PAS Tool Scoring Guide:
Developmentally Disabled Ages 12+

Rate activities/behaviors as generally performed over the last year with *emphasis on current functioning*. If there are discrepancies in functioning, please describe when they happen and what causes them, if known.

Give credit for the highest level of skill which is performed at least 75% of the time. Only give credit for **what the individual actually does**, not for what the individual "can do" or "might be able to do".

When a question groups many activities, rate the individual on his/her ability to complete the task as a whole.

When a customer's skills are uneven (s/he can complete some parts of the task but not other parts) or variable (sometimes s/he does better than other times) **the assessor must determine the best response and explain in comments.**

If a customer has characteristics of more than one response, the assessor must try to obtain more information in order to select the response that most closely describes the customer's typical functioning and explain in comments.

If it is clearly evident that a customer is in need of more assistance than is received, the assessor may take that into consideration in scoring. This should be done conservatively as it may be difficult to determine the exact amount of assistance needed (e.g., only verbal assistance, not hands on assistance may be needed to attain a generally acceptable level of hygiene). **Justification for this need must be documented in the comments and/or summary. Do they have a history of falls with injuries? A script for therapy? How long does it take to complete the task(s)?**

***NOTE: Do NOT score PAS Areas in the field.**
Write down objective and professional comments and observations ONLY.

It is helpful to include in each comment section who is reporting the information (especially if there is more than one caregiver acting as an informant).

IMPORTANT!!! Please review all medical records as soon as they become available. If any discrepancies are noted between the caregiver/rep report and these records, the customer/rep should be contacted to clarify each discrepancy in detail so the assessor can determine how best to score. If the customer has had recent previous PAS's, these should be reviewed prior to the PAS interview and any changes since the last PAS (if reasonably recent) should be addressed and clarified with the customer/rep in order for the assessor to determine how best to score. The clarification(s) should be added to the summary or each individual comment area. If the customer/rep is contacted after the PAS interview for clarification, a dated addendum needs to be added to the summary to include the updates.

Please be objective and professional throughout the PAS process.

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II. FUNCTIONAL ASSESSMENT

A. MOTOR / INDEPENDENT LIVING SKILLS DOMAIN (CONSIDER ONE YEAR)

HAND USE - If individual has one hand or use of one hand only, **rate better hand.**

0. Uses fingers independently of each other
1. Uses thumbs and fingers of hand(s) in opposition
2. Uses raking motion or grasps with hand(s)
3. No functional use of hand(s) ***what prevents them from being able to use their hand(s)?***

Things to consider: How does customer use their hands to complete daily activities (appropriate for their age). For example, can use all fingers independently of each other to complete a variety of tasks, or can only use certain fingers/thumb to perform a task (i.e. pointer finger to push buttons on a keyboard but not the other fingers; can only use their thumb to push buttons on TV remote but not their pointer finger), or is the customer only able to grasp items with their hand, or use a raking motion, or do they have no functional use of either hand?

Describe what happens 75% of the time.

AMBULATION -Use of assistive devices (e.g. canes, walkers, braces) should not affect rating. Applicant can still be independent and use devices. If assistance is needed, please describe it along with the frequency it is provided.

0. Walks **well alone** for **normal** distances and on **all** terrains
1. Walks **well alone** for a **short** distance (10-20 feet); balances **well**; distance limitation may be due to terrain. ***** Describe the limitations, and distance walked.***
2. Walks **unsteadily** alone for a short distance (10 - 20 feet)
3. Walks **only** with **physical** assistance from others ***Who assists?***
4. Does not walk ***What prevents them from being able to ambulate?***

Things to Consider: If client walks alone, is it steadily or not? Include distance walked, and on which terrains.
Describe the support provided, if any. What happens without that support? If client does not walk at all, include the reason why not.

Describe what happens at least 75% of the time.

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WHEELCHAIR MOBILITY - Wheelchair may be motorized or manual.

0. Wheelchair is not used or moves wheelchair independently
1. Moves wheelchair independently, but with some difficulty (may move wheelchair with some bumping and/or difficulty in steering) *****Include in the comment some examples of their difficulties when moving w/c independently.***
2. Individual needs some, but not total assistance, in moving wheelchair *****How does customer participate? What is done for them? How often?***
3. Needs total assistance for moving wheelchair *****What prevents the customer from participating?***

Things to Consider: If client uses a wheelchair – report if it is manual or motorized, or both. Does client propel self without difficulty? How often? In what situations or locations? OR if client has help: How often? Describe support provided, if any: what's being done, and when it is provided. If he/she has different kinds of help, describe the different scenarios.

Describe what happens and score based on what happens at least 75% of the time.

If both types of wheelchairs are used, score according to the chair used the majority of the time, and include that specifically in the comment (which is used most, and how often).

