Tri-Counties Regional Center
SAN LUIS OBISPO • SANTA BARBARA • VENTURA

INDEPENDENT ASSESSMENT OF SUPPORTED LIVING SERVICES

Name of Individual: _____

UCI #: Sex: ☐ F ☐ M DOB ___/___/___ Current Age: _____

☐ Initially Entering SLS ☐ Currently Receiving SLS

TCRC Office: _____ Service Coordinator: _____

Supervisor: _____

Assessing Agency: _____ Vendor #: _____

Assessor: _____ E-Mail: _____

Date Referral Received: ___/___/___ Date of Initial Contact: ___/___/___

Date Assessment Submitted: ___/___/___ Submitted to: _____

I. GENERAL BACKGROUND INFORMATION

A. Diagnosis: _____

B. Ambulatory ___ or Non-Ambulatory ___?

C. Type of day time activities:

1) Work/Supported Employment ___ School ___ Day Program ___

- If a day program, what type of program is it (include service code)?

- What is the name of the school or day program?

- How long has the individual attended this particular school or day program?
  years months.

2) If school, what level? _____

D. Educational History

1) Did the person receive a diploma ☐ or certificate of completion ☐ ?

E. Transportation Needs

1) Public Transportation

- Does the individual know how to use public transportation Yes ___ No ___ and/or services such as Dial-a-Ride? Yes ___ No ___.
- Has the individual been assessed for mobility training? Yes ___ No ___
- Has the individual received mobility training? Yes ___ No ___

2) Does the individual ride a bike? Yes ___ No ___

Summary Section I – Background Information:

Service needs, if any, identified based on the information in this section:

Type: ☐ TCRC Funded ☐ Generic ☐ Natural

Amount: _____ Hours/Week

Comments (Include additional background information and history, current circumstances, etc. except as covered in later sections of this assessment):

II. CIRCLE OF SUPPORT / NATURAL SUPPORTS

A. Is the individual conserved? Yes ___ No ___

1) If the individual is conserved, what is the scope of conservatorship? For example, full, limited, medical, financial, etc. _____

2) Date the conservatorship was legally established. _____/_____/_____.
Is it still valid? Yes ___ No ___ If not valid, explain.

3) Conservator's contact information

- Name: _____
- Mailing address: _____
- Telephone Numbers: _____
- Fax Number: _____

4) What is the individual's relationship to their conservator? (e.g. family member, court appointed, etc.)

5) What is the level of involvement of conservator / frequency of contact with individual?

B. Describe the individual's circle of support. Describe the role of each person who supports the individual. Include information about the level of involvement / frequency of contact etc.

1) Paid / Professional supports. (e.g. Service Coordinator, Therapist, Job Coach, SLS Staff)

Name/Title	Role	Involvement

2) Natural supports (i.e. Family, Friends, Relatives).

Name/Title	Role	Involvement

Summary Section II – Circle of Support:

Service needs, if any, identified based on the information in this section:

Type: ☐ TCRC Funded _____ Hours/Week

☐ Generic _____ Hours/Week

☐ Natural _____ Hours/Week

Comments:

III. CURRENT LIVING ARRANGEMENT

A. Describe the individual's living arrangement:

☐ Living independently ☐ Living at his/her family home

☐ Living with roommate(s) ☐ Living in ICF ☐ Living in DC

☐ Living in an adult residential facility (ARF) or Small Family home (FHA)

1) If living independently or with roommate(s), what type of dwelling does the individual currently reside in?

☐ apartment/condo ☐ duplex ☐ single family home ☐ Other _____

2) Is the Individual eligible for any housing subsidy? Yes ___ No ___ If yes, indicate type:

☐ Section 8 ☐ Other housing subsidy _____

3) If the individual is living alone, would she/he be amenable to and appropriate for shared housing with another person or persons, with or without disabilities? Yes ___ No ___ Explain.

4) If the individual is currently living in a group residential facility (ARF), what is the level of the facility? *(Level 2 – 4i as described in Title 17).* _____

5) If living in an ICF or FHA arrangement, what would be the appropriate level ARF if the individual were in placement? *(Level 2 – 4i as described in Title 17).* _____

6) If living in the family home, describe the extent of daytime and nighttime supervision being provided by the family.

