



Paul R. LePage, Governor

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# Home Support Frequency Tool

## Shared Living and Family Centered Support Part B

### Instructions:

This tool must be completed when an individual(s) living in Shared Living and Family Centered Support requires additional support above the standard level. The request for additional support must be based on the individual's extraordinary medical or behavioral needs that required additional staff support during the past 12 months. The last section of the tool is entitled Community Supports/Employment. This section must be completed for those individuals who require additional staffing support because they do not work or attend a community supports program.

Please answer all questions in this tool for each individual for whom you are requesting additional support. Also include a copy of the individual's Person Centered Plan, as well as any clinical information, behavior plans, or any another recent documentation that supports the information being provided in the tool.

**PLEASE NOTE:** If you are requesting additional support for more than one resident in a home, submit Part B for all residents in **one** packet with Part A of the Home Support Frequency Tool as a cover sheet.

The Department will also be utilizing information from EIS such as reportable events, case notes, etc

### Please check off any accompanying information:

- PCP
- Clinical Information
- Behavior Plan and Copies of Data Collection for Last 12 Months

- Medical Information
- Physician's Orders
- Community Supports/ Employment information
- Other \_\_\_\_\_

### Section I - General Information

Name: _____	Date: _____
Home Address: _____ _____	Medicaid #: _____
Total No. of Consumers Living in the Home: _____	Case Manager: _____
	Person Completing Form: _____

## Section II - Behavioral Information

**Directions:** Please check the boxes that best describe the frequency of this individual's behavior in columns 1-5. For any boxes checked, please indicate the level of intervention supports in columns A-D.

### Keys

#### Frequency

<b>1 = Occasionally</b> Less than once a month	<b>2 = Monthly</b> About once a month	<b>3 = Weekly</b> About once a week	<b>4 = Frequently</b> Several times a week	<b>5 = Daily</b> Once a day or more
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#### Level of Intervention

<b>A</b> = Occasional verbal prompts, instructions, or redirection by caregiver. No environmental modification or assistance from others is required	<b>B</b> = Frequent prompts, instructions or redirection by caregiver, environmental modifications, and/or restrictions on movement may be necessary. No additional assistance from others is necessary.
<b>C</b> = Frequent, possibly informal, but planned interventions by caregiver	<b>D</b> = Use of physical restraint or safety device.

Questions	Frequency					Level of Intervention Support			
	1	2	3	4	5	A	B	C	D
Has tantrums or emotional outbursts									
Damages own or others' property									
Disrupts others' activities									
Is verbally or gesturally abusive									
Is self-injurious (Bites self, mouth, hands or cuts self, bangs head, eye poking)									
Runs or wanders away									
Steals									
Pica, eats inedible objects									
Displays sexually inappropriate behaviors									
Aggressive or hurtful to others (hits, kicks, scratches, cuts or stabs, bites)									
Does not follow rules about electricity, fire, water, tools, traffic, interacting with strangers, or hazardous physical situations like broken windows.									
Sexual misconduct of a criminal nature									
History of criminal behavior (detail in comments section)									
Assaults with the intent to harm									
Please list any additional information:									

### Section III – Health and Medical Information

**Directions:** Please check *YES* for any medical treatments prescribed during the last 12 months. Check *NO* if this treatment has not been prescribed. Then insert codes for how often the treatment (or care for the treatment) is required. Descriptions are given to better determine support frequency.

<b>Support Frequency - How often care or assistance is typically needed for each treatment:</b>					
<b>A</b> = Less than once a week	<b>B</b> = Once a week	<b>C</b> = Several times a week	<b>D</b> = Once a day	<b>E</b> = Multiple times a day	<b>F</b> = Continuous

<b>Prescribed Treatment or Care</b>	<b>YES</b>	<b>NO</b>	<b>A</b>	<b>B</b>	<b>C</b>	<b>D</b>	<b>E</b>	<b>F</b>
1. Catheter - If catheter is used continuously, consider catheter care only, such as insertion, removal, cleaning catheter, emptying bag.								
2. Needle injection - Consider how often an injection is given.								
3. Inhalation therapy or nebulizer - Consider how often each treatment is needed. This does not include oxygen.								
4. Oxygen - If the oxygen is used continuously, consider how often care is needed to administer the oxygen; otherwise, consider how often oxygen is needed.								
5. Respiratory suctioning - Consider how often respiratory suctioning is needed.								
6. Postural drainage - Consider how often postural drainage is needed								
7. Ostomy (colostomy or ileostomy) - Consider care related to the ostomy, such as cleaning the tube area or emptying the bag.								
8. Tracheostomy - Consider care of stoma, cannula, and any other trach care.								
9. Tube feeding (nasogastric, G, or J tube) - Consider how often tube feeding required.								
10. Other (Please describe):								

11. Does the person require any **hands on** or **direct care from a nurse** (LPN or RN) to provide routine care? This does not include routine examinations of assessments, such as blood pressure checks, incident monitoring, monthly assessments, etc.

- No → **If No, Skip to Question 13.**  
 Yes

12a. How often is this **hands on** or **direct care** from a nurse (RN or LPN) currently needed?

- 1 - 5 times a year       2 - 3 times a month       4 - 6 times a week  
 6 - 11 times a year       Once a week       At least once a day  
 Once a month       2 - 3 times a week

12b. If daily hands on or direct care from an LPN/RN is needed, how much LPN/RN care is needed?