TRANSFER - Degree of human assistance necessary on a consistent basis for transfer, such as assistance getting into wheelchair, getting on and off toilet, into and out of bed, in and out of shower/tub. Rate these items **ONLY** with regard to the need for **human** intervention, NOT with regard to the need for assistive devices. *Ability to transfer in and out of a vehicle is **not** rated.*

0. No problem in this area; does transfer self independently but may require use of assistive devices
1. Needs hands-on physical guidance, but does **not** have to be physically lifted, **OR** needs supervision with more than half of transferring activities
2. Needs to be physically lifted or moved, but can participate physically ******How does customer participate?***
3. Must be totally transferred by one or more persons **OR** is bedfast

Things to Consider: Does customer need assistance from another person to get into/off w/c (if applicable), on and off toilet, into/out of bed and in and out of shower/tub? Describe the assistance that is provided for each task by another person. If they receive supervision, please describe with what percentage of the tasks that occurs (50% or more of all the tasks assessed vs. less than 50% of the tasks assessed)**. If they need hands on help from another person, what does this look like (boost to stand vs actively bearing some part of the customer's weight)? Score based on what happens at least 75% of the time.**

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EATING/DRINKING - Rate tasks involved in eating food and/or drinking beverages served.

0. Completes the task independently
1. Able to complete the task with verbal prompts, cue by touch, materials setup, or other modifications (e.g., plate guard, built-up spoon, cutting of food) ***Describe specifically what is done for applicant**
2. Requires hands-on assistance to initiate/complete the task (e.g., place utensils in hand, hand-over-hand scooping, or other assistance) ****Describe specifically what is done for applicant**
3. Does not perform this task even when assisted; is fed
4. Individual is tube fed **(Select this score if tube feeding is the primary means of nourishment)**

Things to consider: What is the customer able to do for themselves when eating food and/or drinking beverages?
If they receive help, please describe a specific frequency for each area in which they are assisted. What does this assistance look like (verbal prompts, cue by touch, set up vs placing utensils in hand, hand over hand scooping)?
If the customer is fed by another person, is it for every meal? What prevents them from performing the task themselves? If tube fed, who manages/administers tube feedings and how often? Describe what happens at least 75% of the time.

DRESSING - Putting on and removing regular articles of clothing, (e.g., skirt, blouse, shirt, pants, dress, shorts, socks and shoes, underwear). This **does NOT include braces, nor** does it reflect the individual's ability to match colors or choose clothing appropriate for the weather. Do NOT include care of clothing.

0. Completes the task independently
1. Able to complete the task with verbal prompts, cue by touch, materials setup, or other modifications (e.g., laying-out of clothes) ****Describe specifically what is done for applicant**
2. Requires hands-on assistance to initiate/complete the task (e.g., help with fasteners)
3. Is **not** able to actively perform **any** part of this task but can physically participate ****Describe specifically what the applicant does to participate (more than just cooperate).**
4. Requires total hands-on assistance and does not physically participate ****What prevents customer from participating?***

Things to Consider: What does client do for him/herself? Does client dress AND undress self? How often? In what situations (i.e. only dresses self in the morning but won't do it at night)**?**
OR if client has help: How often? Describe support provided, if any: what's being done, and when it is provided. If he/she has different kinds of help, describe the different scenarios. Be as specific as possible (i.e. mom fastens buttons and zippers every time every day)**. Include who does what tasks. Who puts on and/or remove diapers/briefs? Include that here. Describe what happens and score based on what happens at least 75% of the time for each task (shirt, shoes, socks, pants, etc.).**

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PERSONAL HYGIENE – Those tasks involved in basic grooming, including hair care, brushing teeth, washing face and hands, shaving, nail care, menses care and use of deodorant.

If the customer performs the tasks at varying levels of independence, indicate the answer that best describes the customer's overall ability in personal hygiene and explain in comments.

0. Completes the task independently
1. Able to complete the task with verbal prompts, cue by touch, materials setup, or other modifications *****Include in the comment specifically what is done for him/her.***
2. Requires hands-on assistance to initiate/complete the task (e.g., put toothpaste on toothbrush or hands on assistance to comb hair). *****Include in the comment what the client does.***
3. This task must be done for the individual but individual can physically participate *****Include in the comment HOW the client participates.***
4. Requires total hands-on assistance and does not physically participate *****Include in the comment the reason (if known) why the client does not participate.***

Things to Consider: What does client do for him/herself? How often does client do it? Is it done by client every time the task is done?
OR if client has help: Describe the support provided – how often? Who does it? And when is it provided? Be as specific as possible (i.e. mom brushes client's teeth in the morning every day; client brushes his teeth every night with set-up of toothpaste done by mom)**. Include who does which tasks, or what parts of the tasks, and why (if known).**
Describe what happens and score based on what happens at least 75% of the time for each task
The comment for this area should include each task (oral care, hair care, washing hands, washing face outside the shower, putting on deodorant, and nail care) and who does it, the frequency it is done and by whom each time, and anything else helpful (such as sensory issues, etc.).

When a group of many tasks are included in one scoring area, rate the customer on the ability to complete each of the tasks.

For example, when scoring Personal Hygiene a customer who needs hands-on help for brushing teeth, but only verbal prompts or no assistance for combing hair or washing face and hands, should be scored a "2" (requires hands-on assistance to initiate/complete the task).

Another example: Mother will put toothpaste on the toothbrush for Client daily. Client will brush his teeth with mom's cues to do so, and mom will re-brush for adequate hygiene as Client will only brush the front teeth. Mother keeps Client's hair cut very short and does not have to comb it. Mother cues Client to wash his hands with soap and rinse well. Mother states that she will re-wash Client's face and hands for adequate hygiene daily. Client is not using deodorant at this time. This would be scored as a 3.

