**Applicant:**

Last Name First Name Medicaid ID #

Address Phone #

**Assessment Completed By:**

Name Date Completed (MM/DD/YY)

Agency Name and Address

Email Phone #

***Instructions***

This document should be used in combination with observations, conversations, chart review, and any other information shared to learn about an applicant’s potential for living in the community. It identifies:

* Potential barriers to community living and
* Need for supports when living in the community.

**The tool gathers information about the following areas:**

* [Housing/Home Modifications](#Housing)
* [Money Matters (Income, Benefits & Employment)](#Money)
* [Self-motivation](#SelfMotivation)
* [Support system](#Support)
* [Behavioral Health (Mental Health and Substance Use)](#MHSA)
* [Medical & Personal Care](#MedCare)

This information is to be used as a guide to help determine whether an individual is/is not recommended for community transition services, to help determine the extent of assistance with moving to the community, and to help determine whether he/she might benefit from a waiver assessment. This information will be used for discharge planning purposes and to assist in developing the appropriate community service plans.

***Goals and Desired Outcomes***

1. **What are your goals, preferences, desired outcomes?**

1. **What is important to you (values, beliefs, how you want to live, activities, hobbies, routines, family traditions, social groups, church, etc.)?**

***Filter Questions***

1. **Where are you currently residing?**

Hospital

Intermediate care facility

Nursing facility

Residential Treatment Center with 16 or more total beds (and the individual is under the age of 22)

None of the above *(STOP*🡪*The individual is ineligible; document on eligibility checklist with comments.)*

Comments/Observations:\_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Do you have a legal guardian?**

Yes (Ensure documentation is on file)

No

1. Guardian Name:

Guardian Phone Number:

Guardian Address:

1. **Are you able to relocate to a community setting or are there any legal reasons you must stay?**

Yes, can relocate to a community setting

No, not legally permitted to leave *(STOP*🡪*The individual is ineligible; document on eligibility checklist with comments.)*

*If “No”, please describe the situation (e.g. court ordered placement) here.*

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***Need for Housing***

1. **Do you have a housing option to return to after discharge?**

Yes – will be returning to my own house

Yes – will be returning to my apartment

Yes – have found new housing

No – need help finding housing

**If “No – need help finding housing”, where in North Dakota would you like to live *(county, city, area of city)?***

**If “Yes”, are you at risk of losing your housing due to your institutional stay?**

Yes

No *(Skip to Question 14)*

Comments/Observations:

1. **Who would you prefer to live with?**

Alone? *(Skip to Question 11)*

With family?

With a roommate?

Comments/Observations:

1. **If you prefer to live with family or roommate, please tell us their name, relationship to you, whether we have permission to contact them, and their contact information. (If more than three, please attach a separate sheet with the information below.)**
2. Name:       Relationship:

Permission to Contact

Phone # 1:      Phone #2:

E-mail 1:      Email 2:

Address:

1. Name:

Relationship:

Permission to Contact

Phone # 1:      Phone #2:

E-mail 1:      Email 2:

Address:

1. Name:       Relationship:

Permission to Contact

Phone # 1:      Phone #2:

E-mail 1:      Email 2:

Address:

Comments/Observations:

1. **Do you prefer to live with a non-smoker?**

Yes

No

Not Applicable

Comments/Observations:

1. **If you will share a living space, what age group do you want to live with?**

18-25

26-35

36-50

51-64

65+

No preference

Not willing to share a living space with others

Not applicable

Comments/Observations:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1. **Please rank the following housing types from one to five (1-5) where one (1) means it is your most preferred housing & five means it is your least preferred.**   *Each number may be used only once.* | | 1. **How much support do you need in each of these living environments?**   *Please check only one per line.* | | | | |
| **Housing Choices** | **Rank** | **Daily** | **Weekly** | **Monthly** | **None** | **Don’t Know** |
| 1. Live in a house, apartment, or room by yourself |  |  |  |  |  |  |
| 1. Live in a house, apartment, room with family |  |  |  |  |  |  |
| 1. Live in a house, apartment, or room with roommate(s) |  |  |  |  |  |  |
| 1. Live in a group setting w/ other clients & have 24/7 staff support on-site |  |  |  |  |  |  |
| 1. Live in an assisted living setting |  |  |  |  |  |  |

