

# Risk Management Assessment and Plan (1.0)

This paper copy is for illustrative purposes only. The Risk Management and Assessment Plan (RMAP) must be completed in Therap. This paper copy does not replace the requirement to create the RMAP in Therap.

## Demographic

<b>Individual Name</b>		<b>DOB</b>	
<b>Gender</b>		<b>Residential Address</b>	
<b>Residential Phone</b>			

## General

<b>From Date</b>	
<b>To Date</b>	

## General Information

<b>Primary Language</b>	
<b>Residence Type</b>	<input type="checkbox"/> ICF/IID <input type="checkbox"/> Group Home <input type="checkbox"/> Own Apartment/Home <input type="checkbox"/> Family Home <input type="checkbox"/> Foster Care Home <input type="checkbox"/> Homeless <input type="checkbox"/> Other
<b>Number of people residing in the home</b>	<input type="checkbox"/> Homeless <input type="checkbox"/> Lives alone <input type="checkbox"/> 2-3 <input type="checkbox"/> 4-6 <input type="checkbox"/> 7-15 <input type="checkbox"/> 16 or more
<b>RMAP Type</b>	<input type="checkbox"/> Initial/Admission <input type="checkbox"/> 30-Day Comprehensive <input type="checkbox"/> Annual <input type="checkbox"/> Update
<b>Dates of Team Reviews</b>	
<b>Person Completing Report</b>	
<b>Title/Relationship to Person Supported</b>	
<b>Licensed Providers &amp; Services Received at Each</b>	
<b>In completing this assessment, consultation and coordination occurred with the following individuals and organizations which have knowledge about the person supported</b>	<input type="checkbox"/> Person Supported <input type="checkbox"/> Legal decision maker <input type="checkbox"/> Family member/caregiver (not decision maker) <input type="checkbox"/> Residential/In home providers <input type="checkbox"/> Day/Employment providers <input type="checkbox"/> Other -
<b>Guardian Name</b>	

## I. Activities of Daily Living

### 1. Eating and Nutrition

Probing Question: Are there doctor's orders, recommended/specialized diet, What is their level of independence in following this diet; What happens if they don't follow the diet; Do they utilize adaptive equipment; supplements, thickened liquids, food consistency or size, rights limitations; indicate abilities/level of independence, cultural considerations/preferences, tube feeding, etc.; Does the person eat at a pace that is problematic; Does the person over-stuff or pocket food in their mouth; Can the person monitor their own nutritional status; etc.

<b>Presents a Risk?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Historical
<b>Severity of Risk</b> <input type="checkbox"/> Mild: Occasional assistance or monitoring <input type="checkbox"/> Severe: Requires regular assistance
<b>Frequency of Risk</b> <input type="checkbox"/> Less than monthly <input type="checkbox"/> At least 1 time per month <input type="checkbox"/> At least 1 time per week <input type="checkbox"/> At least 1 time per day <input type="checkbox"/> At least 1 time per hour
<b>Explain why the person is at risk.</b>
<b>Where are the strategies to reduce risk identified in the plan?</b> <input type="checkbox"/> Virtual Supports <input type="checkbox"/> Outcomes <input type="checkbox"/> Assessment Review <input type="checkbox"/> Health Status Review <input type="checkbox"/> Rights Limitation and Due Process <input type="checkbox"/> Benefits and Insurance <input type="checkbox"/> Additional Safeguards

### 2. Mobility

Probing Question: Abilities, support needs, equipment (e.g., walker, cane, gait belt, wheelchair, one-person assist, etc.), does the person have balance or other gross motor challenges; terrain or environmental considerations, falls, proper medical assessment, etc.

<b>Indicate the person's mobility:</b> <input type="checkbox"/> Moves self around environment without supports <input type="checkbox"/> Sometimes needs assistance, moves self around environment with equipment/supports, or uses wheelchair independently <input type="checkbox"/> Always needs assistance to move around environment
<b>Presents a Risk?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Historical
<b>Severity of Risk</b> <input type="checkbox"/> Mild: Occasional assistance or monitoring <input type="checkbox"/> Severe: Requires regular assistance
<b>Frequency of Risk</b> <input type="checkbox"/> Less than monthly <input type="checkbox"/> At least 1 time per month <input type="checkbox"/> At least 1 time per week <input type="checkbox"/> At least 1 time per day <input type="checkbox"/> At least 1 time per hour

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### 3. Transfers

Probing Question: Abilities, support needs, equipment (Hoyer, gait belt, bed rails, grab bars, etc.), environmental considerations (bed, toilet, shower chair, etc.), level of assistance needed (1:1, 1:2), etc.

<b>Presents a Risk?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Historical
<b>Severity of Risk</b>
<input type="checkbox"/> Mild: Occasional assistance or monitoring <input type="checkbox"/> Severe: Requires regular assistance
<b>Frequency of Risk</b>
<input type="checkbox"/> Less than monthly <input type="checkbox"/> At least 1 time per month <input type="checkbox"/> At least 1 time per week <input type="checkbox"/> At least 1 time per day <input type="checkbox"/> At least 1 time per hour
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### 4. Using the Toilet

Probing Question: Abilities, does the person have full bowel and/or bladder control; support needs (including overnight support), adaptive equipment (Hoyer, gait belt, grab bars, incontinence briefs, etc.), ostomy care, catheter care, environmental considerations, level of assistance needed, Is there a bathroom routine; teaching program, bowel/urination program, preferences (sex of caregiver, cultural/religious), etc.

<b>Presents a Risk?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Historical
<b>Severity of Risk</b>
<input type="checkbox"/> Mild: Occasional assistance or monitoring <input type="checkbox"/> Severe: Requires regular assistance

<p><b>Frequency of Risk</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Less than monthly</li> <li><input type="checkbox"/> At least 1 time per month</li> <li><input type="checkbox"/> At least 1 time per week</li> <li><input type="checkbox"/> At least 1 time per day</li> <li><input type="checkbox"/> At least 1 time per hour</li> </ul>
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## 5. Personal Hygiene

Probing Question: Abilities, unwillingness, support needs and preferences for hygiene including but not limited to toothbrushing, shaving (including face, arms, legs, pubic area, armpits, etc.), menses, deodorant, hair care, nail care, cultural/religious considerations, etc.

<p><b>Presents a Risk?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Yes</li> <li><input type="checkbox"/> No</li> <li><input type="checkbox"/> Historical</li> </ul>
<p><b>Severity of Risk</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Mild: Occasional assistance or monitoring</li> <li><input type="checkbox"/> Severe: Requires regular assistance</li> </ul>
<p><b>Frequency of Risk</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Less than monthly</li> <li><input type="checkbox"/> At least 1 time per month</li> <li><input type="checkbox"/> At least 1 time per week</li> <li><input type="checkbox"/> At least 1 time per day</li> <li><input type="checkbox"/> At least 1 time per hour</li> </ul>
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## 6. Bathing/Showering

Probing Question: Abilities, support needs (level of supervision, adjust water temp), adaptive equipment (Hoyer, gait belt, grab bars, shower chair, etc.), environmental considerations, level of assistance needed, specific routine; teaching program, preferences (shower or bath, what time of day is best, sex of caregiver, cultural/religious).

<p><b>Presents a Risk?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Yes</li> <li><input type="checkbox"/> No</li> <li><input type="checkbox"/> Historical</li> </ul>
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<p><b>Severity of Risk</b></p> <p><input type="checkbox"/> Mild: Occasional assistance or monitoring</p> <p><input type="checkbox"/> Severe: Requires regular assistance</p>
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## 7. Dressing

Probing Question: Abilities, support needs, personal preferences, methods due to physical limitations or coordination, assistance needed to button, zip, tie, mend, etc.; adaptive equipment, ability to dress for weather conditions; etc.

<p><b>Presents a Risk?</b></p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Historical</p>
<p><b>Severity of Risk</b></p> <p><input type="checkbox"/> Mild: Occasional assistance or monitoring</p> <p><input type="checkbox"/> Severe: Requires regular assistance</p>
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## 8. Communication

Probing Question: What is the person's preferred language if not English; Does the person have/need an interpreter; Does the person have a speech impairment; Are they understood by general public; Is there adaptive equipment; if so, ability to operate independently; can they state or share accurate or current information (name, address, telephone #, provider); ability to report injury, pain, illness, or

seek assistance for medical concerns, report suspected abuse, neglect, or exploitation; describe comprehension skills; does the person have compromised communication skills that have led to legal issues or relaying/receiving medical information, etc.

<p><b>What is the person's preferred means of communication:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Spoken</li> <li><input type="checkbox"/> Gestures/body language</li> <li><input type="checkbox"/> Sign language or finger spelling</li> <li><input type="checkbox"/> Communication aid/device</li> <li><input type="checkbox"/> Other</li> </ul>
<p><b>Does the person have cultural and/or linguistic preferences (preferred language other than English, need for interpreter services, etc.)?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Yes</li> <li><input type="checkbox"/> No</li> </ul>
<p><b>Presents a Risk?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Yes</li> <li><input type="checkbox"/> No</li> <li><input type="checkbox"/> Historical</li> </ul>
<p><b>Severity of Risk</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Mild: Occasional assistance or monitoring</li> <li><input type="checkbox"/> Severe: Requires regular assistance</li> </ul>
<p><b>Frequency of Risk</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Less than monthly</li> <li><input type="checkbox"/> At least 1 time per month</li> <li><input type="checkbox"/> At least 1 time per week</li> <li><input type="checkbox"/> At least 1 time per day</li> <li><input type="checkbox"/> At least 1 time per hour</li> </ul>
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<p><b>Where are the strategies to reduce risk identified in the plan?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Virtual Supports</li> <li><input type="checkbox"/> Outcomes</li> <li><input type="checkbox"/> Assessment Review</li> <li><input type="checkbox"/> Health Status Review</li> <li><input type="checkbox"/> Rights Limitation and Due Process</li> <li><input type="checkbox"/> Benefits and Insurance</li> <li><input type="checkbox"/> Additional Safeguards</li> </ul>

**9. Poor Follow Through/Declines Treatments, Services, and/or Supports**

Probing Question: Has the person not followed through with or declined treatments, medical care, services, and/or supports despite being well informed; Are there specific barriers/reasons the person has had difficulty with follow through or declines; What is the person's ability to consent to refusal; What are the consequences/degree; Are there unmet needs? Are there specific situations, people, or events that trigger poor follow through or declining; What does the data show (frequency, severity, increase/decrease over the past year, patterns, etc.); etc.

<p><b>What is the person's preferred means of communication:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Spoken</li> <li><input type="checkbox"/> Gestures/body language</li> <li><input type="checkbox"/> Sign language or finger spelling</li> <li><input type="checkbox"/> Communication aid/device</li> <li><input type="checkbox"/> Other</li> </ul>
<p><b>Does the person have cultural and/or linguistic preferences (preferred language other than English, need for interpreter services, etc.)?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Yes</li> <li><input type="checkbox"/> No</li> </ul>
<p><b>Presents a Risk?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Yes</li> <li><input type="checkbox"/> No</li> <li><input type="checkbox"/> Historical</li> </ul>

<p><b>Severity of Risk</b></p> <input type="checkbox"/> Mild: Occasional assistance or monitoring <input type="checkbox"/> Severe: Requires regular assistance
<p><b>Frequency of Risk</b></p> <input type="checkbox"/> Less than monthly <input type="checkbox"/> At least 1 time per month <input type="checkbox"/> At least 1 time per week <input type="checkbox"/> At least 1 time per day <input type="checkbox"/> At least 1 time per hour
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<p><b>Where are the strategies to reduce risk identified in the plan?</b></p> <input type="checkbox"/> Virtual Supports <input type="checkbox"/> Outcomes <input type="checkbox"/> Assessment Review <input type="checkbox"/> Health Status Review <input type="checkbox"/> Rights Limitation and Due Process <input type="checkbox"/> Benefits and Insurance <input type="checkbox"/> Additional Safeguards

**10. Other ADL Risk Factors Not Identified Above**

<p><b>Identified Risk:</b></p>
<p><b>Severity of Risk</b></p> <input type="checkbox"/> Mild: Occasional assistance or monitoring <input type="checkbox"/> Severe: Requires regular assistance
<p><b>Frequency of Risk</b></p> <input type="checkbox"/> Less than monthly <input type="checkbox"/> At least 1 time per month <input type="checkbox"/> At least 1 time per week <input type="checkbox"/> At least 1 time per day <input type="checkbox"/> At least 1 time per hour
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**II. Instrumental Activities of Daily Living (IADLs)**

**1. Food Preparation**

Probing Question: Indicate abilities/level of independence for meal/snack preparation; Does the person have any difficulty following recipes; Is the person able to perform kitchen tasks such as chopping, cooking, and using appliances; Is the person able to handle food safely (e.g., cooking at the right temperature, preventing cross-contamination); etc.

