

**INSTRUCTIONS
for use of the
CAP-MR/DD WAIVER SERVICES PRIORITIZATION TOOL**

Individuals who seek CAP-MR/DD Waiver services are evaluated for their potential eligibility and then are prioritized according to needs. This evaluation process includes assessment of service and support needs and potential risks that determine the intensity of service needs. Based on the outcome of this assessment, individuals are prioritized as having emergent (crisis), or routine needs based on the following criteria:

Emergent (Crisis)

Individuals who present with emergency/crisis needs are offered entrance to the waiver ahead of other individuals to the extent that capacity is available. The following are considered emergency/crisis situations:

- Homelessness or pending imminent homelessness with no viable housing alternative;
- At significant risk of serious physical harm in current environment
- At significant risk of causing serious physical harm to others in current environment;
- Requiring protection from confirmed abuse, neglect, or exploitation;
- Caregivers unable to provide adequate care due to caregivers' significantly impaired health as documented.

Individuals who are not identified as being in crisis are considered to have routine requests. These individuals will be prioritized using a statewide prioritization tool. The prioritization tool is need based, but the length of time the applicant has been waiting for waiver services is factored into the prioritization.

Applicants are re-evaluated annually with respect to these criteria. As waiver funding becomes available, entrance to the waiver is offered first to individuals with emergent needs, and then to those applicants with routine needs. In the event that two or more individuals are assessed to have the same intensity of needs, the date of application will determine the order of consideration for waiver funding.

Date of Prioritization: This is the date the assessment is completed.

Initial Assessment: Check if this is the first time the form has been completed for this individual.

Update: Check if this is not the first time the form has been completed on this individual.

Individual experiencing one of the situations listed as an emergency need becomes the top priority for consideration for CAP/MR-DD waiver. The remainder of the form does not need to be completed.

ROUTINE NEEDS

The tool has five sections covering the following areas of need:

- I. Habilitation Support**
- II. Medical and Related Support**
- III. Personal Care and Adaptive Equipment**
- IV. Array of Current Supports and Services**
- V. Risk of Institutionalization**

For each of the five sections, there are numbered statements. Select the statement that best describes the individual and the existing support available to that individual (existing support is exclusionary of CAP-C or CAP-DA supports during waiver transfers.). Consider the statements in number order and check **lowest** number that best describes the individual.

Sub-Total: For each of the five sections, there is a space to document the sub-total. Add the numbers checked for the entire section and write it in this space. Do not add the previous section(s) sub-totals to this number.

Total Score: The last page is used for total scoring. For each of the five sections, write the sub-total score. Add each of the sub-total scores to determine the "Total Score". Write the total score in the spaced indicated for total score.

Date the individual's name was initially prioritized: This is the date the initial prioritization was completed.

Length of Time on the Waiting List: Use the above date to determine the length of time the individual has been waiting for a service. This number will be added to the total score, in the event that two or more people have the same total score. In such case, the length of time on the waiting list should be updated to reflect current numbers before comparing the scores of the two or more individuals.

Name: _____

Date of Birth: _____

Date of Prioritization: _____

___ Initial Assessment ___ Update

CAP-MR/DD WAIVER **SERVICES PRIORITIZATION TOOL**

PRIORITIZATION OF EMERGENT (CRISIS) NEEDS:

- ___ Homelessness or pending imminent homelessness with no viable housing alternative
- ___ At significant risk of serious physical harm in current environment
- ___ At significant risk of causing serious physical harm to others in current environment
- ___ Require protection from confirmed abuse, neglect, or exploitation;
- ___ Caregivers unable to provide adequate care due to caregivers' impaired health.

Individual experiencing one of the situations listed as a emergency need becomes the top priority for CAP/MR-DD waiver. The remainder of the form does not need to be completed.

PRIORITIZATION OF ROUTINE NEEDS:

I. HABILITATION SUPPORT

A. Expressive Communication: (check one)

- ___ (0) Communicates with familiar and unfamiliar people regarding illness, danger, and basic wants and needs.
- ___ (1) Assistance is needed to communicate with familiar and unfamiliar people.
Examples are: uses picture cards, sign language interpreter, or a familiar person
- ___ (2) The individual is unable to make needs and wants known.

B. Receptive Communication: (check one)

- ___ (0) Can follow written and/or spoken language with familiar and unfamiliar people regarding illness, danger and basic wants and needs.

- (1) Assistance is needed to follow written and/or spoken language. Examples are: uses picture cards, sign language interpreter, or a familiar person.
- (2) The individual is unable to follow written and/or spoken language.

C. Social Interactions: (check one)

- (0) Requires no support when interacting with others.
- (1) Sometimes requires support when interacting with others.
- (2) Almost always or always requires support when interacting with others.

D. Behavior:

There are some behavior concerns other than is typical for age that can be managed by the family or existing supports. (check one)

- (0) There are no behavior concerns that require support.
- (1) Occurs Daily
- (2) Occurs Several times a day

There are some behavioral concerns beyond what the family or existing supports can manage. (check one)

- (0) There are no behavior concerns that require support.
- (1) Occurs Weekly
- (2) Occurs Daily
- (3) Occurs Several times a day

There are behavioral concerns are not manageable without professional intervention. (check one)

- (0)
- (1) Occasional, occurs less than 11 times a year
- (2) Monthly
- (3) Weekly
- (4) Occurs Daily
- (5) Occurs Several times a day

Habilitation Support Sub-Total: _____

II. MEDICAL AND RELATED SUPPORT NEEDS:

A. Medical Needs: (check one)

- (0) There are no medical concerns that require support.
- (1) There are some medical concerns that can be managed by the family or existing supports.
- (2) There are medical concerns beyond what the family or existing supports can manage.
- (3) Medical needs are not manageable without specialized training/specialized staff.

