	mographic Informa		
Last Name: Last Name.	Can be completed prior to v	(ame: First Name.	
Date of Birth: Date.		MIS Number: MI	C
	Name of Guardian:		3.
Guardianship Status: Type.  Guardian Contact information:		ate of Notification:	Doto
			Date.
Current Location: Name of L		Date of Admission:	Date.
Type of Location: Choose.	Type of Previous Livi	_	Choose.
Status with DDD: Choose.		oose. Intake:	Choose.
<b>Support Coordination Agency:</b>	Click or tap here to enter te		
Support Coordinator: Name.	Contact:	Enter text.	
Primary language used by Individual		er text.	
Primary method of communication	on used by individual:		
Click or tap here to enter text.			
Curr	ent Condition & Dia	ngnosis	
What is the presenting problem		5110515	
what is the presenting problem	m/cmci compianit.		
	Historical Diagnosis		
Diagnosis	-	Date of	of Onset

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Last Name:	First Name:
The individual is exempted	from completion of the Level II Evaluation due to:
Evenution 1	From Completion of Loyal II Evaluation
	From Completion of Level II Evaluation
│	liagnosis of intellectual disability or related condition
☐ Terminal illness	with life expectancy of six months or less
☐ Severe Physical	Illness Click or tap here to enter text.
Respite Care Ad (Only for individual	lmission, not to exceed 30 days per year
☐ Protective Servi	ces, Limited to 7 days
If you checked a box above a box above, please proceed	d with the rest of the form.
	Participant Information
Did a legal representative evaluation?  Yes. Specify	, family member or significant other participate in the
No. Explain	
	Mental Status Exam
In	tellectual Functioning (Please check one)
I —	Moderate ID Severe ID Profound ID
Not Documented (ex	plain):

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Last Name:			Firs	t Name:			
			tal Statu				
Intact		nsight and Judgment (ex	_	(Please che	ck one)		
	~ ·		ll that cur		ly		
Hallucination	ns/Delus	ions	Suic	idal		Homicidal	
Verbally Ab	usive		Phys	sically Abu	sive/Assaul	ltive	
Aggressive/	Γhreaten	ing to Others	s Self-	-Injurious		Disruptive	;
Inappropriat	e Sexual	Behavior	Lack	c of Initiation	on	Destroys F	Property
Takes Prope	rty from	Others	Fear	ful, Screan	ning, Crying	<u> </u>	
Performed R	•			ıders		Other (list	helow):
1 Circinica 1	орони.	Denaviore		ide15	<u> </u>		0010
		4 TO T /T A TO	T O ICI	·			
	1	ADL/IAD	DL Self I	'ertorm	ance		
Independent	Set-up	Supervision	Limited	Extensive	Maximum	Total	Did not
Bed Mobility			Assistance	Assistance	Assistance	Dependence	Observe
Transfer							
Locomotion							
in home/bldg							
Locomotion outside							
home/bldg							LI
Upper Body Dressing							
Lower Body Dressing							
Eating							

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<b>Last Name:</b>	First Name:	

	ADL/IADL Self Performance								
Bathing	Toileting  Personal	dependent	Set-up	Supervision					Did not Observe
Preparation Laundry	Bathing								
Shopping	Preparation								
Mobility									
Nutrition	Mobility								
Medical	Management Nutrition								
Monitoring Scheduling	Medical								
Appointments  List of adaptive equipment:									
	Appointments		linmont						
Impact of physical/medical condition on current functioning:		ариче еці	припени:						
	Impact of	physical/	medical	condition or	current fu	nctioning:			

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What is the prescribed diet?			First Nam	ie:	Last Name:
What is the prescribed diet?  Difficulty Chewing Difficulty Swallowing Modified Liquid Enteral Tube Feedings (explain)  Identify Current Medications			Feeding/Diet		
Difficulty Chewing Difficulty Swallowing Modified Liquid  Enteral Tube Feedings (explain)  Identify Current Medications				ne prescribed diet?	What is the nu
Enteral Tube Feedings (explain)  Identify Current Medications					what is the pi
Enteral Tube Feedings (explain)  Identify Current Medications					
Identify Current Medications	s (explain)	Modified Liquids (ex	Difficulty Swallowin	iculty Chewing I	Difficult
Identify Current Medications					
Identify Current Medications				eral Tube Feedings (explain)	Enteral '
<u> </u>		cations	<b>Current Med</b>	Identify	
				•	Nam
			Ţ.		
		_			

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**Last Name:** 

First Name:

Identif	y Cur	rent Me	dications
Name of Medication	I	Oosage	Indication
ntify medication (and other) aller	gies, int	olerances, a	nd/or incompatibilities:
Salf N	Ionagan	nent of Med	liantions
Without Supervision/Independ			imes with Prompting/Supervision
Always with Prompting/Super		_	Physical Assistance
	VISIOII		
Needs Cognitive Assistance		Other (	(explain)

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Last Name:	First Name:
	Determination
	Ent from Specialized Services. There is no need for mere a medical condition that exceeds or would impede the community.
Determina	ation of Community Based Services
Support Coordination Servi	ces
Individual Supports	
Day Habilitation Services	
Options Counseling Completed by	y:
Signature of Options Counselor:	
Date of Options Counseling:	
	ondition rises to the need for short term/sub-acute or skilled nursing facility, which will not exceed 180 days.
	Ent from custodial care at this time with the expectation of completion of intake and/or identification of a residence that condition improves.
The individual/guardian has services in the community at this t	s not responded to DDD outreach or does not desire DDD time.
Options Counseling Completed by	y:
Signature of Options Counselor:	
Date of Options Counseling:	

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Last Name:	First Name:	
	Summary	
(Include	ndividual's positive traits, strengths, an	nd weaknesses)
`	, , ,	,
	_	
Name:	Title:	DDD Regional Staff Nurse
ignature:	_	Click or tan here to enter
ignature.	Date:	text.

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