<p><b>Presents a Risk?</b></p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Historical
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<p><b>Severity of Risk</b></p> <p><input type="checkbox"/> Mild: Occasional assistance or monitoring</p> <p><input type="checkbox"/> Severe: Requires regular assistance</p>
<p><b>Frequency of Risk</b></p> <p><input type="checkbox"/> Less than monthly</p> <p><input type="checkbox"/> At least 1 time per month</p> <p><input type="checkbox"/> At least 1 time per week</p> <p><input type="checkbox"/> At least 1 time per day</p> <p><input type="checkbox"/> At least 1 time per hour</p>
<p><b>Explain why the person is at risk.</b></p>
<p><b>Where are the strategies to reduce risk identified in the plan?</b></p> <p><input type="checkbox"/> Virtual Supports</p> <p><input type="checkbox"/> Outcomes</p> <p><input type="checkbox"/> Assessment Review</p> <p><input type="checkbox"/> Health Status Review</p> <p><input type="checkbox"/> Rights Limitation and Due Process</p> <p><input type="checkbox"/> Benefits and Insurance</p> <p><input type="checkbox"/> Additional Safeguards</p>

## 2. Shopping

Probing Question: Is the person able to make a shopping list; Is the person able to navigate the grocery store, department store, online shopping, including finding specific items (groceries, household items, clothing, etc.) or comparing prices; etc.

<p><b>Presents a Risk?</b></p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Historical</p>
<p><b>Severity of Risk</b></p> <p><input type="checkbox"/> Mild: Occasional assistance or monitoring</p> <p><input type="checkbox"/> Severe: Requires regular assistance</p>
<p><b>Frequency of Risk</b></p> <p><input type="checkbox"/> Less than monthly</p> <p><input type="checkbox"/> At least 1 time per month</p> <p><input type="checkbox"/> At least 1 time per week</p> <p><input type="checkbox"/> At least 1 time per day</p> <p><input type="checkbox"/> At least 1 time per hour</p>
<p><b>Explain why the person is at risk.</b></p>
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## 3. Laundry/Care of Clothing

Probing Questions: Does the person have access to laundry facilities; Is the person able to properly adjust washing/drying settings on the machine based on load size; Does the person complete the entire laundry process (washing, drying, folding, putting away, completing when necessary); etc.

<p><b>Presents a Risk?</b></p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Historical
<p><b>Severity of Risk</b></p> <input type="checkbox"/> Mild: Occasional assistance or monitoring <input type="checkbox"/> Severe: Requires regular assistance
<p><b>Frequency of Risk</b></p> <input type="checkbox"/> Less than monthly <input type="checkbox"/> At least 1 time per month <input type="checkbox"/> At least 1 time per week <input type="checkbox"/> At least 1 time per day <input type="checkbox"/> At least 1 time per hour
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**4. Living Conditions/Home Maintenance**

Probing Question: Is the person able to maintain their living environment to the extent that the person's health and safety are not compromised? What is the person's level of independence in maintaining their home (e.g., dusting, vacuuming, floor care, garbage removal-including spoiled food, changing linens, etc.); Do they have a tendency to hoard; Is the person unable to complete the tasks or do they choose not to complete the tasks; Risk of eviction/homelessness due to inability to maintain their environment; Level of independence in completing or coordinating home repairs; etc.

<p><b>Presents a Risk?</b></p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Historical
<p><b>Severity of Risk</b></p> <input type="checkbox"/> Mild: Occasional assistance or monitoring <input type="checkbox"/> Severe: Requires regular assistance
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## 5. Ability to Use Telephone

Probing Questions: Does the person have the ability to utilize a telephone for communication; Does the person have access to a telephone or cellular phone; does the person know how to make/end a phone call; Does the person feel comfortable making/receiving phone calls; Is the person able to identify potential spam phone calls, etc.

<b>Presents a Risk?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Historical
<b>Severity of Risk</b> <input type="checkbox"/> Mild: Occasional assistance or monitoring <input type="checkbox"/> Severe: Requires regular assistance
<b>Frequency of Risk</b> <input type="checkbox"/> Less than monthly <input type="checkbox"/> At least 1 time per month <input type="checkbox"/> At least 1 time per week <input type="checkbox"/> At least 1 time per day <input type="checkbox"/> At least 1 time per hour
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## 6. Community Access / Transportation

Probing Question: Abilities, support needs (level of supervision, use of seatbelt, arranging/accessing transportation), equipment needs (ramp, lift, tie downs, etc.), environmental considerations, level of assistance needed, pedestrian skills; transportation safety skills; response to emergencies; do they know how/who to contact in and emergency; carry an ID card; modes of transportation (city bus, ParaTransit, taxi, ride share, personal vehicle, etc.); level of support with bus routes; challenges.

<b>Presents a Risk?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Historical
<b>Severity of Risk</b> <input type="checkbox"/> Mild: Occasional assistance or monitoring <input type="checkbox"/> Severe: Requires regular assistance
<b>Frequency of Risk</b> <input type="checkbox"/> Less than monthly <input type="checkbox"/> At least 1 time per month <input type="checkbox"/> At least 1 time per week <input type="checkbox"/> At least 1 time per day <input type="checkbox"/> At least 1 time per hour
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<b>Where are the strategies to reduce risk identified in the plan?</b> <input type="checkbox"/> Virtual Supports <input type="checkbox"/> Outcomes

- Assessment Review
- Health Status Review
- Rights Limitation and Due Process
- Benefits and Insurance
- Additional Safeguards

## 7. Environmental Safety in Home and Community

Probing Question: This applies to all environments: Ability to safely use hot items (stove, oven, irons etc.); Ability to safely use sharp objects; Ability to safely use cleaning supplies; Ability to adjust the water temp safely on faucets (shower, bath, community); Ability to safely utilize tub, shower, toilet, etc.; Is the person at risk for lack of home security (e.g., opening doors to strangers, leaving windows/doors unlocked, etc.)

### Kitchen Safety

<p><b>Presents a Risk?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Yes</li> <li><input type="checkbox"/> No</li> <li><input type="checkbox"/> Historical</li> </ul>
<p><b>Severity of Risk</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Mild: Occasional assistance or monitoring</li> <li><input type="checkbox"/> Severe: Requires regular assistance</li> </ul>
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### Use of Cleaning Supplies

<p><b>Presents a Risk?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Yes</li> <li><input type="checkbox"/> No</li> <li><input type="checkbox"/> Historical</li> </ul>
<p><b>Severity of Risk</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Mild: Occasional assistance or monitoring</li> <li><input type="checkbox"/> Severe: Requires regular assistance</li> </ul>
<p><b>Frequency of Risk</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Less than monthly</li> <li><input type="checkbox"/> At least 1 time per month</li> <li><input type="checkbox"/> At least 1 time per week</li> <li><input type="checkbox"/> At least 1 time per day</li> <li><input type="checkbox"/> At least 1 time per hour</li> </ul>

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**Electrical Safety**

<b>Presents a Risk?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Historical
<b>Severity of Risk</b>
<input type="checkbox"/> Mild: Occasional assistance or monitoring <input type="checkbox"/> Severe: Requires regular assistance
<b>Frequency of Risk</b>
<input type="checkbox"/> Less than monthly <input type="checkbox"/> At least 1 time per month <input type="checkbox"/> At least 1 time per week <input type="checkbox"/> At least 1 time per day <input type="checkbox"/> At least 1 time per hour
<b>Explain why the person is at risk.</b>
<b>Where are the strategies to reduce risk identified in the plan?</b>
<input type="checkbox"/> Virtual Supports <input type="checkbox"/> Outcomes <input type="checkbox"/> Assessment Review <input type="checkbox"/> Health Status Review <input type="checkbox"/> Rights Limitation and Due Process <input type="checkbox"/> Benefits and Insurance <input type="checkbox"/> Additional Safeguards

**Adjust Water**

<b>Presents a Risk?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Historical
<b>Severity of Risk</b>
<input type="checkbox"/> Mild: Occasional assistance or monitoring <input type="checkbox"/> Severe: Requires regular assistance
<b>Frequency of Risk</b>
<input type="checkbox"/> Less than monthly <input type="checkbox"/> At least 1 time per month <input type="checkbox"/> At least 1 time per week <input type="checkbox"/> At least 1 time per day <input type="checkbox"/> At least 1 time per hour

<b>Explain why the person is at risk.</b>
<b>Where are the strategies to reduce risk identified in the plan?</b>
<input type="checkbox"/> Virtual Supports <input type="checkbox"/> Outcomes <input type="checkbox"/> Assessment Review <input type="checkbox"/> Health Status Review <input type="checkbox"/> Rights Limitation and Due Process <input type="checkbox"/> Benefits and Insurance <input type="checkbox"/> Additional Safeguards

**Bathroom Safety**

<b>Presents a Risk?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Historical
<b>Severity of Risk</b>
<input type="checkbox"/> Mild: Occasional assistance or monitoring <input type="checkbox"/> Severe: Requires regular assistance
<b>Frequency of Risk</b>
<input type="checkbox"/> Less than monthly <input type="checkbox"/> At least 1 time per month <input type="checkbox"/> At least 1 time per week <input type="checkbox"/> At least 1 time per day <input type="checkbox"/> At least 1 time per hour
<b>Explain why the person is at risk.</b>
<b>Where are the strategies to reduce risk identified in the plan?</b>
<input type="checkbox"/> Virtual Supports <input type="checkbox"/> Outcomes <input type="checkbox"/> Assessment Review <input type="checkbox"/> Health Status Review <input type="checkbox"/> Rights Limitation and Due Process <input type="checkbox"/> Benefits and Insurance <input type="checkbox"/> Additional Safeguards

**Home Security**

<b>Presents a Risk?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Historical
<b>Severity of Risk</b>
<input type="checkbox"/> Mild: Occasional assistance or monitoring <input type="checkbox"/> Severe: Requires regular assistance
<b>Frequency of Risk</b>
<input type="checkbox"/> Less than monthly <input type="checkbox"/> At least 1 time per month <input type="checkbox"/> At least 1 time per week <input type="checkbox"/> At least 1 time per day <input type="checkbox"/> At least 1 time per hour

<b>Explain why the person is at risk.</b>
<b>Where are the strategies to reduce risk identified in the plan?</b>
<input type="checkbox"/> Virtual Supports <input type="checkbox"/> Outcomes <input type="checkbox"/> Assessment Review <input type="checkbox"/> Health Status Review <input type="checkbox"/> Rights Limitation and Due Process <input type="checkbox"/> Benefits and Insurance <input type="checkbox"/> Additional Safeguards