B. Medical Needs: Frequency of Professional Medical Interaction: (check one)

- | | |
|--|---|
| <input type="checkbox"/> (1) Occasionally less than 5 times a year | <input type="checkbox"/> (4) Weekly |
| <input type="checkbox"/> (2) Between 6—12 times a year | <input type="checkbox"/> (5) Daily |
| <input type="checkbox"/> (3) Monthly
a day | <input type="checkbox"/> (6) Several times
a day |

C. Sleep Monitoring (Monitoring During Normal Sleeping Hours) (check one)

- (0) Sleep time monitoring are routine for age.
- (1) Sleep time monitoring requires occasional assistance not typically required for a person of the same age.
- (2) Awake person needed to monitor and assist to ensure the health and safety of the individual during sleeping hours.

Medical and Related Support Needs Sub-Total: _____

III. Personal Care and Adaptive Equipment Needs:

A. Personal Care (check one per section):

Eating/Drinking

- (0) No assistance needed beyond what is typical for age.
- (1) Little assistance needed beyond what is typical for age (reminders needed).
- (2) More assistance needed beyond what is typical for age (cutting food).
- (3) Total assistance is needed.

Bathing

- (0) No assistance needed beyond what is typical for age.
- (1) Little assistance needed beyond what is typical for age (reminders needed i.e.: setting water temperature)
- (2) More assistance needed beyond what is typical for age (washing body parts, washing hair, getting in and out the tub).
- (3) Total assistance is needed.

Dressing

- (0) No assistance needed beyond what is typical for age.
- (1) Little assistance needed beyond what is typical for age (reminders needed).
- (2) More assistance needed beyond what is typical for age (buttoning, zipping).
- (3) Total assistance is needed.

Toileting

- (0) No assistance needed beyond what is typical for age.
- (1) Little assistance needed beyond what is typical for age (reminders needed).
- (2) More assistance needed beyond what is typical for age (with clothing, self cleaning)
- (3) Total assistance is needed.

Mobility

- ____ (0) No assistance needed beyond what is typical for age.
- ____ (1) Little assistance needed beyond what is typical for age (reminders needed).
- ____ (2) More assistance needed beyond what is typical for age (assistance with balance, evacuation).
- ____ (3) Total assistance is needed.

B. Adaptive Equipment Needs: wheelchair, special eating tools, augmentative communication devises, etc. (check one)

- ____ (0) No adaptive equipment needed or has adequate adaptive equipment
- ____ (1) Has some adaptive equipment but needs additional or updated equipment.
- ____ (2) Has no adaptive equipment but needs adaptive equipment

Personal care and Adaptive Equipment Needs Sub-Total: _____

IV. Array of Current Supports and Services:

A. Community/Day Services: (check one)

- ____ (0) Individual is receiving community day activities or the person chooses not to receive the community/ day activities.
- ____ (1) Individual is receiving community/day services, but additional supports or services are needed to learn skills necessary for participation.
- ____ (2) The individual does not have access to community/day services due to the need for support to participate.

B1. Residence: (check one)

Individual lives in a Group Home or an AFL

- ____ (0) Current residence is stable with no additional supports needed.
- ____ (1) Additional supports are needed in residence to learn useful skills.
- ____ (2) Intensive staff/skills training are needed to maintain the individual in the current residence.
- ____ (3) Current residence can not meet the needs of the individual, a different residence is necessary.

Individual lives alone in their own home or with Family and/or Natural Supports (unpaid family/care providers): (check one)

- ____ (0) Support person is able to maintain individual at home safely. No additional assistance needed.
- ____ (1) Support person is able, but is requesting more assistance or is unable to provide assistance regularly.
- ____ (2) Has no support person and there is need for assistance.
- ____ (3) Individual is in an unsafe environment and has or lost a significant support person.

B2. Some natural families have more than one person with a disability living in the home. If so, check the appropriate number:

- ___ (0) no additional people, ___ (1) one additional person, ___ (2) two additional people,
___ (3) three additional people

Array of current Supports and Services Sub-Total: _____

V. Risk of Institutionalization

(An Institutional setting is a public or private ICF-MR setting.) (check one)

- ___ (0) The individual's needs are appropriately and adequately met in the community placement. There is no risk for placement in an ICF-MR setting.
___ (1) The individual is in an ICF-MR setting or is in a facility that is too restrictive or is inappropriate for the individual.
___ (2) Without additional supports, the individual will move to a more restrictive setting.
___ (3) The individual will require ICF-MR residence due to the severity of their disability and support needs if services are not received.

Risk of Institutionalization Sub-Total: _____

VI. Length of time on Potentially Eligible List: (check one)

Date of initial prioritization: _____

- ___ (1) Less than 1 year
___ (2) 1 year -2 years
___ (3) 2-3 years
___ (4) More than 4 years

Length of time on Potentially Eligible List Sub-Total: _____

Sub-Total Scores:

I. _____ II. _____ III. _____ IV. _____ V. _____ VI. _____

TOTAL Score: _____

Completed by: _____ **Date:** _____

Informant: _____

Relationship to Individual: _____