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BATHING OR SHOWERING - Washing body (e.g. bath, shower, sponge bath, or bed bath) includes shampooing hair

This includes drawing the bath water, washing, rinsing and drying all parts of the body, and shampooing hair.

The ability to wash face and hands when not bathing should be rated under Personal Hygiene instead.

The ability to *transfer* into the tub or shower is not rated here.

0. Completes the task independently
1. Requires verbal prompts for washing and drying or help with drawing water, checking temperature
2. Requires extensive verbal prompts **or** limited/occasional hands-on assistance to complete task (e.g. shampooing.) *****Include in the comment HOW the client participates.***
3. Requires hands-on assistance during entire bathing process but can physically participate *****Include in the comment HOW the client participates.***
4. Requires total hands on assistance and does **not** physically participate *****Include in the comment the reason client does not participate, if know (medical issue, etc.).***

Things to Consider: Report in comment if client takes a shower or bath or bed bath, etc. What does client do for him/herself? How often does client do it? Is it done by client every time the task is done?

OR if client has help: Describe the support provided – how often? Who does it? And when is it provided? Be as specific as possible (i.e. mom washes client's hair in the bathtub every time client bathes, which is every other day. Client washes his body with set-up and cues throughout bathing process or he won't do it)**.**

Describe what happens, and score based on what happens at least 75% of the time for each task (drawing water, using soap and washing body, shampooing hair, rinsing body/hair, drying body parts)**.**

Comment should include each task: who does it, frequency it is done and by whom each time, and anything else helpful.

If the customer/rep indicates the customer requires verbal prompts, what does that look like? How "extensive" are they? (i.e. Mom provides one reminder to take a shower and wash well versus she provides step by step instructions throughout the entire bathing process).

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FOOD PREPARATION - Preparation of **simple** meals, such as sandwiches, cold cereal, frozen dinners, eggs. Rate the item independent of the heating sources used (e.g., microwave, regular oven, stove top – may use only the microwave and still be independent). **Describe what happens at least 75% of the time.**

0. Completes the task independently
1. Able to complete the task with verbal prompts, cue by touch, materials setup, or other modifications
2. Requires hands-on assistance to initiate/complete the task ******How does customer participate?***
3. Does not perform this task, even when assisted; the task must be done for the person ******What prevents the customer from performing the task?***

Things to consider: What types of simple meals does the customer prepare? How often do they prepare simple meals? If they do prepare simple meals but have help, what does that help look like (i.e. cue by touch, verbal prompts, material set-up vs. the customer performs some part/parts of the task but the caregiver finishes). Do they get this help 75% of the time or less? If they receive hands on help to initiate/complete the task, is this for all meals? Helpful to include what is typically done for breakfast, lunch and dinner to address who makes each meal and what the client does for each meal.

******Note: 75% of the time, for this area, would be one simple meal a day, 5 days a week.***

COMMUNITY MOBILITY - Movement around the neighborhood or community, including accessing buildings, stores, and restaurants, and using **any** mode of transportation, such as walking, wheelchair, cars, buses, taxis, bicycles. **Describe what happens at least 75% of the time.**

0. Moves about the neighborhood or community independently without assistance **[they can go on a simple and/or complex trip alone, independently (*without* instructions or directions or accompaniment)].**
1. Moves about the neighborhood or community independently for a complex trip (several stops, unfamiliar places, bus transfers) with instructions and/or directions **[they need directions/help with a complex trip, but they can do it with that help.]**
2. Moves about the neighborhood or community independently for a simple direct trip and/or familiar locations with instructions and/or directions **[they can only do a simple trip with the help of instructions/directions…(familiar places)]**
3. Moves about the neighborhood or community with some physical assistance and/or occasional accompaniment ******What does that physical assistance look like?* How often?**
4. Moves about the neighborhood or community only with accompaniment *******What prevents them?***

Things to consider: How do they get around the neighborhood? (bus, walk, etc.) Do they go to familiar places only? Do they go to more than one location at a time? Are they given instructions about how to get to a location – is it a familiar place to them, or a new one? If someone goes with them, who is it and how often do they go with them?

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TOILETING – Involves initiating and caring for those bodily functions involving bowel and bladder control.
NOTE: Do NOT rate ability to wash hands after toileting or the ability to transfer on and off the toilet.

0. Completes the task independently
1. Able to complete the task with verbal prompts, cue by touch, materials setup, or other modifications
2. Can **indicate the need** for toileting, but requires hands-on assist to complete/perform the task (e.g. help with fasteners, toilet paper, flushing the toilet)
3. Does **not indicate the need** for toileting, but usually avoids accidents through a toileting schedule (e.g. periodic tripping by caregiver) and requires hands-on assist to complete/perform the task
4. Does **not perform nor indicate the need** for toileting and requires total caregiver intervention

Things to Consider: Does the client indicate the need to use the restroom to void bowel/bladder?
Is client on a tripping schedule? Is it effective?
Does client do it all independently? OR does client have help? Describe the help provided, if any – and also include how often, who does it, and when it is provided.
Be as specific as possible (i.e. Client uses restroom independently daily when he needs to void, and only requires reminders to flush, daily.)**.**

Describe what happens at least 75% of the time.