**Small Objects**

<b>Presents a Risk?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Historical
<b>Severity of Risk</b>
<input type="checkbox"/> Mild: Occasional assistance or monitoring <input type="checkbox"/> Severe: Requires regular assistance
<b>Frequency of Risk</b>
<input type="checkbox"/> Less than monthly <input type="checkbox"/> At least 1 time per month <input type="checkbox"/> At least 1 time per week <input type="checkbox"/> At least 1 time per day <input type="checkbox"/> At least 1 time per hour
<b>Explain why the person is at risk.</b>
<b>Where are the strategies to reduce risk identified in the plan?</b>
<input type="checkbox"/> Virtual Supports <input type="checkbox"/> Outcomes <input type="checkbox"/> Assessment Review <input type="checkbox"/> Health Status Review <input type="checkbox"/> Rights Limitation and Due Process <input type="checkbox"/> Benefits and Insurance <input type="checkbox"/> Additional Safeguards

**Sharp Objects**

<b>Presents a Risk?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Historical
<b>Severity of Risk</b>
<input type="checkbox"/> Mild: Occasional assistance or monitoring <input type="checkbox"/> Severe: Requires regular assistance
<b>Frequency of Risk</b>
<input type="checkbox"/> Less than monthly <input type="checkbox"/> At least 1 time per month <input type="checkbox"/> At least 1 time per week <input type="checkbox"/> At least 1 time per day <input type="checkbox"/> At least 1 time per hour

<b>Explain why the person is at risk.</b>
<b>Where are the strategies to reduce risk identified in the plan?</b>
<input type="checkbox"/> Virtual Supports <input type="checkbox"/> Outcomes <input type="checkbox"/> Assessment Review <input type="checkbox"/> Health Status Review <input type="checkbox"/> Rights Limitation and Due Process <input type="checkbox"/> Benefits and Insurance <input type="checkbox"/> Additional Safeguards

**Cords/Strings**

<b>Presents a Risk?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Historical
<b>Severity of Risk</b>
<input type="checkbox"/> Mild: Occasional assistance or monitoring <input type="checkbox"/> Severe: Requires regular assistance
<b>Frequency of Risk</b>
<input type="checkbox"/> Less than monthly <input type="checkbox"/> At least 1 time per month <input type="checkbox"/> At least 1 time per week <input type="checkbox"/> At least 1 time per day <input type="checkbox"/> At least 1 time per hour
<b>Explain why the person is at risk.</b>
<b>Where are the strategies to reduce risk identified in the plan?</b>
<input type="checkbox"/> Virtual Supports <input type="checkbox"/> Outcomes <input type="checkbox"/> Assessment Review <input type="checkbox"/> Health Status Review <input type="checkbox"/> Rights Limitation and Due Process <input type="checkbox"/> Benefits and Insurance <input type="checkbox"/> Additional Safeguards

**8. Emergency Preparedness**

Probing Question: How do they respond to an alarm/alert; Level of independence to evacuate or seek shelter in an emergency (ability to find exits, respond to drills, evacuate to or seek shelter in designated area, etc.); Are there sensory (visual, auditory, etc.) and/or mobility considerations for evacuation; Ability to access emergency services or calling 911; etc.

<b>Presents a Risk?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Historical
<b>Severity of Risk</b>
<input type="checkbox"/> Mild: Occasional assistance or monitoring <input type="checkbox"/> Severe: Requires regular assistance
<b>Frequency of Risk</b>
<input type="checkbox"/> Less than monthly <input type="checkbox"/> At least 1 time per month <input type="checkbox"/> At least 1 time per week

<input type="checkbox"/> At least 1 time per day <input type="checkbox"/> At least 1 time per hour
<b>Explain why the person is at risk.</b>
<b>Where are the strategies to reduce risk identified in the plan?</b> <input type="checkbox"/> Virtual Supports <input type="checkbox"/> Outcomes <input type="checkbox"/> Assessment Review <input type="checkbox"/> Health Status Review <input type="checkbox"/> Rights Limitation and Due Process <input type="checkbox"/> Benefits and Insurance <input type="checkbox"/> Additional Safeguards

### 9. Medication Management

Probing Question: Does the person take over-the-counter, prescribed, or herbal medication(s) and what conditions are these taken for; Does the person understand the side effects of the medication and possible medication interactions; Is there access to medical and/or pharmacy review of medications; Are there side effects experienced; Has the person experienced any previous adverse reactions to medications or allergies; What is the person's level of independence with medication administration, ordering, and monitoring medications; Does the person experience any difficulty with the administration of medications (e.g., taking as prescribed, swallowing pills, measuring liquid doses, opening medication containers, etc.); Does the person take psychotropic medications; Are medications locked/set up; etc. Please Note: Medications/dosages do not need to be listed here.

<b>Presents a Risk?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Historical
<b>Severity of Risk</b> <input type="checkbox"/> Mild: Occasional assistance or monitoring <input type="checkbox"/> Severe: Requires regular assistance
<b>Frequency of Risk</b> <input type="checkbox"/> Less than monthly <input type="checkbox"/> At least 1 time per month <input type="checkbox"/> At least 1 time per week <input type="checkbox"/> At least 1 time per day <input type="checkbox"/> At least 1 time per hour
<b>Explain why the person is at risk.</b>
<b>Where are the strategies to reduce risk identified in the plan?</b> <input type="checkbox"/> Virtual Supports <input type="checkbox"/> Outcomes <input type="checkbox"/> Assessment Review <input type="checkbox"/> Health Status Review <input type="checkbox"/> Rights Limitation and Due Process <input type="checkbox"/> Benefits and Insurance <input type="checkbox"/> Additional Safeguards
<b>Is the person currently taking medication(s) for mood, anxiety, or psychiatric?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>If yes, how many?</b> <input type="checkbox"/> One or two medications <input type="checkbox"/> Three or four medications <input type="checkbox"/> Five to ten medications

<input type="checkbox"/> Eleven or more medications
<b>Is the person currently taking medication(s) for behavioral challenges?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>If yes, how many?</b> <input type="checkbox"/> One or two medications <input type="checkbox"/> Three or four medications <input type="checkbox"/> Five to ten medications <input type="checkbox"/> Eleven or more medications

### 10. Money Management

Probing Question: What is the person's ability to handle their money (credit card, ATM, checkbook, etc.) budget, remain within their budget, and pay their bills (e.g. has the person accrued debt, borrowed money, or made excessive purchases that they are unable to repay, have they over-drafted their account, does the person gamble, over-purchase apps/games, etc.); Has the person been financially exploited or exploited others; Does the person loan money to others and to what extent; Does the person have other recurring expenses for consideration (e.g., garnished wages, child support, restitution, etc).

<b>Presents a Risk?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Historical
<b>Severity of Risk</b> <input type="checkbox"/> Mild: Occasional assistance or monitoring <input type="checkbox"/> Severe: Requires regular assistance
<b>Frequency of Risk</b> <input type="checkbox"/> Less than monthly <input type="checkbox"/> At least 1 time per month <input type="checkbox"/> At least 1 time per week <input type="checkbox"/> At least 1 time per day <input type="checkbox"/> At least 1 time per hour
<b>Explain why the person is at risk.</b>
<b>Where are the strategies to reduce risk identified in the plan?</b> <input type="checkbox"/> Virtual Supports <input type="checkbox"/> Outcomes <input type="checkbox"/> Assessment Review <input type="checkbox"/> Health Status Review <input type="checkbox"/> Rights Limitation and Due Process <input type="checkbox"/> Benefits and Insurance <input type="checkbox"/> Additional Safeguards

### 11. Employment

Probing Question: What are the person's preferences for employment; If the person is employed, do they maintain their employment independently; Are there barriers to finding employment, maintaining employment, etc.; Do they experience frequent job changes; Does the person experience financial difficulty due to current employment or non-employment; Are there medical or behavioral factors that may affect employment; Does the person have challenges with soft skills (punctuality, hygiene, etc.) or job specific tasks; etc.

<b>Presents a Risk?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Historical
<b>Severity of Risk</b> <input type="checkbox"/> Mild: Occasional assistance or monitoring <input type="checkbox"/> Severe: Requires regular assistance
<b>Frequency of Risk</b> <input type="checkbox"/> Less than monthly <input type="checkbox"/> At least 1 time per month

<input type="checkbox"/> At least 1 time per week <input type="checkbox"/> At least 1 time per day <input type="checkbox"/> At least 1 time per hour
<b>Explain why the person is at risk.</b>
<b>Where are the strategies to reduce risk identified in the plan?</b> <input type="checkbox"/> Virtual Supports <input type="checkbox"/> Outcomes <input type="checkbox"/> Assessment Review <input type="checkbox"/> Health Status Review <input type="checkbox"/> Rights Limitation and Due Process <input type="checkbox"/> Benefits and Insurance <input type="checkbox"/> Additional Safeguards

### 12. Economic Assistance/Benefits

Probing Question: What is the person's ability to apply for and maintain benefits (Medicaid, Medicare, LIHEAP, SNAP, housing, etc.) including providing appropriate follow-up and information (e.g. reporting income, monitoring limits/spend downs, completing applications and timelines for redetermination, etc.); What is the person's ability to obtain, understand, and submit information to the appropriate entities; Does the person rely on benefits to maintain financial stability; etc.

<b>Presents a Risk?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Historical
<b>Severity of Risk</b> <input type="checkbox"/> Mild: Occasional assistance or monitoring <input type="checkbox"/> Severe: Requires regular assistance
<b>Frequency of Risk</b> <input type="checkbox"/> Less than monthly <input type="checkbox"/> At least 1 time per month <input type="checkbox"/> At least 1 time per week <input type="checkbox"/> At least 1 time per day <input type="checkbox"/> At least 1 time per hour
<b>Explain why the person is at risk.</b>
<b>Where are the strategies to reduce risk identified in the plan?</b> <input type="checkbox"/> Virtual Supports <input type="checkbox"/> Outcomes <input type="checkbox"/> Assessment Review <input type="checkbox"/> Health Status Review <input type="checkbox"/> Rights Limitation and Due Process <input type="checkbox"/> Benefits and Insurance <input type="checkbox"/> Additional Safeguards

### 13. Excessive Living Costs

Probing Question: Can the person afford their current living expenses (e.g. housing, utilities, vehicle, home maintenance, etc.); Are these costs a result of personal decisions or are they imposed by external factors; etc.

<b>Presents a Risk?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Historical
<b>Severity of Risk</b> <input type="checkbox"/> Mild: Occasional assistance or monitoring

<input type="checkbox"/> Severe: Requires regular assistance
<b>Frequency of Risk</b> <input type="checkbox"/> Less than monthly <input type="checkbox"/> At least 1 time per month <input type="checkbox"/> At least 1 time per week <input type="checkbox"/> At least 1 time per day <input type="checkbox"/> At least 1 time per hour
<b>Explain why the person is at risk.</b>
<b>Where are the strategies to reduce risk identified in the plan?</b> <input type="checkbox"/> Virtual Supports <input type="checkbox"/> Outcomes <input type="checkbox"/> Assessment Review <input type="checkbox"/> Health Status Review <input type="checkbox"/> Rights Limitation and Due Process <input type="checkbox"/> Benefits and Insurance <input type="checkbox"/> Additional Safeguards

**14. Other IADL Risk Factors Not Identified Above**

<b>Identified Risk:</b>
<b>Severity of Risk</b> <input type="checkbox"/> Mild: Occasional assistance or monitoring <input type="checkbox"/> Severe: Requires regular assistance
<b>Frequency of Risk</b> <input type="checkbox"/> Less than monthly <input type="checkbox"/> At least 1 time per month <input type="checkbox"/> At least 1 time per week <input type="checkbox"/> At least 1 time per day <input type="checkbox"/> At least 1 time per hour
<b>Explain why the person is at risk.</b>
<b>Where are the strategies to reduce risk identified in the plan?</b> <input type="checkbox"/> Virtual Supports <input type="checkbox"/> Outcomes <input type="checkbox"/> Assessment Review <input type="checkbox"/> Health Status Review <input type="checkbox"/> Rights Limitation and Due Process <input type="checkbox"/> Benefits and Insurance <input type="checkbox"/> Additional Safeguards

**III. Behavioral**

**1. Self-Injury**

Probing Question: Includes any behavior which harms one's physical self, such as head banging, biting/hitting, self-skin picking, scratching self, etc. Has the person engaged in self-injurious behaviors; How often does the person exhibit self-injurious behavior; What are the specific self-injurious behaviors the person exhibits; Are there specific situations, people, or events that trigger self-injurious behavior; Are there patterns or warning signs that precede these behaviors? What does the data show (frequency, severity, increase/decrease over the past year, patterns, etc.); When is the self-injurious behavior exhibited (ex. when afraid, scared, threatened, etc.); Has it required/warranted medical intervention; Does the person utilize equipment such as padding, helmet, or other protective equipment; etc.

