Information in this section may be changed throughout the entire year

CONSUMER INFORMATION

1. SS #: _____ 2. Birth Date: _____

Full Legal Name: _____ (3. Last) _____ (4. First) _____ (5. Middle)

6. Street Address: _____

7. City: _____ State: KS 9. Zip: _____

10. Home Phone #: _____

11. County of Residence (3 Digits): _____ 12. Home County (3 Digits): _____

13. KS Medicaid #: _____ 14. Sex (X One): ☐ **MALE (1)** ☐ **FEMALE (2)**

15. **Race** ☐ (Enter One Choice)
1. White 2. African American 3. Native American 4. Asian/Pacific Islander
5. Hispanic 6. Other: _____

16. **Residential Status** (Enter One Choice)
☐
1. Living Alone (No Roommates, paid staff do NOT count as roommates)
2. Living w/ 2 or less persons w/ MRDD (No more than a total of 3 MRDD persons living together)
3. Living w/ 3-7 other persons w/ MRDD (No more than a total of 8 MRDD persons living together)
4. Living w/ 8 or more persons w/MRDD (Setting with more than 8 MRDD persons living together)
5. Living w/ relatives (1 or more people are related by blood, marriage or adoption to him/her)
6. Living w/non-relatives who are not MRDD (Not MRDD & Not related by blood, marriage, adoption)
7. Other: _____

17. **Day Programs** (Enter up to 3 Categories) ☐ ☐ ☐
Choose those that best describe the persons' current activities that occur during the **DAY**.
1. Attends school in a classroom 50% or more of the day with people who are NOT MRDD
2. Attends school in a classroom 49% or less of the day with people who are NOT MRDD

3. Generic community activities LESS than 20 hours per week (Not specifically designed for MRDD)
4. Generic community activities 20 or MORE hours per week (Not specifically designed for MRDD)

5. Work environment designed for persons with MRDD - LESS than 20 hours per week (Ex: Workshop)
6. Work environment designed for persons with MRDD - 20 or MORE hours per week (Ex: Workshop)

7. Competitive employment - LESS than 20 hours per week (At least 75% of Co-workers are not MRDD)
8. Competitive employment - 20 or MORE hours per week (At least 75% of Co-workers are not MRDD)

9. Agency based non-work activities - LESS than 20 hours per week (Not work related & no wages paid)
10. Agency based non work activities - 20 hours or MORE per week (Not work related & no wages paid)

11. Other (Ex: Volunteering, Home School / Person stays home during the Day) _____

Information in this section may be changed throughout the entire year.

18. Identified Disabilities

Enter One Choice for Questions 1-4: 1 = True 2 = False

1. Mental Retardation:
2. Autism: (Autism Only – Capture Aspergers / PDD-NOS in #21 – or Other: if only diagnosis)
3. Cerebral Palsy: (Includes: Diplegic, Hemiparesis, Hemiplegic, Monoplegic, Quadriplegic)
4. Epilepsy / Seizure D/O:
5. Other (Fill In Diagnosis):

19. The **Primary Disability** for this individual, from the previous question is (Enter One Choice)

20. **Special Population** - Enter up to 3 Categories

1. CIP (Persons placed out of any of the SMRH's using Essential Lifestyle Plan – Since 07-01-91)
2. Child In Custody (A child determined to be a child in need of care by the Courts & placed in custody of SRS)
3. Self Directed Care (Self Directed services. Selects, trains, schedules, manages, terminates. Ex: In Home Supports)
4. Self Determination (Participating in Self Determination Project thru CLASS/OCCK/Comcare/TARC/Cottonwood)
5. Special Care Rate (Person approved by HCP for Special Care Rate on or after 07-01-93 & is still using the rate)
6. ICF/MR Closure (Person is placed out of a private ICF/MR after 10-01-94, as aresult of bed or facility closure)
7. SMHH (Person placed into community DD Services from a State Men tal Hospital: Larned, Osawatomi, Rainbow after 7-1-95)

21. **Psychiatric Diagnosis** (Enter up to **3** DSM-IV Diagnosis Codes & Do **NOT** enter here if already captured in #18 of Info Section.)