EXPRESSIVE VERBAL COMMUNICATION – Ability to communicate thoughts verbally with words or sounds.

0. Carries on a complex or detailed conversation
   ****Helpful to include an example of what client talks about at least 75% of the time.**
1. Carries on a simple brief conversation, such as talking about everyday events (e.g., the clothes you are wearing)
   **** Helpful to include an example of what client talks about at least 75% of the time.**
2. Uses simple two-word phrases (e.g., "I go," "give me")
   **** Helpful to include an example of phrases used (2-3words at a time only)**
3. Uses a few simple words and associates words with appropriate objects, such as names of common objects and activities
   **** Helpful to include an example of words used (i.e. only knows "ball", "dog", "cup", "eat" but uses them correctly; does not use phrases).**
4. Uses no words, but does use a personal language or guttural sounds to communicate very basic concepts **** Helpful to include an example of what client does to communicate with sounds**
5. Makes no sounds which are for communication; may babble, cry or laugh

Things to Consider: What happens 75% of the time?
What does applicant typically say or what sounds does he/she make? Include your observations of the customer's communication ability during the PAS interview.

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CLARITY OF COMMUNICATION - Ability to **speak in a recognizable language or** use a formal symbolic substitute, such as American Sign Language or **alternate communication system**.

If client has more than one form of communication, score on what is best understood.

0. Uses speech in a normal manner intelligible to an **unfamiliar** listener; no special effort is required to understand this individual
1. Speech understood by strangers with some difficulty; **unfamiliar** individuals can understand, but due to the lack of clarity, not all of the words are understood and the listener must pay close attention in order to understand
2. Uses a **non-speech** communication system that is understood by an **unfamiliar** listener (e.g., writing, communication board/device, gestures, or pointing)
3. Speech or other communication system **understood only by either those who know the person well or who are trained in the alternate communication system**
4. Does **not** communicate using a recognizable language or formal symbolic substitutions

Things to Consider: What does customer use at least 75% of the time (spoken language, pointing, sign language, writing, etc.)? Is the speech or alternate system understood? This is not about the content of what is said being comprehended, but whether the actual language used is clear and understood.
And who understands client – are they familiar with him/her or not?
Provide examples of both to illustrate and support the score.
Include your observations of the customer's communication ability during the PAS interview.

ASSOCIATING TIME WITH EVENTS AND ACTIONS - Indicate person's sense of time.
Note: does NOT have to tell time.

0. Associates events with specific time (e.g. the concert starts at 7:45) ******Provide example (s) (This would include 6:30, 11:15, etc.)***
1. Associates regular events with specific hour (e.g. dinner is at 6, work starts at 8, bedtime is 10) ******Provide example (s)***
2. Associates regular events with morning, noon, or night (e.g. daily or weekly events, such as we go to school in the morning or I go to bed at night); does not understand time, but knows a sequence of daily events ******Provide example (s)***
3. Does not associate events and actions with time ******What prevents them?***

Things to consider: How does customer associate the concept of time with an event or action? If the customer works/goes to school, how do they associate time and events in those areas? Do they need guidance from someone else? What does that help look like? Describe what happens at least 75% of the time.

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REMEMBERING INSTRUCTIONS AND DEMONSTRATIONS - Can recall examples of instructions or demonstrations on **how** to complete a specific task as demonstrated and/or verbally directed.

Comments **MUST include examples of tasks assessed (not learning a new one or a complex one).**

Note: this is not assessing if the customer remembers to do the task or needs to be reminded to start a task.

******Examples of a task would be an independent living skill (that has not already been assessed), household chore or vocational task.***

0. Displays memory of instructions or demonstrations **without** prompting if they are given once

   ******Provide example (s)***

1. Displays memory of instructions or demonstrations if they are given **once** and if prompted to recall

   ******Provide example (s)***

2. Displays memory of instructions or demonstrations if they are repeated **three** or more times and if prompted to recall ******Provide example (s)***

3. Displays no or extremely limited (rare or very incomplete) memory of instructions or demonstrations

   ******Provide example (s) of what is done: is it hand over hand, or no tasks are done?***

Things to consider? What type of tasks does the customer perform (exclude complex tasks or learning a new task)**?**

Once an instruction or demonstration is given once and without prompts does the customer perform it?

If the customer receives instructions and demonstrations to be given once and then is prompted to recall, what does that look like?

How many times are instructions or demonstrations repeated for client to complete the task each time?

In addition, do they need to be prompted to recall these?

Describe what happens at least 75% of the time.

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C BEHAVIORAL DOMAIN

The purpose of this section is to identify the presence of certain behaviors that may reflect the need for caregiver supervision and/or intervention.

Responses for this section are based on both the frequency and the intensity of the behavior; that is the amount or degree of intervention required to control the problem behavior.

NOTE: It is important to note that to score behaviors the assessor must determine if the behavior is **minor**, **moderate**, **serious** or **extremely urgent**. That is determined primarily by the intensity of the intervention and to a lesser degree, the frequency of the behavior. For example, a minor behavior such as whining may occur daily but not be a serious problem.

Reminder: Rate activities/behaviors as generally performed over the last year with emphasis on current functioning.

