|  |  |
| --- | --- |
| **Person Completing Profile and Title:**       | **Date Profile Completed:**       |

|  |
| --- |
| **Individual Identification** |
| **Individuals Name**:       | **Date of Birth**:       | **DMH ID#**:       |
| **Financial Resource Source**:  | **Amount**: $       | **Spend Down Amount**: $      |
|  **Payee:**       | **Family Involvement** [ ]  Frequent [ ]  Infrequent [ ]  None | **Guardianship (please provide name, address, telephone, and email):**      [ ]  Limited[ ]  Full |
| **Choice of Residential Services:** (See Appendix A for Waiver Manual description at end of this document)ISL [ ]  Shared Living (Host/Companion) [ ]  Group Home [ ]  |

|  |
| --- |
| **Diagnosis Information**  |
| ICD 10:       |

|  |
| --- |
| **County Preference** |
| **1st Choice** Choose an item. | **2nd Choice** Choose an item. |
| **3rd Choice** Choose an item. | **4th Choice** Choose an item. |
| **Additional Counties Requested****1)**      **2)**      **3)**      **4)**       | **Statewide Referral:** [ ]  **Yes or** [ ]  **No** |

|  |
| --- |
| **Why is the individual being placed on the referral database:**  |
| **If applicable, what are the current Rights Restrictions:**  |
| **Provide a brief description of unique or special support needs (examples could include diet, preference in staff, etc…):**  |
| **Please provide a summary of the current situation. What has happened recently to cause the need for Residential Services or a change of provider? If applicable, please provide date(s) and description of the most recent hospitalizations, law enforcement involvement, crisis stay, and/or maladaptive behavior episode. If applicable, include all possible contribution factors:**  |
| **If currently receiving residential services how long has the consumer been at their current residence and with the current provider? How many moves have occurred for the consumer in the past 24 months?**  |

Continue on next page…

|  |
| --- |
| **About the Individual**  |
| **Day Activities & Services**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Activity / Service** | **Full****Time** | **Part Time** | **Currently Receiving** | **Needed at new home** |
| ☐[ ]  | Day HabilitationCommunity Integration  | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  |
| [ ]  | Vocational Training | [ ]  | [ ]  | [ ]  | [ ]  |
| ☐ | School |[ ] [ ] [ ]  [ ]  |
|[ ]  Physical Therapy |[ ] [ ] [ ]  [ ]  |
|[ ]  Speech Therapy |[ ] [ ] [ ]  [ ]  |
|[ ]  Occupational Therapy |[ ] [ ] [ ]  [ ]  |
|[ ]  Competitive Employment |[ ] [ ] [ ] [ ]
| [ ]  | Supported Employment | [ ]  | [ ]  | [ ]  | [ ]  |
| ☐ | Sheltered Employment |  [ ]  |  [ ]  |  [ ]  |  [ ]  |
| [ ]  | Volunteer | [ ]  | [ ]  | [ ]  | [ ]  |

 | **Daily Living Needs** (All That Apply) **None Minimal Moderate Extensive**

|  |  |
| --- | --- |
| Bathing |[ ]  [ ]  [ ]  [ ]   |
| Dressing | [ ]  | [ ]  [ ]  [ ]  |
| Grooming | [ ]  | [ ]  [ ]  [ ]  |
| Eating | [ ]  | [ ]  [ ]  [ ]  |
| Cooking | [ ]  | [ ]  [ ]  [ ]  |
| Toileting | [ ]  | [ ]  [ ]  [ ]  |
| MoneyManagement | [ ]  | [ ]  [ ]  [ ]  |
| Medication Management  | [ ]  |  [ ]  [ ]  [ ]  |
|  |  |  |
|  |  |  |

 |
| **Levels of Supervision Needed** (Mark All That Apply) **–** (see Appendix B for clarification for some items at end of this document)

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|[ ]  Requires RN/LPN oversight on all shifts |[ ]  Max Time Alone (Community) – Less Than 15 Minutes |
|[ ]  Awake, Overnight Staff |[ ]  Max Time Alone (Community)– Less Than 1 Hour |
|[ ]  24 Hour  |[ ]  Max Time Alone (Community)– 1-3 Hours |
|[ ]  General Supervision |[ ]  Max Time Alone (Community)– 3-10 Hours |
|[ ]  Heighten Supervision  |[ ]  Max Time Alone (Community)– 10+ Hours |
| [ ]  | Line of Sight Supervision  |[ ]  Max Time Alone (Community) – 10+ Hours |
|[ ]  Close Proximity Supervision  |[ ]  Max Time Alone (Home) – Less Than 15 Minutes |
|[ ]  Arms-Length Supervision  |[ ]  Max Time Alone (Home) – Less Than 1Hour |
|[ ]  1:1 Staffing (Home) |[ ]  Max Time Alone (Home) – 1-3 Hours |
|[ ]  1:1 Staffing (Community) |[ ]  Max Time Alone (Home) – 3-10 Hours |
|[ ]  More Than 1:1 Staffing (Home) |[ ]  Max Time Alone (Home) – 10+ Hours |
| [ ] [ ]  | More Than 1:1 Staffing (Community)Unable to Evacuate Without Assistance |[ ]  Remote Monitoring / Remote Supports Appropriate  |