1) 2) 3)

22. **Intellectual Assessment** – Fill In

1. Normal
2. Mild
3. Moderate
4. Severe
5. Profound
6. Undetermined

23. **Hearing** – (with aids if used) - Fill In

1. Normal
2. Mild Loss
3. Moderate Loss
4. Severe Loss
5. Profound Loss
6. Undetermined

24. **Vision** (with glasses /contacts if used) – Fill In

1. Fully Sighted
2. Moderate Impairment
3. Severe Impairment
4. Light Perception
5. Total Blindness
6. Undetermined

GUARDIAN INFORMATION

Legal Guardian – If Consumer is age **18** or over - Need Court Documents in BCI~~main file at Jo Co CDDO~~.
Natural Guardian – If Consumer is age **17** or younger - The biological Parents are the Natural Guardians. Need Birth Certificate in CDDO file.

25. Guardian Last Name: Guardian First Name:

27. Street Address: 28. City:

29. State: 30. Zip: 31. Phone #:

SERVICE COORDINATOR / CASE MANAGEMENT INFORMATION

Service Coordinator Name:
32. (Last) 33. (First)

34. Service Coordinator Phone#:

35. Agency # for Serv. Coordinator (6 Digits): 36. Date of This Report:

Information in this section can **ONLY** be changed during the Annual BASIS Assessment. - Use for individuals age **5** and over.

SS #:

Full Legal Name: 1. (Last) 2. (First) 3. (Middle)

1. **TYPE OF REPORT** (Enter One Choice)

1. Initial Assessment 2. Annual Re-Evaluation 3. Special Re-Eval With HCP Permission 4. Re-Admitted From Same CDDO
5. Transferred From Another Facility 6. Child Is Reaching 5 Years of Age 7. Correcting Social Security #

2. **Date BASIS Assessment Was Completed:**

3. **MEDICAL CONDITIONS** - (Refer to Medical Conditions Reference provided by SRS, for correct classification)

Current supporting documentation must be dated within the past **24** months. (Ex. Health Assessments, Medical Reports, Medical Test Results, etc.)
To mark "YES" the condition **MUST** be a **current diagnosis** from a Physician & **ONE** of the following must apply:

1) Currently taking maintenance medication(s) for the condition 2) The condition requires on-going support from staff
3) Person receives ongoing medical care with a Physician - which reviews treatment at least **1** time per year
Enter One Choice: 1= TRUE 2 = FALSE

	RESPIRATORY	
	CARDIOVASCULAR	
	GASTRO-INTESTINAL	
	GENITO-URINARY	
	NEOPLASTIC DISEASE	
	NEUROLOGICAL DISEASE Not captured here if in #18 on Pg 1	

4A. **SEIZURE HISTORY - Does the individual have a history of seizures-?** X ONE: **YES (1)** **NO (2)**

Must be epileptic in nature and **NOT** medication induced or caused by another medical condition such as High Blood Pressure. Must be diagnosed by a physician. If the individual has NOT had a seizure within a **5** year time period **&** they are **NOT** receiving treatment for a seizure condition then mark "NO".
Ask support staff to gather necessary seizure documentation from physician for future BASIS Assessments.
Do NOT mark "YES" unless this person has been diagnosed with seizures on Page #1 of BASIS - Identified Disabilities.

Verify In Section 18 Identified Disabilities **Skip To # 5A**

4B. **SEIZURE TYPE -** Which Type Of Seizure Has The Individual Experienced in the Last 12 Months ? **Send Tracking Forms to CDDO**

Enter One Choice In *Every* Box: TRUE = 1 or FALSE = 2

	No Seizures This Year	In the last 12 Months
	Had Simple Partial:	Simple motor movements affected, no loss of awareness. Simple Partial Motor Signs OR Simple Partial Sensory Signs
	Had Complex Partial:	Involves Loss of Awareness
	Had Generalized Absence:	Petit Mal
	Had Generalized Tonic Clonic:	Grand Mal
	Had Some Type of Seizure:	Mark ONLY If Unsure Of The Seizure Type

4C. **SEIZURE FREQUENCY -** Frequency of Seizures in the Past **12** Months. (Enter One Choice)

Individual Experienced Seizures That Involve Loss Of Awareness &/Or Consciousness. **Send Tracking Forms to CDDO**

1. None During The Past 12 Months
2. Less Than Once A Month – ** Highest frequency that can be marked without tracking. (RT04-22-10)
3. About Once A Month
4. About Once A Week
5. Several Times A Week
6. Once A Day Or More - **Send Medical Documentation to CDDO**

Information in this section can **ONLY** be changed during the Annual BASIS Assessment. - Use for individuals age **5** and over.