The following definitions should be applied when answering questions related to behavior:

"Physical Interruption" requires immediate physical (hands-on) interaction of the caregiver to stop the customer's behavior.

"Occasional" less than weekly.

"Frequent" weekly to every other day.

"Constant" at least once a day.

All behaviors in this section scored above a zero must be described in comments and the intervention specified.

If there are any differences between the DD PAS Manual and what is in the ACE program, please follow the guidance from the PAS Manual.

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AGGRESSION - Physical attacks on others, includes throwing objects, punching, biting, pushing, pinching, pulling hair, or scratching.

Do NOT include self-injurious behaviors, threatening, or only property destruction.

Destruction of property alone, or abuse of animals, is not rated, but should be described in the PAS Summary section.

0. Problem does not occur or occurs at a level not requiring intervention
1. **Minor** problem; occasional aggression which requires some additional supervision in a few situations **and/or** verbal redirection
2. **Moderate** problem; frequent aggression that requires close supervision **and/or** frequent verbal or physical redirection
3. **Serious** problem; constant aggression that requires close supervision **and/or** constant verbal or physical interruption.
4. **Extremely Urgent** problem; has had episode(s) **causing injury in the last year**, requires close supervision **and** physical interruption

Things to Consider: What is being done and to whom? (Must be directed at a person/people)
How often is it done?
What is the injury caused? (Cuts, scrapes, bruises, headaches, crying, ER visit, etc.)**?**
If there was an injury in the last year, what was done about it? When did it happen approximately? (An exact date is preferred).
What is done to prevent or stop the attack(s)? Does it work? How often is it done?

VERBAL OR PHYSICAL THREATENING - Threatens to do harm to self, others or objects. Do NOT include *actual* acts of physical aggression or self-injury.

0. Problem does not occur or occurs at a level not requiring intervention
1. **Minor** problem; makes occasional threats which are **not taken seriously** and **do not** frighten others nor result in aggression from others; requires some additional supervision **and/or** verbal redirection
2. **Moderate** problem; makes frequent threats that **sometimes** cause fear **and/or** aggression from others; requires close supervision **and/or** frequent verbal or physical redirection
3. **Serious** problem; makes constant threats that sometimes cause fear **and/or** aggression from others; requires close supervision **and/or** constant verbal or physical interruption
4. **Extremely Urgent** problem; has had **serious incident(s) in the last year**; incidents always generate fear and/or are likely to result in aggression from others; requires close supervision and physical interruption.

Things to Consider: What is the client threatening to do, and to whom/what?
How often is it being threatened?
If the person is threatening to hurt themselves, how do they plan to do this?
Are they who are threatened fearful of the client and his/her threats? How often?
What is done to prevent or stop the threat(s)?

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SELF-INJURIOUS BEHAVIOR - Biting, scratching, putting inappropriate objects into ear, mouth, or nose, repeatedly picking at skin, head slapping or banging.

Do not include medical noncompliance issues or behaviors that might be considered life style choices (e.g., sexual activity, smoking, non-compliance with dietary restrictions).

0. Problem does not occur or occurs at a level not requiring intervention
1. **Minor** problem; occasional incidents which require some additional supervision in a few situations **and/or** occasional verbal redirection
2. **Moderate** problem; frequent incidents that require close supervision **and/or** frequent verbal or physical redirection
3. **Serious** problem; constant incidents; requires close supervision and/or verbal or physical interruption **[Note: Physical interruption** requires immediate physical (hands-on) interaction of the caregiver to stop the customer's behavior.**]**
4. **Extremely Urgent** problem; has had episode(s) **causing serious injury requiring immediate medical attention in the last year,** requires close supervision and physical interruption

Things to Consider: What is being done? (The actual behavior) **Is it repeated?**
How often is it being done?
What is the injury or result of the behavior? (Cuts, scrapes, bruises, headaches, ER visit, etc.)
If there was a serious injury in the last year, what was done about it (first aid? ER visit? etc.)
And when did the serious injury happen approximately? (An exact date is preferred)
What is done to prevent/stop the behavior(s)? How often? Does it work to stop/prevent it?

RESISTIVENESS/REBELLIOUSNESS – Being inappropriately stubborn and or uncooperative, including passive or active obstinate behaviors.

Do NOT include difficulties with auditory processing or reasonable expressions of self-advocacy.

Do NOT include verbal threatening or acts of physical aggression to self or others**.**

0. Problem does not occur or occurs at a level not requiring intervention
1. **Minor** problem; occurs occasionally and requires occasional attention, prompting and/or verbal redirection for cooperation
2. **Moderate** problem; occurs frequently and requires frequent attention, prompting and/or physical redirection for cooperation
3. **Serious** problem; occurs constantly and requires constant attention, prompting and/or physical redirection for cooperation

Things to consider: Please describe the behavior in detail. How is this behavior inappropriately stubborn and/or how is the customer being uncooperative? Please provide a specific frequency that each of these behaviors occur? Does the behavior require attention? How often? What is being done to stop, decrease or eliminate these behaviors?

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III. MEDICAL ASSESSMENT

"**Acute**" An active condition having a sudden onset, lasting a short time and requiring intervention. The condition may still be considered acute if the customer is in a convalescent stage of an acute illness.