<b>Presents a Risk?</b>
-------------------------

<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Historical
<b>Severity of Risk</b> <input type="checkbox"/> Mild: Occasional assistance or monitoring <input type="checkbox"/> Severe: Requires regular assistance
<b>Frequency of Risk</b> <input type="checkbox"/> Less than monthly <input type="checkbox"/> At least 1 time per month <input type="checkbox"/> At least 1 time per week <input type="checkbox"/> At least 1 time per day <input type="checkbox"/> At least 1 time per hour
<b>Explain why the person is at risk.</b>
<b>Where are the strategies to reduce risk identified in the plan?</b> <input type="checkbox"/> Virtual Supports <input type="checkbox"/> Outcomes <input type="checkbox"/> Assessment Review <input type="checkbox"/> Health Status Review <input type="checkbox"/> Rights Limitation and Due Process <input type="checkbox"/> Benefits and Insurance <input type="checkbox"/> Additional Safeguards

## 2. Verbal Aggression

Probing Question: This may include swearing, cursing, yelling, name-calling, insulting, making significant threats to the safety of others, bullying, etc. Does the person engage in verbal aggression; How does the person express verbal aggression; How often does the person use verbal aggression; How intense is the verbal aggression (ex. mild frustration versus threatening language); Are there specific situations, people, or events that tend to trigger verbal aggression? Does the person target specific people; What does the data show (frequency, severity, increase/decrease over the past year, patterns, etc.); etc.

<b>Presents a Risk?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Historical
<b>Severity of Risk</b> <input type="checkbox"/> Mild: Occasional assistance or monitoring <input type="checkbox"/> Severe: Requires regular assistance
<b>Frequency of Risk</b> <input type="checkbox"/> Less than monthly <input type="checkbox"/> At least 1 time per month <input type="checkbox"/> At least 1 time per week <input type="checkbox"/> At least 1 time per day <input type="checkbox"/> At least 1 time per hour
<b>Explain why the person is at risk.</b>
<b>Where are the strategies to reduce risk identified in the plan?</b> <input type="checkbox"/> Virtual Supports <input type="checkbox"/> Outcomes <input type="checkbox"/> Assessment Review <input type="checkbox"/> Health Status Review <input type="checkbox"/> Rights Limitation and Due Process <input type="checkbox"/> Benefits and Insurance

Additional Safeguards

### 3. Physical Aggression/Assault

Probing Question: This may include pushing, grabbing, spitting, biting, punching, attacking, breaking objects, throwing things, etc. Does the person engage in physical aggression, assault, or property destruction; How does the person express physical aggression; How often does the person use physical aggression; How intense in the physical aggression; Are there specific situations, people, or events that tend to trigger physical aggression? Does the person target specific people; What does the data show (frequency, severity, increase/decrease over the past year, patterns, etc.); etc.

<b>Presents a Risk?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Historical
<b>Severity of Risk</b> <input type="checkbox"/> Mild: Occasional assistance or monitoring <input type="checkbox"/> Severe: Requires regular assistance
<b>Frequency of Risk</b> <input type="checkbox"/> Less than monthly <input type="checkbox"/> At least 1 time per month <input type="checkbox"/> At least 1 time per week <input type="checkbox"/> At least 1 time per day <input type="checkbox"/> At least 1 time per hour
<b>Explain why the person is at risk.</b>
<b>Where are the strategies to reduce risk identified in the plan?</b> <input type="checkbox"/> Virtual Supports <input type="checkbox"/> Outcomes <input type="checkbox"/> Assessment Review <input type="checkbox"/> Health Status Review <input type="checkbox"/> Rights Limitation and Due Process <input type="checkbox"/> Benefits and Insurance <input type="checkbox"/> Additional Safeguards

### 4. Property Damage

Probing Question: This may include intentional or non-intentional damage, destruction, or vandalism of real or personal property and may include destruction due to failure to take proper care of something, etc. Does the person engage in property destruction; To what extent is the property destruction; Are there specific situations, people, or events that tend to trigger the property destruction? Does the person target specific objects; Whose property is damaged; What does the data show (frequency, severity, increase/decrease over the past year, patterns, etc.); etc.

<b>Presents a Risk?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Historical
<b>Severity of Risk</b> <input type="checkbox"/> Mild: Occasional assistance or monitoring <input type="checkbox"/> Severe: Requires regular assistance
<b>Frequency of Risk</b> <input type="checkbox"/> Less than monthly <input type="checkbox"/> At least 1 time per month <input type="checkbox"/> At least 1 time per week <input type="checkbox"/> At least 1 time per day <input type="checkbox"/> At least 1 time per hour

**Explain why the person is at risk.**

**Where are the strategies to reduce risk identified in the plan?**

- Virtual Supports
- Outcomes
- Assessment Review
- Health Status Review
- Rights Limitation and Due Process
- Benefits and Insurance
- Additional Safeguards

## 5. Criminal/Offending Behavior

Probing Question: Includes any criminal concerns, criminal justice issues or concerns, or problems with the law. What types of criminal behavior or offenses has the person been involved in (theft, assault, drug related offenses, fraud, etc.); What was the person's role in the offense (e.g., leader, follower, involved under duress); Does the person have a history of predatory or sexual offending behavior; Who is preferred target; is it impulsive or pre-meditated; Does the person have an excessive fascination with children/others or a history of sexual abuse of children/others; Does the person have a fascination with fire or history of fire setting; Are there specific situations, stressors, or emotions that seem to trigger the person's offending behavior; Has there been a determination of fitness to proceed; are there other reporting requirements (e.g., probation or stipulation); Are there specific situations, people, or events that tend to trigger criminal/offending behavior? What does the data show (frequency, severity, increase/decrease over the past year, patterns, etc.); etc.

**Presents a Risk?**

- Yes
- No
- Historical

**Severity of Risk**

- Mild: Occasional assistance or monitoring
- Severe: Requires regular assistance

**Frequency of Risk**

- Less than monthly
- At least 1 time per month
- At least 1 time per week
- At least 1 time per day
- At least 1 time per hour

**Explain why the person is at risk.**

**Where are the strategies to reduce risk identified in the plan?**

- Virtual Supports
- Outcomes
- Assessment Review
- Health Status Review
- Rights Limitation and Due Process
- Benefits and Insurance
- Additional Safeguards

## 6. Sexual Activity

Probing Question: Includes sexually inappropriate behavior and/or a wide range of behaviors such as disrobing, masturbating in public, sexually aggressive behavior, voyeurism, etc. Does the person understand consensual and non-consensual; Do they understand rights of others/personal boundaries; Does the person understand the risks associated with sexual activity (ex. spread of STIs, HIV, unintended pregnancies, etc.); Does the person practice safe sex; Does the person participate in any risky sexual practices; Is the person able to avoid being taken advantage of sexually; Does the person know who to report to if they experience sexual abuse; etc.

**Presents a Risk?**

<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Historical
<b>Severity of Risk</b> <input type="checkbox"/> Mild: Occasional assistance or monitoring <input type="checkbox"/> Severe: Requires regular assistance
<b>Frequency of Risk</b> <input type="checkbox"/> Less than monthly <input type="checkbox"/> At least 1 time per month <input type="checkbox"/> At least 1 time per week <input type="checkbox"/> At least 1 time per day <input type="checkbox"/> At least 1 time per hour
<b>Explain why the person is at risk.</b>
<b>Where are the strategies to reduce risk identified in the plan?</b> <input type="checkbox"/> Virtual Supports <input type="checkbox"/> Outcomes <input type="checkbox"/> Assessment Review <input type="checkbox"/> Health Status Review <input type="checkbox"/> Rights Limitation and Due Process <input type="checkbox"/> Benefits and Insurance <input type="checkbox"/> Additional Safeguards

## 7. Elopement

Probing Question: Includes intentional act of escaping, fleeing, running off, bolting, suddenly running, or darting away. Does the person frequently attempt to leave or wander; What tends to trigger the person's desire to leave or wander (e.g., anxiety, boredom, confusion, frustration, etc.); If they have eloped before, what were the circumstances; What was the objective for the person (why did they leave, what did they want, where did they go, etc.); What was the outcome; Do they have skills to return by self (e.g., recognize landmarks, able to state their address, provide ID, etc.); Does the person have any cognitive impairments (e.g., dementia, history of brain injury, etc.) that may contribute to the risk? Are there specific situations, people, or events that tend to trigger elopement; What does the data show (frequency, severity, increase/decrease over the past year, patterns, etc.); etc.

<b>Presents a Risk?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Historical
<b>Severity of Risk</b> <input type="checkbox"/> Mild: Occasional assistance or monitoring <input type="checkbox"/> Severe: Requires regular assistance
<b>Frequency of Risk</b> <input type="checkbox"/> Less than monthly <input type="checkbox"/> At least 1 time per month <input type="checkbox"/> At least 1 time per week <input type="checkbox"/> At least 1 time per day <input type="checkbox"/> At least 1 time per hour
<b>Explain why the person is at risk.</b>
<b>Where are the strategies to reduce risk identified in the plan?</b> <input type="checkbox"/> Virtual Supports <input type="checkbox"/> Outcomes <input type="checkbox"/> Assessment Review <input type="checkbox"/> Health Status Review

- Rights Limitation and Due Process
- Benefits and Insurance
- Additional Safeguards

### 8. Contacts with Emergency Medical Services or Law Enforcement

Probing Question: Has the person initiated 911 calls without a true emergency; Does the person fabricate illness for admission to the ER or ambulance use; Are there specific situations, stressors, or emotions that seem to trigger the person's desire to contact Emergency Medical Services or Law Enforcement; Is there a medical/psychiatric condition that may contribute to these contacts; What does the data show (frequency, severity, increase/decrease over the past year, patterns, etc.); etc. Please note: If contacts are due to a true medical/psychological emergency, this should be identified in the Medical/Psychological Risk Factors section.

<p><b>Presents a Risk?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Yes</li> <li><input type="checkbox"/> No</li> <li><input type="checkbox"/> Historical</li> </ul>
<p><b>Severity of Risk</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Mild: Occasional assistance or monitoring</li> <li><input type="checkbox"/> Severe: Requires regular assistance</li> </ul>
<p><b>Frequency of Risk</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Less than monthly</li> <li><input type="checkbox"/> At least 1 time per month</li> <li><input type="checkbox"/> At least 1 time per week</li> <li><input type="checkbox"/> At least 1 time per day</li> <li><input type="checkbox"/> At least 1 time per hour</li> </ul>
<p><b>Explain why the person is at risk.</b></p>
<p><b>Where are the strategies to reduce risk identified in the plan?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Virtual Supports</li> <li><input type="checkbox"/> Outcomes</li> <li><input type="checkbox"/> Assessment Review</li> <li><input type="checkbox"/> Health Status Review</li> <li><input type="checkbox"/> Rights Limitation and Due Process</li> <li><input type="checkbox"/> Benefits and Insurance</li> <li><input type="checkbox"/> Additional Safeguards</li> </ul>

### 9. Substance Use

Probing Question: Includes use of legal/illegal drugs - may include, but is not limited to prescription medications, over-the-counter medications, alcohol, tobacco, inhalants such as paint, etc.; Does the person engage in substance abuse; Which substances does the person use; Have they experienced negative legal, job, health, or personal issues as a result of using of the listed substances; Are there specific situations, people, environments, or events that trigger substance use; Is there a family history of substance abuse; Has the person received treatment? What does the data show (frequency, severity, increase/decrease over the past year, patterns, etc.); etc.

