Name: Date of Birth: Record Number:

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NC TBI Waiver Overall Safety and Wellness Assessment

Completed by: _____ Date Assessment Completed: _____
Name/Position

| Input Obtained From | | |
|---|---|---|
| ☐ | Individual | |
| ☐ | Family / Friends (List name/relationship) | |
| | | |
| | | |
| ☐ | Support Workers (List name/relationship) | |
| | | |
| | | |
| ☐ | Other (List name/relationship) | |

Purpose of Assessment

- Identify supports necessary to successfully participate in essential activities of life
- Identify significant risks regarding the individual's health/safety and the safety of others.
- Inform team of supports and/or risks that need to be addressed.
- Assist support team to ensure a balance between what is 'important TO' the participant and what is 'important FOR' the individual

Instructions

1) This assessment must be completed within 90 calendar days prior to planning meeting and when there are significant changes in the individual's life.
2) The assessment must be completed with input from the individual/legally responsible person and other members of the support team.
3) The individual's preferences, needed supports and strategies to address identified risks must be included in the plan.

| A. Demographic Information | | | |
|---|---|---|---|
| Current Living Situation | ☒ | Private Residence (residence leased or owned by individual or family)<br>☐ Alone ☐ With Family ☐ With Others/ Describe: | Residence is<br>☐ Owned ☐ Rented/Leased |
| | ☐ | Non-Private Residence ≤6 beds (residence leased or owned by provider)<br>☐ Alone ☐ Residential Facility (licensed for ___ beds) Type: _____ | |
| | ☐ | Alternative Family Living (AFL) ☐ Unlicensed/1 bed ☐ Licensed for ____ beds | |

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|---|---|---|---|
| | ☐ | Congregate Living > 6 Beds<br>☐ Nursing Facility<br>☐ Developmental Center/State Operated Facility<br>☐ Hospital<br>☐ Rehabilitation Center<br>☐ Other:_____ | Is residence/living situation expected to change?<br>☐ Yes ☐ No If yes, describe: |

| | | |
|---|---|---|
| Is the primary language spoken by the individual and family English? | ☐ Yes ☐ No | ☐ Interpreter Services Required (Check if yes).<br>Language Spoken: _____ |

| | | |
|---|---|---|
| Current MH/DD/SA Services (include service and provider) | ☐Personal Care<br>☐Respite<br>☐Transportation<br>☐Day Program<br>☐Other, describe: | ☐Employment Supports<br>☐Mental Health Treatment<br>☐Behavioral Health Treatment<br>☐Substance Use Disorder Treatment |
| Total number of unplanned hospitalizations in the last year (medical and behavioral). | | |
| Total number of hospitalizations in the last year (medical and behavioral). | | |
| What natural support(s) does member have? | Name(s)/Relationship to Member: | |
| What does this/these natural support(s) provide? | ☐Personal Care<br>☐Respite<br>☐Transportation<br>☐Other, describe: | |

| B. Durable Medical Equipment Supports (mark all that are in place now) | | | |
|---|---|---|---|
| ☐ | Personal Lift | ☐ | PERS Unit (Personal Emergency Response System) |
| ☐ | Bedrails | ☐ | Telecommunication display (TDD) |
| ☐ | Hospital Bed | ☐ | Elevated Commode Seat |
| ☐ | Shower Chair | ☐ | Bedpan or Bedside Commode |
| ☐ | Wheelchair ☐ Manual ☐ Power | ☐ | Walker/Cane |
| ☐ | Orthopedic Braces | ☐ | Prosthetic Device |

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| | | | |
|---|---|---|---|
| ☐ | Medical Devices (e.g., pacemaker, C-PAP machine, glucometer, seizure management device, prosthetic device, etc. Does not include glasses, contacts, or hearing aids). Describe: | ☐ | Augmentative Communication (Describe) |
| ☐ | Environmental controls (Describe) | ☐ | Other – Describe |
| Needed Material Supports (needed durable medical equipment that is not in place at this time) | | | |
| Describe: | | | |

| C. Modifications (mark all that are in place now) | | | |
|---|---|---|---|
| ☐ | Vehicle Modifications (Describe) | ☐ | Home Modifications (Describe) |
| Needed Modifications Supports (needed vehicle or home modifications, assistive technology/devices, etc. that are not in place at this time) | | | |
| Describe: | | | |

| D. Physician Supports | | | | | |
|---|---|---|---|---|---|
| ☐ | Profession | Name/Clinic (Indicate MD, NP, or PA) | Recommended Frequency of Visits (e.g. monthly, quarterly, annually, as needed) | Approximate Date of Last Visit | Approximate Date of Next Visit (If Known) |
| ☐ | Primary Care Physician* (If none is identified, complete sections S and T) | | | | |
| ☐ | Psychiatrist | | | | |
| ☐ | Neuropsychiatrist | | | | |
| ☐ | Neurologist | | | | |
| ☐ | Orthopedist | | | | |
| ☐ | Physical Medicine and Rehabilitation | | | | |