 |
| **Additional comments if needed:** |

Continue on next page…

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Medical Support Needs** (All That Apply)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Mobility** |  | **Vision** |  | **Speech** |  | **Hearing** |
|[ ]  Walks Independently  |[ ]  Normal |[ ]  Normal |[ ]  Normal |
|[ ]  Walks unaided with difficulty |[ ]  Impaired but corrected with glasses |[ ]  Difficult to understand |[ ]  Partial hearing loss |
|[ ]  Walks with supportive devices  |[ ]  Travel vision but legally blind | [ ]  | Communicate with sign language |[ ]  Hearing Aids |
|[ ]  Manual wheelchair without assistance | [ ] [ ]  | No functional vision Blind  |[ ]  Communicates using assisted devices |[ ]  Deaf |
|[ ]  Manual wheelchair with assistance |[ ]  Unknown or undetermined visual ability |[ ]  Communicates using gestures or eye pointing  |[ ]  Unknown or undetermined hearing abilities  |
|[ ]  Manual wheelchair with transfer assistance |  |  |[ ]  No functional communication  |  |  |
|[ ]  Electric wheelchair without assistance |  |  |  |  |  |  |
| [ ]  | Electric wheelchair with assistance |  |  |  |  |  |  |
|[ ]  Requires total assistance with mobility |  |  |  |  |  |  |
|[ ]  Crawls |  |  |  |  |  |  |
|[ ]  Braces |  |  |  |  |  |  |
|  |  |  | **Other Medical issues** |  |  |
|[ ]  Seizures (Controlled) |[ ]  Seizures (Uncontrolled) |[ ]  Diabetes – Insulin Dependent |[ ]  Diabetes – Non Insulin Dependent |
|[ ]  Illness that interfere with daily routine |[ ]  Illnesses that require medical attention  |[ ]  Incontinence/ Wears depends |[ ]  Bowel Care |
|[ ]  Colostomy  |[ ]  Catheterization  |[ ]  Dentures |[ ]  Special diet |
|[ ]  Special diet preparation |[ ]  Chocking |[ ]  Dehydration |[ ]  Tube Feeding |
|[ ]  Ambulatory |[ ]  Non-Ambulatory |[ ]  Accessible environment |[ ]  Accessible transportation |
|[ ]  Falling |[ ]  Ventilator  |[ ]  Aspiration  |[ ]  Tracheotomy |
|[ ]  Suctioning  |[ ]  Therapeutic Position  |[ ]  Skin Break Down  |[ ]  Allergy(s) |
|[ ]  Psychotropic Medication  |  |  |  |  |  |  |

 |
| **Intellectual Skills** (All That Apply)**Support Needed (Yes or No)** **Yes No Yes No Yes No**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| [ ]  [ ]  |  Coping Skills: Does not handle  everyday stress | [ ]  [ ]   | Judgment Impaired: Rational Health Decisions? | [ ]  [ ]  Judgement Impaired:  Rational Decision  |  |  |  |  |  |  |  |
| [ ]  [ ]   | Coping Skills: Dislikes disruptions in environment |  [ ]  [ ]   | Judgment Impaired: Rational Decisions Financial |  Social/Relationships  |  |  |  |  |  |  |  |
| [ ]  [ ]  | Judgment Impaired: Easily Taken Advantage Of |  [ ]  [ ]   | Judgment Impaired: Rational Decisions Safety |  |  |  |  |  |  |  |  |
| [ ]  [ ]  | Judgment Impaired: Inability to Advocate for Self |  [ ]  [ ]   | Recognize Reality: Paranoia or Delusional Behavior |  |  |  |  |  |  |  |  |