B. Can the individual be left alone?

1) During the daytime? Yes ___ No ___

2) In the evening? Yes ___ No ___

3) Overnight? Yes ___ No ___

4) How long can the individual be left alone for? Up to _____ Hours

C. What does the individual typically do when they are alone?

D. Has being left alone been problematic for the individual in the past? Yes ___ No ___
If yes, please provide details regarding any incidents of concern as a result of being left alone.

E. Can the individual leave the home independently? Yes ___ No ___ If no, explain.

F. Does the individual currently receive any type of in-home support services such as IHSS / ILS / SLS, or Personal Assistance on a regular basis? Yes ___ No ___ If yes, list type and hours per week below. If receiving SLS, show PS and TH hours separately.

Service: _____ Hours/Week: _____

Service: _____ Hours/Week: _____

Service: _____ Hours/Week: _____

Service: _____ Hours/Week: _____

Service: _____ Hours/Week: _____

Service: _____ Hours/Week: _____

Service: _____ Hours/Week: _____

1) What are the primary areas in which the individual utilizes this support?

☐ meal planning/preparation ☐ budgeting/financial management

☐ health/medication management ☐ household management

☐ shopping ☐ self-help/hygiene

☐ other _____

2) What days and hours is each service provided?

Day	Service	Time Period (s)	Total Hours	Overnight?
				☐ Yes ☐ No
Mon				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
Tues				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
Weds				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
Thur				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
Fri				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
Sat				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
Sun				☐ Yes ☐ No
				☐ Yes ☐ No

G. Is the individual aware of and/or currently accessing any generic / natural supports (other than IHSS if shown above)? Yes ___ No ___ If yes, describe type and amount.

H. Does the individual's current living situation and residence location support his/her needs for access to transportation, shopping, community integration opportunities such as parks, recreation centers, churches, etc.? Yes ___ No ___
Describe available resources and distance from residence.

Summary Section III – Current Living Arrangement:

Service needs, if any, identified based on the information in this section:

Type: ☐ TCRC Funded _____ Hours/Week
☐ Generic _____ Hours/Week
☐ Natural _____ Hours/Week

Comments:

IV. GOALS

A. Describe a goal that the individual would like to achieve within the next year. What services and supports does the individual (or individual's advocate and/or circle of support if individual is unable to communicate unassisted) believe are needed to achieve this goal?

Goal:

Services and Supports Needed:

B. Describe a goal that the individual would like to achieve within the next 2-3 years. What services and supports does the individual (or individual's advocate and/or circle of support if individual is unable to communicate unassisted) believe are needed to achieve this goal?

Goal:

Services and Supports Needed:

Summary Section IV – Goals:

Service needs, if any, identified based on the information in this section:

Type: ☐ TCRC Funded _____ Hours/Week

☐ Generic _____ Hours/Week

☐ Natural _____ Hours/Week

Comments:

V. INTERVIEWS

Interviews

PERSONS TO INTERVIEW / INFO SOURCES

- Service Coordinator (also previous SC if with current SC less than 1 year)
- Family members if involved in person's life
- Current SLS agency & staff, IHSS Staff, Day Program staff
- Residential staff if currently in ARF or FHA home
- Co-workers if employed, Job Coach
- Friends, community group members, teachers (if in school)
- Medical providers (with release from person)
- Other persons suggested by individual being assessed

Name	Title / Relationship to Individual	How Interviewed (Telephone, In Person, etc.)	Date of Interview

Summary Section V - Interviews:

Service needs, if any, identified based on the information in this section:

Type: ☐ TCRC Funded _____ Hours/Week

☐ Generic _____ Hours/Week

☐ Natural _____ Hours/Week

Comments:

VI. OBSERVATIONS OF INDIVIDUAL (In Addition To Interview With Individual)

Date of Observation	Location of Observation	Name(s) of other(s) Present	Relationship to Individual

Summary Section VI – Observations

Service needs, if any, identified based on the information in this section:

Type: ☐ TCRC Funded _____ Hours/Week

☐ Generic _____ Hours/Week

☐ Natural _____ Hours/Week

Comments:

VII. RECORD REVIEW

Date of Review	Type of Record (e.g. IPP, Annual Review, Psychological Evaluation, etc.)	Source/Author	Date of Record