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| | | | | | |
|---|---|---|---|---|---|
| ☐ | Dentist | | | | |
| ☐ | Eye Doctor | | | | |
| ☐ | Hearing Doctor | | | | |
| ☐ | Other(Identify Profession) | | | | |

E. Rehabilitation Team

| | Profession | Name/Clinic | Recommended Frequency of Visits (e.g. monthly, quarterly, annually, as needed) | Approximate Date of Last Visit | Approximate Date of Next Visit (If Known) |
|---|---|---|---|---|---|
| ☐ | Registered Nurse | | | | |
| ☐ | Licensed Practical Nurse | | | | |
| ☐ | Physical Therapist | | | | |
| ☐ | Occupational Therapist | | | | |
| ☐ | Speech Language Pathologist | | | | |
| ☐ | Psychologist | | | | |
| ☐ | Counselor | | | | |
| ☐ | Social Worker | | | | |
| ☐ | Cognitive Rehab Therapist | | | | |
| ☐ | Behavior Therapist | | | | |
| ☐ | Dietician | | | | |
| ☐ | Other (Describe) | | | | |
| ☐ | Other (Describe) | | | | |

F. Medication Supports

| Name of Medication | What Is It For? | Dosage / Frequency | How Is It Taken? (Method of administration – oral, injection, suppository, etc.) | To Be Given By (self, family, staff, etc.) |
|---|---|---|---|---|
| | | | | |

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| Allergies, Interactions and Adverse Reactions: | | | | |

| G. Medical Treatment Supports (e.g. catheterization, tube feeding, dressing changes, suctioning, oxygen, splints, braces, etc.) | | | | |
|---|---|---|---|---|
| Treatment | What Is It For? | Frequency | How Is It Performed? | To Be Completed By (Self, family, staff, etc.) |
| | | | | |
| | | | | |
| | | | | |

| H. General Health Risks and Supports | | |
|---|---|---|
| Yes | No | |
| ☐ | ☐ | Requires support to manage a medical or health condition (ex. Seizures, Diabetes, Sleep Apnea, Narcolepsy, Lifethreatening allergy, etc.) Describe: |
| ☐ | ☐ | Requires support to promote skin integrity (e.g. has pressure sore or history of pressure sores, incontinent with cognitive impairment) Describe: |
| ☐ | ☐ | Requires support to promote oral hygiene/health Describe: |
| ☐ | ☐ | Requires support to identify or manage pain (Pain Clinic, Spinal fusion, Positioning, etc.) Describe: |

| I. Health Screening/Preventative Care | | |
|---|---|---|
| ☐ | (select all that have been received) | |
| ☐ | Annual Physical with CBC Panel Date: | Comments: |
| ☐ | Height/Weight Measurement | Comments: |

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| | | |
|---|---|---|
| ☐ | Breast and/or Testicular exam | Comments: |
| ☐ | Mammography – Women | Comments: |
| ☐ | Gynecological exam – Women | Comments: |
| ☐ | Prostate screening – Men | Comments: |
| ☐ | Hypertension screening | Comments: |
| ☐ | Cholesterol screening | Comments: |
| ☐ | Diabetes Type II screening | Comments: |
| ☐ | Colonoscopy | Comments: |
| ☐ | Preventative Dental Care | Comments: |
| ☐ | Other Health Screenings/Preventative Care<br>Describe: | Comments: |

| J. Nutrition Supports | | |
|---|---|---|
| Yes | No | |
| ☐ | ☐ | 1. Food/Liquid Consistency - Requires food or liquid to be in particular consistency or size (e.g. chopped into specific pieces, ground up, pureed, thickened, etc.). Describe: |
| ☐ | ☐ | 2. Physician Recommended Diet - Requires physician recommended diet (e.g. diabetic, low salt, high/low calorie, nutritional supplement, etc.) Describe:<br><br>Does individual/caregiver understand the dietary restriction/follow? |
| ☐ | ☐ | G-Tube Feeding Required for Nutrition |
| ☐ | ☐ | Requires support due to history or risk of dehydration. Describe: |
| ☐ | ☐ | Requires support due to 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). Describe: |
| ☐ | ☐ | Requires support due to history or risk of eating habits (i.e. refuses to eat, forgets to eat or forgets that they have already eaten). Describe: |
| ☐ | ☐ | Other: |

