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**Supports and Training for Employing People Successfully (STEPS)**

**Services Assessment**

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***\*To navigate to the assessment you need, click the name or page number of the assessment.***

# STEPS (Support and Training for Employing People Successfully)

**Services Assessment**

|  |  |
| --- | --- |
| **Participant Name:** First and Last | **Participant address:** Street Address |
| **Phone number:** Contact Number | **City, State:** City, State |
| **DOB:** M/D/Y | **Zip code:** Zip Code |
| **Gender:** [ ] Female[ ] Male [ ]  Non-Binary [ ]  Trans-masc [ ]  Trans-femme |
| **CC/CM:** Who completed the assessment | **MCO:** Choose One |
| **Attendees:** Others who attended and their role |
| **Attendees:** Others who attended and their role |
| **Attendees:** Others who attended and their role |
| **Attendees:** Others who attended and their role |

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| **Assessment Type** | **Reason for completion** | **Date Completed** |
| Choose type. | Why was the assessment completed/re-completed? Example: New job, initial assessment, life change. | Choose date. |

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| --- | --- |
|  | **\*Only to be completed for annual or revised** **re-assessments.** |
| **Services** | **Was the service assessed?** | **What services remain the same?** | **What services were changed?** |
| Pre-vocational |[ ] [ ] [ ]
| Independent living skills |[ ] [ ] [ ]
| Transportation |[ ] [ ] [ ]
| Supported Employment |[ ] [ ] [ ]
| Personal Assistance Services |[ ] [ ] [ ]
| Supplemental Services – ***Only available with PAS –* Only mark as assessed if it will appear on the Service Plan** | Enhanced Services |[ ] [ ] [ ]
|  | Home-Delivered Meals |[ ] [ ] [ ]
|  | PERS |[ ] [ ] [ ]
|  | Medication Management System |[ ] [ ] [ ]

|  |
| --- |
| If a service wasn’t assessed, please provide an explanation why. |
| Pre-vocational | Enter explanation |
| Independent living skills | Enter explanation |
| Transportation | Enter explanation |
| Supported Employment | Enter explanation |
| Personal Assistance Services | Enter explanation |

# Diagnosis Information

|  |
| --- |
| **Primary Diagnosis/Condition:** Click or tap here to enter text. |
| **Source of information:** Click or tap here to enter text. |

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| *Please review every condition with the participant* |
| **Health Conditions** | **\*Primary Condition** | **Secondary Condition** | **Notes:** List diagnosis and impairments. Example, if paralyzed, to what extent does the paralysis limits the member's function.  |
| Alcoholism/Drug use |[ ] [ ]  Enter notes if applicable |
| Alzheimer's Disease, other memory loss conditions (specify) | [ ]  | [ ]  | Enter notes if applicable |
| Arthritis (specify) | [ ]  | [ ]  | Enter notes if applicable |
| Behavioral Health (specify) | [ ]  | [ ]  | Enter notes if applicable |
| Cancer/Leukemia | [ ]  | [ ]  | Enter notes if applicable |
| Circulation Problems (Swelling limbs, clotting problems, etc.) | [ ]  | [ ]  | Enter notes if applicable |
| Diabetes | [ ]  | [ ]  | Enter notes if applicable |
| GI Tract Problems (Ulcer, Colitis, etc.) | [ ]  | [ ]  | Enter notes if applicable |
| Head Injury (include date of onset) | [ ]  | [ ]  | Enter notes if applicable |
| Hearing Problem | [ ]  | [ ]  | Enter notes if applicable |
| Heart Problems | [ ]  | [ ]  | Enter notes if applicable |
| High Blood Pressure | [ ]  | [ ]  | Enter notes if applicable |
| Infectious Diseases (specify) | [ ]  | [ ]  | Enter notes if applicable |
| Kidney/Bladder Problems | [ ]  | [ ]  | Enter notes if applicable |
| Lung/Breathing Problems (specify) | [ ]  | [ ]  | Enter notes if applicable |
| Intellectual/Developmental Disability (specify) | [ ]  | [ ]  | Enter notes if applicable |
| Missing Limb (specify) | [ ]  | [ ]  | Enter notes if applicable |
| Open Wounds, Bed Sores | [ ]  | [ ]  | Enter notes if applicable |
| Osteoporosis | [ ]  | [ ]  | Enter notes if applicable |
| Paralysis (specify) | [ ]  | [ ]  | Enter notes if applicable |
| Neurological Disease (such as Parkinson's) or mobility problems | [ ]  | [ ]  | Enter notes if applicable |
| Seizures | [ ]  | [ ]  | Enter notes if applicable |
| Significant Weight Loss/Gain, Obesity or Under Weight (specify) | [ ]  | [ ]  | Enter notes if applicable |
| Speech Problem | [ ]  | [ ]  | Enter notes if applicable |
| Stroke | [ ]  | [ ]  | Enter notes if applicable |
| Uses Wheelchair, Walker, or other aid | [ ]  | [ ]  | Enter notes if applicable |
| Vision Problems (Glaucoma, Cataracts, etc.) | [ ]  | [ ]  | Enter notes if applicable |
| Other (Specific) | [ ]  | [ ]  | Enter notes if applicable |
|  |  |  |  |
| **\*Must check a Primary Condition** |  |  |  |