<p><b>Presents a Risk?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Yes</li> <li><input type="checkbox"/> No</li> <li><input type="checkbox"/> Historical</li> </ul>
<p><b>Severity of Risk</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Mild: Occasional assistance or monitoring</li> <li><input type="checkbox"/> Severe: Requires regular assistance</li> </ul>
<p><b>Frequency of Risk</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Less than monthly</li> <li><input type="checkbox"/> At least 1 time per month</li> <li><input type="checkbox"/> At least 1 time per week</li> <li><input type="checkbox"/> At least 1 time per day</li> <li><input type="checkbox"/> At least 1 time per hour</li> </ul>

<b>Explain why the person is at risk.</b>
<b>Where are the strategies to reduce risk identified in the plan?</b>
<input type="checkbox"/> Virtual Supports <input type="checkbox"/> Outcomes <input type="checkbox"/> Assessment Review <input type="checkbox"/> Health Status Review <input type="checkbox"/> Rights Limitation and Due Process <input type="checkbox"/> Benefits and Insurance <input type="checkbox"/> Additional Safeguards

**10. Social Isolation**

Probing Question: Does the person spend time in isolation? Why does the person spend time in isolation (preference, forced, symptom); Are there barriers that may contribute to isolation (lack of social skills, physical/mental health, lack of transportation, etc.); Which methods for social interaction does the person prefer (in-person, online, one-on-one, group, etc.); Are there specific situations, people, environments, or events that trigger isolation; What does the data show (frequency, severity, increase/decrease over the past year, patterns, etc.); etc.

<b>Presents a Risk?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Historical
<b>Severity of Risk</b>
<input type="checkbox"/> Mild: Occasional assistance or monitoring <input type="checkbox"/> Severe: Requires regular assistance
<b>Frequency of Risk</b>
<input type="checkbox"/> Less than monthly <input type="checkbox"/> At least 1 time per month <input type="checkbox"/> At least 1 time per week <input type="checkbox"/> At least 1 time per day <input type="checkbox"/> At least 1 time per hour
<b>Explain why the person is at risk.</b>
<b>Where are the strategies to reduce risk identified in the plan?</b>
<input type="checkbox"/> Virtual Supports <input type="checkbox"/> Outcomes <input type="checkbox"/> Assessment Review <input type="checkbox"/> Health Status Review <input type="checkbox"/> Rights Limitation and Due Process <input type="checkbox"/> Benefits and Insurance <input type="checkbox"/> Additional Safeguards

**11. Other Behavioral Risk Factors Not Identified Above**

<b>Identified Risk:</b>
<b>Severity of Risk</b>
<input type="checkbox"/> Mild: Occasional assistance or monitoring <input type="checkbox"/> Severe: Requires regular assistance
<b>Frequency of Risk</b>
<input type="checkbox"/> Less than monthly <input type="checkbox"/> At least 1 time per month <input type="checkbox"/> At least 1 time per week <input type="checkbox"/> At least 1 time per day

<input type="checkbox"/> At least 1 time per hour <b>Explain why the person is at risk.</b>
<b>Where are the strategies to reduce risk identified in the plan?</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Virtual Supports</li> <li><input type="checkbox"/> Outcomes</li> <li><input type="checkbox"/> Assessment Review</li> <li><input type="checkbox"/> Health Status Review</li> <li><input type="checkbox"/> Rights Limitation and Due Process</li> <li><input type="checkbox"/> Benefits and Insurance</li> <li><input type="checkbox"/> Additional Safeguards</li> </ul>

**12. Does the person have a behavior plan?**

<input type="checkbox"/> Yes <input type="checkbox"/> No
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**IV. Medical and Psychological**

**1. Gastrointestinal**

Probing Question: Does the person have any gastrointestinal diagnoses (Gastroesophageal reflux (GERD), Crohn’s disease, gluten intolerance, Diverticuli disease; fistulas, abscesses; colon polyps, colon cancer, Colitis, Irritable bowel syndrome (IBS), constipation, ulcers, etc.); What are the symptoms; Are there identified triggers that may worsen symptoms; compliance with supports; etc.

<b>Presents a Risk?</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Yes</li> <li><input type="checkbox"/> No</li> <li><input type="checkbox"/> Historical</li> </ul>
<b>Severity of Risk</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Mild: Occasional assistance or monitoring</li> <li><input type="checkbox"/> Severe: Requires regular assistance</li> </ul>
<b>Frequency of Risk</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Less than monthly</li> <li><input type="checkbox"/> At least 1 time per month</li> <li><input type="checkbox"/> At least 1 time per week</li> <li><input type="checkbox"/> At least 1 time per day</li> <li><input type="checkbox"/> At least 1 time per hour</li> </ul>
<b>Explain why the person is at risk.</b>
<b>Where are the strategies to reduce risk identified in the plan?</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Virtual Supports</li> <li><input type="checkbox"/> Outcomes</li> <li><input type="checkbox"/> Assessment Review</li> <li><input type="checkbox"/> Health Status Review</li> <li><input type="checkbox"/> Rights Limitation and Due Process</li> <li><input type="checkbox"/> Benefits and Insurance</li> <li><input type="checkbox"/> Additional Safeguards</li> </ul>

**2. Neurological/Seizures**

Probing Question: What type; What do they typically look like; How often; Controlled with medication; Are there identified stimuli or triggers that may contribute to seizure activity (flashing lights, stress, fatigue, alcohol, loud noises, low blood sugar, drinking lots of water, fever, constipation, etc.); Does the person utilize equipment (helmet, monitoring systems, etc.); Environmental considerations; etc.

<p><b>Presents a Risk?</b></p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Historical
<p><b>Severity of Risk</b></p> <input type="checkbox"/> Mild: Occasional assistance or monitoring <input type="checkbox"/> Severe: Requires regular assistance
<p><b>Frequency of Risk</b></p> <input type="checkbox"/> Less than monthly <input type="checkbox"/> At least 1 time per month <input type="checkbox"/> At least 1 time per week <input type="checkbox"/> At least 1 time per day <input type="checkbox"/> At least 1 time per hour
<p><b>Explain why the person is at risk.</b></p>
<p><b>Where are the strategies to reduce risk identified in the plan?</b></p> <input type="checkbox"/> Virtual Supports <input type="checkbox"/> Outcomes <input type="checkbox"/> Assessment Review <input type="checkbox"/> Health Status Review <input type="checkbox"/> Rights Limitation and Due Process <input type="checkbox"/> Benefits and Insurance <input type="checkbox"/> Additional Safeguards

**3. Emergency Meds Needed (for seizures, allergies, cardiac concerns, etc.)**

Probing Question: Does the person require emergency medications (e.g., Epi-Pen for bee stings, nitro for heart condition, or Vagus nerve stimulator (VNS) for seizures, etc.); What are these medications taken for; etc.

<p><b>Presents a Risk?</b></p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Historical
<p><b>Severity of Risk</b></p> <input type="checkbox"/> Mild: Occasional assistance or monitoring <input type="checkbox"/> Severe: Requires regular assistance
<p><b>Frequency of Risk</b></p> <input type="checkbox"/> Less than monthly <input type="checkbox"/> At least 1 time per month <input type="checkbox"/> At least 1 time per week <input type="checkbox"/> At least 1 time per day <input type="checkbox"/> At least 1 time per hour
<p><b>Explain why the person is at risk.</b></p>
<p><b>Where are the strategies to reduce risk identified in the plan?</b></p> <input type="checkbox"/> Virtual Supports <input type="checkbox"/> Outcomes <input type="checkbox"/> Assessment Review <input type="checkbox"/> Health Status Review <input type="checkbox"/> Rights Limitation and Due Process <input type="checkbox"/> Benefits and Insurance <input type="checkbox"/> Additional Safeguards

#### 4. Cardio/Respiratory

Probing Question: History of or currently a diagnosis of heart condition (e.g., congestive heart failure (CHF), COPD, asthma, heart attack, high blood pressure/hypertension, etc.); What symptoms does the person experience as a result of this diagnosis; Does the person have a diagnosis that requires the use of oxygen; nebulizer treatments, inhaler, respiratory suctioning, postural drainage, ventilator, CPAP; Do activities/weather affect the condition; etc.

<b>Presents a Risk?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Historical
<b>Severity of Risk</b> <input type="checkbox"/> Mild: Occasional assistance or monitoring <input type="checkbox"/> Severe: Requires regular assistance
<b>Frequency of Risk</b> <input type="checkbox"/> Less than monthly <input type="checkbox"/> At least 1 time per month <input type="checkbox"/> At least 1 time per week <input type="checkbox"/> At least 1 time per day <input type="checkbox"/> At least 1 time per hour
<b>Explain why the person is at risk.</b>
<b>Where are the strategies to reduce risk identified in the plan?</b> <input type="checkbox"/> Virtual Supports <input type="checkbox"/> Outcomes <input type="checkbox"/> Assessment Review <input type="checkbox"/> Health Status Review <input type="checkbox"/> Rights Limitation and Due Process <input type="checkbox"/> Benefits and Insurance <input type="checkbox"/> Additional Safeguards

#### 5. Diabetes

Probing Question: Do they have a diagnosis of Type I or II diabetes; Is there a family history; Is the person at risk to develop diabetes; Is their blood sugar typically high or low; What are the symptoms typically experienced; Ability of the person to recognize their symptoms; etc.

<b>Presents a Risk?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Historical
<b>Severity of Risk</b> <input type="checkbox"/> Mild: Occasional assistance or monitoring <input type="checkbox"/> Severe: Requires regular assistance
<b>Frequency of Risk</b> <input type="checkbox"/> Less than monthly <input type="checkbox"/> At least 1 time per month <input type="checkbox"/> At least 1 time per week <input type="checkbox"/> At least 1 time per day <input type="checkbox"/> At least 1 time per hour
<b>Explain why the person is at risk.</b>
<b>Where are the strategies to reduce risk identified in the plan?</b> <input type="checkbox"/> Virtual Supports <input type="checkbox"/> Outcomes

- Assessment Review
- Health Status Review
- Rights Limitation and Due Process
- Benefits and Insurance
- Additional Safeguards

## 6. Skin Integrity/Breakdown

Probing Question: Does the person have any skin conditions (psoriasis, eczema, pressure ulcers, etc); Do they experience skin breakdown or are they at risk for skin breakdown (incontinence requiring briefs, repositioning); Have there been significant changes with the person (e.g., weight gained/lost, changes in mobility, etc.); Does the person have special sunburn precautions; Does the person have the ability to care for/clean skin folds properly; How long does it take the person's skin to heal; Does the person bruise easily; etc.