1. **Would you like assistance in looking for housing options?**

Yes

No

Not applicable—have housing

Comments/Observations:

1. **Are there any physical changes or modifications to your housing (home modification) needed in order to help you?**

Yes

No

Not Applicable

If yes, describe:

1. **Are there any barriers or issues that would make obtaining housing difficult?**

Limited or no income

Previously evicted

Outstanding warrant/criminal history

Other. Please explain:

No barriers or issues stated (*please note this does not necessarily mean that barriers/issues do not exist)*

Comments/Observations:

***Self-Motivation***

1. **What steps have you taken to plan your discharge from here?**      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **Are there things that may be difficult when returning to the community?**

1. **On a scale from 1 to 5, where 1 is “haven’t thought about it and not at all ready” and 5 is “very ready”, how ready are you to relocate?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1 | 2 | 3 | 4 | 5 |
| Haven’t thought about it. Not at all ready | Thought about it but not ready | Undecided | Somewhat ready | Very ready |

1. **How do you wish to be integrated into the community (involved in activities, volunteer, socializing outside of the home, friendships, church, informal supports, etc.)?**

1. **Next, I’m going to read a list of some of the places you may want to live close to in the community.**

**After I say each, first let me know if you think it’s important. Then, let me know if you think you’d like to be able to walk to that place or if it would be okay to take public transportation or get a ride from a friend.**

*If you think of any that I didn’t mention, let me know at the end and I’ll write them down.*

| **Resources/ Amenities** | Important | Walk to | Ride | N/A | Comments |
| --- | --- | --- | --- | --- | --- |
| 1. Houses of family/ friends |  |  |  |  |  |
| 1. Bus stop |  |  | N/A |  |  |
| 1. Open spaces/parks |  |  |  |  |  |
| 1. Church, Synagogue, Mosque, or other place of worship |  |  |  |  |  |
| 1. Malls/shopping areas |  |  |  |  |  |
| 1. Food bank |  |  |  |  |  |
| 1. Library |  |  |  |  |  |
| 1. Grocery store |  |  |  |  |  |
| 1. Pharmacy |  |  |  |  |  |
| 1. Post office |  |  |  |  |  |
| 1. Recreation/ sport/fitness centers |  |  |  |  |  |
| 1. Convenience Store |  |  |  |  |  |
| 1. County Job and Family Services |  |  |  |  |  |
| 1. Addiction counseling |  |  |  |  |  |
| 1. Hospital |  |  |  |  |  |
| 1. Medical services/public health clinic |  |  |  |  |  |
| 1. Dentist/dental clinic |  |  |  |  |  |
| 1. Ophthalmologist/vision clinic |  |  |  |  |  |
| 1. Mental health clinic/drop-in centers (MH) |  |  |  |  |  |
| 1. Housing supports (Housing Authority, Landlord’s office) |  |  |  |  |  |
| 1. Self-help/support groups (AA, OA, NA) |  |  |  |  |  |
| 1. Employment/ School/Vocational Training |  |  |  |  |  |
| 1. Other: |  |  |  |  |  |
| 1. Other: |  |  |  |  |  |
| 1. Other: |  |  |  |  |  |

1. **Have you ever been arrested?**

Yes

No (Skip to question 22)

* 1. **If yes, would you please tell me what happened?**

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* 1. **Will this have an impact on where you can live in the community?**

Yes

No

Comments/Observations:\_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Money Matters***

***Income & Benefits***

1. **Have you enlisted or served in the U.S. Military?**

Yes

No

Comments/Observations:\_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Do you have any of the following sources of monthly income?**

SS (Social Security)

SSDI (Social Security Disability Insurance)

Benefits from the Veterans’ Administration?

Other. Please tell me about it:

None

1. **Do you have any of the following health-related expenses?**

Insurance premium

Prescription Medication

Other. Please note here:

1. **Have you or someone on your behalf submitted a Medicaid application?**

Yes

No

Not applicable

Comments/Observations:\_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Are there any current applications (for SS/SSDI, Veterans Assistance, etc.) in appeal?**

Yes

No

Not applicable

Comments/Observations:     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Would you like assistance with the application or appeal process?**

Yes

No

Not Applicable

Comments/Observations:     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Would you like assistance setting up public benefits such as food stamps, cash assistance, etc.?**

Yes

No

Not applicable

Comments/Observations:     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Employment***

1. **Would you like to work for pay once you move to the community?**

Yes—How many hours/week would you like to work?