"**Chronic**" A condition which is either always present or occurs periodically, or is marked by a long duration. If a customer is being treated for a condition over a long period, the condition would probably be considered chronic. For example, a seizure disorder that is controlled with medication would be considered chronic rather than historical.

"**History**" A condition which occurred in the past, may or may not have required treatment, but is not currently active. If possible, the approximate date of the condition should be noted for historical diagnoses. If the date is not available, then it must be documented in the comments approximately how long ago the condition occurred.

This section is used to record **only** the diagnoses and specific medical conditions that have a relationship to the customer's **current** developmental/ILS status, cognitive, mood and behavior status, medical treatments, skilled nursing care or risk of death.

The assessor should review each category of conditions listed to ensure that no **significant** diagnoses are omitted.

Comment fields are provided to clarify any diagnosis indicated.

Comments should always be included for any condition marked which would be considered a general category. For example, items such as (16.d.) Behavior Disorders, (6.j.) Genetic Anomalies, or (6.l.) Congenital Anomalies should have a clarifying comment as to the specific condition.

As previously mentioned, conditions that are marked as historical must be explained with a date or with an approximate time frame, such as "about 4 years ago".

DO NOT list surgical procedures (V codes) as diagnoses. These may be recorded in the summary comments section.

The customer's DD qualifying diagnosis MUST always be indicated as a major diagnosis.

NOTE: It's helpful to include WHO made each diagnosis and WHEN.

PreAdmission Screening
Developmentally Disabled
Ages 12+

Customer Name _____ Person ID _____

A. MEDICAL CONDITIONS

A = Acute, C = Chronic, H = History (Circle appropriate answers)

Neurological/Congenital/Developmental Conditions		A, C, H	Comments
1. Cerebral Palsy			
a.	Diplegia	A C H	
b.	Hemiplegia	A C H	
c.	Quadriplegia	A C H	
d.	Paraplegia	A C H	
e.	Unspecified Cerebral Palsy	A C H	
2. Epilepsy/Seizure Disorder			

NOTE: Indicate **DATE of LAST Seizure** and **FREQUENCY of *EACH TYPE*** of Seizure in Comments.

a	**Generalized non-convulsive** (absence, petit mal, minor, akinetic, atonic.)	A C H	
b.	**Generalized convulsive** (clonic, myoclonic, tonic, tonic-clonic, grand mal, major)	A C H	
c.	**Unspecified** (complex partial, psychomotor, temporal lobe, simple partial, Jacksonian, epilepsia partialis, continual	A C H	
3. Mental Retardation			
a	Mild Mental Retardation	A C H	
b	Moderate Mental Retardation	A C H	
c	Severe Mental Retardation	A C H	
d	Profound Mental Retardation	A C H	
e	Unspecified Mental Retardation	A C H	
f.	Borderline Intelligence	A C H	

PreAdmission Screening
Developmentally Disabled
Ages 12+

Customer Name _____ Person ID _____

III. MEDICAL ASSESSMENT
A. MEDICAL CONDITIONS (continued)

A = Acute, C = Chronic, H = History (Circle appropriate answers)

		A, C, H	Comments
4. Autism			
a.	Autism	A C H	
b.	Pervasive Developmental Disorder	A C H	
c.	Autistic-Like Behaviors	A C H	
5. Attention Deficit Disorder (ADD)			
a.	ADD with Hyperactivity	A C H	
b.	ADD without Hyperactivity	A C H	
6. Other Neurological / Congenital / Developmental Conditions			
a.	Prematurity	A C H	
b.	Fetal Alcohol Syndrome	A C H	
c.	Developmental Delays	A C H	
d.	Hydrocephaly	A C H	
e.	Macrocephaly	A C H	
f.	Microcephaly	A C H	
g.	Meningitis	A C H	
h.	Encephalopathy	A C H	
i.	Spina Bifida	A C H	
j.	Genetic Anomalies	A C H	
k.	Down's Syndrome	A C H	
l.	Congenital Anomalies	A C H	
m.	Near Drowning	A C H	
n.	Head Trauma	A C H	
o.	Dementia (Organic Brain Syndrome)	A C H	

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Customer Name _____ Person ID _____

III. MEDICAL ASSESSMENT

A. MEDICAL CONDITIONS (continued)

A = Acute, C = Chronic, H = History (Circle appropriate answers)

Other Medical Conditions	A, C, H	Comments
7. Hematologic		
a. Anemia	A C H	
b. HIV Positive	A C H	
c. AIDS	A C H	
d. Leukemia	A C H	
e. Hepatitis	A C H	
8. Cardiovascular		
a. CHF	A C H	
b. Hypertension	A C H	
c. Congenital Anomalies of Heart	A C H	
d. Cardiac Murmurs	A C H	
e. Rheumatic Heart Disease	A C H	
9. Musculoskeletal		
a. Arthritis	A C H	
b. Fracture	A C H	
c. Contracture	A C H	
d. Anomalies of Spine (Kyphoscoliosis, Scoliosis, Lordosis)	A C H	
e. Paralysis	A C H	
10. Respiratory		
a. Asthma	A C H	
b. Bronchitis	A C H	
c. Pneumonia	A C H	
d. Respiratory Distress Syndrome	A C H	

