

Department of County Human Services

Aging, Disability and Veterans Services Division, Adult Care Home Program

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

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

 Initial screening Re-Admission

Date of Screening: _____ Date of Entry: _____

Resident's legal name: _____ DOB: _____

Resident's preferred name: _____

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

Who will move the resident into the ACH? _____

Will the resident be bringing their own furniture and belongings? Yes No

Will all these items fit in the room? _____

Resident's primary contact person: _____ Relationship: _____

Phone: _____ Other people important to resident: _____

Phone numbers: _____

Important relationships with restricted or no contact orders: _____

Day Support, Highschool Transitional Program, Employment Program: Yes No

Agency: _____

Schedule: _____ Contact: _____

Resident history:

Comments:

Does the resident have current legal restrictions? no yes
_____Is the resident a registered sex offender? no yes
_____Does resident have a legal guardian? no yes
_____Does resident have a Health Care Representative? no yes _____Do you have a release of information signed by the resident or guardian? Yes No

How many times has the resident moved in the last 5 years? _____

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

Medical:

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

Receiving benefits from:

Medicare #: _____ Medicaid # _____
Home health agency: _____ Phone: _____
Contact: _____ Will they remain involved? Yes No
Services: _____

Funeral Plan? Yes No Funeral home: _____

Special medical instructions or health care directives (DNR, POLST): Yes No

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

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

- Face to face meeting with resident.** Date: _____ Where: _____
- Discussion with Service Coordinator:** Date _____ & Name: _____
- Chart review and discussion with hospital staff (nurse, social worker): Date: _____
Contacts: _____
- Meeting with family member(s) /legal representative:** Date: _____
Contact: _____
- Individual Support Plan (ISP) form (Available through the resident's Service Coordinator)
- Current Functional Assessment and Behavior Support Plan
- Referral packet (Available through the DD program)
- Discussion with current provider** (If resident is in another ACH, Group Home, etc.)
- RN notes/history & physical form from current home, if applicable
- PASR II (Available from case manager for Nursing Facility residents with MH/behavior history)

Medical diagnoses: Pay close attention to the following diagnoses which range from mild to severe and can require complex medical management: Diabetes, Heart Disease, Seizures, Traumatic Brain Injury, Dementia, PICA

List all diagnoses: _____

Other medical / physical / mental conditions: _____

Hearing support needs: Yes No, explain: _____

Vision support needs: Yes No, explain: _____

Medications: Insulin Psychotropics Medical marijuana Controlled substances PRN's

List all others: _____

Current pharmacy: _____

Delivery and payment arrangements for meds: _____

Does resident self-administer any meds, treatments, or need support to master skill?

(doctor's order required) Yes No,

explain: _____

Do any tasks require delegation? Yes No specify tasks:

Which RN will I contact for consultations and delegations? _____

RN who will delegate: _____

RN consultation tasks: _____

RN or Physician responsible for monitoring resident care in the home:

Name: _____ Phone: _____ Frequency of visits: _____

Medical equipment /supplies

Incontinence supplies – type:

Eye glasses Bedside commode Cane Walker Wheelchair Power chair Oxygen

Hospital bed G-tube Other: _____

Medical equipment supplier(s): _____

Delivery and payment arrangements for supplies: _____

Mobility need(s): _____

Are there Protocols in place for these identified risks: Aspiration Dehydration Seizure

Constipation Diabetes Other

Missing protocols: _____

Staff needed for medical supports? Yes No, please indicate: Exclusive focus 1:1 2:1

Staff needed for ADL care? Yes No, please indicate: Exclusive focus 1:1 2:1

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

Behavior Supports: Demonstrated risk supported within the last 5 years

Existing Behavior Support Plan: Yes No Protective Personal Intervention (PPI): Yes No

1:1 Hours for Behavior Supports: _____ hrs 2:1 Hours for Behavior Supports: _____ hrs