 |
| **Additional comments if needed:** |

Continue on next page…

|  |
| --- |
| **Behavioral Issues (All that Apply)** |
|  | **History of …** | **Present** | **Behavioral Services in place for…** |
| Chemical Abuse |[ ] [ ] [ ]
| Dishonesty |[ ] [ ] [ ]
| Elopement |[ ] [ ] [ ]
| Physical Aggression |[ ] [ ] [ ]
| PICA - Eats non-food items |[ ] [ ] [ ]
| Property Destruction |[ ] [ ] [ ]
| Self-Abuse |[ ] [ ] [ ]
| Sexuality - Vulnerability |[ ] [ ] [ ]
| Sexuality (Predator - Preference Female) |[ ] [ ] [ ]
| Sexuality (Predator - Preference Male) |[ ] [ ] [ ]
| Sexuality (Predator - Children) |[ ] [ ] [ ]
| Social Interactions |[ ] [ ] [ ]
| Extra Support for Transportation |[ ] [ ] [ ]
| Verbal Aggression |[ ] [ ] [ ]
| Stealing |[ ] [ ] [ ]
| Fire Setting |[ ] [ ] [ ]
| Self Stimulatory Behaviors |[ ] [ ] [ ]
| Impulse Control |[ ] [ ] [ ]
| Arrests |[ ] [ ] [ ]
| Antisocial Behaviors |[ ] [ ] [ ]
| Suicidal thoughts/attempts |[ ] [ ] [ ]
| Psychiatric diagnosis  |[ ] [ ] [ ]
| Family stresses  |[ ] [ ] [ ]
| **Sexually Aberrant Behavior**(Defined as inappropriate sexual behavior that puts the individual or others at risk of physical or psychological harm and/or causes high level of concern within the community. Examples: criminal sexual behaviors, non-consensual sexual acts, predatory behaviors, etc.)Yes [ ] No[ ]  |
| **Additional comments if needed:** |

Continue on next page…

**TO BE COMPLETED BY CLC**

|  |
| --- |
| **Information for Determining Rate**  |
| **Support Intensity Scale/Vineland Index** *(for shared living only):*      **Rate Allocation Score** *(for group home)****:***       **ISL Rate:**        |

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| --- |
| **Sex Offender Registry Check**  |
| **Community Living Coordinator has checked appropriate sex offender registry for this individual**:For adults (over the age of 21), CLC checked Highway Patrol Sex Offender Registry on this date      For juveniles (under the age of 21), CLC check Highway Patrol Sex Offender Registry on this date       AND letter was sent to Juvenile Office to check Juvenile Sex Offender Registry on this date     . |

**Appendix A. – Residential Services Definitions**

* **ISL.** Stands for Individualized Support Living. 4/26/19 waiver definition states,
	+ “Individualized supported living is characterized by creativity, flexibility, responsiveness and diversity. Individualized support living enables people with disabilities to be fully integrated in communities. ISL services provider individualized supports, delivered in a personalized manner, to individuals who live in homes of their choice. Individuals receiving ISL support may choose with whom and where they live, and the type of community activities in which they wish to be involved.” (pg. 61)
* **Shared Living.** 4/26/19 waiver definition states,
	+ “Shared Living is an arrangements in which an individual chooses to live with a couple, another individual, or family in the community to share their life experiences together. Shared Living can be provided in the home of a care giver (Host Home Services) or in the individual’s home (Companion Services).” (pg. 91
* **Group Home.** 4/26/19 waiver definition states,
	+ “Group home services provide care, supervision, and skills training in activities of daily living, home management and community integration. The services are provided to groups of individual in group homes, residential care centers, and semi-independent living situations (clustered apartment programs) licensed or certified by DMH Licensure, certification and accreditation all meet the requirements of 45 CFR Par 1387 for board and care facilities. A unit of services is one day (24 hours).” (pg. 54)

**Appendix B – Level of Supervision**

* **General Supervision** - The level of supervision is no greater than for anyone else in the same area, and is provided through established staffing patterns and routines.
* **Heightened Supervision** - The staff in the area must know where the person is at all times, visually observe the person within \_\_\_\_\_\_\_\_\_ minute intervals (no greater than 15 minutes), and be able to intervene as needed.
* **Line-of-Sight Supervision** - An assigned staff person must remain within twenty-five (25) feet of the person, keep that person constantly within his or her line of sight, and be able to intervene as needed within ten (10) seconds.
* **Close Proximity Supervision -** An assigned staff person must remain within \_\_\_\_\_\_\_\_\_\_ feet (no greater than 15 feet) of the person, keep that person constantly within his or her line of sight, and be able to intervene within five (5) seconds.
* **Arms-Length Supervision**. An assigned staff person must remain within 36 inches (3 feet) of the person, keep that person constantly within his or her line of sight, and be able to intervene immediately as needed.

**Appendix C. – Important Links**

* Community Transition Manual (<https://dmh.mo.gov/dd/manuals/docs/communitytransitionmanual.pdf>)
* Individualized Supported Living Services and Budget Manual (<https://dmh.mo.gov/dd/manuals/docs/islserviceandbudgetmanual.doc>)
* Shared Living Manual (<https://dmh.mo.gov/dd/manuals/docs/sharedlivingmanual.pdf>)
* Housemate Compatibility Tool (<https://dmh.mo.gov/dd/docs/housematecompatibilitytool.docx>)
* Checklist for Community Moves (<https://dmh.mo.gov/dd/docs/checklistforresidentialcommunitylivingmoves.docx>)