# Health & Safety Information

|  |
| --- |
| ***Please check the appropriate boxes and provide explanations where needed.*** |
| 1. | Current place of residence |  | 9. | Are there any abuse, neglect, or exploitation issues that should be reported to help you? |
|[ ]  House/Townhouse |[ ]  Duplex |  |  |  |
|[ ]  Apartment/Condominium |[ ]  Assisted Living |  | [ ]  Yes | [ ]  No |
|[ ]  Congregate/Group Living |[ ]  Mobile Home |  | If yes, please identify. Click or tap here to enter text. |
|[ ]  Nursing Facility |[ ]  Transitional housing |  |  |
|[ ]  Homeless |  |  |  |  |
|  |  |  |  |  |  |  |
| 2. | Consumer’s current residence is? |  | 10. | Does your home have the following? |
|[ ]  Owned (or being purchased/mortgage) |  |  | 1 = Does not have, 2 = Not working, 3 = Working |
|[ ]  Rented, private |[ ]  Rented, subsidized |  |  | *(indicate the code that applies)* |
|[ ]  Rent free (e.g., family, friends) |  |       | Electricity |       | Refrigerator |
|[ ]  Other |  |       | Gas/propane |       | Stove |
|  |  |  |       | Piped water, hot/cold |       | Oven/Toaster oven |
| 3. | How many addresses has the consumer had in the last 12 months |  |       | Air conditioner/fan |       | Microwave |
|  |  |  |       | Heating system |       | Flush toilet |
|       |  |       | Laundry facilities |       | Tub/shower |
|  |  |  |       | Smoke detector |       | Radio/television |
| 4. | Client’s residence location |  |       | Carbon Monoxide detector |       | Telephone |
|[ ]  Rural (< 20,000) |  |  |  |  |  |
|[ ]  Town (20,000 – 100,000) |  |  |  |
|[ ]  Urban (> 100,000) |  | 11. | What type of housing has the consumer had in the past 12 months? (*Check all that apply)* |
|  |  |  |  |  |
| 5. | Do you feel safe inside your home? |  |[ ]  Owned own |[ ]  Transitional housing |
| [ ]  Yes | [ ]  No |  |[ ]  Rental home |[ ]  Correctional facility |
| If no, why not? Click or tap here to enter text. |  |[ ]  Someone else’s home |[ ]  Homeless |
|  |  |[ ]  Group home setting |[ ]  Other |
|  |  |[ ]  Hotel |  |
|  |  |  |  |  |
| 6. | Do you feel safe in your neighborhood? |  | 12. | Are there health or physical safety problems? |
| [ ]  Yes | [ ]  No |  |  | *Check all that apply* |
| If no, why not? Click or tap here to enter text. |  |[ ]  Dirt/garbage |[ ]  Furnishings/rugs |
|  |  |[ ]  Yard/storage buildings |[ ]  House/basement |
|  |  |[ ]  Animals/pets |[ ]  Poor lighting |
|  |  |  |[ ]  Other: Click or tap here to enter text. |
| 7. | Do you feel safe outside your neighborhood? |  |  |  |  |  |
| [ ]  Yes | [ ]  No |  | 13. | Do you have difficulty getting into your home or any room in your home *(Check all that apply)* |
| If no, why not? Click or tap here to enter text. |  |  |  |
|  |  |[ ]  Entrance(s) |
|  |  |[ ]  Living/family room |
|  |  |[ ]  Bathing facility/tub |
| 8. | Is there anything inside or outside of your home that you worry about or are uncomfortable about? |  |[ ]  Toilet facility |
|  |  |  |[ ]  Laundry |
| [ ]  Yes | [ ]  No |  |[ ]  Bedroom |
| If yes, why? Click or tap here to enter text. |  |[ ]  Kitchen |
|  |  |[ ]  No difficulty |
|  |  |  |  |

# Services Descriptions

|  |  |
| --- | --- |
| **Services** | **Description** |
| Pre-vocational services | Pre-Vocational Services are designed to lead to integrated competitive employment by assisting participants to determine vocational goals, develop or re-establish employment related skills, and participate in internships or work experiences. |
| Independent living Skills | Independent Living Skills (ILS) Training is designed to improve participant’s ability to live as independently as possible at home and in the community using existing community resources. The provision of ILS Training may reduce or eliminate the need for Personal Assistance Services and/or Transportation |
| Transportation | Transportation to and from job interviews, work, and essential locations such as grocery stores and banks. |
| Supported Employment | Supported Employment is designed to provide assistance to participants to determine vocational goals, to learn job responsibilities, determine and request job accommodation, as well as other supports to maintain successful employment. |
| Personal Assistance Services | Personal Assistance Services (PAS) are designed to provide hands-on assistance, or cuing and prompting, for Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). Cuing/prompting must be face-to-face.Participants will need to show need for supports for 2 Activities of Daily Living before they are eligible for supports for Instrumental Activities of Daily Living.\*Capable Persons policy will be considered for this assessment.General Limitation: A capable person living in the home of the participant with whom he or she has a significant relationship shall not be paid to provide PAS or similar services for IADLs that the person would ordinarily perform or be responsible to perform. |
| *Supplemental Services* – ***Only available with PAS*** | Enhanced Services | Assistance for participants who require hands-on care during the night, including re-positioning, tracheotomy care, and care for chronic incontinence; need must be documented by a physician. |
| Home-Delivered Meals | Meal delivery if determined cost effective when compared to meal preparation by a personal assistant. |
| PERS | Personal Emergency Response Systems (PERS) allowing participants to seek help when alone.  |
| Medication Management Systems | A device, monitored or unmonitored, that provides reminders for medication times and dispenser proper doses. |

# Pre-Vocational Assessment

**\*Once completed and if service provision is indicated the service provider will develop a more thorough plan that uses a person-centered approach to learn Pre-Vocational skills. Only completed at Initial Assessment, if indicated.**

Have the consumer indicate yes or no if they feel competent in the skills listed below. Then ask if they would like assistance to develop this skill. If they do not feel competent in the skill, they do not have to want to develop it.