5A. PRESCRIPTION MEDICATION

Is The Individual Currently Taking *Prescription* Medication ? (X ONE) ☐ **YES (1)** ☐ **NO (2)**

Skip to # 6

Mark "YES" if medications are taken on an ongoing scheduled basis, prescribed by a physician & can NOT be purchased without a prescription from a physician.
Do NOT count over the counter medications here, even if prescribed by a physician.
Do NOT count any temporary medications such as antibiotics or medications taken as needed - PRN
(Ex: NOT counted here even if the as needed (PRN) medications are for Behaviors &/or Seizures)

Fill in all prescribed Medications & Class type. **For an extensive list send med listing with class(es) noted.**

5B. MEDICATIONS - Capture **ALL** *Prescription* medication classes that the person receives / is currently taking:

Prescription Medications - Guidelines from 5A apply here also. Medications are to be identified by CLASS TYPE.
If the medication has 2 class types, then capture it only once under the most appropriate class for the consumers' use of the medication.

	ANTI - *PSYCHOTIC*
	ANTI - *ANXIETY*
	ANTI - *DEPRESSANT*
	ANTI - *CONVULSANT*
	DIABETES
	SEDATIVE / HYPNOTIC
	OTHER MAINTENANCE

1 = **NOT** TAKING
2 = CURRENTLY TAKES

5C. INJECTION Does Individual Receive Ongoing Medication By Injection ?

(**Underline or Enter Type:** Allergies, B-12 Injections, Birth Control, Botox, Growth Hormone, Insulin)

This does **NOT** include annual flu shots, PRN (as needed) injections such as flu shots, dialysis, blood transfusions, baclofen pumps or injections by &/or thru feeding tubes.

X ONE: ☐ **YES (1)** ☐ **NO (2)**

ONLY mark **YES** if the medication is injected directly into the skin surface of the individual. List Medication(s) below.

5D. ☐ LEVEL OF SUPPORT

Enter One Choice & Provide Explanation

Mark the level of support the individual requires the Majority of the time when taking **prescription** medications.
This section does not address the ordering of refills of medications or picking them up from the pharmacy.
If there is more than one level of assistance required, mark highest level required. (Ex: Tablets & Injections – Capture Injections)

Level of Support Needed For **Prescription** Medications

1. **No Medication(s)**
2. **Total Support** - The care giver or medical provider must physically administer the medication by such means as Injections, Creams / Ointments, Eye Drops, Inhaler, Mixed into food / drink. The person is physically incapable of taking medication or is resistive – *Majority* of the time - spits out or refuses to swallow. Person receives ongoing injections: Allergy Shots, B-12, Birth Control, Botox, Growth Hormone, Seizure injection or Insulin from their staff or physician.
3. **Assistance** - The care giver keeps the medication and gives them to the person at the appropriate time for self-administration. Medications given to person served by: Parents, School, Provider Staff, Other:
4. **Supervision** - The person keeps & takes own medications at appropriate time. Pill boxes may be stocked by family, staff or bubble packed. The care giver must prompt or confirm that he/she has indeed taken them & not missed any doses. (Ex. Pill box with alarm, that alerts consumer to take medications at specific times.)
5. **Independent** - The person is totally responsible for his/her own medications and does not require any assistance with this task. Pill boxes may be stocked by family, staff or bubble packed. No prompts or reminders are required, no missed doses.

Information in this section can **ONLY** be changed during the Annual BASIS Assessment. - Use for individuals age **5** and over.

6. MEDICAL CONSEQUENCES - Indicate if these questions apply to this individual.

Enter 1 = True OR 2 = False for each question and provide an explanation

☐ Missed more than a total of **14 Calendar Days** of regular activities due to medical conditions during the last year. Exclude trips to doctor for routine exams/assessments or mental health treatments/conditions. This addresses only days missed due to actual medical illness or condition.

