the most current IQ score, or if the IQ isn't listed, give the consumer's level of functioning within the range of mental retardation (mild, moderate, severe, profound):

IQ: _____ Range: _____ Date of Evaluation: _____

Complete this section for consumers applying for or receiving HCBS Brain Injury Waiver.

Diagnosis: _____ Date Injury Occurred: _____

Health Care Provider Information:

Who is your regular doctor? None

Name	Address	Phone
Date of last visit (if known):	Reason:	

Who is your regular dentist? None

Name	Address	Phone
Date of last visit (if known):	Reason:	

Are you seeing any other doctors, such as a psychiatrist, or specialists of any kind?

Yes (list below) No Don't know

Name	Specialty	Address	Phone

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Section B: Medical and Physical Health

Health Conditions

B1. Overall, how would you rate your physical health?

<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> No Response
Comments:				

B2. Do you have any health problems that require assistance to manage?

<input type="checkbox"/> Cardiac <input type="checkbox"/> Skin Related <input type="checkbox"/> G.I. Disorders <input type="checkbox"/> Urinary Tract <input type="checkbox"/> Weight problems <input type="checkbox"/> Evidence of communicable disease <input type="checkbox"/> Other – Specify <input type="checkbox"/> None	
How do they affect you and how long have you had them?	
Comments:	

B3. Any respiratory problems that require assistance to manage?

<input type="checkbox"/> Ventilator <input type="checkbox"/> Oxygen <input type="checkbox"/> Suctioning <input type="checkbox"/> Tracheotomy <input type="checkbox"/> Cardiorespiratory monitor <input type="checkbox"/> Chest physiotherapy <input type="checkbox"/> Nebulizer treatment <input type="checkbox"/> Other – Specify <input type="checkbox"/> None	
How do they affect you and how long have you had them?	
Comments:	

B4. Do you regularly receive any of the following medical treatments?

	<input type="checkbox"/> no	<input type="checkbox"/> yes	Days per week	Hours per day
Nursing	<input type="checkbox"/>	<input type="checkbox"/>		
Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>		
Occupational Therapy	<input type="checkbox"/>	<input type="checkbox"/>		
Speech Therapy	<input type="checkbox"/>	<input type="checkbox"/>		
Supervision for Safety	<input type="checkbox"/>	<input type="checkbox"/>		
Diabetes Education	<input type="checkbox"/>	<input type="checkbox"/>		
Dialysis	<input type="checkbox"/>	<input type="checkbox"/>		
Respiratory Treatment	<input type="checkbox"/>	<input type="checkbox"/>		
Catheter Care	<input type="checkbox"/>	<input type="checkbox"/>		
Colostomy Care	<input type="checkbox"/>	<input type="checkbox"/>		
Nasogastric Tube Care	<input type="checkbox"/>	<input type="checkbox"/>		
Other	<input type="checkbox"/>	<input type="checkbox"/>		

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Consumer Name:

B5. Hearing

- No hearing impairment.
- Hearing impairment, but managed through assistive devices
- Hearing difficulty at level of conversation.
- Hears only very loud sounds.
- No useful hearing.
- Not determined.

Comments:

B6. Vision

- Has no impairment of vision.
- Vision impairment, but managed through assistive devices
- Has difficulty seeing at level of print (far-sighted).
- Has difficulty seeing obstacles in environment (near-sighted).
- Has no useful vision.
- Not determined.

Comments:

B7. Speech/Communication

- Communicates independently or impairment has been compensated to function independently.
- Communicates with difficulty but can be understood.
- Communicates with sign language, symbol board, written messages, gestures or an interpreter.
- Communicates inappropriate content, makes garbled sounds, or displays echolalia.
- Does not communicate.

Comments:

B8. Sensory Perception (e.g. – taste, smell, tactile, spatial)

- No impairment
- Impaired – Specify

Comments:

B9. Cognitive Status

- Alert and fully oriented
- Alert and oriented with significant alteration on self-concept/mood
- Generally oriented through use of assistive techniques
- Cognitive deficits (e.g. orientation, attention/concentration, perception, memory, reasoning)
- Exhibits mental status changes consistent with psychiatric disorder
- Comatose, but responsive
- Comatose, but unresponsive
- Other – Specify

Comments:

B10. Musculoskeletal/Fine or Gross Motor Skills

- No Impairment of Musculoskeletal/Fine or Gross Motor Skills
- Impaired muscle tone
- Contractures
- Scoliosis
- Paralysis: Hemiplegia Paraplegia Quadriplegia Other (Specify)

Comments:

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Consumer Name:

Complete This Section For Adults (Age 18 and Over)

B11. Do you have someone who could stay with you for a while if you were sick or needed help?