Summary Section VII – Record Review:

Service needs, if any, identified based on the information in this section:

Type: ☐ TCRC Funded _____ Hours/Week

☐ Generic _____ Hours/Week

☐ Natural _____ Hours/Week

Comments:

VIII. HEALTH

A. What type of medical insurance does the individual have?

☐ Medi-Cal ☐ Medicare ☐ Tri-Care ☐ Private _____

B. Primary physician's contact information

Name: _____

Mailing address: _____

Telephone Numbers: _____

Fax Number: _____

C. Date of the individual's most recent physical exam? _____/_____/_____

Height: ___ft. ___in. Weight: _____ lbs. Approximate BMI: _____

D. Does the individual have any chronic medical conditions, e.g. thyroid, seizure disorder, diabetes, cardiac condition. Yes ___ No __ If yes, list below.

E. Date of the individual's most recent dental exam? _____/_____/_____

F. Dentist's contact information

- Name: _____
- Mailing address: _____
- Telephone Numbers: _____
- Fax Number: _____

2) Does the individual have Denti-Cal or any other dental insurance? Yes ___ No ___ If yes, describe coverage.

3) Does the individual have any unmet dental needs or chronic dental problems at this time? Yes ___ No ___ If yes, describe.

G. Does the individual have any mental health conditions? Yes ___ No ___
If yes, describe what they are and what treatment the individual is receiving.

H. Therapist's (MD, PhD, MFT, etc.) contact information

1) Name: _____
2) Mailing address: _____
3) Telephone Numbers: _____
4) Fax Number: _____

I. What prescription medications is the individual currently taking?

Medication	Dosage	Frequency	Condition Treating

J. What over-the-counter medications and/or supplements does the individual take?

Medication	Dosage	Frequency	Reason for taking

K. Does the individual have any known medication allergies? Yes ___ No ___
If yes, list medication and reaction below:

Medication	Reaction

L. Can the individual take medications independently without prompting? Yes ___ No ___

1) If the individual requires prompting, what type of prompting? For example, visual schedule, personal alarm, verbal prompting, physical administration of medication by a caregiver.

M. Is the Individual physically able to administer medications, e.g. injections? Yes ___ No ___
If not, what assistance is needed and how frequently?

1) If diabetic, is the individual able to perform blood sugar testing and independently determine dosage? Yes ___ No ___ If no, what assistance is needed?

N. Is the individual medication compliant? Yes ___ No ___ If yes, how long have they been compliant? If not, how long have they been non-compliant? Provide details.

O. If the individual is not completely medication compliant, what is the reason?

1) How often does the individual typically take medications?

2) Does the individual understand the purpose of their medication(s)? Yes ___ No ___

3) What interventions have been attempted to increase compliance?

Summary Section VIII - Health:

Service needs, if any, identified based on the information in this section:

Type: ☐ TCRC Funded _____ Hours/Week

☐ Generic _____ Hours/Week

☐ Natural _____ Hours/Week

Comments:

IX. FINANCIAL

A. Describe the individual's financial resources / benefit information.

1) Monthly gross income from SSI, SSP, SSA, and/or employment?

Amount	**Source**
$ _____	_____
$ _____	_____
$ _____	_____
$ _____	_____

2) Does the individual have other financial resources such as a trust, insurance settlement, etc? Yes ___ No ___ If yes, provide amount and describe how and when funds are disbursed to the individual or conservator/representative payee.

B. Does the individual have a representative payee? Yes ___ No ___
If yes, who is the payee?

☐ Conservator ☐ Family Member: _____

☐ Other: _____

C. List the individual's current or projected monthly expenses including food, rent, transportation, medical/dental/prescriptions, utilities, phone, etc. (Continue on back of page if necessary)

Expense	Amount
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____

D. Describe the individual's current spending habits.

E. What is the amount of monthly discretionary funds the individual has access to?

$_____

F. Does the individual demonstrate an understanding of the value of coins and dollars, e.g. can count change returned for a simple financial transaction?
Yes ___ No ___ If no, describe issues.