<p><b>Presents a Risk?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Yes</li> <li><input type="checkbox"/> No</li> <li><input type="checkbox"/> Historical</li> </ul>
<p><b>Severity of Risk</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Mild: Occasional assistance or monitoring</li> <li><input type="checkbox"/> Severe: Requires regular assistance</li> </ul>
<p><b>Frequency of Risk</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Less than monthly</li> <li><input type="checkbox"/> At least 1 time per month</li> <li><input type="checkbox"/> At least 1 time per week</li> <li><input type="checkbox"/> At least 1 time per day</li> <li><input type="checkbox"/> At least 1 time per hour</li> </ul>
<p><b>Explain why the person is at risk.</b></p>
<p><b>Where are the strategies to reduce risk identified in the plan?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Virtual Supports</li> <li><input type="checkbox"/> Outcomes</li> <li><input type="checkbox"/> Assessment Review</li> <li><input type="checkbox"/> Health Status Review</li> <li><input type="checkbox"/> Rights Limitation and Due Process</li> <li><input type="checkbox"/> Benefits and Insurance</li> <li><input type="checkbox"/> Additional Safeguards</li> </ul>

## 7. Orthopedic

Probing Question: Does the person have a history of or diagnosis of arthritis, bursitis, dislocations, fibromyalgia, foot pain/problems, fractures, gout, hip dysplasia, kyphosis, osteoporosis, Paget's Disease, ruptured disk, scoliosis, etc.; Is there a family history; Are there other factors that put them at risk; etc.

<p><b>Presents a Risk?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Yes</li> <li><input type="checkbox"/> No</li> <li><input type="checkbox"/> Historical</li> </ul>
<p><b>Severity of Risk</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Mild: Occasional assistance or monitoring</li> <li><input type="checkbox"/> Severe: Requires regular assistance</li> </ul>
<p><b>Frequency of Risk</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Less than monthly</li> <li><input type="checkbox"/> At least 1 time per month</li> <li><input type="checkbox"/> At least 1 time per week</li> <li><input type="checkbox"/> At least 1 time per day</li> <li><input type="checkbox"/> At least 1 time per hour</li> </ul>

<b>Explain why the person is at risk.</b>
<b>Where are the strategies to reduce risk identified in the plan?</b>
<input type="checkbox"/> Virtual Supports <input type="checkbox"/> Outcomes <input type="checkbox"/> Assessment Review <input type="checkbox"/> Health Status Review <input type="checkbox"/> Rights Limitation and Due Process <input type="checkbox"/> Benefits and Insurance <input type="checkbox"/> Additional Safeguards

**8. Sensory**

Probing Question: Includes conditions/impairments related to taste, touch, smell, sound, temperature, or sight. Such as hearing limitations; vision issues; tactile defensiveness, sensory integration, PICA, sensitivity/lack of sensitivity to touch, light, smell, taste, or sound; Environmental factors; etc.

<b>Presents a Risk?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Historical
<b>Severity of Risk</b>
<input type="checkbox"/> Mild: Occasional assistance or monitoring <input type="checkbox"/> Severe: Requires regular assistance
<b>Frequency of Risk</b>
<input type="checkbox"/> Less than monthly <input type="checkbox"/> At least 1 time per month <input type="checkbox"/> At least 1 time per week <input type="checkbox"/> At least 1 time per day <input type="checkbox"/> At least 1 time per hour
<b>Explain why the person is at risk.</b>
<b>Where are the strategies to reduce risk identified in the plan?</b>
<input type="checkbox"/> Virtual Supports <input type="checkbox"/> Outcomes <input type="checkbox"/> Assessment Review <input type="checkbox"/> Health Status Review <input type="checkbox"/> Rights Limitation and Due Process <input type="checkbox"/> Benefits and Insurance <input type="checkbox"/> Additional Safeguards

**9. Vision**

Probing Question: Does the person have any vision impairments or eye conditions; Is the person able to see clearly at various distances (near and far); Does the person have difficulty seeing in low/high light conditions; Is the person able to distinguish colors or perceive contrasts clearly; Has the person recently experienced any changes in their vision, such as blurriness, double vision, or loss of vision; etc.

<b>Presents a Risk?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Historical
<b>Severity of Risk</b>
<input type="checkbox"/> Mild: Occasional assistance or monitoring <input type="checkbox"/> Severe: Requires regular assistance
<b>Frequency of Risk</b>

<input type="checkbox"/> Less than monthly <input type="checkbox"/> At least 1 time per month <input type="checkbox"/> At least 1 time per week <input type="checkbox"/> At least 1 time per day <input type="checkbox"/> At least 1 time per hour
<b>Explain why the person is at risk.</b>
<b>Where are the strategies to reduce risk identified in the plan?</b> <input type="checkbox"/> Virtual Supports <input type="checkbox"/> Outcomes <input type="checkbox"/> Assessment Review <input type="checkbox"/> Health Status Review <input type="checkbox"/> Rights Limitation and Due Process <input type="checkbox"/> Benefits and Insurance <input type="checkbox"/> Additional Safeguards

## 10. Hearing

Probing Question: Does the person have any hearing impairment or hearing loss; Does the person have difficulty hearing in noisy environments or where there is background noise; Can the person hear high-pitched sounds, such as alarms or sirens, clearly; Does the person have difficulty hearing people speaking in normal conversational tones; Has the person experienced any recent changes in their hearing, such as muffled sounds, ringing in the ears (tinnitus), or sudden loss of hearing; etc.

<b>Presents a Risk?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Historical
<b>Severity of Risk</b> <input type="checkbox"/> Mild: Occasional assistance or monitoring <input type="checkbox"/> Severe: Requires regular assistance
<b>Frequency of Risk</b> <input type="checkbox"/> Less than monthly <input type="checkbox"/> At least 1 time per month <input type="checkbox"/> At least 1 time per week <input type="checkbox"/> At least 1 time per day <input type="checkbox"/> At least 1 time per hour
<b>Explain why the person is at risk.</b>
<b>Where are the strategies to reduce risk identified in the plan?</b> <input type="checkbox"/> Virtual Supports <input type="checkbox"/> Outcomes <input type="checkbox"/> Assessment Review <input type="checkbox"/> Health Status Review <input type="checkbox"/> Rights Limitation and Due Process <input type="checkbox"/> Benefits and Insurance <input type="checkbox"/> Additional Safeguards

## 11. Dental

Probing Question: Does the person have any dental issues, such as cavities, gum disease, or tooth loss; Has the person had any recent dental treatments or procedures (e.g., fillings, extractions, cleanings, orthodontics); Does the person have any dental conditions that require ongoing care or special attention, such as dry mouth or sensitive teeth; Has the person experienced any difficulty with dental care or hygiene (e.g., fear of dentists, inability to follow instructions); Has the person experienced pain, discomfort, or sensitivity in their teeth or gums; etc.

<p><b>Presents a Risk?</b></p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Historical
<p><b>Severity of Risk</b></p> <input type="checkbox"/> Mild: Occasional assistance or monitoring <input type="checkbox"/> Severe: Requires regular assistance
<p><b>Frequency of Risk</b></p> <input type="checkbox"/> Less than monthly <input type="checkbox"/> At least 1 time per month <input type="checkbox"/> At least 1 time per week <input type="checkbox"/> At least 1 time per day <input type="checkbox"/> At least 1 time per hour
<p><b>Explain why the person is at risk.</b></p>
<p><b>Where are the strategies to reduce risk identified in the plan?</b></p> <input type="checkbox"/> Virtual Supports <input type="checkbox"/> Outcomes <input type="checkbox"/> Assessment Review <input type="checkbox"/> Health Status Review <input type="checkbox"/> Rights Limitation and Due Process <input type="checkbox"/> Benefits and Insurance <input type="checkbox"/> Additional Safeguards

**12. Occupational Therapy / Physical Therapy**

Probing Question: Does the person have difficulty with daily activities, coordination limitations, sensory limitations, limited range of motion, weakness, pain, postural limitations, functional limitations, musculoskeletal issues, or any other signs and symptoms that require therapy services?

<p><b>Presents a Risk?</b></p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Historical
<p><b>Severity of Risk</b></p> <input type="checkbox"/> Mild: Occasional assistance or monitoring <input type="checkbox"/> Severe: Requires regular assistance
<p><b>Frequency of Risk</b></p> <input type="checkbox"/> Less than monthly <input type="checkbox"/> At least 1 time per month <input type="checkbox"/> At least 1 time per week <input type="checkbox"/> At least 1 time per day <input type="checkbox"/> At least 1 time per hour
<p><b>Explain why the person is at risk.</b></p>
<p><b>Where are the strategies to reduce risk identified in the plan?</b></p> <input type="checkbox"/> Virtual Supports <input type="checkbox"/> Outcomes <input type="checkbox"/> Assessment Review <input type="checkbox"/> Health Status Review <input type="checkbox"/> Rights Limitation and Due Process <input type="checkbox"/> Benefits and Insurance <input type="checkbox"/> Additional Safeguards

### 13. Change in Health or Mental Status

Probing Question: Includes a noticeable and impactful alteration in someone's physical well-being and psychological state, which could manifest as changes in mood, energy levels, sleep patterns, appetite, behavior, or ability to function in daily life, often triggered by major life events, stress, illness, or other factors; this could include both positive and negative shifts in one's overall health status; Include results of standardized tool or assessment used to assess cognitive functioning (e.g. dementia) and mental health status - if completed by their physician, this can be reflected here.

<b>Presents a Risk?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Historical
<b>Severity of Risk</b> <input type="checkbox"/> Mild: Occasional assistance or monitoring <input type="checkbox"/> Severe: Requires regular assistance
<b>Frequency of Risk</b> <input type="checkbox"/> Less than monthly <input type="checkbox"/> At least 1 time per month <input type="checkbox"/> At least 1 time per week <input type="checkbox"/> At least 1 time per day <input type="checkbox"/> At least 1 time per hour
<b>Explain why the person is at risk.</b>
<b>Where are the strategies to reduce risk identified in the plan?</b> <input type="checkbox"/> Virtual Supports <input type="checkbox"/> Outcomes <input type="checkbox"/> Assessment Review <input type="checkbox"/> Health Status Review <input type="checkbox"/> Rights Limitation and Due Process <input type="checkbox"/> Benefits and Insurance <input type="checkbox"/> Additional Safeguards
<b>Screening – Cognitive (Dementia)</b> <b>Screening completed?</b> <input type="checkbox"/> Yes <b>Date:</b> <b>Tool/Assessment Used:</b> <b>Completed by (physician, support staff, etc.):</b> <b>Results:</b> <input type="checkbox"/> No <b>If no assessment was completed, was it because the person could not self-report AND there was no proxy/guardian available to provide responses?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Provide an Explanation:</b>

**Screening – Mental Health****Screening completed?** Yes**Date:****Tool/Assessment Used:****Completed by (physician, support staff, etc.):****Results:** No**If no assessment was completed, was it because the person could not self-report AND there was no proxy/guardian available to provide responses?** Yes No**Provide an Explanation:****14. Loss of Significant Others in the Person's Life**

Probing Question: Is there a potential for loss, has the person experienced a loss, or are they no longer in contact with someone who is important to them (identify who - caregiver, boyfriend, girlfriend, staff, family member, friends, pets, etc.); when did this loss occur; how has this affected the person; etc.