Customer Name _____ Person ID _____

III. MEDICAL ASSESSMENT

A. MEDICAL CONDITIONS (continued)

A = Acute, C = Chronic, H = History (Circle appropriate answers)

	A, C, H	COMMENTS
10. Respiratory (continued)		
e. Bronchopulmonary Dysplasia	A C H	
f. Cystic Fibrosis	A C H	
g. Reactive Airway Disease	A C H	
h. Tracheomalacia	A C H	
i. Congenital Pulmonary Problems	A C H	
11. Genitourinary		
a. Urinary Tract Infection	A C H	
12. Gastrointestinal		
a. Constipation	A C H	
b. Ulcers	A C H	
c. Hernia	A C H	
d. Esophagitis	A C H	
e. Gastroesophageal Reflux	A C H	
13. EENT		
a. Blindness	A C H	
b. Cataract	A C H	
c. Hearing Deficit	A C H	
d. Ear Infection	A C H	
e. Disorders of Eye Movements (Exotropia, Strabismus, Nystagmus)	A C H	
f. Glaucoma	A C H	
14. Metabolic		
a. Hypothyroidism	A C H	
b. Hyperthyroidism	A C H	
c. Diabetes Mellitus	A C H	
d. Pituitary Problem	A C H	

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Customer Name _____ Person ID _____

III. MEDICAL ASSESSMENT

A. MEDICAL CONDITIONS (continued)

A = Acute, C = Chronic, H = History (Circle appropriate answers)

	A, C, H	Comments
15. Skin Conditions		
a. Decubitus	A C H	
b. Acne	A C H	
16. Psychiatric		
a. Major Depression	A C H	
b. Bipolar Disorder	A C H	
c. Schizophrenia	A C H	
d. Behavioral Disorders	A C H	
e. Conduct Disorder	A C H	
f. Alcohol Abuse	A C H	
g. Drug Abuse	A C H	

17. Other Diagnoses

								Diagnosis
ICD-9	a.						A C H	
ICD-9	b.						A C H	
ICD-9	c.						A C H	
ICD-9	d.						A C H	
ICD-9	e.						A C H	

	Category	Condition	Diagnosis
MAJOR DIAGNOSES			

Comments: _____

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Customer Name _____ Person ID _____

III. MEDICAL ASSESSMENT

B. MEDICATIONS/TREATMENTS

(Include PRN medications/treatments received in last thirty (30) days and any other current medications/treatments). Include dosage, frequency, duration, route, form for each medication.

Include dosage, frequency, duration, route (by mouth, injection, etc.), form for each medication and average use of major PRN medications.

	MEDICATIONS / TREATMENTS / COMMENTS	RX	OTC
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			

Comments: _____

_____

_____

PreAdmission Screening
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Customer Name _____ Person ID _____

C. SERVICES AND TREATMENTS -- (Circle appropriate answers) Provide explanation when (N) is circled

If a Need is indicated, the assessor must explain in comments. The determination of need should be based on documentation, such as physician order, the recommendation of a therapist, or a clearly defined medical condition for which the service is routine treatment.

Indicate the frequency of services by selecting (C) for Continuously, (D) for Daily to several times daily, (W) for Weekly to 3 times a week (if more often than 3 times a week consider daily), and (M) for Monthly or greater. An ongoing service or treatment which lasts several hours or more may be considered continuous (e.g., tube feeding or oxygen at night only).

			Frequency of Service			
1. Injections/IV	Receives	Needs	Cont.	Daily	Wkly.	Monthly
a. Intravenous Infusion Therapy	R	N	C	D	W	M
b. Intramuscular/Subcutaneous Injections	R	N	C	D	W	M

Comments: _____

2. Medications/Monitoring	Receives	Needs	Cont.	Daily	Wkly.	Monthly
a. Drug Regulation	R	N	C	D	W	M
b. Drug Administration	R	N	C	D	W	M

Comments: _____

3. Dressings	Receives	Needs	Cont.	Daily	Wkly.	Monthly
a. Decubitus Care	R	N	C	D	W	M
b. Wound Care	R	N	C	D	W	M
c. Non-Bladder/Bowel Ostomy Care	R	N	C	D	W	M

Comments: _____

4. Feedings	Receives	Needs	Cont.	Daily	Wkly.	Monthly
a. Parenteral Feedings/TPN	R	N	C	D	W	M
b. Tube Feedings	R	N	C	D	W	M

Comments: _____

5. Bladder/Bowel	Receives	Needs	Cont.	Daily	Wkly.	Monthly
a. Catheter Care	R	N	C	D	W	M
b. Ostomy Care	R	N	C	D	W	M
c. Bowel Dilatation	R	N	C	D	W	M

Comments: _____

PreAdmission Screening
Developmentally Disabled
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Customer Name _____ Person ID _____

(Circle appropriate answers) **Provide explanation when (N) is circled**.