|  |  |  |  |
| --- | --- | --- | --- |
| **40 skills**Are you able to do the following skills? | **Yes** | **No** | **Would you like to develop this skill?** |
| **Communication Skills** |
| Speak in public or present an idea Notes | [ ]  Yes | [ ]  No |[ ]
| Writing reports Notes | [ ]  Yes | [ ]  No |[ ]
| Accepting constructive criticism Notes | [ ]  Yes | [ ]  No |[ ]
| Following multi-step directions Notes | [ ]  Yes | [ ]  No |[ ]
| Reading and following employee documents/training materials Notes | [ ]  Yes | [ ]  No |[ ]
| **Technical Skills** |
| Use physical coordination (hand-eye coordination) Notes | [ ]  Yes | [ ]  No |[ ]
| Using tools safely and efficiently Notes | [ ]  Yes | [ ]  No |[ ]
| Operating vehicles, machines, and electronic equipment Notes | [ ]  Yes | [ ]  No |[ ]
| Repairing machines and equipment Notes | [ ]  Yes | [ ]  No |[ ]
| Gardening, landscaping, or faming Notes | [ ]  Yes | [ ]  No |[ ]
| Using a computer Notes | [ ]  Yes | [ ]  No |[ ]
| Using programs like word, excel, adobe etc. Notes | [ ]  Yes | [ ]  No |[ ]
| **Management Skills** |
| Managing or motivating others Notes | [ ]  Yes | [ ]  No |[ ]
| Selling or promoting products Notes | [ ]  Yes | [ ]  No |[ ]
| Prioritizing task so that larger goals are met on time Notes | [ ]  Yes | [ ]  No |[ ]
| Following rules Notes | [ ]  Yes | [ ]  No |[ ]
| Presenting a professional image Notes | [ ]  Yes | [ ]  No |[ ]
| **Number Skills** |
| Using percentages, decimals, and fractions Notes | [ ]  Yes | [ ]  No |[ ]
| Do simple addition and subtraction Notes | [ ]  Yes | [ ]  No |[ ]
| **Creative Skills** |
| Using artistic abilities (Photography, decorating, painting, sculpting) Notes | [ ]  Yes | [ ]  No |[ ]
| Using Musical abilities (singing, composing) Notes | [ ]  Yes | [ ]  No |[ ]
| Drawing, sketching, illustrating, graphic design Notes | [ ]  Yes | [ ]  No |[ ]
| **People and Social Skills** |
| Physically care for others Notes | [ ]  Yes | [ ]  No |[ ]
| Host, welcome, or serve customers (Like in retail or a restaurant) Notes | [ ]  Yes | [ ]  No |[ ]
| Helping someone complete a task Notes | [ ]  Yes | [ ]  No |[ ]
| Leading groups and activities Notes | [ ]  Yes | [ ]  No |[ ]
| Problem solving Notes | [ ]  Yes | [ ]  No |[ ]
| Using courtesy when dealing with others Notes | [ ]  Yes | [ ]  No |[ ]
| Ability to follow a routine Notes | [ ]  Yes | [ ]  No |[ ]
| Telling time to the nearest 5 minutes Notes | [ ]  Yes | [ ]  No |[ ]
| Knowing at what times things happen (work schedule, mealtimes, etc.) Notes | [ ]  Yes | [ ]  No |[ ]
| Recognizing break time Notes | [ ]  Yes | [ ]  No |[ ]
| Behaving appropriately on break Notes | [ ]  Yes | [ ]  No |[ ]
| Independently returning from break on time Notes | [ ]  Yes | [ ]  No |[ ]
| **Business Skills** |
| Using a business phone (Multiple lines, transferring calls, etc.) Notes | [ ]  Yes | [ ]  No |[ ]
| Knowing how to follow a business budget Notes | [ ]  Yes | [ ]  No |[ ]
| Setting up/Closing out a cash register Notes | [ ]  Yes | [ ]  No |[ ]
| Managing money and bills (Physically handling money, recognizing currency) Notes | [ ]  Yes | [ ]  No |[ ]
| Organizing and categorizing information Notes | [ ]  Yes | [ ]  No |[ ]
|  |
| Are there any skills not listed that you feel very comfortable with or that you feel you excel at? | Describe |
| Are there any skills not listed that you recognize that you need to improve to become more employable? | Describe |
| If you have been employed previously, do you feel that employment was based on your skills and knowledge? | Describe |
| Do you feel that you would benefit from pre-vocational skills training to become employed? | [ ]  Yes | [ ]  No |

|  |
| --- |
| **If a consumer indicates that they would like assistance to develop at least 3 skills, they qualify for this service (within program limits).** |
| Does the assessment indicate that this support is needed? | [ ]  Yes | [ ]  No |
| Is the individual requesting this support? | [ ]  Yes | [ ]  No |
| Are they receiving this service from another source? | [ ]  Yes | [ ]  No |

# Independent Living Skills Assessment

**\* Once completed and if service provision is indicated the service provider will develop a more thorough plan that uses a person-centered approach to learn Independent Living skills. Only completed at Initial Assessment, if indicated.**

Have the consumer indicate yes or no if they feel competent in the skills listed below. Then ask if they would like assistance to develop this skill. If they do not feel competent in the skill, they do not have to want to develop it.

|  |  |  |  |
| --- | --- | --- | --- |
| **27 skills** | **Yes** | **No** | **Would you like to develop this skill?** |
| **Communication Skills** |
| Reading and comprehending complex sentences Notes | [ ]  Yes | [ ]  No |[ ]
| Reading and following instructions Notes | [ ]  Yes | [ ]  No |[ ]
| Comparing/cross-checking two or more list Notes | [ ]  Yes | [ ]  No |[ ]
| Filling out forms Notes | [ ]  Yes | [ ]  No |[ ]
| Comfortably speaking to people that you don’t know Notes | [ ]  Yes | [ ]  No |[ ]
| Finding information Notes | [ ]  Yes | [ ]  No |[ ]
| Relates experiences when asked Notes | [ ]  Yes | [ ]  No |[ ]
| Knowing when to ask for help Notes | [ ]  Yes | [ ]  No |[ ]
| Listening to others for comprehension. (Being able to put what was said or what was read into your own words) Notes | [ ]  Yes | [ ]  No |[ ]
| Explaining your disability Notes | [ ]  Yes | [ ]  No |[ ]
| Accepting your disability Notes | [ ]  Yes | [ ]  No |[ ]
| Describing the accommodations that you need Notes | [ ]  Yes | [ ]  No |[ ]
| Knowing your legal rights Notes | [ ]  Yes | [ ]  No |[ ]
| **Self - Management Skills** |
| Setting task goals and priorities Notes | [ ]  Yes | [ ]  No |[ ]
| Planning and making decisions Notes | [ ]  Yes | [ ]  No |[ ]
| Being patient with others Notes | [ ]  Yes | [ ]  No |[ ]
| Motivating yourself to get things done even when you don’t want to Notes | [ ]  Yes | [ ]  No |[ ]
| Knowing how to take directions even if you don’t like it Notes | [ ]  Yes | [ ]  No |[ ]
| Seeking help when you need it Notes | [ ]  Yes | [ ]  No |[ ]
| Speaking up for yourself Notes | [ ]  Yes | [ ]  No |[ ]
| Can handle frequent changes Notes | [ ]  Yes | [ ]  No |[ ]
| Being on time/punctual Notes | [ ]  Yes | [ ]  No |[ ]
| Creating/maintaining a personal budget Notes | [ ]  Yes | [ ]  No |[ ]
| **Critical Thinking Skills** |
| Problem solving Notes | [ ]  Yes | [ ]  No |[ ]
| Evaluating consequences and outcomes Notes | [ ]  Yes | [ ]  No |[ ]
| Making safe and reasonable decisions Notes | [ ]  Yes | [ ]  No |[ ]
| Using maps Notes | [ ]  Yes | [ ]  No |[ ]
|  |  |  |  |
|  |
| Are there any skills not listed that you feel very comfortable with or that you feel you excel at? | Describe |
| Are there any skills not listed that you recognize that you need to improve to become more independent? | Describe |
| Do you feel that you would benefit from independent skills training to be more independent? | [ ]  Yes | [ ]  No |

|  |
| --- |
| **If a consumer indicates that they would like assistance to develop at least 3 skills, they qualify for this service (within program limits).** |
| Does the assessment indicate that this support is needed? | [ ]  Yes | [ ]  No |
| Is the individual requesting this support? | [ ]  Yes | [ ]  No |
| Are they receiving this service from another source? | [ ]  Yes | [ ]  No |