**Caregiver****Presents a Risk?** Yes No Historical**Severity of Risk** Mild: Occasional assistance or monitoring Severe: Requires regular assistance**Frequency of Risk** Less than monthly At least 1 time per month At least 1 time per week At least 1 time per day At least 1 time per hour**Explain why the person is at risk.****Where are the strategies to reduce risk identified in the plan?** Virtual Supports Outcomes Assessment Review Health Status Review Rights Limitation and Due Process Benefits and Insurance Additional Safeguards**Family Member****Presents a Risk?** Yes No Historical**Severity of Risk** Mild: Occasional assistance or monitoring Severe: Requires regular assistance**Frequency of Risk**

<input type="checkbox"/> Less than monthly <input type="checkbox"/> At least 1 time per month <input type="checkbox"/> At least 1 time per week <input type="checkbox"/> At least 1 time per day <input type="checkbox"/> At least 1 time per hour
<b>Explain why the person is at risk.</b>
<b>Where are the strategies to reduce risk identified in the plan?</b> <input type="checkbox"/> Virtual Supports <input type="checkbox"/> Outcomes <input type="checkbox"/> Assessment Review <input type="checkbox"/> Health Status Review <input type="checkbox"/> Rights Limitation and Due Process <input type="checkbox"/> Benefits and Insurance <input type="checkbox"/> Additional Safeguards

**Someone Significant – Staff Member, Natural Supports**

<b>Presents a Risk?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Historical
<b>Severity of Risk</b> <input type="checkbox"/> Mild: Occasional assistance or monitoring <input type="checkbox"/> Severe: Requires regular assistance
<b>Frequency of Risk</b> <input type="checkbox"/> Less than monthly <input type="checkbox"/> At least 1 time per month <input type="checkbox"/> At least 1 time per week <input type="checkbox"/> At least 1 time per day <input type="checkbox"/> At least 1 time per hour
<b>Explain why the person is at risk.</b>
<b>Where are the strategies to reduce risk identified in the plan?</b> <input type="checkbox"/> Virtual Supports <input type="checkbox"/> Outcomes <input type="checkbox"/> Assessment Review <input type="checkbox"/> Health Status Review <input type="checkbox"/> Rights Limitation and Due Process <input type="checkbox"/> Benefits and Insurance <input type="checkbox"/> Additional Safeguards

**Pets**

<b>Presents a Risk?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Historical
<b>Severity of Risk</b> <input type="checkbox"/> Mild: Occasional assistance or monitoring <input type="checkbox"/> Severe: Requires regular assistance
<b>Frequency of Risk</b> <input type="checkbox"/> Less than monthly <input type="checkbox"/> At least 1 time per month

<input type="checkbox"/> At least 1 time per week <input type="checkbox"/> At least 1 time per day <input type="checkbox"/> At least 1 time per hour
<b>Explain why the person is at risk.</b>
<b>Where are the strategies to reduce risk identified in the plan?</b> <input type="checkbox"/> Virtual Supports <input type="checkbox"/> Outcomes <input type="checkbox"/> Assessment Review <input type="checkbox"/> Health Status Review <input type="checkbox"/> Rights Limitation and Due Process <input type="checkbox"/> Benefits and Insurance <input type="checkbox"/> Additional Safeguards

### 15. Suicidal Ideation or Attempt

Probing Question: Means wanting to take one's own life or thinking about suicide with or without making plans to commit suicide. Has the person ever indicated thoughts of or attempts to harm themselves or take their own life? How often does the person exhibit suicidal ideation or make attempts; Are there specific situations, people, or events that trigger suicidal ideation or attempts; Are there patterns or warning signs that precede this? What does the data show (frequency, severity, increase/decrease over the past year, patterns, etc.); When is the suicidal ideation or attempt exhibited (e.g., when afraid, scared, threatened, etc.); Has it required/warranted medical intervention; Has the person been diagnosed with any mental health conditions that may contribute to suicidal ideation/attempts; etc.

<b>Presents a Risk?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Historical
<b>Severity of Risk</b> <input type="checkbox"/> Mild: Occasional assistance or monitoring <input type="checkbox"/> Severe: Requires regular assistance
<b>Frequency of Risk</b> <input type="checkbox"/> Less than monthly <input type="checkbox"/> At least 1 time per month <input type="checkbox"/> At least 1 time per week <input type="checkbox"/> At least 1 time per day <input type="checkbox"/> At least 1 time per hour
<b>Explain why the person is at risk.</b>
<b>Where are the strategies to reduce risk identified in the plan?</b> <input type="checkbox"/> Virtual Supports <input type="checkbox"/> Outcomes <input type="checkbox"/> Assessment Review <input type="checkbox"/> Health Status Review <input type="checkbox"/> Rights Limitation and Due Process <input type="checkbox"/> Benefits and Insurance <input type="checkbox"/> Additional Safeguards

### 16. Recent/Repeated Use of Medical/Psychiatric Services

Probing Question: Recent/repeated medical/psychiatric events requiring use of services (e.g., ER, hospitalization, home health, skilled nursing facility, ND State hospital, etc.). Is there a medical/psychiatric condition that may contribute to these events; What does the data show (frequency, severity, increase/decrease over the past year, patterns, etc.); etc.

<b>Presents a Risk?</b> <input type="checkbox"/> Yes
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<input type="checkbox"/> No <input type="checkbox"/> Historical
<b>Severity of Risk</b> <input type="checkbox"/> Mild: Occasional assistance or monitoring <input type="checkbox"/> Severe: Requires regular assistance
<b>Frequency of Risk</b> <input type="checkbox"/> Less than monthly <input type="checkbox"/> At least 1 time per month <input type="checkbox"/> At least 1 time per week <input type="checkbox"/> At least 1 time per day <input type="checkbox"/> At least 1 time per hour
<b>Explain why the person is at risk.</b>
<b>Where are the strategies to reduce risk identified in the plan?</b> <input type="checkbox"/> Virtual Supports <input type="checkbox"/> Outcomes <input type="checkbox"/> Assessment Review <input type="checkbox"/> Health Status Review <input type="checkbox"/> Rights Limitation and Due Process <input type="checkbox"/> Benefits and Insurance <input type="checkbox"/> Additional Safeguards
<b>Has the person had recent or repeated use of medical services?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>If yes, what sort of medical services were accessed?</b> <input type="checkbox"/> ER <input type="checkbox"/> Hospitalization <input type="checkbox"/> Home Health <input type="checkbox"/> Skilled Nursing
<b>Select any of the applicable conditions for hospitalization:</b> <input type="checkbox"/> Dehydration <input type="checkbox"/> Bowel Obstruction <input type="checkbox"/> Seizure <input type="checkbox"/> Aspiration <input type="checkbox"/> Gastroesophageal reflux (GERD) <input type="checkbox"/> Pneumonia <input type="checkbox"/> Other

### 17. Inability to Tolerate a Medical Exam/Procedure

Probing Question: Are there specific types of exams, procedures, or medical settings that the person finds particularly difficult to tolerate (e.g., blood draws, imaging tests, physical exams); What is the person's reaction to these procedures (emotional, physical, behavioral, etc.); What are the risks if the procedures cannot be completed; Are there factors that impact the person's level of comfort in tolerating exams/procedures, etc.

<b>Presents a Risk?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Historical
<b>Severity of Risk</b> <input type="checkbox"/> Mild: Occasional assistance or monitoring <input type="checkbox"/> Severe: Requires regular assistance
<b>Frequency of Risk</b> <input type="checkbox"/> Less than monthly <input type="checkbox"/> At least 1 time per month <input type="checkbox"/> At least 1 time per week <input type="checkbox"/> At least 1 time per day <input type="checkbox"/> At least 1 time per hour

<b>Explain why the person is at risk.</b>
<b>Where are the strategies to reduce risk identified in the plan?</b>
<input type="checkbox"/> Virtual Supports <input type="checkbox"/> Outcomes <input type="checkbox"/> Assessment Review <input type="checkbox"/> Health Status Review <input type="checkbox"/> Rights Limitation and Due Process <input type="checkbox"/> Benefits and Insurance <input type="checkbox"/> Additional Safeguards

**18. Obesity/Anorexia/Bulimia**

Probing Question: Does the person have an identified eating disorder or diagnosis of obesity that affects their health; Does the person binge eat, purge after eating, severely restrict their eating, do they have feelings of extreme distress or concern about body weight or shape, are there identified triggers that increase the frequency of the person bingeing, purging, restricting food, etc.

<b>Presents a Risk?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Historical
<b>Severity of Risk</b>
<input type="checkbox"/> Mild: Occasional assistance or monitoring <input type="checkbox"/> Severe: Requires regular assistance
<b>Frequency of Risk</b>
<input type="checkbox"/> Less than monthly <input type="checkbox"/> At least 1 time per month <input type="checkbox"/> At least 1 time per week <input type="checkbox"/> At least 1 time per day <input type="checkbox"/> At least 1 time per hour
<b>Explain why the person is at risk.</b>
<b>Where are the strategies to reduce risk identified in the plan?</b>
<input type="checkbox"/> Virtual Supports <input type="checkbox"/> Outcomes <input type="checkbox"/> Assessment Review <input type="checkbox"/> Health Status Review <input type="checkbox"/> Rights Limitation and Due Process <input type="checkbox"/> Benefits and Insurance <input type="checkbox"/> Additional Safeguards

**19. Swallowing Disorder/Choking or Aspiration**

Probing Question: Does the person have a diagnosed swallowing disorder, difficulties with biting, chewing, moving, or swallowing food; Has the person had recent/repeated instances of choking or aspiration; Has there been a medical evaluation with proper follow up for diagnosis; is Speech/ENT involved; etc. Please note: For any specific food/diet modifications, list in ADLs-Eating/Meal Preparation/Nutrition.

<b>Presents a Risk?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Historical
<b>Severity of Risk</b>
<input type="checkbox"/> Mild: Occasional assistance or monitoring <input type="checkbox"/> Severe: Requires regular assistance
<b>Frequency of Risk</b>

<input type="checkbox"/> Less than monthly <input type="checkbox"/> At least 1 time per month <input type="checkbox"/> At least 1 time per week <input type="checkbox"/> At least 1 time per day <input type="checkbox"/> At least 1 time per hour
<b>Explain why the person is at risk.</b>
<b>Where are the strategies to reduce risk identified in the plan?</b> <input type="checkbox"/> Virtual Supports <input type="checkbox"/> Outcomes <input type="checkbox"/> Assessment Review <input type="checkbox"/> Health Status Review <input type="checkbox"/> Rights Limitation and Due Process <input type="checkbox"/> Benefits and Insurance <input type="checkbox"/> Additional Safeguards

**20. Abuse, Neglect, or Exploitation**

Probing Question: Review GERs and incidents of ANE over the last 12 months; has the person experienced abuse, neglect, or exploitation; if so, what types; are there continued impacts that the person is experiencing from these incidents, etc.

<b>Presents a Risk?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Historical
<b>Severity of Risk</b> <input type="checkbox"/> Mild: Occasional assistance or monitoring <input type="checkbox"/> Severe: Requires regular assistance
<b>Frequency of Risk</b> <input type="checkbox"/> Less than monthly <input type="checkbox"/> At least 1 time per month <input type="checkbox"/> At least 1 time per week <input type="checkbox"/> At least 1 time per day <input type="checkbox"/> At least 1 time per hour
<b>Explain why the person is at risk.</b>
<b>Where are the strategies to reduce risk identified in the plan?</b> <input type="checkbox"/> Virtual Supports <input type="checkbox"/> Outcomes <input type="checkbox"/> Assessment Review <input type="checkbox"/> Health Status Review <input type="checkbox"/> Rights Limitation and Due Process <input type="checkbox"/> Benefits and Insurance <input type="checkbox"/> Additional Safeguards

**21. Other Medical and/or Psychological Risk Factors Not Identified Above**

<b>Identified Risk:</b>
<b>Severity of Risk</b> <input type="checkbox"/> Mild: Occasional assistance or monitoring <input type="checkbox"/> Severe: Requires regular assistance
<b>Frequency of Risk</b> <input type="checkbox"/> Less than monthly <input type="checkbox"/> At least 1 time per month

<input type="checkbox"/> At least 1 time per week <input type="checkbox"/> At least 1 time per day <input type="checkbox"/> At least 1 time per hour
<b>Explain why the person is at risk.</b>
<b>Where are the strategies to reduce risk identified in the plan?</b> <input type="checkbox"/> Virtual Supports <input type="checkbox"/> Outcomes <input type="checkbox"/> Assessment Review <input type="checkbox"/> Health Status Review <input type="checkbox"/> Rights Limitation and Due Process <input type="checkbox"/> Benefits and Insurance <input type="checkbox"/> Additional Safeguards

## V. Community and Social

### 1. Community Living

Probing Question: What is the person's ability to live in the community; Are there barriers that challenge the person's ability to live in the community (e.g., is the person at risk for eviction or being homeless, are there frequent moves for seemingly unjustified reasons, are there difficulties with the person's landlord or neighbors, are there safety concerns regarding the person's neighborhood, are they being discriminated against, etc.)