If "**YES (1)**", List Condition(s):

☐ Was **Hospitalized** for a medical problem in the last year – the past 12 months.
(Ex: In-patient overnight hospital stay, do **NOT** count out-patient procedures or psychiatric treatments/hospitalizations)

If "**YES (1)**", List Reason For Overnight Stay:

☐ Presently requires care giver to be trained in ***Special Health Care Procedures***
Ex: **B**ed (Special) for Positioning, **B**races – worn daily, **B**elly Board Needed Daily, **B**reathing or Inhalation Treatments / Nebulizer – 3x's every week or more, **C**atheter daily, **C**hair (Special) for Positioning, **C**PAP Machine, **C**rutches, **D**ecubitus Care & Equipment, **D**iabetic - daily testing, **E**ating Utensils (Special) if required per written documentation from a health care professional, **E**nemas - prescribed & ongoing, **F**eed – Intravaneous, **F**lotation Cushion or Pad, **F**luoride Treatments – prescribed and Staff training is required – Not just mouthwash or toothpaste. **G**astronomy Tube (G-Tube) or Nasal Gastric Tube, **H**earing Aids, **N**ebulizer – 3x's every week or more, **O**rthopedic Shoes – wears daily, **O**stomy Equipment, **O**xygen Equipment, **P**acemaker – Transtelephonic Transmitter, **P**arenteral Equipment – intravenous or other feedings, **P**ositioning - frequent turning in bed, **P**rosthetic Device: Limb- Hand- etc. , **P**rotective Head Device Needed Daily, **R**espirator, **S**leep Apnea Monitor, **S**plints – worn daily, **S**terile Dressings– Daily for chronic condition, **S**uctioning needed daily, **T**ed Hose, **T**racheostomy Care, **V**agus Nerve Stimulator, **W**heelchair (Electric / Manual).
(****NOTE: Do **NOT** Count: Behavior Management, CPR, Heimlich Maneuver, or Seizure Training / Seizure Suppositories here.)

NONE REPORTED			

☐ Presently requires a ***Special Diet*** that is specifically planned by a nutritionist,dietician, nurse or physician.
(Ex: High Fiber, Low Calorie, Low Sodium) The diet is individualized. Must be ordered by a physician, is specific for the person **&** requires support from: Staff, Spouse, Family, or Circle of Support in order to follow the diet. It must be part of a written, formalized diet (ex. 1800 calories per day, diabetes diagnosis) and it should be included in the Person Centered Support Plan. Mark "YES" only if additional support staff is needed **&** documentation exists that the diet is related to some type of medical condition. (Ex. Obesity, Seizures, Severe Food Allergies) A recommendation from a physician to reduce caloric intake in order to lose weight, or pureed food would NOT be considered a special diet because it is too vague. Capture specialized consistency in Self Care Section – Chewing & Swallowing Food – and not here.

Supporting documentation must be dated within the past **24 months**.

Date of Document	Type of Diet	Targeted Medical Condition

7. MOBILITY

Indicate Which ONE best describes the individual's typical level of mobility:
Consider sensory deficits in your assessment if they significantly impede mobility. (Ex. Blindness) Enter One Choice

☐
1. Walks Independently
2. Walks Independently but with difficulty (NO Corrective Device or Aid needed but persons gait is not steady)
3. Walks Independently with Corrective Device (Ex. AFO's, Braces, Cane, Gait Belt, Prescribed Orthopedic Inserts, Lift Shoes, Walker)
4. Walks only with assistance from another person.
5. Can Not Walk

8A. WHEELCHAIR

☐ **YES (1)** ☐ **NO (2)** **Skip to # 9**

Does Individual Use a Wheelchair / Stroller Chair ? X ONE

If NO, then skip to #9. Only mark "YES" if the person typically uses a wheelchair or a stroller chair on a daily Basis for ***50%*** or more of the time and it is used for mobility purposes.

8B. WHEELCHAIR MOBILITY

☐ Choose **ONE** response that best describes wheelchair mobility – Manual or Electric / Motorized

1. Can use wheelchair independently, including transferring
2. Can use wheelchair independently, with assistance in transferring
3. Requires assistance in transferring and moving
4. No Mobility – Must be transferred and moved

Information in this section can **ONLY** be changed during the Annual BASIS Assessment. - Use for individuals age **5** and over.

*** Skills Noted With Asterisk Are On Worksheet**

9. **MOTOR CONTROL -** Indicate whether or not the individual can perform each of the following. 1=True 2= False

View these questions as the person is ***PRESENTLY*** capable of doing these. These do **NOT** address their *willingness / unwillingness* to engage in these.