Yes (Complete below) No

Name:

Relationship:

Address:

City, State, Zip code:

Phone:

B12. Is there anybody you would **not** want to be involved with your care if you were sick or needed help?

Yes (Complete below) No

Name:

Relationship:

HEALTH CONDITIONS RISK FACTORS	YES	NO
R1. Has the consumer had a seizure in the past year?	<input type="checkbox"/>	<input type="checkbox"/>
R2. Does the consumer have a diagnosis of any other serious medical conditions or other serious health concerns (i.e., diabetes, cerebral palsy, heart condition, etc.)? If yes, list all conditions/concerns:	<input type="checkbox"/>	<input type="checkbox"/>
R3. Does the consumer have any life threatening allergies (such as peanuts, bee stings, or shellfish)?	<input type="checkbox"/>	<input type="checkbox"/>
R4. Is the consumer in need of a primary health care provider (or the provider's contact information is unknown)?	<input type="checkbox"/>	<input type="checkbox"/>
R5. Is the consumer in need of a dentist (or dentist's contact information is unknown)?	<input type="checkbox"/>	<input type="checkbox"/>
R6. Is the consumer in need of a specialist (or the specialist's contact information is unknown)?	<input type="checkbox"/>	<input type="checkbox"/>
R7. Has the consumer had difficulty making, keeping, or following through with appointments in the last year?	<input type="checkbox"/>	<input type="checkbox"/>
R8. In the past year, has the consumer gone to a hospital emergency room? If yes, how many times? Why?	<input type="checkbox"/>	<input type="checkbox"/>
R9. In the past year, has the consumer stayed overnight or longer in a hospital? If yes, how many times? Why?	<input type="checkbox"/>	<input type="checkbox"/>
R10. Is the consumer in need of someone to help if he or she was sick or injured?	<input type="checkbox"/>	<input type="checkbox"/>
Comment on any risk factors marked as "Yes" and address the issue in the Crisis Intervention Plan. Comments:	No. of risks:	

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Assistive Devices/Special Equipment

B19. Do you use (or need) any of the following special equipment or aids? None

(If a consumer doesn't have an item but needs it, mark the "Needs" box)

Uses	Needs		Uses	Needs	
<input type="checkbox"/>	<input type="checkbox"/>	Dentures	<input type="checkbox"/>	<input type="checkbox"/>	Hospital bed
<input type="checkbox"/>	<input type="checkbox"/>	Cane	<input type="checkbox"/>	<input type="checkbox"/>	Medical phone alert
<input type="checkbox"/>	<input type="checkbox"/>	Walker	<input type="checkbox"/>	<input type="checkbox"/>	Supplies, e.g. Incontinence pads
<input type="checkbox"/>	<input type="checkbox"/>	Wheelchair (manual, electric)	<input type="checkbox"/>	<input type="checkbox"/>	Bedside commode
<input type="checkbox"/>	<input type="checkbox"/>	Brace (leg, back)	<input type="checkbox"/>	<input type="checkbox"/>	Bathing equipment
<input type="checkbox"/>	<input type="checkbox"/>	Helmet	<input type="checkbox"/>	<input type="checkbox"/>	Lift chair
<input type="checkbox"/>	<input type="checkbox"/>	Communication Devices	<input type="checkbox"/>	<input type="checkbox"/>	Transfer equipment
<input type="checkbox"/>	<input type="checkbox"/>	Hearing aid	<input type="checkbox"/>	<input type="checkbox"/>	Adaptive eating equipment
<input type="checkbox"/>	<input type="checkbox"/>	Glasses/contact lenses	<input type="checkbox"/>	<input type="checkbox"/>	Harness/gait belt
<input type="checkbox"/>	<input type="checkbox"/>	Weighted blankets or vest	<input type="checkbox"/>	<input type="checkbox"/>	Other (Specify):

Comments:

ASSISTIVE DEVICES RISK FACTORS	YES		NO	
	3	2	1	0
3 = Frequently 2 = Sometimes 1 = Rarely 0 = Never				
R24. Is the consumer in need of assistance with adaptive equipment (need it purchased, need training, need repairs, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R25. Would a power outage interfere with the consumer's necessary adaptive equipment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comment on any risk factors marked as "Yes" and address the issue in the Crisis Intervention Plan. Comments:	No. of risks:			

Nutrition

B20. How is your appetite?

<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor

Comments:

B21. Has there been an unexplained weight loss or weight gain in the past year?

<input type="checkbox"/> Yes (specify in comments) <input type="checkbox"/> No

Comments:

B22. Are there health concerns related to your nutrition?

<input type="checkbox"/> Yes (specify in comments) <input type="checkbox"/> No

Comments:

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B23. Do you have a diagnosed eating disorder (such as overeating, purging, hoarding food)?