<b>Presents a Risk?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Historical
<b>Severity of Risk</b> <input type="checkbox"/> Mild: Occasional assistance or monitoring <input type="checkbox"/> Severe: Requires regular assistance
<b>Frequency of Risk</b> <input type="checkbox"/> Less than monthly <input type="checkbox"/> At least 1 time per month <input type="checkbox"/> At least 1 time per week <input type="checkbox"/> At least 1 time per day <input type="checkbox"/> At least 1 time per hour
<b>Explain why the person is at risk.</b>
<b>Where are the strategies to reduce risk identified in the plan?</b> <input type="checkbox"/> Virtual Supports <input type="checkbox"/> Outcomes <input type="checkbox"/> Assessment Review <input type="checkbox"/> Health Status Review <input type="checkbox"/> Rights Limitation and Due Process <input type="checkbox"/> Benefits and Insurance <input type="checkbox"/> Additional Safeguards

### 2. Leisure Activities

Probing Question: What is the person's ability to seek out, access, and partake in leisure activities; What are the person's preferences for volunteering; Are there barriers to the person accessing and/or partaking in leisure activities; Are there safety concerns associated with specific leisure activities (swimming, etc.)

<b>Presents a Risk?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Historical
<b>Severity of Risk</b> <input type="checkbox"/> Mild: Occasional assistance or monitoring <input type="checkbox"/> Severe: Requires regular assistance
<b>Frequency of Risk</b> <input type="checkbox"/> Less than monthly <input type="checkbox"/> At least 1 time per month <input type="checkbox"/> At least 1 time per week <input type="checkbox"/> At least 1 time per day <input type="checkbox"/> At least 1 time per hour
<b>Explain why the person is at risk.</b>
<b>Where are the strategies to reduce risk identified in the plan?</b> <input type="checkbox"/> Virtual Supports <input type="checkbox"/> Outcomes <input type="checkbox"/> Assessment Review <input type="checkbox"/> Health Status Review <input type="checkbox"/> Rights Limitation and Due Process <input type="checkbox"/> Benefits and Insurance <input type="checkbox"/> Additional Safeguards

### 3. Social Interaction and Relationships

Probing Question: Do they establish and maintain friendships and relationships; Are there particular people, groups, or settings where the person might be more at risk for tension or miscommunication; Are there situations where social interactions could lead to unexpected consequences; What is the person's ability to engage and be safe on the Internet, social media platforms, or electronic devices; Are there patterns in social interactions that could possibly lead to negative outcomes; etc.

<b>Presents a Risk?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Historical
<b>Severity of Risk</b> <input type="checkbox"/> Mild: Occasional assistance or monitoring <input type="checkbox"/> Severe: Requires regular assistance
<b>Frequency of Risk</b> <input type="checkbox"/> Less than monthly <input type="checkbox"/> At least 1 time per month <input type="checkbox"/> At least 1 time per week <input type="checkbox"/> At least 1 time per day <input type="checkbox"/> At least 1 time per hour
<b>Explain why the person is at risk.</b>
<b>Where are the strategies to reduce risk identified in the plan?</b> <input type="checkbox"/> Virtual Supports <input type="checkbox"/> Outcomes <input type="checkbox"/> Assessment Review <input type="checkbox"/> Health Status Review <input type="checkbox"/> Rights Limitation and Due Process <input type="checkbox"/> Benefits and Insurance

Additional Safeguards

#### 4. Parenthood

Probing Question: Does the person have a child or express the wish to have a child; do they understand the responsibilities; are there religious or cultural considerations; are they the primary caregiver for the children; is there another agency involved with the care or protection of the child; etc.

<b>Presents a Risk?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Historical
<b>Severity of Risk</b> <input type="checkbox"/> Mild: Occasional assistance or monitoring <input type="checkbox"/> Severe: Requires regular assistance
<b>Frequency of Risk</b> <input type="checkbox"/> Less than monthly <input type="checkbox"/> At least 1 time per month <input type="checkbox"/> At least 1 time per week <input type="checkbox"/> At least 1 time per day <input type="checkbox"/> At least 1 time per hour
<b>Explain why the person is at risk.</b>
<b>Where are the strategies to reduce risk identified in the plan?</b> <input type="checkbox"/> Virtual Supports <input type="checkbox"/> Outcomes <input type="checkbox"/> Assessment Review <input type="checkbox"/> Health Status Review <input type="checkbox"/> Rights Limitation and Due Process <input type="checkbox"/> Benefits and Insurance <input type="checkbox"/> Additional Safeguards
<b>Is the person a parent (this includes adult children)?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>If yes, what age is/are the child/children?</b> <input type="checkbox"/> Over the age of 18 <input type="checkbox"/> Under the age of 18 <input type="checkbox"/> Unknown age
<b>If the child is under 18, do they live with the person?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No

#### 5. Family Dynamics

Probing Question: Are there significant family relationships or other dynamics; etc.

<b>Presents a Risk?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Historical
<b>Severity of Risk</b> <input type="checkbox"/> Mild: Occasional assistance or monitoring <input type="checkbox"/> Severe: Requires regular assistance
<b>Frequency of Risk</b> <input type="checkbox"/> Less than monthly <input type="checkbox"/> At least 1 time per month <input type="checkbox"/> At least 1 time per week <input type="checkbox"/> At least 1 time per day <input type="checkbox"/> At least 1 time per hour

<b>Explain why the person is at risk.</b>
<b>Where are the strategies to reduce risk identified in the plan?</b>
<input type="checkbox"/> Virtual Supports <input type="checkbox"/> Outcomes <input type="checkbox"/> Assessment Review <input type="checkbox"/> Health Status Review <input type="checkbox"/> Rights Limitation and Due Process <input type="checkbox"/> Benefits and Insurance <input type="checkbox"/> Additional Safeguards

**6. Other Community and Social Risk Factors Not Identified Above**

<b>Identified Risk:</b>
<b>Severity of Risk</b>
<input type="checkbox"/> Mild: Occasional assistance or monitoring <input type="checkbox"/> Severe: Requires regular assistance
<b>Frequency of Risk</b>
<input type="checkbox"/> Less than monthly <input type="checkbox"/> At least 1 time per month <input type="checkbox"/> At least 1 time per week <input type="checkbox"/> At least 1 time per day <input type="checkbox"/> At least 1 time per hour
<b>Explain why the person is at risk.</b>
<b>Where are the strategies to reduce risk identified in the plan?</b>
<input type="checkbox"/> Virtual Supports <input type="checkbox"/> Outcomes <input type="checkbox"/> Assessment Review <input type="checkbox"/> Health Status Review <input type="checkbox"/> Rights Limitation and Due Process <input type="checkbox"/> Benefits and Insurance <input type="checkbox"/> Additional Safeguards

**VI. Staffing and Supervision**

**1. Residential Services (Residential Habilitation, Independent Habilitation, ICF/IID, etc.)**

<b>Does the person receive residential services?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Supervision during the day (when the person is awake):</b>
<input type="checkbox"/> As needed supports (periodic or follow-along support) <input type="checkbox"/> Scheduled, less frequent than daily support <input type="checkbox"/> Daily support (person receives regular peak time support for a limited number of hours per day) <input type="checkbox"/> Person receives 24-hour residential support with basic staff supervision. Staff are not required to have continuous visual observation of the person and staff can support others. <input type="checkbox"/> Line of sight supervision (Staff must always have a visual of the person – staff may support more than one person, but cannot perform other duties that conflict with the line-of-sight) <input type="checkbox"/> 1:1 supervision – One staff is dedicated and responsible for the person (Staff must always have a visual of the person – staff cannot support more than one person and cannot perform other duties that conflict with the one-on-one support/visual).

<p><b>Supervision during overnight hours:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> No support provided during sleep hours</li> <li><input type="checkbox"/> As needed supports (On-call or nearby access to support)</li> <li><input type="checkbox"/> Asleep overnight support on site</li> <li><input type="checkbox"/> Awake overnight support on site</li> <li><input type="checkbox"/> Awake overnight support with line of sight (e.g., visual observation of bedroom)</li> </ul>
<p><b>If the person can safely be alone for a specific amount of time, indicate the amount of time and any relevant conditions.</b></p>
<p><b>If the person requires staff to be within a certain distance, indicate this.</b></p>

**2. Family Support Services (In-Home Support, Respite, etc.)**

<p><b>Does the person receive Family Support services?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Yes</li> <li><input type="checkbox"/> No</li> </ul>
<p><b>Supervision during awake hours:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Non-Continuous – Staff is not required to have visual observation of the person but must be able to assist when needed.</li> <li><input type="checkbox"/> Continuous – Staff must always have a visual of the person.</li> </ul>
<p><b>Supervision during overnight hours:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> No support provided during sleep hours</li> <li><input type="checkbox"/> As needed supports (On-call or nearby access to support)</li> <li><input type="checkbox"/> Asleep overnight support on site</li> <li><input type="checkbox"/> Awake overnight support on site</li> <li><input type="checkbox"/> Awake overnight support with line of sight (e.g., visual observation of bedroom)</li> </ul>
<p><b>Is staff required to remain with the person until primary caregiver returns?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Yes</li> <li><input type="checkbox"/> No</li> </ul>
<p><b>If the person can safely be alone for a specific amount of time, indicate the amount of time and any relevant conditions.</b></p>
<p><b>If the person requires staff to be within a certain distance, indicate this.</b></p>

**3. Day Program/Employment Services**

<p><b>Does the person receive day program/employment services?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Yes</li> <li><input type="checkbox"/> No</li> </ul>
<p><b>Supervision during day program/employment:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> As needed supports (periodic or follow-along support)</li> <li><input type="checkbox"/> Scheduled or peak time support for a limited number of hours per day</li> <li><input type="checkbox"/> Person receives basic staff supervision. Staff are not required to have continuous visual observation of the person and staff can support others.</li> <li><input type="checkbox"/> Line-of-sight supervision (Staff must always have a visual of the person – staff may support more than one person, but cannot perform other duties that conflict with the line-of-sight)</li> </ul>

<input type="checkbox"/> 1:1 supervision – One staff is dedicated and responsible for the person (Staff must always have a visual of the person – staff cannot support more than one person and cannot perform other duties that conflict with the one-on-one support/visual).
<b>If the person can safely be alone for a specific amount of time, indicate the amount of time and any relevant conditions.</b>
<b>If the person requires staff to be within a certain distance, indicate this.</b>

#### 4. Community Activities

<b>Does the person receive support while engaging in community activities?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Supervision during day program/employment:</b> <input type="checkbox"/> As needed supports (periodic or follow-along support) <input type="checkbox"/> Scheduled or peak time support for specific locations or periods of the day <input type="checkbox"/> Person receives basic staff supervision. Staff are not required to have continuous visual observation of the person and staff can support others. <input type="checkbox"/> Line-of-sight supervision (Staff must always have a visual of the person – staff may support more than one person, but cannot perform other duties that conflict with the line-of-sight) <input type="checkbox"/> 1:1 supervision – One staff is dedicated and responsible for the person (Staff must always have a visual of the person – staff cannot support more than one person and cannot perform other duties that conflict with the one-on-one support/visual).
<b>If the person can safely be alone for a specific amount of time, indicate the amount of time and any relevant conditions.</b>
<b>If the person requires staff to be within a certain distance, indicate this.</b>