	Roll from back to stomach	
	Pull self to standing (From a chair to a standing position)	
	Walk Up & Down stairs by alternating feet from step to step	
	Pick up a small object * (Ex: Paperclip, cheerio, marble, dice, Assessor's sorting items)	
	Transfer an object from hand to hand	
	Mark with a pencil, crayon or chalk * (Ex: Can scribble, marks NOT required to be legible)	
	Turn pages of a book one at a time	
	Copy a circle from an example *	
	Cut with scissors along a straight line * (Perfection is NOT the threshold) RT 04-30-09	

**** ATTACH COMPLETED BASIS WORKSHEET. OBTAIN A COPY AS APPLICABLE: PCSP / IEP**

10. **COGNITIVE ABILITY -** Indicate whether or not the individual can perform each of the following. 1=True 2= False

These questions are used to determine cognitive abilities. Person should be able to perform the task the **Majority** of the time, and *NOT* necessarily 100% of the time.

	Sort objects by size (Prompt to sort by small, med, large. Shapes similar in color/shape)	
	Correctly spell first & last name * (Mark "YES" if by - writing, verbally, sign language, etc.)	
	Tell time to nearest 5 min. – Digital OR Analog * (Knows the meaning relative to their day)	
	Distinguish between RIGHT & LEFT	
	Count 10 or more objects *	
	Understand 3 out of 5 simple functional signs* (Stop, Restroom, Exit, Recycle, Walk / Don't Walk)	
	Do simple addition & subtraction * (Single digit math only, calculators NOT allowed)	
	Read & Comprehend simple sentences *	
	Read & Comprehend newspaper or magazine article *	

11. **COMMUNICATION -** Indicate whether or not the individual typically (most of the time) displays each of the following receptive & expressive communication skills. 1 = True 2 = False

The person's communication style must be considered in this question. **Be prepared to accept responses in the form of: written, verbal, sign language or symbolic.** The questions below address comprehension and NOT compliance. Behaviors are captured in Section #12.

	Understands the meaning of "No"	
	Understands 1 step directions - Familiar to environment / person Ex: Put on your coat	
	Understands 2 step directions- Familiar to environment/person Ex. Put on coat & go outside	
	Understands a Joke (OR) Story	
	Indicates "Yes" or "No" to a simple question (Responds typically, appropriately, consistently)	
	Asks simple questions (Communicates wants / needs with communication board / device, body movements / language, sign language, gestures, points / leads to item, verbally)	
	Relates experience when asked – Person tells what happened during school / work day	
	Tells a story, joke or the plot of a television (T.V.) show	
	Describes realistic plans in detail – They are realistic to person's environment & ability & can be as simple as what they plan to do tonight or during the weekend – short term. Does NOT necessarily include future goals.	

Information in this section can **ONLY** be changed during the Annual BASIS Assessment. - Use for individuals age **5** and over.

12. **BEHAVIOR:** Indicate the frequency of each behavior over the past **12** months Enter One Choice

Behaviors are considered to be unacceptable by the norms or society, for a particular setting, or are socially unacceptable. Do NOT use averages and track behaviors daily. In order to capture behaviors the documentation & tracking data should be submitted to the BASIS Assessor prior to the BASIS being submitted to the State of Kansas. Behavior information and data will be reviewed for each BASIS, with the initial BASIS Assessment being the only exception. Determine if the behavior requires **staff support and /or if there is risk involved**. If a behavior occurs daily there should be documentation in the PCSP & / or BSP that explains how the behavior(s) will be addressed. Tracking sheets should be submitted with the BASIS Assessment.

SCALE: **1.** Not this year **2.** Occasionally – Less than once a month **3.** Monthly – About once a month
4. Weekly – About once a week **5.** Frequently – Several times per week **6.** Daily – Once a day or more