Supervision Requirement: (hearing or visual; hearing and visual, redirecting, independent)

explain : _____

Summary of any At-Risk Behaviors:

Receptive Communication Style: _____

Expressive Communication Style: _____

Speaks English: Yes No Primary language:

Night needs: Wanders Cueing Restroom assistance Medication Repositioning

Behavioral Other: _____

Awake Staff needed? Yes No, explain: _____

Transportation needs: Public transit Family Medical transport Tri-Met Lift

Vehicle safety issues: _____

Who will be responsible for setting up transportation? _____

Financial: Representative Payee Manages own finances, Weekly allotted cash on hand:

\$_____

Contact information for Representative Payee: _____

Who will be responsible for making payment to the ACH operator? _____

Who will report any wages to Social Security? _____

Dietary Needs: Diabetic Low sodium Lactose intolerant Low sugar Renal Low fat

Vegetarian Vegan Gluten free Kosher Food

allergies: _____

Modified diet Specific food requests explain: _____

Personal & lifestyle preferences: Sleeps late Stays up late Early riser Prefers privacy

Smoker Very social Drinks alcohol Recreational marijuana

Other: _____

Personal preferences for activities: Gardening Attends job Arts Enjoys music

Reads Cooking/baking Crafts Attends religious events Wants to be out in the

community Attends day program Plays musical instrument /sings Enjoys outings

Cards/board games Belongs to social club, Other:

Does resident have a pet to bring? Yes No, Is resident able to care for the pet? Yes No

Are pet vaccinations current? Yes No, Who will pay for food, supplies, vet? _____

Responsibilities for pet to remain: _____

Evacuation: Can be evacuated, along with other residents, in 3 minutes or less: Yes No

Evacuation needs: Cueing Wheelchair Transfer Walker Other:

Notes:

ACHP Classification Level Worksheet for Adult Care Home Operators

Resident's Name: _____ **Date:** _____

| Services | Level 1 | Level 2B | Level 2M |
|--|---|---|--|
| <p>Assistance with ADLs</p> <ul style="list-style-type: none"> • Bathing & Hygiene • Dressing & Grooming • Eating • Elimination (bladder and bowel) • Mobility (ambulation and transfer) • Cognition & Behavior (include communication) | <p><input type="checkbox"/> Mostly independent but may need assistance with 4 or fewer ADLs</p> | <p><input type="checkbox"/> Mostly independent but may need full assistance with less than 3 ADLs. May be full assistance in communication, cognition,</p> | <p><input type="checkbox"/> Full assistance in all ADLs. Requires one-on-one assist for direct feeding, constant cueing, or to prevent choking or aspiration. Includes nutritional IV or feeding tube set-up by another person. <i>Needs assistance through all phases, every time.</i></p> |
| <p>Delegated nursing tasks</p> | <p><input type="checkbox"/> Not allowed in a level 1 home</p> | <p><input type="checkbox"/> May be allowed for routine and stable conditions</p> | <p><input type="checkbox"/> May be unstable or life threatening conditions. Complex medical condition such as (A) Brittle diabetes or diabetes not controlled through medical or physical interventions;(B) Significant risk of choking or aspiration;(C) Physical, intellectual, or mental limitations that render the individual totally dependent on others for access to food or fluids;(D) Mental health or alcohol or drug problems that are not responsive to treatment interventions; or</p> |

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

Classification:

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

Residents whose needs are appropriate for Level 2B homes will not need any 2M services

Potential Resident's Classification: _____

Determination: After taking everything listed above into consideration:

I have determined that the resident's needs are outside of the classification of this adult care home and that I can meet there needs, and I have requested an exception to serve the resident.

Yes No

I have determined that the resident's **primary** needs are within the classification of this adult care home and that I can meet the care needs of this resident. Yes No

I could meet this resident's needs with these additional resources (environmental modifications, staff

training) and I have requested an exception to serve the resident: _____

If declining placement based on support needs, please explain why:

Signature of operator: _____ Date: _____