- Yes (specify in comments)
 No

ASSESSOR: If no, does the consumer's behavior indicate a possible eating disorder or suggest the need for further evaluation?

- Yes (specify in comments)
 No

Comments:

B24. Do you have any problems that make it difficult to eat? Yes (complete below) No

- | | |
|--|---|
| <input type="checkbox"/> Dental problems | <input type="checkbox"/> Can't eat certain foods |
| <input type="checkbox"/> Swallowing problems | <input type="checkbox"/> Problem with gag reflex |
| <input type="checkbox"/> Texture Aversions | <input type="checkbox"/> Sensitive stomach/nausea |
| <input type="checkbox"/> Taste problems | <input type="checkbox"/> Tube feeding (some or all of the time) |
| <input type="checkbox"/> Any other eating problems? (Describe) | |

Comments:

B25. Are you on a special diet: Yes (complete below) No

- | | |
|---|--|
| <input type="checkbox"/> Low salt | <input type="checkbox"/> Calorie supplement |
| <input type="checkbox"/> Low fat | <input type="checkbox"/> Gluten Free |
| <input type="checkbox"/> Low sugar | <input type="checkbox"/> Milk/lactose free |
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Altered Consistency |
| <input type="checkbox"/> Other special diet? (Describe) | |

Comments:

NUTRITION RISK FACTORS 3 = Frequently 2 = Sometimes 1 = Rarely 0 = Never	YES		NO	
	3	2	1	0
R26. Is the consumer at risk of choking or other problems when eating?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R27. Is the consumer's health at risk due to poor nutrition (e.g.- eating disorder, refusal to eat, inability to afford nutritious food, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R28. Is the consumer (or the caretaker) ever non-compliant with the prescribed diet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R29. Would the consumer's health be at risk if his or her diet is not strictly followed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comment on any risk factors marked as "Yes" and address the issue in the Crisis Intervention Plan. Comments:	No. of risks:			

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Daily Living Skills

B26. Daily Living Skills

Activity	Independent	Supervision or Verbal Prompts/Cueing	Physical Assistance	Total Dependence	Frequency	
					Daily	Intermittent
a. Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Grooming & personal hygiene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Mobility in bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Transferring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Stair climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Mobility with wheelchair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments (note use of assistive devices or adaptive equipment needed to demonstrate skill):

B27. Toilet Use

<input type="checkbox"/> Continent – Bowel and bladder <input type="checkbox"/> Continent with verbal or physical prompts <input type="checkbox"/> Continent except for specified periods of time (e.g. enuresis) <input type="checkbox"/> Incontinent – bladder <input type="checkbox"/> Incontinent – bowel <input type="checkbox"/> Catheter or -ostomy (e.g. suprapubic catheter, colostomy, ileostomy) <input type="checkbox"/> Inappropriate toileting habits (e.g. fails to close door, use toilet paper, or wash hands, etc.)
Comments:

DAILY LIVING SKILLS RISK FACTORS	YES		NO	
	3	2	1	0
3 = Frequently 2 = Sometimes 1 = Rarely 0 = Never				
R30. Is the consumer's health at risk due to poor hygiene?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R31. Is the consumer at risk for falling? In the past year has the consumer fractured a bone? If yes, how did this occur?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R32. Is the consumer at risk of being dropped or injured during transfer?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comment on any risk factors marked as "Yes" and address the issue in the Crisis Intervention Plan. Comments:	No. of risks:			

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Consumer Needs, Wants, and Desired Results Related to Medical and Physical Health
<p>What are your strengths and abilities related to your medical and physical health?</p> <p><i>ASSESSOR:</i> List any other strengths and abilities not mentioned by the consumer or guardian:</p> <p>Do you have any other needs related to your medical and physical health that haven't been addressed above?</p> <p><i>ASSESSOR:</i> List any other needs related to medical and physical health not mentioned by the consumer or guardian.</p> <p>Do you have any wants related to your medical and physical health?</p> <p>What are your desired results related to your medical and physical health?</p>

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Section C: Mental Health, Behavioral & Substance Use

Emotional and Mental Health

C1. Have you ever been diagnosed with a mental illness?

<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what is it?

C2. Have you received mental health services in the past?

<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, describe:

C3. Are you currently receiving any mental health services or counseling?

<input type="checkbox"/> Yes (If yes, complete below) <input type="checkbox"/> No	
Provider Name and Address	Comments

C4. Emotional Assessment. How have you been feeling during the past month?

	Yes	No
Are you satisfied with your life today?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been depressed or very unhappy?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been feeling like you have too much energy or can't stop being busy?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been anxious?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had mood swings?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had difficulty sleeping?	<input type="checkbox"/>	<input type="checkbox"/>
Have you felt unmotivated or felt a lack of energy?	<input type="checkbox"/>	<input type="checkbox"/>
Have you felt lonely or isolated?	<input type="checkbox"/>	<input type="checkbox"/>
Comments:		

C5. ASSESSOR: Other mental health symptoms.