- Direct nursing care is not needed every day
- Less than 8 hours a day
- 8 to less than 16 hours a day
- 16 to less than 24 hours a day
- Continuous, 24 hour direct nursing care required

*If continuous nursing care needed, provide explanation in box at end of health section.*

13a. Does individual have a history of seizures?

YES  NO

13b. If yes, which types of seizures has individual experienced in the last 12 months?  
(Check all that apply)

- No seizures this year
- Simple partial (simple motor movements affected; no loss of awareness)
- Complex partial (loss of awareness)
- Generalized - Absence (petit mal)
- Generalized - Tonic-Clonic (grand mal)
- Had some type of seizure - not sure of type

13c. In the past year, how frequently has individual experienced seizures that involve loss of awareness and/or loss of consciousness?

- None during the past year
- Less than once a month
- About once a month
- About once a week
- Several times a week
- Once a day or more

14. Check all diagnosed health conditions:

- No diagnosed health conditions
- Allergy - not life threatening
- Allergy - severe or life threatening
- Arthritis (osteoarthritis or rheumatoid arthritis)
- Asthma
- Auto immune disorder (rheumatoid arthritis, multiple sclerosis, lupus, etc.)
- Blindness - no functional eyesight
- Cancer
- Chronic constipation or diarrhea
- Deafness - no functional hearing
- Dementia or Alzheimer's disease
- Dental or gum disease
- Diabetes - oral medication required
- Diabetes - injected medication required
- Dysphagia (swallowing disorder)
- Eating disorder (anorexia or bulimia)
- Hepatitis
- High blood pressure or hypertension
- High cholesterol, hypercholesterolemia, or hyperlipidemia
- Kidney disease requiring dialysis
- Osteoporosis or osteopenia
- Parkinson's disease
- Pregnancy
- Pressure ulcer
- Pulmonary condition (emphysema, COPD, pulmonary edema)
- Severe scoliosis
- Sleep apnea
- Stroke or CVA
- Substance abuse - current
- Substance abuse - history of
- Hyperthyroid, hypothyroid, or thyroid disease
- Over weight

- |   |                                       |
|---|---------------------------------------|
| <input type="checkbox"/> Epilepsy or seizure disorder                     | <input type="checkbox"/> Under weight |
| <input type="checkbox"/> Foot or nail condition requiring podiatrist care | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> GERD, acid reflux, or reflux esophagitis         | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Heart condition                                  | <input type="checkbox"/> Other: _____ |

15. **Check all of the following which currently apply:**

- Requires food or liquid to be in particular consistency or size (for ex., chopped into specific pieces, ground up, pureed, thickened, etc.). Describe: \_\_\_\_\_
- Food consistency requirement change within past 3 months. Describe: \_\_\_\_\_
- Medically prescribed special diet (for ex., diabetic, low salt, high/low calorie, etc.). Describe: \_\_\_\_\_
- Unusual food preferences or food aversion. Describe: \_\_\_\_\_
- History or risk of dehydration
- History or risk of choking (swallowing risk factors include coughing during or after meals, excessive throat clearing during or after meals, or gagging on food or liquids)
- Currently smokes
- Two or more falls within past 3 months
- Hands on assistance or close supervision required to use stairs within his/her residence
- Tactile kinesthetic issues (for example, hypersensitivity to touch and other sensory stimulation such as light or sound)
- Medical devices (for ex., pacemaker, C-PAP machine, glucometer, seizure management device, prosthetic device, etc. Does not include glasses, contacts, or hearing aids). Describe: \_\_\_\_\_
- None of these apply

16. **Medical office visits, or off-site medical or mental health care**

Typical number of office visits person had in past year to see a licensed professional for medical or mental health care (such as a doctor; dentist; nurse; laboratory technician; physical, respiratory, or speech therapist; podiatrist; psychiatrist; psychologist; or behavioral therapist). This does not include in-home visits. Consider off-site medical or mental health office visits only (includes emergency room visits).

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> None in past year  | <input type="checkbox"/> 6 - 11 times a year  | <input type="checkbox"/> 2 - 3 times a month | <input type="checkbox"/> 2 or more times a week |
| <input type="checkbox"/> 1 - 5 times a year | <input type="checkbox"/> 12 - 23 times a year | <input type="checkbox"/> Once a week         |   |

17. Indicate all types of prescription maintenance medications the individual receives on an ongoing (Check all that apply.)

- No prescription medications received
- Antipsychotic, antidepressant or other medications for behavior management (e.g., Thorazine, Mellaril, Prolixin, Lithium, Elavil) basis.
- Antianxiety agent for behavior management (e.g., Librium, Valium)
- Anticonvulsant (e.g., seizures/behavioral issues)
- Diabetes medication (oral/pump/injection)
- Other maintenance medications prescribed to treat an existing medical condition

18. Please describe the level of support the individual receives when taking all medications.

- Total support (Staff assumes total responsibility for giving individual medication; e.g., injection, in food, drops.)
- Assistance (Staff keeps medication and gives to individual for self-administration)
- Supervision (individual keeps own medication but needs verbal prompts from staff)
- Independent (Individual is totally responsible for medication)

Insert additional information

**Section IV - Community Supports/Employment**

A. Does this person attend a Community Supports program? YES  NO

If yes, indicate number of hours per week. \_\_\_\_\_

If no, please provide information below as to why person does not attend a Community Supports program.

B. Is this person employed? YES  NO

If yes, indicate number of hours per week. \_\_\_\_\_