# Transportation Assessment

|  |
| --- |
| *Transportation* |
| This portion of the assessment only applies to employment-related transportation for obtaining and maintaining employment and essential transportation. |
| Capable person policy applies to personal assistance; employment transportation is separate. Transportation is limited to up to 10 hours a week as NEEDED. |
| **NOTES:** 1) Transportation support is allowed only for people who cannot drive due to their disability and includes both private and public transportation methods. **2) If a STEPS participant drives for any reason the expectation is that the member provides their own transportation.** 3) When transportation for medical appointments is needed, consumers must use NEMT (non-emergency medical transportation) services. |
| Do you have a driver’s license? | [ ]  Yes | [ ]  No |
| Do you have a vehicle? | [ ]  Yes | [ ]  No |
| Do you have limitations for driving? | [ ]  Yes | [ ]  No |
| If Yes, Please Describe |
| **Time per Task Guide:** | **Total Assist** | **Medium Assist** | **Light Assist** | **Cue/Prompt** |
| Scheduling transportation needs | 20 min/week | 15 min/week | 10 min/week | 5 min/week |
| Transportation to/from store/bank/laundry mat | Up to 1 hour per week based on distance/drive time | NA |
| Transportation to/from work (**Must include work address and how many days per week member works**) | Up to 1 hour per workday based on distance/drive time | NA |
| In the last 3 days how did you get this done and for what purpose? |
| Please Describe  |
| What transportation options are you considering? **All options must be considered for the most cost-effective option.** |
| Please Describe (Public transport, agency provided, attendant care, reason for need, etc.): |
| Are any hours of support needed? | [ ]  Yes | [ ]  No |
| If support is needed, list **each task** and describe the amount and frequency of support needed. Include an estimate of the weekly hours of support needed. (Thorough justification of time greater than examples above is required.) |
| Please Describe |
| Recommend Independent living skills training? | [ ]  Yes | [ ]  No |
| Describe skills needed (ex: learning how to ride the bus, how to schedule rides, etc. |

Complete one calculation depending on the transportation option chosen (if known):

|  |
| --- |
| *Agency, Bus Pass Cost, or Reimbursement to Participant* |
| Service providers name | If known |
| Monthly Cost | $0.00 |

**OR**

|  |
| --- |
| *PA Provided Transportation* |
| Weekly Hours |       |
| Monthly Hours | Weekly Hours x 4.33 | Total: 0 (Rounded) | 0.00 |
| Monthly Cost | Monthly Hours x $15 | Total: $ 0.00 |

# Supported Employment

**\* Once completed and if service provision is indicated the service provider will develop a more thorough plan that uses a person-centered approach to provide Supported Employment services.**

The Job Coach or Employment Specialist should provide a summary regarding supports and services required to obtain and/or maintain the participant’s employment.

|  |
| --- |
| **Supported Employment** |
| * Orienting and training participants to new or evolving job responsibilities
* Reminders to practice work-appropriate behaviors
* Reminders to interact appropriately with other employees and the public
* Reminders to practice safety measures
* Support to increase accuracy and/or speed
* Support to deal with mental health symptoms
* Overseeing and directing Job Coaches
* Consulting with, and providing technical assistance for, participants and/or their employers
* Negotiating customized jobs for participants
 | * Determining participants interests and skills
* Locating employment possibilities for participants
* Analyzing job tasks to determine suitability for participants
* Addressing employer’s concerns regarding hiring individuals with disabilities
* Facilitating the hiring of participants by employers
* Identifying workplace supports that help participants maintain employment and facilitating additional support as indicated
* Communicating and coordinating with participants’ Community Service Coordinators.
 |
| ***Support can be provided for up 13.25 hours per month for the first 15 months on the program*** |

|  |  |
| --- | --- |
| Please provide a detailed report of the participants on-going support needs for Supported Employment. | Please describe. |
| **Number of hours per month:** | 0.00 | **\*Within 13.25 hours** |
| **\* Completed using information from the Job Coach or Employment Specialist ONLY** |

# Personal Assistance Services Assessment

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| --- |
| ***Activities of Daily Living*** |

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| *Bathing and Personal Hygiene* |
| **Time per Task Guide:** | **Total Assist** | **Medium Assist** | **Light Assist** | **Cue/Prompt** |
| * Bathing: Tub/shower or Sponge bath (includes transfer & washing hair; 2 hrs/day Maximum)
 | 45-60 minutes | 30-45 minutes | 10-30 minutes | 5-10 minutes |
| * Oral Care: Brush Teeth/Denture Care
 | 10 minutes | 8 minutes | 5 minutes | 5 minutes |
| * Hair Care: Style, Set, Comb/Brush (no haircuts, color, etc.)
 | 15-20 minutes | 10-15 minutes | 5-10 minutes | 5 minutes |
| * Skin Care: Dry Off, Inspect Skin, Apply Lotion, Deodorant
 | 15-20 minutes | 10 minutes | 5 minutes | 5 minutes |
| * Shaving (No haircuts)
 | 15 minutes | 10 minutes | 5 minutes | 5 minutes |
| * Inspect/Clean/Trim Nails (once per week, no mani/pedi)
 | 15 minutes | 10 minutes | 5 minutes | 5 minutes |
| Can you perform this task without any support? | [ ]  Yes | [ ]  No |
| In the last 3 days how did you get this done? |
|  | Please Describe |
| How much or what aspects of this task are you able to do safely on your own? |
|  | Please Describe |
| Are any hours of support needed? | [ ]  Yes | [ ]  No |
| If support is needed, list **each task** and describe the amount and frequency of support needed. Include an estimate of the weekly hours of support needed. (Thorough justification of time greater than examples above is required.) |
| Please Describe |
| Recommend independent living skills training? | [ ]  Yes | [ ]  No |

|  |  |  |
| --- | --- | --- |
| Total weekly hours needed (Round to nearest 15-minutes) | hours | Total:       |
| Total Monthly hours needed | (weekly hours X 4.33 = monthly hours) | Hours Total: 0 (Rounded) | 0.0 |

|  |
| --- |
| Time conversion chart |
| 15 min = .25 hr. | 30 min = .5 hr. | 45 min = .75 hr. | 60 min = 1.0 hr. |