			Frequency of Service			
6. Respiratory	Receives	Needs	Cont.	Daily	Wkly.	Monthly
a. Suctioning	R	N	C	D	W	M
b. Oxygen	R	N	C	D	W	M
c. SVN	R	N	C	D	W	M
d. Ventilator	R	N	C	D	W	M
e. Trach Care	R	N	C	D	W	M
f. Postural Drainage	R	N	C	D	W	M
g. Apnea Monitor	R	N	C	D	W	M

Comments: _____

7. Therapies	Receives	Needs	Cont.	Daily	Wkly.	Monthly
a. Physical Therapy	R	N	C	D	W	M
b. Occupational Therapy	R	N	C	D	W	M
c. Speech Therapy	R	N	C	D	W	M
d. Respiratory Therapy	R	N	C	D	W	M
e. Alcohol/Drug Treatment	R	N	C	D	W	M
f. Vocational Rehabilitation	R	N	C	D	W	M
g. Individual/Group Therapy	R	N	C	D	W	M
h. Behavioral Modification Program	R	N	C	D	W	M

Comments: _____

8. Rehabilitative Nursing	Receives	Needs	Cont.	Daily	Wkly.	Monthly
a. Teaching/Training Program	R	N	C	D	W	M
b. Bowel/Bladder Retraining	R	N	C	D	W	M
c. Turning & Positioning	R	N	C	D	W	M
d. Range of Motion	R	N	C	D	W	M
e. Other Rehab Nursing (specify)	R	N	C	D	W	M

Comments: _____

9. Other	Receives	Needs	Cont.	Daily	Wkly.	Monthly
a. Peritoneal Dialysis	R	N	C	D	W	M
b. Hemodialysis	R	N	C	D	W	M
c. Chemotherapy/Radiation	R	N	C	D	W	M
d. Restraints	R	N	C	D	W	M
e. Fluid Intake/Output	R	N	C	D	W	M
f. Other (specify)	R	N	C	D	W	M

Comments: _____

PreAdmission Screening
Developmentally Disabled
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Customer Name _____ Person ID _____

D. MEDICAL STABILITY

1. The number of acute hospitalizations that occurred in the past year
Do not include birth *as a hospitalization for an infant unless the hospitalization continued due to the* ***child's*** *medical problems.* _____

2. Currently requires direct care staff or caregiver **trained in special health care procedures** (e.g., ostomy care, positioning, adaptive devices, G-tube feedings, SVN, seizure precautions [if current seizure activity], diabetic monitoring) ☐ YES ☐ NO

- **Do** include training for procedures that are intermittent but on-going (i.e. SVNs seasonally). Make comments as to the procedure and who is trained.
- **Do not** include personal care that would not require special training, such as routine help with ADLs or applying AFO's or a simple brace.
- **Do not** include training for a procedure that the customer has received in the past but no longer routinely requires.

3. Currently **requires special diet** planned by dietitian, nutritionist, or nurse ☐ YES ☐ NO
Indicate ***(Y)*** *yes for this item if the individual requires a special diet ordered by a physician, planned by a dietitian, nutritionist or nurse (e.g., high fiber, low calorie, low sodium, pureed) and* ***write in the type of diet in the comments section.***

This would include formula for tube feedings, but would *not* ***include formula for infants and young children who typically receive one of a variety of infant formulas by bottle or sippy cup.***

Comments: _____

E. SENSORY FUNCTIONS - (circle appropriate answers)

Hearing -- refers to the ability to receive sounds, and does **not** refer to the ability to comprehend mentally the meaning of sound. ***If an assistive device is used, hearing should be rated while using the device.**

0) Unable to Assess/No Impairment. Hears all normal conversational speech, including when using the telephone, watching television, and participating in group activities, or unable to assess.
1) Minimal Impairment. Has difficulty hearing when not in quiet surrounding. May have impairment in one ear but may hear adequately with the other ear.
2) Moderate Impairment. Although hearing-deficient, compensates when speaker adjusts tonal quality and speaks distinctly; or can hear only when a speaker's face is clearly visible.
3) Severe Impairment. Highly impaired/absence of useful hearing; hears only some sounds; frequently fails to respond even when speaker adjusts tonal quality, speaks distinctly, or faces customer.

Customer Name _____ Person ID _____

VISION -- refers to perceiving objects visually. In this section, the assessor will evaluate the customer's ability to see close objects and objects at a distance in adequate lighting, using any visual appliances (e.g., glasses, magnifying glass).

A medical condition or disease affecting the eye that does <u>not</u> affect the ability to <u>see</u> should <u>not</u> be considered in determining adequacy of sight.

0) Unable to Assess/No Impairment. There is no impairment or impairment is compensated by corrective lenses (e.g., can see newsprint, TV, medication labels) or unable to assess.
1) Minimum Impairment. Difficulty with focus at close (reading) range but can see large print and obstacles but not details. May be blind in one eye but has been able to compensate.
2) Moderate Impairment. Very poor focus at close range. Unable to see large print and/or field of vision is limited (tunnel vision or central vision loss).
3) Severe Impairment. May only see light, shapes, colors, or has no vision.

Comments: _____

III. MEDICAL ASSESSMENT
F. SUMMARY _____

PreAdmission Screening
Developmentally Disabled
Ages 12+

Customer Name _____ Person ID _____

ELIGIBILITY REVIEW REQUESTED? ☐ **Yes** ☐ **No** **DATE** _____

Signature and Title _____ Date _____

Signature and Title _____ Date _____

Completion Time _____ (Minutes) Travel Time _____ (Minutes)

Customer Name _____ Person ID _____

III. MEDICAL ASSESSMENT

F. SUMMARY (continued) _____