G. Does the individual have the ability to manage finances independently?

1) Reads & pays bills Yes ___ No ___
2) Maintains bank account Yes ___ No ___
3) Uses credit/debit card Yes ___ No ___
4) Uses ATM & PIN Nos Yes ___ No ___
5) Follows a budget Yes ___ No ___

H. Does the individual require support to manage finances? Yes ___ No ___ If yes, describe the type / amount of support.

I. Has the individual ever been financially exploited? Yes ___ No ___
If yes, please explain.

J. Is the individual believed to be at risk of being financially exploited? Yes ___ No ___
If yes, please explain.

Summary Section IX – Financial:
Service needs, if any, identified based on the information in this section:

Type: ☐ TCRC Funded _____ Hours/Week
☐ Generic _____ Hours/Week
☐ Natural _____ Hours/Week

Comments:

X. DOMESTIC AND SELF-HELP SKILLS

DOMESTIC SKILLS:

A. **Use of Telephone**

Yes ___ No ___ Can look up telephone numbers in a phonebook / address book.
Yes ___ No ___ Can dial phone numbers to place outgoing calls.
Yes ___ No ___ Can answer the telephone appropriately and talk on telephone.
Yes ___ No ___ Can send / read text messages.

B. **Laundry**

Yes ___ No ___ Can discriminate between soiled and clean items.
Yes ___ No ___ Can separate clothing by dark/color/white, types of items.
Yes ___ No ___ Can read and understand cleaning instructions on clothing tags (e.g. dry clean only)
Yes ___ No ___ Can operate a washing machine and dryer
Yes ___ No ___ Can use an iron
Yes ___ No ___ Can select appropriate laundry products
Yes ___ No ___ Can fold laundry
Yes ___ No ___ Can put laundry away

C. **Shopping**

Yes ___ No ___ Can generate a list of needed food and household items
Yes ___ No ___ Can budget for necessary items
Yes ___ No ___ Can discriminate regular priced items from sale items
Yes ___ No ___ Can discriminate items that are a necessity from those that are discretionary
Yes ___ No ___ Can complete a sales transaction (i.e. provide total monies due)

D. **Food Preparation**

Yes ___ No ___ Can read and follow a simple recipe
Yes ___ No ___ Can gather items needed for a recipe
Yes ___ No ___ Can identify four basic food groups
Yes ___ No ___ Can use basic cooking utensils
Yes ___ No ___ Can follow basic instructions for cooking packaged food items
Yes ___ No ___ Can prepare basic personal breakfast
Yes ___ No ___ Can prepare basic personal lunch
Yes ___ No ___ Can prepare basic personal dinner
Yes ___ No ___ Can operate cooking appliances safely and appropriately (oven, stovetop, microwave, toaster oven, etc.).
Yes ___ No ___ Can discriminate perishable food from nonperishable food and store accordingly.
Yes ___ No ___ Can store prepared foods and leftovers properly
Yes ___ No ___ Can identify when food has spoiled.
Yes ___ No ___ Can identify expiration date

E. **Housekeeping**

Yes ___ No ___ Can hand wash dishes
Yes ___ No ___ Can operate a dishwasher

Yes ___ No ___ Can make bed / change linens
Yes ___ No ___ Can take out trash
Yes ___ No ___ Can operate a vacuum, broom, and mop
Yes ___ No ___ Can change a light bulb
Yes ___ No ___ Can discriminate between cleaning products according to purpose
Yes ___ No ___ Can clean sinks, toilets
Yes ___ No ___ Engages in regular house keeping

SUMMARY SECTION X – DOMESTIC SKILLS:

Service needs, if any, identified based on the information in this section:

Type: ☐ TCRC Funded _____ Hours/Week
☐ Generic _____ Hours/Week
☐ Natural _____ Hours/Week

Comments (Include description of type/degree of assistance needed for tasks the individual is unable to perform independently e.g. indirect, direct verbal, modeling, etc., up to full physical assistance):

SELF-HELP SKILLS:

F. **Bathing / Dental Hygiene**

Yes ___ No ___ Showers / bathes (including washing hair and body parts).
Yes ___ No ___ Can identify appropriate hygiene products
Yes ___ No ___ Can control bath / shower water temperature
Yes ___ No ___ Can brush teeth
Yes ___ No ___ Can floss teeth
Yes ___ No ___ Brushes teeth regularly
Yes ___ No ___ Bathes / washes hair regularly