No

Not applicable

Comments/Observations:

1. **Would you like to volunteer once you move to the community?**

Yes— How many hours/week would you like to volunteer?

No

Not applicable

Comments/Observations:

1. **Would you like help finding employment or volunteer opportunities?**

Yes

No

Not applicable

Comments/Observations:

1. **Please describe your credit history?**
2. **Are there any outstanding bills or payments owed to anyone?** *(e.g. to utility companies, landlords, etc.)*

***Support System***

If you are found eligible for community transition services, the next step would be to do some careful planning. This involves discussing what you need and planning to meet those needs. Sometimes planning works best when others important to you are involved.

1. **Who do you trust the most and would be helpful to you in planning?**

Name:

**May I contact him/her?**

Yes

No

**What is the best way to contact him/her?**

**Contact Information:**

Phone Number:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail:     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. **Are there other family or friends who would be helpful in planning your return to the community?** *(friends/family that can call upon in times of distress)*

Yes

No

**Contact Information:**

Phone Number:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Contact Information:**

Phone Number:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. **Who are other connections you have (or had previously) in your community, church, service groups, etc.?**

***Behavioral Health (Mental Health and Substance Use)***

Behavioral HealthScreening Tools are to be completed with assistance from the Social Worker/Discharge Planner of the institutional facility in which the applicant resides.

Clinical documentation should be used to its fullest extent to verify information presented by the applicant. This documentation should be on-site at the institutional facility in the participant’s chart and accessible by the Social Worker/Discharge Planner.

If any of the boxes are marked “Yes” on either of the screening tools, then a referral should be considered for a Mental Health, Substance Use, or combined assessment.

The purpose of implementing this process is to ensure that any mental health or substance use concerns are identified prior to transition in the community. This will allow for a greater continuity of care and success for the individual.

***Mental Health***

1. **Have there ever been struggles with mental health concerns or have you ever received a mental health diagnosis?**

Self-reported:

**Does this currently affect you?**

Yes

No

**If yes, are you receiving current services (medication(s), counseling, etc.)?**

Yes

No

**Are there services in the community you would prefer to use?**

Yes

No

**If yes, please identify:**

Staff-reported:

Family-reported:

Chart review:

Observation:

No

**Additional Comments/Observations:**

1. **Would you like assistance connecting to community mental health resources?**

Yes

No

Not Applicable

Comments/Observations:

1. **Has there been any hospitalizations due to mental health concerns?**

Yes. If yes, how many in the past 2 years?

No

Not Applicable

Comments/Observations:

1. **Have you received case management services from a mental health agency in the past?**

Yes

No

Not Applicable

Comments/Observations:

1. **Have you thought about hurting yourself or had suicidal thoughts in the past 90 days?** *(e.g.,* *attempted suicide; made suicidal gesture; expressed suicidal ideation)*

Yes

No

Not applicable

Comments/Observations:

1. **Have you had thoughts of hurting others in the past 90 days?** *(e.g.,* *assaultive to other children or adults; reckless and puts self in dangerous situations; attempts to or has sexually assaulted other individuals)*

Yes

No

Not applicable

Comments/Observations:

1. **Do you have difficulty getting along with others?** *(Regularly involved in physical fights with others; verbally threatens people; damages possessions of self or other; runs away; steals; regularly lies; mute; confined due to serious law violations; does not seem to feel guilt after misbehavior, etc.)*

Yes

No

Not applicable

Comments/Observations:

1. **Do you enjoy being around other people?**

Yes

No

Not applicable

Comments/Observations:

1. **Describe the relationships in your life?**

Comments/Observations:

1. **Do you have problems completing your own basic needs or activities of daily living?**

*(Known history of developmental disorder; “not socialized”; incapable of managing basic age appropriate self-care skills.)*

Yes

No

Not applicable

Comments/Observations:

1. **Describe how you handle your feelings or deal with stress:**

(*Severe temper; screams uncontrollably; cries inconsolably; withdrawn and uninvolved with others, regularly expresses strong emotions such as the feeling that others are out to get them; excessive preoccupation, etc.)*