|  |
| --- |
| *Mobility* |
| **Time per Task Guide:** | **Total Assist** | **Medium Assist** | **Light Assist** | **Cue/Prompt** |
| * Transfers for bathing, toileting, bed, etc.
 | 10 minutes | 8 minutes | 5 minutes | NA |
| * Locomotion indoors (e.g., Hoyer lift, push manual wheelchair, etc.)
 | 10 minutes | 8 minutes | 5 minutes | NA |
| * Locomotion to & from vehicle *(includes transfer)*
 | 10 min/trip | 8 min/trip | 5 min/trip | NA |
| * Assistance with doctor ordered ROM, per day
 | 15 mins max/ day | 10 minutes | 5 minutes | 5 minutes |
| Can you perform this task without any support? | [ ]  Yes | [ ]  No |
| In the last 3 days how did you get this done? |
|  | Please Describe |
| How much or what aspects of this task are you able to do safely on your own? |
|  | Please Describe |
| Are any hours of support needed? | [ ]  Yes | [ ]  No |
| If support is needed, list **each task** and describe the amount and frequency of support needed. Include an estimate of the weekly hours of support needed. (Thorough justification of time greater than examples above is required.) |
| Please Describe |
| Recommend independent living skills training? | [ ]  Yes | [ ]  No |

|  |  |  |
| --- | --- | --- |
| Total weekly hours needed (Round to nearest 15-minutes) | hours | Total:       |
| Total Monthly hours needed | (weekly hours X 4.33 = monthly hours) | Hours Total: 0 (Rounded) | 0.0 |

|  |
| --- |
| Time conversion chart |
| 15 min = .25 hr. | 30 min = .5 hr. | 45 min = .75 hr. | 60 min = 1.0 hr. |

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| --- |
| *Dressing* |
| **Time per Task Guide:** | **Total Assist** | **Medium Assist** | **Light Assist** | **Cue/Prompt** |
| * Dressing (60 min. max/day)
 | 30 minutes | 15 minutes | 10 minutes | 5 minutes |
| * Setting out clothes ( 5 min. max per day)
 | NA | 5 minutes | 5 minutes | 5 minutes |
| *If total assistance to dress is needed, then this does not apply.* |
| * Clothing Appropriateness (including matching)
 | 5 minutes | 5 minutes | 5 minutes | 5 minutes |
| Can you perform this task without any support? | [ ]  Yes | [ ]  No |
| In the last 3 days how did you get this done? |
|  | Please Describe |
| How much or what aspects of this task are you able to do safely on your own? |
|  | Please Describe |
| Are any hours of support needed? | [ ]  Yes | [ ]  No |
| If support is needed, list **each task** and describe the amount and frequency of support needed. Include an estimate of the weekly hours of support needed. (Thorough justification of time greater than examples above is required.) |
| Please Describe |
| Recommend independent living skills training? | [ ]  Yes | [ ]  No |

|  |  |  |
| --- | --- | --- |
| Total weekly hours needed (Round to nearest 15-minutes) | hours | Total:       |
| Total Monthly hours needed | (weekly hours X 4.33 = monthly hours) | Hours Total: 0 (Rounded) | 0.0 |

|  |
| --- |
| Time conversion chart |
| 15 min = .25 hr. | 30 min = .5 hr. | 45 min = .75 hr. | 60 min = 1.0 hr. |

|  |
| --- |
| *Prosthetic / Orthotic / Medical Device(s)* |
| *Examples of such devices include: limbs, shoes, lifts, braces, wheelchairs, walkers, canes, helmets, splints, CPAP, hearing aids, glucose meter, communication/tech devices, and other devices that assist an individual to perform ADLs.*  |
| **Time per Task Guide:** | **Total Assist** | **Medium Assist** | **Light Assist** | **Cue/Prompt** |
| * Putting on and removing devices
 | 15 minutes | 10 minutes | 5 minutes | 5 minutes |
| * Maintenance and cleaning of devices (Time may vary depending on type of device)
 | 15 minutes | 10 minutes | 5 minutes | 5 minutes |
| Name/Type of Medical Device:  |
| Can you perform this task without any support? | [ ]  Yes | [ ]  No |
| In the last 3 days how did you get this done? |
|  | Please Describe |
| How much or what aspects of this task are you able to do safely on your own? |
|  | Please Describe |
| Are any hours of support needed? | [ ] Yes | [ ]  No |
| If support is needed, list **each task** and describe the amount and frequency of support needed. Include an estimate of the weekly hours of support needed. (Thorough justification of time greater than examples above is required.) |
| Please Describe |
| Recommend independent living skills training? | [ ] Yes | [ ]  No |

|  |  |  |
| --- | --- | --- |
| Total weekly hours needed (Round to nearest 15-minutes) | hours | Total:       |
| Total Monthly hours needed | (weekly hours X 4.33 = monthly hours) | Hours Total: 0 (Rounded) | 0.0 |

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| --- |
| Time conversion chart |
| 15 min = .25 hr. | 30 min = .5 hr. | 45 min = .75 hr. | 60 min = 1.0 hr. |

|  |
| --- |
| *Toileting* |
| **Time per Task Guide:** | **Total Assist** | **Medium Assist** | **Light Assist** | **Cue/Prompt** |
| * Bed pan/Commode/Toilet (includes transfer)
 | 15-30 minutes | 10-15 minutes | 5-10 minutes | 5 minutes |
| * Bowel program (includes digital/ suppository, time to take effect, clean up)
 | 30-60 minutes | 15-30 minutes | 15 minutes | NA |
| * Clean self after toileting (includes clothing change)
 | 15 minutes | 10 minutes | 5 minutes | 5 minutes |
| * Empty ostomy/urine bag
 | 15 minutes | 10 minutes | 5 minutes | 5 minutes |
| * Changing of incontinence products
 | 15 minutes | 10 minutes | 5 minutes | 5 minutes |
| * Menstrual hygiene & related needs
 | 10 minutes | 10 minutes | 5 minutes | 5 minutes |
| * Establish/maintain toileting schedule
 | 5 minutes | 5 minutes | 5 minutes | 5 minutes |
| Can you perform this task without any support? | [ ]  Yes | [ ]  No |
| In the last 3 days how did you get this done? |
|  | Please Describe |
| How much or what aspects of this task are you able to do safely on your own? |
|  | Please Describe |
| Are any hours of support needed? | [ ]  Yes | [ ]  No |
| If support is needed, list **each task** and describe the amount and frequency of support needed. Include an estimate of the weekly hours of support needed. (Thorough justification of time greater than examples above is required.) |
| Please Describe |
| Recommend independent living skills training? | [ ]  Yes | [ ]  No |

|  |  |  |
| --- | --- | --- |
| Total weekly hours needed (Round to nearest 15-minutes) | hours | Total:       |
| Total Monthly hours needed | (weekly hours X 4.33 = monthly hours) | Hours Total: 0 (Rounded) | 0.0 |

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| --- |
| Time conversion chart |
| 15 min = .25 hr. | 30 min = .5 hr. | 45 min = .75 hr. | 60 min = 1.0 hr. |