	1. Has Tantrums OR Emotional Outbursts - **A combination of 2** or more of the following behaviors exhibited simultaneously: Screaming, crying, swearing, banging on walls-doors-windows-other objects, throwing self on floor. **NOTES: NONE REPORTED**
	2. Damages Own Or Other's Property - **Deliberately** breaking, defacing or destroying things by: hitting, tearing, cutting, throwing, burning, marking, or scratching. (Ex. Person strips his / her bed and urinates on it daily – capture as daily) **NOTES: NONE REPORTED**
	3. Physically Assaults Others - **Deliberately causing physical pain** to other People or to Animals by hitting, kicking, biting, pinching, scratching, pulling hair or striking with an object. **NOTES: NONE REPORTED**
	4. Disrupts Other's Activities - Interfering significantly with activities of others by clinging, pestering or teasing, arguing or complaining, picking fights, laughing or crying without reason, interrupting, yelling or screaming. Behavior is considered to be beyond socially acceptable. **NOTES: NONE REPORTED**
	5. Is Verbally Or Gesturally Abusive - Swearing, verbal threats, name-calling, obscene gestures, gestures indicate aggressive intent or threat. Behavior must be intentional / deliberate & the individual must intend to abuse others with their behavior. RT043009 **NOTES: NONE REPORTED**
	6. Is Self - Injurious - **Causing injury to own body by:** hitting self, banging head, scratching, cutting or puncturing, biting, rubbing skin, pulling out hair, picking on skin or removing scabs, chewing nails into the quick & causing them to bleed, damaging cuticles or nail bed, or pinching self. (Alcoholism, Anorexia &Bulimia are **NOT** recorded here – capture in Psychiatric Section. Do NOT count eating candy if the person has Diabetes. Do NOT capture standard piercing of ears, eyelids, nose, lips, belly button, etc). **NOTES: NONE REPORTED**
	7. Teases Or Harasses Peers - Any behavior performed **deliberately** to annoy another person. **NOTES: NONE REPORTED**
	8. Resists Supervision - Non compliant behavior. Refusing to follow instructions. Ex. Says "No", Decides not to complete the task, or must be asked multiple times before the task is completed. **NOTES: NONE REPORTED**
	9. Runs Or Wanders Away - Repeatedly, deliberately or inadvertently leaves a program area, group activity or living area and requires staff support to insure the persons health & safety. (Ex. While shopping, at school, home, work) **NOTES: NONE REPORTED**
	10. Steals - **Deliberately or intentionally** taking the belongings, including food / drink, from another. **NOTES: NONE REPORTED**
	11. Eats Inedible Objects - Putting an object that is unfit to be eaten, into their mouth and **swallowing / ingesting** the item. (Ex: Raw Meat, Rotten Food, Dirty Food From Floor, Paper, Pencil Erasers, Play-Doh, Glue, etc.) **NOTES: NONE REPORTED**
	12. Displays Sexually Inappropriate Behavior - Circle of Support is **NOT** required to determine the intent of the person. Capture here if the behavior is exhibited. Examples: unwelcomed hugs &/or kisses, public undressing, inappropriate touching of self or others, public masturbation, making sexual remarks or gestures, forcing sexual attentions on others, or voyeurism - one who is sexually aroused by watching an unsuspecting person who is naked, in the process of disrobing, or is engaged in sexual activity. **NOTES: NONE REPORTED**
	13. Smears Feces - **Deliberately** handling, throwing or spreading bowel movement / fecal matter. (This question does **NOT** address bodily fluids, other than fecal matter.) **NOTES: NON REPORTED**

Information in this section can **ONLY** be changed during the Annual BASIS Assessment. - Use for individuals age **5** and over.

13. BEHAVIOR CONSEQUENCES - Enter One Choice Per Question 1 = True 2 = False

As a result of any behavior problem(s) consider whether or not each of the following ***PRESENTLY*** apply. Circle **YES** or **NO** for each consequence of a person's behavior as it is currently exhibited. Respond based on what has happened as a result of any behavior on the part of the individual, and not just those listed in the previous question.

☐ Behavior problems currently prevent this individual from moving to a **Less Restrictive Setting**.

To answer **YES** to this question the person MUST be exhibiting some aberrant behavior (departure from the normal, unusual or unexpected) which his / her current environment (which may include the school setting) is helping to lessen. The behavior should not be infrequent. Consider if the person places themselves or others in danger with their behaviors. It is not appropriate to answer this question YES because you believe that the person would display some aberrant behavior in a different environment.

☐ Individual has a written **Behavior Intervention Plan**. (If **YES**, place copy with supporting BASIS documents)

There MUST be a current copy of the Behavior Plan on file in BCI. This question may be answered YES without a written Behavior Intervention Plan in place, but the information in the following conditions must be clearly documented in the Person Centered Support Plan.

In order to mark **YES** the Behavior Plan or PCSP **MUST** adhere to **ALL** of the following conditions:	
1. There is a clear definition of the behavior(s) at issue	&
2. There is a clear definition of what support staff are doing with regard to the behavior (Prevention and support strategies, responses)	&
3. There is collection of information as to the **Frequency** of the behavior(s) at issue (RT07-22-10)	&
4. The plan ensures that the supports are specific to the individual involved (Ex. Person Centered Support Plan).	
NONE REPORTED OR RECEIVED	

☐ Individual's environment must be **Carefully Structured** to avoid behavior problems.