Comments/Observations:

**Additional Comments/Observations regarding Behavioral Health Support Needs:**

***Substance Use/Identified Risk***

1. **How often did you drink alcohol prior to being in your current living situation?**

Comments/Observations:

1. **How often did you use other substances prior to being in your current living situation?**

Comments/Observations:

1. **Have there ever been struggles with substance use or have you been diagnosed with a substance use disorder?**

Self-reported:

Staff-reported:

Family-reported:

Chart review:

Observation:

No

**Additional Comments/Observations:**

1. **Has anyone in your life ever expressed concern for your substance use (alcohol or drugs)?**

Yes

No

Not applicable

Comments/Observations:

1. **Have you ever received treatment for substance use?**

Yes

* If “Yes”, how many episodes have occurred in the last 2 years?
* Number of Residential:
* Number of Outpatient:
* Number of times needing withdrawal management (detox):

No

Not applicable

Comments/Observations:

1. **Would you like assistance connecting to community addiction treatment or recovery support services?**

Yes

No

Not applicable

Comments/Observations:

1. **Do you need to use more of a substance to achieve the desired affect?**

Yes

No

Not applicable

Comments/Observations:

**Additional Comments/Recommendations:**

\_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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***Medical and Personal Care Needs***

1. Please check all of the following for which you need assistance:

Establishing or maintaining contact with a primary care physician.

Establishing or maintaining contact with therapists (OT, PT, ST, Counselor, Psychologist)

Managing medications

Medical care (e.g. diabetes management, breathing treatments, shots)

Accessing the home and/or community due to mobility needs

Managing personal hygiene

Help with routine tasks (preparing meals, cleaning, bathing/showering, dressing)

Nutritional intake/counseling/management

Emergency response assistance

Specialized equipment/assistive technology

Accessing local community supports such as home energy assistance, cell phone support, etc.

Fall risk

Other. Please specify:

None

Comments/Observations:

1. **Will you need nursing services?**

Yes

* + How many hours per week?
  + For what purposes?

No

**Additional Comments/Observations:**

1. **Do you need assistance with medication?**

Yes

* + How many hours per week?
  + For what purposes?

No

**Additional Comments/Observations:**

1. **Do you have any medical diagnoses?**

Self-reported:

Staff-reported:

Family-reported:

Chart review:

Observation:

No

**Additional Comments/Observations:**

1. **Does the current physician support discharge?**

Yes

No

**Physician Name:**

**Additional Comments/Observations:**

1. **Do you have a good appetite?**

Yes

No

**Additional Comments/Observations:**

1. **Are you on a special diet?**

Yes

* + Please describe
  + For what purposes?

No

**Additional Comments/Observations:**

1. **Do you wear glasses?**

Yes

No

**Additional Comments/Observations:**

1. **Do you use a hearing aid?**

Yes

No

**Additional Comments/Observations:**

1. **Do you have speech concerns?**

Yes

No

**Additional Comments/Observations:**

1. **Do you use assistive devices?**

Yes

* + Please describe
  + For what purposes?

No

**Additional Comments/Observations:**

1. **Do you have cognitive deficits (memory (long/short), able to follow conversations, problem solving, etc.)?**

Yes

* + Please describe:

No

**Additional Comments/Observations:**

1. **Do you have behavior concerns (aggressive, irritated, sleep patterns, wandering, etc.)?**

Yes

* + Please describe:

No

**Additional Comments/Observations:**

**Additional Comments and Observations** (*Paint the picture of the person*)**:**

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1. **Barriers to Community Living that must be addressed prior to discharge**

*(Check all that apply)*

Physical health issues must improve prior to return

History of Substance Abuse with risk to relapse requires coordination in the community care plan

History and/or current mental health issues require coordination into the community care plan

Lack of sufficient income to support community living

Bad debt—need for credit recovery

Criminal history may delay housing connections

Probate court issues

Lack of awareness or unrealistic expectations regarding disability or needed supports

Lack of support by Guardian and/or Family

Lack of support by physician and or psychiatrist

Lack of independent living skills

Language or communication barriers

Need for accessible housing/home modifications/assistive technology

Lack of informal supports

Lack of community service providers

Lack of affordable housing options

Lack of transportation

Qualification for services in the community