G. **Dressing**

Yes ___ No ___ Can dress self completely
Yes ___ No ___ Can select clean clothing
Yes ___ No ___ Can select appropriate clothing for weather, occasion
Yes ___ No ___ Can select appropriate sizes of clothes & shoes when shopping
Yes ___ No ___ Can tie shoes
Yes ___ No ___ Can fasten and unfasten a button
Yes ___ No ___ Can zip a zipper
Yes ___ No ___ Can buckle a belt

H. **Toileting**

Yes ___ No ___ Can void completely without incontinence
Yes ___ No ___ Can clean genital areas completely after toileting
Yes ___ No ___ Can use the restroom when necessary at nighttime without incontinence
Yes ___ No ___ Can use sanitary pads, tampons etc. when needed

I. **Transfer**

Yes ___ No ___ Can independently get in and out of bed.
Yes ___ No ___ Can independently get in and out of a chair.
Yes ___ No ___ Can independently get in and out of a vehicle.
Yes ___ No ___ Can walk up and down stairs.
Yes ___ No ___ Can independently get on/off toilet
Yes ___ No ___ Can independently get in/out of shower

J. **Ambulation**

Yes ___ No ___ Can walk / ambulate freely.
Yes ___ No ___ Can operate wheelchair, cane, walker.
Yes ___ No ___ Can sit unsupported in a chair / wheelchair.

K. **Feeding**

Yes ___ No ___ Can feed self
Yes ___ No ___ Can hold a drinking glass / utensils

L. **Health & Safety**

Yes ___ No ___ Can handle medical appointments independently
Yes ___ No ___ Can administer medication independently

Yes ___ No ___ Can administer basic first aid to self
Yes ___ No ___ Can identify situations when medical intervention is appropriate
Yes ___ No ___ Can call 911 or SLS emergency number

M. If presently in a supported living arrangement, is the individual currently receiving Training and Habilitation (Subcode TH) services to assist in acquiring domestic and self-help skills? Yes ___ No ___ If yes, how long have TH services been in place? _____ years _____ months.

1) Based on the ratings in this section in combination with observations, interviews, and record reviews included in this assessment, is the individual likely to benefit from additional TH services? Explain.

Summary Section X – Self Help Skills:

Service needs, if any, identified based on the information in this section:

Type: ☐ TCRC Funded _____ Hours/Week
☐ Generic _____ Hours/Week
☐ Natural _____ Hours/Week

Comments (Include description of type/degree of assistance needed for tasks the individual is unable to perform independently e.g. indirect, direct verbal, modeling, etc., up to full physical assistance):

XI. COMMUNITY ACCESS & TRANSPORTATION

A. What are the various ways that the individual currently accesses the community?

1) Does the individual use a computer to access community information, social networking sites, etc.? Yes ___ No ___
2) Is the individual in danger of exploitation or abuse as a result of use of social media, chat rooms, etc. Yes ___ No ___ If yes, explain.

B. How does the individual typically get to the grocery store, bank, laundromat, and other personal errands?

C. How does the individual get to day program / work site / school?

D. How does the individual get around in the community?

E. Where does the individual travel to on a regular basis? *For example, day program, work site, shopping center, social activities etc.*

F. What mode of transportation does the individual use? *For example, does the individual drive, ride a bicycle, take public transportation, is the individual transported by family members / staff.*

G. Has the individual received transport / mobility training? Yes ___ No ___ If not, has the individual been assessed for training? Yes ___ No ___

H. What is the level of assistance that is required in the following areas:

1) Reading bus schedule _____
2) Planning route _____

3) Purchasing fare _____

4) Making transfers _____

I. Has the individual experienced problems / behavioral challenges while out in the community?
Yes ___ No ___ If yes, describe.

J. Have there been safety concerns in the past in regard to the individual traveling independently?
Yes ___ No ___ If yes, explain.

K. Are there current safety concerns regarding the individual traveling independently?
Yes ___ No ___ If yes, please explain.

Summary Section XI – Community Access & Transportation:

Service needs, if any, identified based on the information in this section:

Type: ☐ TCRC Funded _____ Hours/Week

☐ Generic _____ Hours/Week

☐ Natural _____ Hours/Week

Comments:

XII. SAFETY AWARENESS, RISK TO SELF AND OTHERS

A. How does the individual describe what it means to be safe in their home and how do they practice safety in their home? (e.g. slip & fall hazards, electrical hazards, hot stoves, fire, answering the door.)