Written plan should clearly document how the environment is being structured. At a minimum this information should be listed in the PCSP.

List Type of Structure - Strict Daily Routine, Locked Refrig / Pantry, Banned From Certain Areas of Home / School / Work, Other:

☐ Because of behavior problems the staff must sometimes **Intervene Physically** with individual.

The intervention listed below is used to stop an *endangering behavior.* (Ex: physically restrain individual or guide individual). Blocking with body can be captured here, if it is the *ONLY* intervention that will stop the endanger behavior.

1. List Endangering Behavior(s):

2. List Restrictive Intervention Listed in ELP /PCSP / QLP / BIP / etc. :

☐ Because of behavior problems a supervised "**Time Out**" period is needed at least once a week.

(Ex: Individual is asked to stop a preferred activity for a length of time, or the individual loses a choice or opportunity. The individual does NOT self initiate a "Time Out"). Time out should meet **ALL** of the following criteria and it should be difficult to answer "**YES**":

1. **Behavior Specific** - Time out is only used as a ***specific*** **consequence** to a ***specific*** **behavior** defined in the **BSP or PCSP** & for which data is being collected over time to measure the effectiveness of the intervention.
2. **Exclusionary** - Time out should occur in a private area.
3. **Supervised** - The time out period must be supervised **ONE on ONE** by a person who is responsible for assuring only the person's health and welfare during the entire time out period. This does not require 100 % visibility of the individual, staff may monitor by listening **ONE on ONE** to the person. (Do NOT average - Ex. 52 times a month does NOT = weekly for the year as a whole.)

NOT PART OF A WRITTEN PLAN - NO TRACKING

☐ Because of behavior problems this individual requires **1 on 1 Supervision** for many program activities.

Does 1:1 staff have no other responsibilities except to be with, support & provide direct care ONLY to this person for **50 % or more of their waking hours** ? Do **NOT** mark "YES" if 1 on 1 supervision is due to a physical disability with behaviors present (ex: Cerebral Palsy).

List Location Where 1:1 is Received: School, Work, Res, Other: WORKS / LIVES IN A GROUP SETTING

Information in this section can **ONLY** be changed during the Annual BASIS Assessment. - Use for individuals age **5** and over.

14. SELF CARE - Enter One Choice

These questions should be viewed as whether or not the person is presently capable of doing these. Base answers on the person's capabilities and not their willingness / unwillingness to engage in these activities. If the individual's situation does not allow them to do the task on their own, then estimate their ability to do the task independently. Do **NOT** consider if the person cognitively understands the reason for completing the task, simply capture their ability with each task.

SCALE	
1. Total Support	The person is **completely dependent** on others to carry our activities on their behalf. Total support requires that the service provider be involved throughout the task. (Dependent)
2. Assistance	The person often **requires physical aid** in order to accomplish tasks. The service provider would offer regular verbal prompting and instructions as well as regular physical hands-on-aid. (Helping)
3. Supervision	The person is able to perform tasks with **some verbal direction**. (Reminding)
4. Independent	The person **can perform the task** with no prompting. The person may need supervision and/or assistance in exceptional circumstances. (Independent)

	Toileting: Bowels (Bowel Movement – Voiding & Wiping) Does *NOT* address menses cycle, mobility to toilet, dressing / undressing, washing hands, or flushing toilet. **NOTES:**
	Toileting: Bladder (Urination – Voiding & Wiping) Does *NOT* address menses cycle, mobility to toilet, dressing / undressing, washing hands, or flushing toilet. **NOTES:**
	Taking A Shower (OR) Bath Does NOT address mobility to get into the tub / shower. Capture the ability to participate, to wash hair or self & set own water temperature. **NOTES:**
	Brushing Teeth (&/OR) Cleaning Dentures Mark **2** if the person requires hand over hand help, Mark **1** if person opens mouth & provider must brush for them. **NOTES:**
	Brushing (OR) Combing Hair Determine if the person can brush or comb their entire head. Does their disability limit their range of motion ? **NOTES:**
	Selecting Clothes Appropriate To Weather Addresses the choice of clothing and ***NOT*** if the person can get the item out of the closet. **NOTES:**
	Putting On Clothes (Dressing Self) Do **NOT** consider Bra, Buttons, Snaps, Tie Shoes, Zippers, etc. - If the person does ***NOT typically*** wear these. **NOTES:**
	Undressing Self Do **NOT** consider Bra, Buttons, Snaps, Tie Shoes, Zippers, etc. - If the person does ***NOT typically*** wear these. **NOTES:**
	Drinking From A Cup (OR) A Glass Addresses the act of drinking. (Ex: Person can drink from: cup, glass, straw, sippy cup). **NOTES:**
	Chewing & Swallowing Food Ex: Mark **3** if the person needs verbal prompts to slow down or to not overstuff their mouth (Ex. Choking) Mark **2** if the person has difficulty with swallowing and must have food: Pureed, Cut Small, or Modified. Mark **1** if the person requires assistance with swallowing food. **NOTES:**
	Feeding Self Addresses the act of getting food from table or other surface and into their mouth with either utensils (**OR**) fingers. Does NOT take into consideration if the person cuts up their own food, prepares their own meals, or brings the meal to the table. **NOTES:**