	Yes	No
Has the consumer had hallucinations (seen or heard things that weren't really there)?	<input type="checkbox"/>	<input type="checkbox"/>
Has the consumer reported feelings of paranoia?	<input type="checkbox"/>	<input type="checkbox"/>
Has the consumer had delusions (irrational thoughts that weren't true)?	<input type="checkbox"/>	<input type="checkbox"/>
Comments:		

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Complete This Section For Children (Age 17 and Under)

C6. Has the child experienced difficulty in interpersonal relationships within the family?

Yes No

Comments:

C7. Does the parent/guardian exhibit mental health related concerns?

Yes No

If yes, is he/she currently receiving treatment and following through with treatment?

Yes No

Comments:

Behavioral

C8. ASSESSOR: Behavioral Assessment.

Behavioral Issue	Does not exhibit	Has been modified to socially acceptable levels	May require verbal or physical intervention
Has episodes of disorientation, being withdrawn, or similar behaviors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Noncompliance with rules or directions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physically abusive to self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Verbally aggressive toward others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physically aggressive toward others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exhibits disruptive behavior (e.g. arguing, shouting, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exhibits destructive behavior (e.g. destroying property, burning, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exhibits stereotypical, repetitive behavior (e.g. rocking, twirling fingers or objects, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obsessive/compulsive behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antisocial behavior (e.g. lying, stealing, inappropriate touching, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wanders into private areas, or habitually elopes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acts in a sexually inappropriate or aggressive manner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Engages in excessive liquid consumption	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:			

Alcohol/Tobacco/Substance Use

C9. Do you drink any alcoholic beverages?

Yes

No

If yes, on average, counting beer, wine, and other alcoholic beverages, how many drinks do you have each day?

Comments:

C10. Do you smoke or use tobacco?

Yes

No

If yes, how much and how often? (*frequency per day*)

Comments:

C11. Has tobacco use caused you any problems?

Yes

No

If yes, please describe:

Comments:

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C12. Do you use any other illegal substances such as marijuana, cocaine, or amphetamines?

<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, specify:
Comments:

C13. Are the people who are involved in your life (spouse, parents/guardian, friends, etc.) concerned about your alcohol/tobacco/substance use?

<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, explain:
Comments:

C14. Do you live with or spend time with a person that has alcohol/substance abuse concerns, including misuse of prescription medication? (For children, this includes the parent/guardian)

<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, specify:
Comments:

C15. ASSESSOR: Does the person need education about substance use/abuse?

<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please describe:
Comments:

C16. ASSESSOR: Are you concerned about the person's alcohol/tobacco/substance use?

<input type="checkbox"/> Yes <input type="checkbox"/> No
Comments:

MENTAL HEALTH/BEHAVIORAL/SUBSTANCE USE RISK FACTORS <small>3 = Within the last 6 months 2 = Within the last year 1 = more than 1 year ago 0 = Never</small>	YES		NO	
	3	2	1	0
R33. Has the consumer ingested foreign objects or been diagnosed with PICA?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R34. Has alcohol use caused the consumer any problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R35. Has substance use caused the consumer any problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R36. Has the consumer engaged in self-injurious behaviors?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R37. Has the consumer left or attempted to leave home or other supervised activities without permission, or when it would be unsafe to do so?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R38. Has the consumer been aggressive toward others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R39. Has the consumer used weapons or objects to hurt self or others? <i>(If 3 or 2, assure that referral has been made to a qualified mental health professional)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R40. Has the consumer threatened suicide or made suicidal gestures? <i>(If 3 or 2, assure that referral has been made to a qualified mental health professional)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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MENTAL HEALTH/BEHAVIORAL/SUBSTANCE USE RISK FACTORS <small>3 = Within the last 6 months 2 = Within the last year 1 = more than 1 year ago 0 = Never</small>	YES		NO	
	3	2	1	0
R41. Has the consumer attempted suicide? <i>(If 3 or 2, assure that referral has been made to a qualified mental health professional)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R42. Has the consumer engaged in criminal behavior?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R43. Has the consumer had a significant life change or event occur?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R44. Does the consumer have a history of other life-threatening behaviors? Specify:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comment on any risk factors marked as "Yes" and address the issue in the Crisis Intervention Plan. Comments:	No. of risks:			

C17. **ASSESSOR:** In your opinion would this person benefit from a:

<input type="checkbox"/> Mental health referral
<input type="checkbox"/> Mental health evaluation
<input type="checkbox"/> Substance abuse referral
<input type="checkbox"/> Substance abuse evaluation
<input type="checkbox"/> Referral for a behavioral assessment
<input type="checkbox"/> Other (specify):
<input type="checkbox"/> None
Comments:

Consumer Needs, Wants, and Desired Results Related to Mental Health, Behavior, or Substance Abuse
What are your strengths and abilities related to mental health, behavior, or substance abuse? ASSESSOR: List any other strengths and abilities not mentioned by the consumer or guardian: Do you have any other needs related to mental health, behavior, or substance abuse that haven't been addressed above? ASSESSOR: List any other needs related to mental health, behavior, or substance abuse not mentioned by the consumer or guardian. Do you have any wants related to mental health, behavior, or substance abuse? What are your desired results related to mental health, behavior, or substance abuse?