| K. Vision Related Supports |
|---|

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| | |
|---|---|
| ☐ | No support needed to see well |
| ☐ | Requires corrective lenses to see well<br>Does participant have and wear corrective lenses? ☐ Yes ☐ No<br>Describe Supports: |
| ☐ | Requires large print and/or other modification even with corrective lenses<br>Are needed modifications provided? ☐ Yes ☐ No<br><br>Describe Supports: |
| ☐ | Requires support to participate in activities requiring vision even with corrective lenses<br>Describe Supports: |
| ☐ | Requires environmental modification due to sensitivity to bright light or other visual stimuli (e.g. too many visual distractions in the room to focus).<br>Describe supports: |
| ☐ | Individual is legally blind. |

| L. Hearing Related Supports | |
|---|---|
| ☐ | No support needed to hear speech |
| ☐ | Requires prosthesis/hearing aid(s) to hear well<br>Does participant have and wear prosthesis? ☐ Yes ☐ No Describe<br>Supports: |
| ☐ | Requires environmental modification (e.g., increased volume, special seating), lip reading or some use of alternative communication (e.g., writing, pointing) even with prosthesis<br>Are needed environmental modifications provided? ☐ Yes ☐ No Describe<br>Supports: |
| ☐ | Does not hear well enough to understand most or all speech, even with prosthesis<br>Describe Supports: |
| ☐ | Individual is legally deaf |

| M. Supports for Communicating Needs (select one only) | |
|---|---|
| ☐ | None; can communicate most or all needs |
| ☐ | Speaks with difficulty but can be understood |
| ☐ | Requires extra time to formulate words to communicate needs |
| ☐ | Requires extra time to process questions |
| ☐ | Requires assistance (e.g. technology or someone that knows the person well) to communicate needs Describe: |
| How does the participant communicate best? (e.g. speaking, gesturing, communication board, sign language, etc.): | |
| If member does not communicate verbally, how do they communicate? (e.g. sign language, pointing) Describe: | |

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| N. Positive Behavior Support | | |
|---|---|---|
| Yes | No | Exhibits or has a history of the following |
| ☐ | ☐ | Requires support to stay on task due to short attention span, easy distractibility and/or inability to concentrate |
| ☐ | ☐ | Impulsive, impatient, low tolerance for pain or frustration |
| ☐ | ☐ | Uncooperative, resistant to care, demanding |
| ☐ | ☐ | Violent and/or threatening violence toward people or property |
| ☐ | ☐ | Requires support to manage unpredictable or explosive anger |
| ☐ | ☐ | Rocking, rubbing, moaning or other self-stimulating behavior |
| ☐ | ☐ | Wandering or elopement |
| ☐ | ☐ | Repetitive behaviors, physical or verbal (e.g. restlessness, pacing, repeating the same thoughts/comments) |
| ☐ | ☐ | Anxiousness |
| ☐ | ☐ | Sudden changes of mood |
| ☐ | ☐ | Easily initiated or excessive crying and/or laughter |
| ☐ | ☐ | Self-injurious or self-neglecting behavior |
| ☐ | ☐ | Lack of awareness of personal limitations/disabilities and how they interface with everyday activities |
| ☐ | ☐ | Problems getting started on activities without prompting |
| ☐ | ☐ | Problems following through on activities without prompting |
| ☐ | ☐ | Behavior or reaction does not fit the situation |
| ☐ | ☐ | Unable to recognize non-verbal cues from others |
| ☐ | ☐ | Other, describe: |
| | | Support Needs for Behavior |
| ☐ | ☐ | Requires support to learn about and/or avoid actions that endanger self or others (e.g., crossing the street safely) or due to lack of action (e.g., no response to fire, will allow others to victimize). |
| ☐ | ☐ | Requires support to participate in school, work and/or recreation within established rules (e.g., refuses rules, refuses direction, disrupts or unaware of rules or social norms). |
| ☐ | ☐ | Requires support to prevent, manage or provide therapy for behaviors or conditions that can potentially cause physical harm to self or others or that may be a misdemeanor (e.g., aggression, self-injury, property destruction, forgetting to eat, eating too much, extreme food or liquid seeking, pica, running away, window peeping, stripping in public, shoplifting, sleep disturbance). |
| ☐ | ☐ | Requires a highly structured environment with specially trained staff to prevent or manage behaviors that are expected to cause serious harm to self or others if not addressed or that may be a felony (e.g., aggression or self injury causing bleeding or broken bones, fire setting behavior, sexual behavior with a minor or incompetent/non-consenting adult, felony theft, felony possession of drugs, dealing drugs). |
| ☐ | ☐ | Requires a highly structured environment with specially trained staff to prevent or manage behaviors that are imminently life threatening (e.g., suicidal, homicidal, sexual assaults). |
| Notes (if applicable): | | |