B. How does the individual describe what it means to be safe in the community and how do they practice safety in the community? (Traffic, strangers, _____)

C. For each category below, describe a hypothetical situation to the individual and record how the individual would respond to the situation using the individual's own words.

1) Personal injury / illness

2) Phone calls / visits from unknown individuals

3) Smell of smoke / sound of fire alarm / sight of fire

4) Earthquake

5) Stranger asking for money

D. Does the individual have an individualized safety / crisis plan for responding to emergencies in the home or community, natural disasters, etc.? Yes ___ No ___

E. Does the individual have the ability to call 911? Yes ___ No ___

F. Risk to Self and Others

1) What appear to be risks to this individual of living in the community? Include physical, medical, safety/stranger awareness risks.

2) What are the potential risks to roommates, neighbors, others in the community?

3) How would identified risks affect choice of the following:
   - Type and utilization of direct and/or natural/generic services

   - Residence type and/or location

4) Do risks identified above exceed risks that would be acceptable for a person without disabilities living in similar circumstances? Yes ___ No ___ Explain.

Summary Section XII – Safety Awareness / Risk to Self & Others:
Service needs, if any, identified based on the information in this section:

Type: ☐ TCRC Funded _____ Hours/Week
☐ Generic _____ Hours/Week
☐ Natural _____ Hours/Week

Comments:

XIII. SOCIAL

A. Describe the individual's social and leisure activities.

1) What does the individual enjoy doing for fun / leisure when at home?

2) What does the individual enjoy doing for fun / leisure in the community?

3) Does the individual participate in community groups such as clubs, religious organizations, recreation department activities, sports teams, community garden, adult education classes, etc.? Yes ___ No ___
If yes, list and describe frequency of participation.

4) Is the individual able to provide names of person(s) in these community groups? Yes ___ No ___

5) Does the individual take college or adult education classes? Yes ___ No ___
If yes, describe.

6) What are the individual's preferred activities / outings?

- How often does the individual engage in these preferred activities / outings?

7) Does the individual have a calendar for social / recreational / community events? Yes ___ No ___

8) Describe the individual's personal interests / hobbies / skills.

Summary Section XIII – Social:

Service needs, if any, identified based on the information in this section:

Type: ☐ TCRC Funded _____ Hours/Week

☐ Generic _____ Hours/Week

☐ Natural _____ Hours/Week

Comments:

XIV. COMMUNICATION

A. Primary Language: English ___ Spanish ___ Other _____

B. Are any of the following communication styles / systems used? Yes ___ No ___
(See definitions below) If yes, check all that apply.

- ☐ Verbal: Communicates in full sentences ___, phrases ___, or single words ___.
- ☐ Vocalization (Non-Verbal)
- ☐ Low tech device such as PECS (Picture Exchange Communication System)
- ☐ High tech device such as Augmentative Communication Device i.e., Dynavox, etc?
- ☐ Sign language: ASL (American Sign Language), SEE (Signed Exact English) or Pigeon.
- ☐ Object Communication
- ☐ Photo Communication System
- ☐ Gestures
- ☐ Motoric
- ☐ Written

DEFINITIONS:

Motoric: Hand-over-hand physical manipulation of a person or object to communicate a need or want.

Gestural: Pointing, showing, looking at (e.g., the person looks or points to a desired item and then looks toward another person to indicate he wants the item).

Vocalization: Use of non-word sounds to communicate needs, get attention.

Sign language: Communication with a conventional sign language system.

Using objects: The individual hands an object to another person to communicate a need or want (e.g., the individual holds out a cup to indicate "drink").

Using photos: Use of photographs to communicate (pointing to or holding up photographs of objects, actions or events to communicate wants/needs).

Pictorial: Use of drawings representing a desired object, action, etc. (an individual shows a drawing of a ball to indicate that he wants to play catch).

Written: Individual writes words or phrases to communicate.