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| --- |
| *Eating* |
| **Time per Task Guide:** | **Total Assist** | **Medium Assist** | **Light Assist** | **Cue/Prompt** |
| * Remind/Coax to begin and/or cease eating or drinking
 | NA | NA | NA | 5 minutes |
| * Cutting or blending food
 | 10 minutes | 8 minutes | 5 minutes | NA |
| * Direct feeding by mouth
 | 15 minutes | 10 minutes | 5 minutes | NA |
| * Nourishment by other means (e.g. tube feeding, parenteral nutrition)
 | 30-60 minutes | 15-30 minutes | 10-15 mins | NA |
| Can you perform this task without any support? | [ ]  Yes | [ ]  No |
| In the last 3 days how did you get this done? |
|  | Please Describe |
| How much or what aspects of this task are you able to do safely on your own? |
|  | Please Describe |
| Are any hours of support needed? | [ ]  Yes | [ ]  No |
| If support is needed, list **each task** and describe the amount and frequency of support needed. Include an estimate of the weekly hours of support needed. (Thorough justification of time greater than examples above is required.) |
| Please Describe |
| Recommend independent living skills training? | [ ]  Yes | [ ]  No |

|  |  |  |
| --- | --- | --- |
| Total weekly hours needed (Round to nearest 15-minutes) | hours | Total:       |
| Total Monthly hours needed | (weekly hours X 4.33 = monthly hours) | Hours Total: 0 (Rounded) | 0.0 |

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| --- |
| Time conversion chart |
| 15 min = .25 hr. | 30 min = .5 hr. | 45 min = .75 hr. | 60 min = 1.0 hr. |

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| --- |
| ***Instrumental Activities of Daily Living*** |

|  |
| --- |
| *Medication Management* |
| **Time per Task Guide:** | **Total Assist** | **Medium Assist** | **Light Assist** | **Cue/Prompt** |
| * Ordering medication(s) (10 min/week max)
 | 5-10 minutes | 5 minutes | 5 minutes | 5 minutes |
| * Taking medications
 | 15 minutes | 10 minutes | 5 minutes | 5 minutes |
| * Setting up medications
 | 15 minutes | 10 minutes | 5 minutes | 5 minutes |
| * Check compliance (only if there is no time given for taking meds)
 | 5 minutes | 5 minutes | 5 minutes | 5 minutes |
| Can you perform this task without any support? | [ ]  Yes | [ ]  No |
| In the last 3 days how did you get this done? |
|  | Please Describe |
| How much or what aspects of this task are you able to do safely on your own? |
|  | Please Describe |
| Will/is automated medication management equipment be(ing) used? \*If yes, see supplemental services section. | [ ]  Yes | [ ]  No |
| Capable person policy considered? | [ ]  Yes | [ ]  No |
| Are any hours of support needed? | [ ]  Yes | [ ]  No |
| If support is needed, list **each task** and describe the amount and frequency of support needed. Include an estimate of the weekly hours of support needed. (Thorough justification of time greater than examples above is required.) |
| Please Describe |
| Recommend independent living skills training? | [ ]  Yes | [ ]  No |

|  |  |  |
| --- | --- | --- |
| Total weekly hours needed (Round to nearest 15-minutes) | hours | Total:       |
| Total Monthly hours needed | (weekly hours X 4.33 = monthly hours) | Hours Total: 0 (Rounded) | 0.0 |

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| --- |
| Time conversion chart |
| 15 min = .25 hr. | 30 min = .5 hr. | 45 min = .75 hr. | 60 min = 1.0 hr. |

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| --- |
| *Meal Preparation*  |
| **Time per Task Guide:** | **Total Assist** | **Medium Assist** | **Light Assist** | **Cue/Prompt** |
| * Development of healthy menu (includes special diet, specify below)
 | 20 min/wk | 15 min/wk | 10 min/wk | 5 min/wk |
| Safe preparation of foods |
| * Meals
 | 30 min/meal | 15 min/meal | 10 min/meal | 5 min/meal |
| * Snacks
 | 10 min/snack | 8 min/snack | 5 min/snack | 5 min/snack |
| * Future meals (prepare & freeze)
 | 30 min/wk | 20 min/wk | 10-15 min/wk | 5-10 min/wk |
| * Clean up after meals
 | 15 min/meal | 10 min/meal | 8 min/meal | 5 min/meal |
| * Clean up after snacks
 | 5 min/snack | 5 min/snack | 5 min/snack | 5 min/snack |
| Can you perform this task without any support? | [ ]  Yes | [ ]  No |
| In the last 3 days how did you get this done? |
|  | Please Describe |
| How much or what aspects of this task are you able to do safely on your own? |
|  | Please Describe |
| Capable person policy considered? | [ ]  Yes | [ ]  No |
| Home delivered meals considered? | [ ]  Yes | [ ]  No |
| Are any hours of support needed? | [ ]  Yes | [ ]  No |
| If support is needed, list **each task** and describe the amount and frequency of support needed. Include an estimate of the weekly hours of support needed. (Thorough justification of time greater than examples above is required.) |
| Please Describe |
| Recommend independent living skills training? | [ ]  Yes | [ ]  No |

|  |  |  |
| --- | --- | --- |
| Total weekly hours needed (Round to nearest 15-minutes) | hours | Total:       |
| Total Monthly hours needed | (weekly hours X 4.33 = monthly hours) | Hours Total: 0 (Rounded) | 0.0 |

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| --- |
| Time conversion chart |
| 15 min = .25 hr. | 30 min = .5 hr. | 45 min = .75 hr. | 60 min = 1.0 hr. |

|  |
| --- |
| *Shopping* |
| **Time per Task Guide:** | **Total Assist** | **Medium Assist** | **Light Assist** | **Cue/Prompt** |
| * Medication Pick-up
 | 15-30 min/wk | 10-15 min/wk | 5-10 min/wk | 5 min/wk |
| * Making shopping list
 | 15 min/wk | 10 min/wk | 5 min/wk | 5 min/wk |
| * Shopping for personal items
 | 30 min/wk | 20 min/wk | 15 min/wk | 5 min/wk |
| * Shopping for groceries
 | 1-2 hours/wk | 1 hour/wk | 30 min/wk | 5 min/wk |
| Can you perform this task without any support? | [ ]  Yes | [ ]  No |
| In the last 3 days how did you get this done? |
|  | Please Describe |
| How much or what aspects of this task are you able to do safely on your own? |
|  | Please Describe |
| Capable person policy considered? | [ ]  Yes | [ ]  No |
| Are any hours of support needed? | [ ]  Yes | [ ]  No |
| If support is needed, list **each task** and describe the amount and frequency of support needed. Include an estimate of the weekly hours of support needed. (Thorough justification of time greater than examples above is required.) |
| Please Describe |
| Recommend independent living skills training? | [ ]  Yes | [ ]  No |

