Person Supported: _____

FUNCTIONAL PROTOCOL

DEPARTMENT OF INTELLECTUAL AND DEVELOPMENTAL DISABILITIES
Therapeutic Services
_____ ASSESSMENT
___Initial Assessment ___Re-assessment

Name of Person Supported:_____
DOB:_____ Age:_____ Gender:_____
Date(s) of Assessment:_____ ISP Effective Date:_____
Physician:_____
ISC/Agency:_____
Residential/Day/PA Provider:_____

***Reason for referral*:**
Indicate reason for referral per information provided by ISC. Need for service may be identified through risk assessment, identification of health and safety needs, and/or barriers in meeting the person's identified outcomes or support goals that fall within the scope of services covered under the waiver. If person transferred from another provider, the original reason for referral should be identified as well as the current reason for needing to continue services.

***Individual concerns/desired goals*:**
Indicate person's preferences/outcomes, support outcomes in ISP. What does the person want to do and how can services help accomplish that? Indicate any concerns and input provided by person supported, family, legal representative, support coordinator/case manager, direct support staff, etc. regarding therapy-related issues, concerns, capabilities or other needed information related to the provision of services.

Relevant health history:
List diagnoses. Provide pertinent medical consultations or examinations, diagnostic tests, and/or other health information related to service. Include any new and recent medical problems or health status changes that are pertinent to service.

Relevant discipline specific data:
Clinical examination and applicable clinical parameters related to therapy/nutrition discipline such as fine gross motor skills, perceptual skills, daily living skills, use of adaptive equipment, falls history, balance, strength, mobility skills, communication skills, oral-motor skills, vision, hearing abilities, height, weight history, laboratory values, medication review, etc. Describe physical status based on most recent, physical, vision, hearing, and medical exams; describe how the person communicates: verbal, non-verbal, single words, gestures, Braille, etc.)

Relevant adaptive equipment/assistive technology needs: *List all adaptive equipment used, current status, and need for assistive technology services. List equipment necessary to ensure health, safety, comfort, and function.*

Person Supported: _____

***Comprehensive Analysis*:**

Questions to consider when writing the comprehensive analysis:

- *Why was this person referred to me?*
- *What is this person trying to accomplish?*
- *What are the individual's preferences, strengths, abilities, and potentials?*
- *Do the clinical findings impact function?*
- *How do the various clinical findings relate to one another?*
- *Are there health and safety risks identified?*
- *Are my services needed?*
- *If so, how can my services make a functional difference for this individual related to personal outcomes? Describe how services can improve the person's health and safety and/or how it will allow the person to overcome barriers to achieving outcomes*
- *What could the person do if they have the right supports? Or if you decide the person does not need therapy/nutrition, explain why your services may not be the most appropriate at this time.*

The analysis should not just re-state the issues documented in the assessment, but connect the issues to the person's overall health and safety concerns and function.

Recommendations:

Include recommendations that are pertinent to problem areas supported in the body of the assessment and the comprehensive analysis.
Recommendations should:

- *Provide individualized functional solutions to help overcome barriers to personal outcomes*
- *Promote needed supports to help address health or safety/identified risk issues*

If applicable, additional recommendations can include modifications for prevention/treatment of potential, other interventions for desired therapy/nutrition outcomes, and referral to other professionals (physician and clinicians) for further evaluation of problems identified (i.e. vision, hearing, positioning, health issues, behavior, etc). Recommendations outside your discipline should be general in nature (i.e. recommend physician or audiologist appointment to assess hearing. It is not appropriate to request a hearing aid).

Service Provider's Signature/Credentials: _____ _____

Printed Name **Date Completed**

_____

Signature

The assessment is to be filed in the therapy/nutrition file/record for the person and copies of the assessment are to be sent to the: a) ISC or case manager and b) the primary provider. The therapist/dietitian is to review the assessment findings with the person supported and provide a copy upon request. Reassessment required when recommending new services, change in existing services, or preparing for discharge. An updated POC completed when significant change in service needs or if services are recommended into a new ISP year.