Information in this section can **ONLY** be changed during the Annual BASIS Assessment. - Use for individuals age **5** and over.

15. DAILY LIVING SKILLS - Enter One Choice

These questions should be viewed as whether or not the person is presently capable of doing these. Base answers on the person's capabilities and not their willingness / unwillingness to engage in these activities. If the individual's situation does not allow them to do the task on their own, then estimate their ability to do the task independently. Do **NOT** consider if the person cognitively understands the reason for completing the task, simply capture their ability with each task. (RT04-22-10)

SCALE	
1. Total Support	The person is **completely dependent** on others to carry our activities on their behalf. Total support requires that the service provider be involved throughout the task. (Dependent)
2. Assistance	The person often **requires physical aid** in order to accomplish tasks. The service provider would offer regular verbal prompting and instructions as well as regular physical hands-on-aid. (Helping)
3. Supervision	The person is able to perform tasks with **some verbal direction**. (Reminding)
4. Independent	The person **can perform the task** with no prompting. The person may need supervision and/or assistance in exceptional circumstances. (Independent)

	Making Bed Includes pulling the sheet and comforter up on the bed. Does **NOT** address the changing of the sheets or washing of the linens. **NOTES:**
	Cleaning Room Includes: picking up items, putting items away, dusting, vacuuming. **NOTES:**
	Doing Laundry Includes: sorting, running machines, correct amount of detergent, switching loads, folding clothes, hanging up items. (Does **NOT** address how the person gets to the Laundromat). **NOTES:**
	Using Telephone Includes dialing **&** talking. Mark the ***higher*** need of these 2. (Does **NOT** address if they can locate a particular # in the phone book). **NOTES:**
	Shopping For A Simple Meal Person can decide what to put on a shopping list for a simple meal (ex: Spaghetti) **&** can locate the items in the store. Mark the ***higher*** need of these 2 components. Does **NOT** include paying for items. (RT01-30-07) **NOTES:**
	Preparing Foods That Do Not Require Cooking Ex. Cereal or Sandwich. Putting components together for a snack / meal. Does **NOT** include getting food out of pantry / refrigerator (OR) putting away in pantry refrigerator when finished. Opening a granola bar would **NOT** be considered putting components together. **NOTES:**
	Using The Stove (OR) Microwave Mark the person's ***highest ability*** to use either the Stove **(OR)** Microwave. Consider if they are given a new item. Could they read the directions & prepare it, or would they need verbal directions from their caregiver ? **NOTES:**
	Crossing The Street In A Residential Neighborhood Consider if the person looks both ways **&** Also if they have the mobility to cross the street on their own. Mark the ***higher*** need of these. **NOTES:**
	Using Public Transportation For A Simple Direct Trip Is person is capable of calling to schedule a ride for Special Services, Taxi, etc. **&** Consider their mobility to get onto / into the mode of transportation once it arrives. Capture the ***higher*** need of these 2 components. Does **NOT** include paying for transportation. **NOTES:**
	Managing Own Money May be marked as **2**, if the person has a conservator / payee that provides hands on financial assistance. Ex. Mark at least a **2** if the person carries $ in a purse / wallet, or buys lunch, soda, snacks, etc. **OR** if the person signs checks or carries a bank card, but requires help with budgeting or balancing checkbook. **NOTES:**

16. ASSESSMENT COMPLETED BY:

Assessor Last Name: _____ First Name: _____

Phone #: _____