|  |  |  |
| --- | --- | --- |
| Total weekly hours needed (Round to nearest 15-minutes) | hours | Total:       |
| Total Monthly hours needed | (weekly hours X 4.33 = monthly hours) | Hours Total: 0 (Rounded) | 0.0 |

|  |
| --- |
| Time conversion chart |
| 15 min = .25 hr. | 30 min = .5 hr. | 45 min = .75 hr. | 60 min = 1.0 hr. |

|  |
| --- |
| *Housekeeping* |
| **Time per Task Guide:** | **Total Assist** | **Medium Assist** | **Light Assist** | **Cue/Prompt** |
| **HOUSEKEEPING MAX OF 2 TOTAL HOURS PER WEEK TOTAL** |  |
| * Clean bathroom and/or kitchen
 | 20-30 minutes | 10-20 minutes | 5-10 minutes | 5 minutes |
| * Clean floors, carpets, rugs, dusting
 | 30-45 minutes | 20-35 minutes | 10-25 minutes | 5 minutes |
| * Make bed and/or change linens
 | 15 minutes | 10 minutes | 5 minutes | 5 minutes |
| * Remove trash
 | 10 minutes | 8 minutes | 5 minutes | 5 minutes |
| Can you perform this task without any support? | [ ]  Yes | [ ]  No |
| In the last 3 days how did you get this done? |
|  | Please Describe |
| How much or what aspects of this task are you able to do safely on your own? |
|  | Please Describe |
| Capable person policy considered? | [ ]  Yes | [ ]  No |
| Are any hours of support needed? | [ ]  Yes | [ ]  No |
| If support is needed, list **each task** and describe the amount and frequency of support needed. Include an estimate of the weekly hours of support needed. (Thorough justification of time greater than examples above is required.) |
| Please Describe |
| Recommend independent living skills training? | [ ]  Yes | [ ]  No |

|  |  |  |
| --- | --- | --- |
| Total weekly hours needed (Round to nearest 15-minutes) | hours | Total:       |
| Total Monthly hours needed | (weekly hours X 4.33 = monthly hours) | Hours Total: 0 (Rounded) | 0.0 |

|  |
| --- |
| Time conversion chart |
| 15 min = .25 hr. | 30 min = .5 hr. | 45 min = .75 hr. | 60 min = 1.0 hr. |

|  |
| --- |
| *Laundry*  |
| ***Note:*** *Reviews of time for laundry tasks above what is specified here can be requested on a case by case basis with thorough justification. For example, if incontinence issues exist more time can be granted for laundry* |
| **Time per Task Guide:** | **Total Assist** | **Medium Assist** | **Light Assist** | **Cue/Prompt** |
| **IN-RESIDENCE LAUNDRY MAX OF 2 HOURS TOTAL PER WEEK** |  |  |  |
| **OUTSIDE OF RESIDENCE LAUNDRY MAX of 3 HOURS TOTAL PER WEEK** |  |  |
| * Sorting
 | 10 minutes | 8 minutes | 5 minutes | 5 minutes |
| * Folding and putting away
 | 15 minutes | 10 minutes | 5 minutes | 5 minutes |
| * Washing/dryer outside of residence, per load
 | 15-30 minutes | 15-20 minutes | 10-15 minutes | 5 minutes |
| * Washer/dryer in residence, per load
 | 10-15 minutes | 5-10 minutes | 5-10 minutes | 5 minutes |
| Can you perform this task without any support? | [ ]  Yes | [ ]  No |
| In the last 3 days how did you get this done? |
|  | Please Describe |
| How much or what aspects of this task are you able to do safely on your own? |
|  | Please Describe |
| Capable person policy considered? | [ ]  Yes | [ ]  No |
| Are any hours of support needed? | [ ]  Yes | [ ]  No |
| If support is needed, list **each task** and describe the amount and frequency of support needed. Include an estimate of the weekly hours of support needed. (Thorough justification of time greater than examples above is required.) |
| Please Describe |
| Recommend independent living skills training? | [ ]  Yes | [ ]  No |

|  |  |  |
| --- | --- | --- |
| Total weekly hours needed (Round to nearest 15-minutes) | hours | Total:       |
| Total Monthly hours needed | (weekly hours X 4.33 = monthly hours) | Hours Total: 0 (Rounded) | 0.0 |

|  |
| --- |
| Time conversion chart |
| 15 min = .25 hr. | 30 min = .5 hr. | 45 min = .75 hr. | 60 min = 1.0 hr. |

|  |
| --- |
| *Money Management* |
| **Time per Task Guide:** | **Total Assist** | **Medium Assist** | **Light Assist** | **Cue/Prompt** |
| * Opening mail
 | 8 min/day | 7 min/day | 5 min/day | 5 min/day |
| * Developing, reviewing and maintaining a budget
 | 20 min/week | 15 min/week | 10 min/week | 5 min/week |
| * Paying bills
 | 30 min/week | 20 min/week | 15 min/week | 5 min/week |
| * Assistance with bank accounts
 | 30 min/week | 20 min/week | 15 min/week | 5 min/week |
| Can you perform this task without any support? | [ ]  Yes | [ ]  No |
| In the last 3 days how did you get this done? |
|  | Please Describe |
| How much or what aspects of this task are you able to do safely on your own? |
|  | Please Describe |
| Capable person policy considered? | [ ]  Yes | [ ]  No |
| Are any hours of support needed? | [ ]  Yes | [ ]  No |
| If support is needed, list **each task** and describe the amount and frequency of support needed. Include an estimate of the weekly hours of support needed. (Thorough justification of time greater than examples above is required.) |
| Please Describe |
| Recommend independent living skills training? | [ ]  Yes | [ ]  No |

|  |  |  |
| --- | --- | --- |
| Total weekly hours needed (Round to nearest 15-minutes) | hours | Total:       |
| Total Monthly hours needed | (weekly hours X 4.33 = monthly hours) | Hours Total: 0 (Rounded) | 0.0 |

|  |
| --- |
| Time conversion chart |
| 15 min = .25 hr. | 30 min = .5 hr. | 45 min = .75 hr. | 60 min = 1.0 hr. |