Case Management Comprehensive Assessment

Section D: Housing and Environment

D1. What is your current housing type?

- Own Home (includes parent/guardian's home for children)
- Friend/Relative Home
- Foster Care
- RB-SCL
- RCF
- RCF-PMI
- RCF-MR
- ICF-MR
- ICF/Nursing Facility
- MHI
- Skilled Nursing Facility
- Homeless
- Jail
- Other (specify):

Comments:

D2. What is your current living arrangement?

- Living Alone
- Living with Family/Friend
- Living with Spouse/Significant Other
- Living with Parents
- Living in Congregate Setting
- Other (specify):

Comments:

D3. Would you like to continue to live where you do now, or is there somewhere else you would prefer to live?

- Continue to live here
- Don't know
- Prefer to live elsewhere (Specify and briefly describe the barriers, if any:)

Comments:

D4. Is there someone who regularly helps you care for your home or yourself, or who regularly helps with errands or other things? (For children, do NOT include the parent/guardian, but do include others who assist the parent/guardian.)

- Yes
- No

If yes, how often?

Caregiver's Name:

D5. Do you have any home modifications? Check all that apply:

- | | |
|---|--|
| <input type="checkbox"/> Safe Room | <input type="checkbox"/> Shatter Proof Windows |
| <input type="checkbox"/> Door/Window Alarms | <input type="checkbox"/> Fenced yard |
| <input type="checkbox"/> Wheelchair Ramp | <input type="checkbox"/> None |
| <input type="checkbox"/> Other (specify): | |

Are any home modifications needed?

- Yes (specify):
- No

Case Management Comprehensive Assessment

Consumer Name:

Complete This Section For Children (Age 17 and Under)

(If the child is currently living in a institutional setting, skip questions D6 through D9 and not the living situation in the comment section below.)

D6. Does the family with whom the child is residing have a stable housing situation? Yes No
If not, does the family need assistance in identifying additional resources?

D7. Does the parent/guardian have a physical disability that impairs his/her ability to meet the child's needs? Yes No
If yes, what have the parents done to ensure the child's needs are being met consistently?

D8. Does the family have adequate financial resources? Yes No
If not, does the family need assistance in identifying additional resources?

D9. Does the child have his or her own money? Yes No
Where does it come from?

Other Comments:

Independent Living Skills

D10. How well can you prepare meals for yourself? (Meals may include sandwiches, pre-cooked meals and TV dinners.)

- Need no help or supervision
- Need some help or occasional supervision
- Need a lot of help or constant supervision
- Can't do it at all

Comments:

D11. Do you know your telephone number?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
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D12. Do you know your address?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
------------------------------	-----------------------------	------------------------------

D13. ASSESSOR: Can this consumer be left without supervision?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
------------------------------	-----------------------------	------------------------------

If yes, for how long?

D14. How well are you able to answer the telephone?

- Need no help or supervision
- Need some help or occasional supervision
- Need a lot of help or constant supervision
- Can't do it at all

Comments:

D15. How well are you able to make a telephone call?

- Need no help or supervision
- Need some help or occasional supervision
- Need a lot of help or constant supervision
- Can't do it at all

Comments:

Case Management Comprehensive Assessment

Consumer Name:

D16. How well can you handle your own money? (understands use of money, can pay for things, can pay bills, can balance the checkbook, etc. as appropriate for age)

- Need no help or supervision
- Need some help or occasional supervision
- Need a lot of help or constant supervision
- Can't do it at all

Comments:

D17. How well can you manage shopping for food and other things you need?

- Need no help or supervision
- Need some help or occasional supervision
- Need a lot of help or constant supervision
- Can't do it at all

Comments:

Complete This Section For Adults (Age 18 and Over)

D18. How well can you manage to do light housekeeping, like dusting or sweeping?

- Need no help or supervision
- Need some help or occasional supervision
- Need a lot of help or constant supervision
- Can't do it at all

Comments:

D19. How well can you do heavy housekeeping, like yard work, or emptying the garbage?