C. Are the checked communication systems used across all environments and situations or only some? Explain.

Summary Section XIV – Communication:

Service needs, if any, identified based on the information in this section:

Type: ☐ TCRC Funded _____ Hours/Week

☐ Generic _____ Hours/Week

☐ Natural _____ Hours/Week

Comments (Include a description of the type of communication the individual uses in different situations including but not limited to requesting attention, indicating physical pain, need to got to the bathroom, hunger, etc.):

XV. BEHAVIOR

A. Describe any maladaptive behaviors that may affect individual's ability to succeed in supported living. Include information regarding frequency, intensity, and duration.

B. Does the individual have a history of behavioral incidents? Yes ___ No ___ If yes, describe type, frequency and antecedents.

C. Have there been any recent behavioral incidents (last ___ months)? Yes ___ No ___ If yes, describe the incident(s). Include any known antecedents.

D. Was there a LPS 5150 hold for the any of the incident(s) described in B. above? Yes ___ No ___ If yes, describe why, when, where.

1) Was there a new diagnosis given during the LPS 5150 hold(s)? Yes ___ No ___ If yes, what was the diagnosis?

E. Does the individual have a current behavior plan? Yes ___ No ___ If yes, who created the plan and how and by whom is it being implemented?

Summary Section XV – Behavior:

Service needs, if any, identified based on the information in this section:

Type: ☐ TCRC Funded _____ Hours/Week
☐ Generic _____ Hours/Week
☐ Natural _____ Hours/Week

Comments:

XVI. LEGAL / FORENSIC

A. Legal History

1) Does the individual have a history of legal charges? Yes ___ No ___
If yes, list below. Include outcome such as conviction, jail, probation, dismissal, conditional release / diversion, court ordered treatment, 6500, etc.

Date	Location	Charge	Outcome
___/___/___			
___/___/___			
___/___/___			
___/___/___			
___/___/___			
___/___/___			

2) Is the individual a registered sex offender? Yes ___ No ___

3) Is the individual currently on diversion / probation? If yes, describe the type and terms of the agreement(s).

4) Are any forensic-related support services in place for the individual? Yes ___ No ___
If yes, describe the type and amount of support received by the individual.

Summary Section XVI – Legal / Forensic:

Service needs, if any, identified based on the information in this section:

Type: ☐ TCRC Funded _____ Hours/Week
☐ Generic _____ Hours/Week
☐ Natural _____ Hours/Week

Comments:

REPORT OF INDEPENDENT ASSESSMENT

Assessing Agency: _____ **Vendor #:** _____

Individual Assessed: Name: _____ **UCI#:** _____

Date of Report: _____ **Submitted to**: _____

_____ Date Submitted: _____

Signature & Printed Name of Assessor

DISCLAIMER

This assessment was prepared pursuant to Section 4689 (p) of the Welfare and Institutions code. The following is a summary of findings regarding the services and supports determined by the Independent Assessor to be necessary, appropriate, and cost effective for the individual who is the subject of this assessment based on the interviews, observations, and reviews of records conducted by the assessor. The service recommendations in the following report do not constitute a mandate for changes to existing or proposed services. All decisions with respect to increases, decreases, or any other changes in services to be provided to the individual are to be made by the individual's TCRC planning team.

Note: The service needs shown in the table below are taken from the Summary section at the end of each assessment topic. Please review those summaries for additional information regarding determination of need for services.

Section	Hours/Week TCRC-Funded	Hours/Week Generic	Hours/Week Natural
I. Background			
II. Circle of Support			
III. Living Arrangements			
IV. Goals			
V. Interviews			
VI. Observations			
VII. Record Review			
VIII. Health			
IX. Financial			
X. Domestic Skills			
X. Self Help Skills			

XI. Community Access & Transportation			
XII. Safety / Risk			
XIII. Social			
XIV. Communication			
XV. Behaviors			
XVI. Legal/Forensic			
Weekly Totals			
***Monthly Totals**			

*Weekly total X 4.3

SUMMARY OF SERVICE RECOMMENDATIONS

(Expressed as hours/week)

Subcode	Assessor Recommendation	Current Services	Difference
Personal Service (PS)			
Personal Service – Overnight (PSB)			
Training and Habilitation (TH)			
Generic/Natural Supports*			
Generic/Natural Supports*			
Generic/Natural Supports*			
Generic/Natural Supports*			
Generic/Natural Supports*			

*See description below.