PROCEDURE NO. 2-6-10

ISSUED: 06-08-98
REVISED: 02-07-25
REVIEWED: 02-07-25

SUBJECT: Functional Assessment

PURPOSE: The goal of the assessment is to develop the clearest picture of the individual's personal goals and desires, strengths, assets and supports necessary to achieve a quality lifestyle and carry out the mandate of Office of Programs Policy No 2.

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Functional Assessments (FA) are completed by the Home Coordinator with Program Manager Review, prior to the following times:

1. Annually at the Individual Plan meeting.

2. 30-day review of a new placement or a new service

Functional Assessments need to be completed one week prior to a review of placement and two weeks prior for yearly IP meetings. Copies of the FA need to be shared with the individual, the case manager and other team members.

Home Coordinators will gather information for the functional assessment from a variety of sources. Dependent on the individual, this information may be based on staff, family and guardian observation. The pre-planning questionnaire will be completed with all individuals who are able to give the Home Coordinator feedback. The questionnaire will be attached to the functional assessment. Information gathered from the questionnaire will be used to develop the functional assessment. Additional clarification may be used to reflect different opinions between individual served and guardian

The profile format will be:

Section One: **Preferences**- This section of the assessment will describe the living environment where the individual chooses to live, day work program, preferred routine and daily schedule. (I.e. early or late riser, day/afternoon/night job, time for favorite activity, preferred bedtime etc) This section of the assessment will identify likes/dislikes of the person supported as well hopes, goals and dreams for the future. It should include their preferred activities/interests both at home and in the community. Describe the community resources a person uses as well as relationships the individual served has with people without disabilities. The assessment should discuss any challenges or barriers to the individual being able to achieve their desired goals and how they can be overcome. This section should include employment goals and wishes.

Section Two: Supports-This section of the assessment discusses what needs to occur for the individual supported to meet their needs and wants. It should cover on how they communicate their wants and needs, what skills they complete independently. This section of the assessment should also cover what has been successful in supporting the individual in the past and what has not been successful. Things to take into consideration include:

- What can the person supported do for themselves?
- What do others have to assist him/her with?
- What skills have they developed since the last assessment?

Section Three: Health and Safety; this section will include the following:

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- List of all current medications the individual is taking and why they are taking them.
- It will list all adaptive equipment and why it is required.
- It will include relevant information regarding medical appointments over the past year (PCP, dental, psych etc.) A description of any hospitalizations that occurred in the previous year and any significant changes in medical or behavioral issues during the previous plan year.

Section Four: Recommendations: This will include both short and long term goals for the individual supported in order to achieve their desired outcomes.

Section Five: Signatures

This report was completed by: _____

This report was shared with me:_____
Individual Supported

This report was reviewed by: _____

Date: _____

Approved by:_____
Director of Residential & Community Services

Date:_____

Attachment: Functional Assessment Questions
Functional Assessment Template

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PRE-PLANNING QUESTIONS FOR ISP

NAME:_____

DATE(S) OF INTERVIEW:_____

IHP DATE:_____

A. MEETING

1. Is the established meeting date and time agreeable?

   _____

2. Who would you like to attend your ISP?

   _____

3. Where do you want to have the meeting?

   _____

B. HOME

1. Where do you want to live?

   _____

2. Who do you want to live with?

   _____

3. Do you have any concerns with the staff working with you?

   _____

4. What hours do you need the most assistance?

   _____

5. Do you want to assist in selecting staff when vacancies occur?

   _____

6. Are your special needs (i.e. communications, special diet, etc.) being met?

   _____

7. Are your transportation needs being met?

   _____

   Would you like to use public transportation, taxi?

   _____

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8. Are you able to do things as you wish i. e. stay up late, eat foods you like, etc?

_____

9. What assistance would you like in maintaining relationships with family and friends?

_____

10. Are your medical needs being met?

_____

Please identify your preference for:

Physician_____

Dentist_____

C. WORK

1. Where do you want to work/day placement?

_____

2. What can we do to help you with regard to work/day placement?

_____

D. COMMUNITY RESOURCE

1. What is your religious preference?

_____

2. What assistance would you like to practice your religion?

_____

3. What assistance would you like in participating in religious and ethnic activities?_____

_____

4. What do you like to do for fun (recreation/leisure)? _____

_____

What would you like to learn to do during your free time?

_____

5. Do you have access to recreational pursuits (movies, swimming, shopping, etc) as often as you would like? _____

_____

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E. MONEY

1. What items would you like to save for? (I.e. vacations, stereo, TV?)

_____

2. Do you have enough money to do the things you would like to do?

_____

F. OVERALL

1. What other issues/concerns do you wish to have addressed at your meeting?

_____

G. SUMMARY

Describe how this information was obtained, i.e. verbal, signed, guardian input.

_____

Staff Signature:_____ Date:_____

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I. Preferences

A. What environment did the individual choose to live in (ISL, Group Home, or Independent apartment? If there is a desire by the individual supported to change their current residential placement, please describe current obstacles or plan to try and meet this choice.
B. What form of day placement (Community Connections, Residential or Work Program) does your individual supported currently have or is there a desire by the individual to change the current placement, if so identify the obstacles?
C. Describe the individual supporter's preferred routine and daily schedule.
D. Describe the individual supporter's preferred activities/Interest both in the community and in the home.
E. Describe the generic community resources an individual utilizes and relationships the individuals has with people not paid to work with them.
F. Please identify likes and dislikes for the individual supported. Please ensure to cover people, places and things.
G. Identify the hopes, goals and dreams of the individual supported.
H. What barrier does the individual supported have that pose challenges for them to pursue their wants and dreams?

II. Supports

A. How does the individual supported communicate their wants and needs (Hopes, Goals and Dream)?(If not spoken lang. please ensure to identify means of communication and how input was obtained for functional)
B. What functional skills and abilities is the individual supported currently doing independently?
C. What areas do the individual supported need assistance with their current level of functionality and ability?
D. What has been successful supporting the individual in the past and what has not been successful?
E. What does the individual supported want to learn? And how do they learn best?
F. What obstacles occur that prevent the above supports from being successful?

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G. What needs to occur for the individual supported to meet their needs and wants?

III. Health and Safety

A. List all current medications and what they are taken for.
B. Adaptive equipment
C. Please list previous date of appointments, doctor, and location appointment held:

Physical:
Primary Care:
Dental:
Psych:
Other: (podiatry, Neurology, etc.)

D. Any significant medical or behavioral occurrences in previous plan year; and is anything still pending in these areas?
E. Has any hospitalizations occurred in previous plan year?

IV. Recommendations

1. Please list any short term goals identified for the individual supported.
2. Please list any long term goals identified for the individual supported.

V. **Signatures**

1. This report was completed by:_____Date_____
2. This report was reviewed by:_____ Date_____
3. This report was shared with me:_____ __Date_____

Individual Supported

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