- Need no help or supervision
- Need some help or occasional supervision
- Need a lot of help or constant supervision
- Can't do it at all

Comments:

D20. How well can you do your own laundry, including putting clothes in the washer or dryer, starting and stopping the machine, and drying the clothes?

- Need no help or supervision
- Need some help or occasional supervision
- Need a lot of help or constant supervision
- Can't do it at all

Comments:

D21. *ASSESSOR*: Does the consumer have deficits that pose a threat to his/her ability to live in the community?

- Yes
- No
- Unsure

Case Management Comprehensive Assessment

Consumer Name: _____

Complete This Section For Children (Age 17 and Under)

D22. Does the child do chores? Yes No
If yes, what are they?

How independent is the child in completing chores?

- Need no help or supervision
- Need some help or occasional supervision
- Need a lot of help or constant supervision
- Can't do it at all

Comments:

HOUSING AND ENVIRONMENTAL SAFETY RISK FACTORS	Yes	No		
R45. Would this consumer's health be at risk if a paid provider or natural support person did not show up to provide scheduled services?	<input type="checkbox"/>	<input type="checkbox"/>		
R46. Is the consumer at risk at home because of any of these conditions:				
structural damage	<input type="checkbox"/>	<input type="checkbox"/>		
barriers to accessibility (steps, etc.)	<input type="checkbox"/>	<input type="checkbox"/>		
electrical hazards	<input type="checkbox"/>	<input type="checkbox"/>		
signs of careless smoking	<input type="checkbox"/>	<input type="checkbox"/>		
insects or pests	<input type="checkbox"/>	<input type="checkbox"/>		
poor lighting	<input type="checkbox"/>	<input type="checkbox"/>		
insufficient water or no hot water	<input type="checkbox"/>	<input type="checkbox"/>		
insufficient heat	<input type="checkbox"/>	<input type="checkbox"/>		
fire hazards	<input type="checkbox"/>	<input type="checkbox"/>		
tripping hazards	<input type="checkbox"/>	<input type="checkbox"/>		
unsanitary conditions	<input type="checkbox"/>	<input type="checkbox"/>		
R47. Does the consumer need to be supervised at all times?	<input type="checkbox"/>	<input type="checkbox"/>		
R48. Is the consumer without means of communication (no phone or PERS)?	<input type="checkbox"/>	<input type="checkbox"/>		
For the following items use: 3 = Frequently 2 = Sometimes 1 = Rarely 0 = Never				
R49. Is the consumer unable to respond to emergencies independently? If consumer is never left alone, mark not applicable: <input type="checkbox"/> N/A	3	2	1	0
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R50. Is the consumer physically stronger than any of his/her caregivers?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R51. Does the consumer lack awareness of dangerous/emergency situations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R52. Does the consumer put him/herself in danger due to careless or risky behaviors (careless smoking, leaving doors unlocked, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R53. Is the consumer isolated (lack of transportation, lack of social network)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R54. Is the consumer's neighborhood unsafe (high risk of crime, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R55. Is the consumer at risk in the community due to unsafe behaviors?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comment on any risk factors marked as "Yes" and address the issue in the Crisis Intervention Plan. Comments:	No. of risks:			

Case Management Comprehensive Assessment

Consumer Name:

Abuse/Neglect

D23. *ASSESSOR*: Does the consumer have a history of incidents that have resulted in injury or threat of injury in the past year?
(Consult incident reports as necessary)

<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, are the causes of the incidents covered in the Crisis Intervention Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No (specify why not):

ABUSE/NEGLECT RISK FACTORS	YES		NO	
	3	2	1	0
3 = Within the last 6 months 2 = Within the last year 1 = more than 1 year ago 0 = Never				
R56. Has the consumer been physically abused?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R57. Has the consumer been sexually abused?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R58. Has the consumer been emotionally or psychologically abused?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R59. Is there evidence of neglect to the consumer by a caregiver?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R60. Is there evidence of neglect by the consumer (self neglect)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R61. Has the consumer been denied basic necessities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R62. Has the consumer witnessed abuse or neglect of another person, including domestic violence?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R63. Would the consumer be an "easy target"?	<input type="checkbox"/>		<input type="checkbox"/>	
Comment on any risk factors marked as "Yes" and address the issue in the Crisis Intervention Plan. Comments:	No. of risks:			

Consumer Needs, Wants, and Desired Results Related to Housing and Environment
<p>What are your strengths and abilities related to your housing and environment?</p> <p><i>ASSESSOR</i>: List any other strengths and abilities not mentioned by the consumer or guardian:</p> <p>Do you have any other needs related to your housing and environment that haven't been addressed above?</p> <p><i>ASSESSOR</i>: List any other needs related to housing and environment not mentioned by the consumer or guardian.</p> <p>Do you have any wants related to your housing and environment?</p> <p>What are your desired results related to your housing and environment?</p>

Case Management Comprehensive Assessment

Section E: Social

E1. Do you feel you need help with social skills?