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| ***Supplemental Services***  |
| **Do not** complete any of the Supplemental Services sections **unless** the consumer qualifies for PAS and only if there is a justified need for the service. |

|  |
| --- |
| *Enhanced Services* |
| Assistance for participants who require hands-on care during the night, including re-positioning, tracheotomy care, and care for chronic incontinence; need must be documented by a physician.  |
| Limitations: ES cannot be provided by a participant’s spouse, parent, or any individual residing in the home with the participant; however, exceptions may be authorized under the following conditions:* The participant lives in a rural area in which access to a provider is beyond a 50-mile radius from the participant’s home and the family member is the only provider available to meet the participant’s needs.
* The participant lives alone and has severe cognitive impairment, physical disability, or intellectual disability.
 |
| Do you have a medical condition documented by a physician that requires hands-on support during the night? **\*The STEPS Program Manager requires a copy of this documentation** | [ ]  Yes | [ ]  No |
| In the last 3 days how did this get done? |
|  | Please Describe |
| What tasks need to be performed to ensure health and safety? |
|  | Please Describe |
| How many nights per week are services needed? (Up to 7) | # per week |

|  |  |
| --- | --- |
| Total nights per week |       |
| Total nights per month | Nights per week x 4.33 = Total nights per month | Total: 0 (Rounded) | 0.0 |
| Monthly Cost | Number of nights per month x $85 = Total monthly cost | Total: $ 0.00 |

|  |
| --- |
| *Home delivered meals* |
| **Maximum of 62 meals per month** |
| Were there hours approved under “meal prep”? **\*If yes, Home Delivered Meals cannot be authorized** | [ ]  Yes | [ ]  No |
| Capable persons policy applicable? **\*If policy is applicable, Home Delivered Meals cannot be authorized** | [ ]  Yes | [ ]  No |
| If support is needed, please describe how this is more cost effective. |
| Please Describe |
| Number of meals per day (up to 2) |       |
| Number of days per week meals needed |       |
| Total weekly meals needed | 0 | Total Monthly Meals: | 0 |
| Monthly meals x $6.04 = Monthly cost | Total cost: $ 0.00 |

|  |
| --- |
| *PERS* |
| **Personal Emergency Response Systems (PERS) allowing participants to seek help when alone.**  |
| Were there hours approved under “Enhanced services”? **\*If yes, PERS cannot be authorized** | [ ]  Yes | [ ]  No |
| If support is needed, please describe how this is more cost effective. |
| Please Describe |
| Services providers name | If known |
| PERS installation fee | If known: $0.00 |
| PERS monthly fee | If known: $0.00 |

|  |
| --- |
| *Medication Management Equipment* |
|  |
| Do you already have a medication management system in place? **\*Standard med box doesn’t count** | [ ]  Yes | [ ]  No |
| Were there hours approved under Medication Management? **\*If yes, Medication Management Equipment cannot be authorized** | [ ]  Yes | [ ]  No |
| If support is needed, please describe how this is more cost effective. |
| Please Describe |
| Services providers name | If known |
| Medication monitoring installation fee | If known: $0.00 |
| Medication monitoring monthly fee | If known: $0.00 |

## **Personal Assistance Services Summary**

|  |  |  |  |
| --- | --- | --- | --- |
| **Activity of Daily Living** | **Independent Skills Training Recommended?** | **Monthly Hours** | **Monthly Service Cost** |
| Bathing and Personal Hygiene | [ ]  | 0 |  |
| Mobility | [ ]  | 0 |  |
| Dressing | [ ]  | 0 |  |
| Prosthetic/Orthotic/Medical Devices | [ ]  | 0 |  |
| Toileting | [ ]  | 0 |  |
| Eating | [ ]  | 0 |  |
| **ADL Total:** |  | 0 | $ 0.00 |
| **Instrumental Activities of Daily Living** | **Independent Skills Training Recommended?** | **Monthly Hours** | **Monthly Service Cost** |
| Medication Management | [ ]  | 0 |  |
| Meal Preparation | [ ]  | 0 |  |
| Shopping | [ ]  | 0 |  |
| Housekeeping | [ ]  | 0 |  |
| Laundry | [ ]  | 0 |  |
| Money Management | [ ]  | 0 |  |
| **IADL Total:** |  | 0 | $ 0.00 |
| **ADLs/IADLs Combined Total:** |  | 0 | $ 0.00 |
| **Supplemental Services** |  | **Total Monthly** | **Monthly Service Cost** |
| Enhanced Services |  | 0 | $ 0.00 |
| Home Delivered Meals |  | 0 | $ 0.00 |
| PERS |  | $ 0.00 |
| Medication Management System |  | $ 0.00 |
| **Supplemental Service Total:** |  | $ 0.00 |
| **Grand Total Monthly Cost:** |  | $ 0.00 |

**Installation and Equipment one time cost**

|  |  |  |
| --- | --- | --- |
| **Service** | **Description** | **One time cost** |
| PERS | Describe service | $ 0.00 |
| Medication Management | Describe service | $ 0.00 |

# STEPS Services Summary Page

♦Use this page to provide a narrative summary of each section of the assessment. The CSC will use this page to complete the Individualized Service Plan. Please ensure that any units are whole units (no partial units accepted) and that all hours have been rounded to the nearest 15-minute increment.♦

|  |  |  |
| --- | --- | --- |
| **Service Assessment** | **Request or Qualify?** | **Summary of assessment** |
| Pre-Vocational Assessment | [ ]  Yes | [ ]  No | Provide summary. |
| Independent Living Skills Assessment | [ ]  Yes | [ ]  No | Provide summary. |
| Were any ADLs or IADLs recommended for IL Skills Training? [ ]  | Provide summary. |
|  | **Hours or Units** |  |
| Supported Employment | 0.00 | Provide summary. |
| Transportation Assessment \*Enter manually from Transportation section | Cost or hours | Provide summary. |
| PAS Assessment | 0 | Provide summary. |
| ***Only with PAS*** | Enhanced Services | 0 | Provide summary. |
| Home meals | 0 | Provide summary. |
| PERS | 1 unit, if applicable | Provide summary. |
| Med Minder | 1 unit, if applicable | Provide summary. |
| Assistive Service | In your opinion, would this consumer benefit from Assistive Services |

# STEPS Services Assessment Signature Page

|  |  |
| --- | --- |
| Date of STEPS Services Assessment: | Enter a date |

I participated in the development of this STEPS Services Assessment and agree that it reasonably reflects my need for support.

I am responsible for complying with STEPS program policies and procedures as laid out in the STEPS Program Policy Manual, including those that apply to the STEPS Services Assessment. NOTE: Participants unwilling to follow the program policies and procedures will not be able to remain in the program.

I understand that I am responsible for accurately reporting my need for assistance during the STEPS assessment. NOTE: Falsifying the need for services will result in removal from the program and may be reported to the Office of the Attorney General Medicaid Fraud Control Unit (MFCU).

I understand that the time currently reflected in my STEPS Services Assessment is subject to review by the State and my Managed Care Organization (MCO), and that this review may result in a change.

|  |  |  |
| --- | --- | --- |
|       |  |       |
| Assessor’s signature |  | Date |
|  |  |  |
|       |  |       |
| Participant’s signature |  | Date |