- Yes
 No

Comments:

E2. What is a typical day like for you? (or ask: What do you usually do, starting from the morning?)

What, if anything, would you change about your typical day?

Comments:

E3. What activities or things do you enjoy doing?

Are there activities you enjoy that you would like to do more frequently?

- Yes
 No

If yes, what are they?

Is anything needed to support or help you to do these activities?

- Yes
 No

If yes, what?

Comments:

E4. If you choose to practice a religion, are able to attend as often as desired?

- Yes (Specify where):
 No
 N/A

Comments:

E5. ASSESSOR: Does the consumer have knowledge or self-concept of his or her own sexuality appropriate to age level?

- Yes
 No

Comments:

E6. Do you communicate with friends, relatives, or others (not including paid helpers) as often as you would want?

- Yes
 No

By what means (phone, email, etc)? How Often?

Comments:

Case Management Comprehensive Assessment

Consumer Name:

Complete This Section For Adults (Age 18 and Over)

E7. Do you spend time with others who do not live with you as often as you would want?

Yes No

Comments:

E8. Do you have someone to confide in when you have a problem?

Yes No

If yes, specify name and relationship:

Complete This Section For Children (Age 17 and Under)

E9. Who are your friends?

E10. What do you like to do with them?

E11. Where do you see your friends?

E12. Do you and your parents agree on your choice of friends?

Yes No

If no, why not?

Consumer Needs, Wants, and Desired Results Related to Social Functioning

What are your strengths and abilities related to your social functioning?

ASSESSOR: List any other strengths and abilities not mentioned by the consumer or guardian:

Do you have any other needs related to your social functioning that haven't been addressed above?

ASSESSOR: List any other needs related to social functioning not mentioned by the consumer or guardian.

Do you have any wants related to your social functioning?

What are your desired results related to your social functioning?

Case Management Comprehensive Assessment

Section F: Transportation

F1. Do you need help with transportation?

- Yes
 No

If yes, when and where:

F2. How do you get to the places you want to go? (Check all that apply).

- Walk
 Bicycle
 Drive
 Take a bus or taxi
 Friend or family member drives
 Staff/Provider
 Other:

Comments:

F3. How well are you able to use public transportation or drive to places beyond walking distance?

- Need no help or supervision
 Need some help or occasional supervision
 Need a lot of help or constant supervision
 Not Available
 Can't do it at all

Comments:

F4. Are there any vehicle modifications needed?

- Yes
 No

If yes, specify:

Comments:

Consumer Needs, Wants, and Desired Results Related to Transportation

What are your strengths and abilities related to transportation?

ASSESSOR: List any other strengths and abilities not mentioned by the consumer or guardian:

Do you have any other needs related to transportation that haven't been addressed above?

ASSESSOR: List any other needs related to transportation not mentioned by the consumer or guardian.

Do you have any wants related to transportation?

What are your desired results related to transportation?

Case Management Comprehensive Assessment

Section G: Education

G1. Are you currently in school?

<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify where: If no, and the consumer is a child, why not?
Comments:

G2. If in school, are you involved in any extra-curricular activities?

<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A If yes, specify:
Comments:

G3. ASSESSOR: Is the consumer able to:

	Yes	No	Comments
Read?	<input type="checkbox"/>	<input type="checkbox"/>	
Write?	<input type="checkbox"/>	<input type="checkbox"/>	
Sign his/her name?	<input type="checkbox"/>	<input type="checkbox"/>	

G4. Are you interested in furthering your education?

<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what area do you want to further your education in?
Comments:

G5. Do you need assistance or support in gaining access to educational services?

<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify what type of assistance is needed:
Comments:

G6. ASSESSOR: Does the consumer have any intellectual or cognitive difficulties?

<input type="checkbox"/> No intellectual problems
<input type="checkbox"/> Has difficulties but is able to function with minimal assistance or adaptive devices
<input type="checkbox"/> Has intellectual problems requiring verbal or physical assistance (check all that apply): <ul style="list-style-type: none"> <input type="checkbox"/> Difficulty with or unable to tell time <input type="checkbox"/> Does not know survival words or signs <input type="checkbox"/> Problems with reading <input type="checkbox"/> Problems with writing <input type="checkbox"/> Difficulty with number skills <input type="checkbox"/> Difficulty with reasoning and problem solving <input type="checkbox"/> Memory problems <input type="checkbox"/> Other – specify

Case Management Comprehensive Assessment

Consumer Name:

Complete This Section For Adults (Age 18 and Over)

G7. What is the highest level of education you have completed?

- | | |
|--|---|
| <input type="checkbox"/> Less than High School | <input type="checkbox"/> Trade School |
| <input type="checkbox"/> Some High School | <input type="checkbox"/> Some College |
| <input type="checkbox"/> GED | <input type="checkbox"/> College Graduate |
| <input type="checkbox"/> Graduated Special Education | <input type="checkbox"/> Graduate Degree |
| <input type="checkbox"/> High School Graduate | <input type="checkbox"/> Unknown |

Comments:

Complete This Section For Children (Age 17 and Under)

G8. What grade are you in? N/A

G9. Do you like school?

- Yes
 No
 N/A

If no, why not?

G10. *ASSESSOR*: Is the child following the school's attendance policy?

- Yes
 No
 N/A

If no, what are the circumstances?

G11. *ASSESSOR*: Does the child have a Special Education Plan?

- Yes (specify): IEP 504 Plan
 No
 N/A

G12. *ASSESSOR*: Is there an aide or mentor assigned to the child?

- Yes
 No
 N/A

G13. *ASSESSOR*: Is the child on target to graduate with his or her class?

- Yes
 No
 N/A

Case Management Comprehensive Assessment

Consumer Name:

Consumer Needs, Wants, and Desired Results Related to Education
<p>What are your strengths and abilities related to education?</p> <p><i>ASSESSOR:</i> List any other strengths and abilities not mentioned by the consumer or guardian:</p> <p>Do you have any other needs related to education that haven't been addressed above?</p> <p><i>ASSESSOR:</i> List any other needs related to education not mentioned by the consumer or guardian.</p> <p>Do you have any wants related to education?</p> <p>What are your desired results related to education?</p>

Case Management Comprehensive Assessment

Section H: Vocational

Complete this section for consumers age 14 or older.

H1. Do you work?

- Yes
- No
- N/A

Comments:

Questions for consumers who are currently working:

H2. What is your current work setting?

	Where Employed:
<input type="checkbox"/> Competitive employment: full-time	
<input type="checkbox"/> Competitive employment: part-time	
<input type="checkbox"/> Supported Employment	
<input type="checkbox"/> Enclave	
<input type="checkbox"/> Sheltered work	

If competitively employed, do you use natural supports in the work environment? Yes No

Comments:

H3. Are you happy in your current job?

- Yes
- No

If no, what job would you like to do?

Why does this job appeal to you?

Comments:

Questions for consumers who are not currently working:

H4. Are you able to work in the community?

- Yes
- No

Comments:

H5. Do you want to work in the community?

- Yes
- No

If yes what job would you like to do?

Why does this job appeal to you?

Comments:

Case Management Comprehensive Assessment

Consumer Name:

Question for consumers who are working, or who are not working but are willing and able to work:

H6. Do you need help in any of the following areas?

	Yes	No
Looking for and obtaining a job	<input type="checkbox"/>	<input type="checkbox"/>
Job interviewing	<input type="checkbox"/>	<input type="checkbox"/>
Attending work as scheduled	<input type="checkbox"/>	<input type="checkbox"/>
Arriving to work on time and returning to work after lunch and breaks	<input type="checkbox"/>	<input type="checkbox"/>
Being appropriately dressed and groomed for work	<input type="checkbox"/>	<input type="checkbox"/>
Accepting work assignments and completing them according to instructions	<input type="checkbox"/>	<input type="checkbox"/>
Independently initiating work	<input type="checkbox"/>	<input type="checkbox"/>
Attending to work tasks without distraction	<input type="checkbox"/>	<input type="checkbox"/>
Following written directions	<input type="checkbox"/>	<input type="checkbox"/>
Performing a 1-step task	<input type="checkbox"/>	<input type="checkbox"/>
Performing a 2-3 step task	<input type="checkbox"/>	<input type="checkbox"/>
Communicating wants or needs	<input type="checkbox"/>	<input type="checkbox"/>
Timely informing employer when going to miss work	<input type="checkbox"/>	<input type="checkbox"/>
Accepting changes in schedule or routine	<input type="checkbox"/>	<input type="checkbox"/>
Getting along with co-workers	<input type="checkbox"/>	<input type="checkbox"/>
Other, including any barriers to obtaining employment:		
Comments:		

Consumer Needs, Wants, and Desired Results Related to Vocational Functioning
<p>What are your strengths and abilities related to your vocational functioning?</p> <p><i>ASSESSOR:</i> List any other strengths and abilities not mentioned by the consumer or guardian:</p> <p>Do you have any other needs related to your vocational functioning that haven't been addressed above?</p> <p><i>ASSESSOR:</i> List any other needs related to vocational functioning not mentioned by the consumer or guardian.</p> <p>Do you have any wants related to your vocational functioning?</p> <p>What are your desired results related to your vocational functioning?</p>