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| O. Safety Supports in Home and Community | | |
|---|---|---|
| Yes | No | |
| ☐ | ☐ | Has stairs within home and requires hands on assistance or close supervision to use stairs. Describe: |
| ☐ | ☐ | Requires support to regulate water temperature.<br>Describe: |
| ☐ | ☐ | Requires support to prepare meals (e.g. cutting food items, following recipes correctly, etc.) Describe: |
| ☐ | ☐ | Requires support to get dressed appropriately for weather conditions (e.g. cold temperatures, rainy, etc.) Describe: |
| ☐ | ☐ | Requires cueing or prompting to remember to complete activities of daily living (e.g. eating, bathing, etc.) Describe: |
| ☐ | ☐ | Requires close supervision due to risk of wandering away or elopement. Describe: |
| ☐ | ☐ | Requires support due to inability to make safe choices when at home (e.g. not putting metal in microwave or toaster, not opening door to strangers, forgetting to turn off stove, remembering to put leftovers in the refrigerator, etc.).<br>Describe: |
| ☐ | ☐ | Requires support to prevent victimization in the home or community. Describe: |
| ☐ | ☐ | Requires Trauma Informed Supports due to past trauma or known triggers. Describe: |
| ☐ | ☐ | Requires support due to inability to make safe choices when in the community (e.g. crossing street safely, refusing ride from a stranger, etc.) Describe: |
| ☐ | ☐ | Requires support to evacuate home in event of fire. Describe: |
| ☐ | ☐ | Requires support to access help in emergencies. Describe: |
| ☐ | ☐ | Requires support because home is not accessible to meet needs. Describe: |
| ☐ | ☐ | Requires support or assistance because of other safety concerns within the home or community that could put the person at risk (unsanitary/unsafe housing, unsafe neighborhood, caregiver stress, aging caregiver(s), service refusal/interfering, social isolation, etc.).<br>Describe: |
| ☐ | ☐ | Requires support to develop or maintain Emergency Preparedness Plans (Supports to develop personalized plan, i.e. Special Needs Registry or other community resources). |
| ☐ | ☐ | individual is sexually active. If yes, is individual aware of safe sex practices? ☐ Yes ☐ No |
| ☐ | ☐ | Individual has minor child(ren) living with them. If yes, is individual able to provide care for them independently? ☐ Yes ☐ No |
| ☐ | ☐ | Individual has pet(s). If yes, is individual able to provide care for them independently? ☐ Yes ☐ No |
| ☐ | ☐ | Requires someone to be awake and/or available at night to ensure health/safety. Describe: |

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| | | |
|---|---|---|
| ☐ | ☐ | Requires periodic supports or safety checks at night. Describe: |
| ☐ | ☐ | Requires constant monitoring at night. ("Constant Monitoring" is defined as someone awake and continually attentive to the individual's needs throughout the night.) Describe: |

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Does this person require 24 hour supervision to ensure safety? ☐ Yes ☐ No

If "no", how many hours at one time can this person typically be safely left

- alone in the house or residence, with no other adults at home? _____Hours.
- alone in the community or other setting away from the home? _____ Hours.

If precautions need to be taken to ensure safety when left alone, describe:

P. Abuse, Neglect, and Exploitation Risk

| Yes | No | |
|---|---|---|
| ☐ | ☐ | Requires support because member is unable to avoid being taken advantage of financially (e.g. not giving money to strangers, not being able to count change correctly, not giving out personal financial information to strangers, etc.) |
| ☐ | ☐ | Requires support because member is unable to avoid being taken advantage of from strangers (e.g. refusing rides, non-consensual sexual contact). |
| ☐ | ☐ | Requires support because member is unable to avoid being taken advantage of by family members (e.g. emotional/psychological abuse, physical abuse, financial abuse). |
| ☐ | ☐ | Requires support because member is unable to avoid being neglected (e.g. caregiver or natural support fails to provide caregiver assistance) |
| ☐ | ☐ | Requires support because member is unable to avoid self-neglect (e.g. forgetting to complete health and safety related tasks, forgetting to report abuse by others, etc.) |

Notes (If Applicable):

Q. Alcohol and Drug Use

| Yes | No | |
|---|---|---|
| ☐ | ☐ | Member has a known history of excessive alcohol use. |
| ☐ | ☐ | Member has a known history of illegal drug use. |
| ☐ | ☐ | Member has a known history of abusing prescription medications. |
| ☐ | ☐ | Member has been in alcohol or drug treatment in the past. |
| ☐ | ☐ | Member may benefit from alcohol or drug treatment now. |
| ☐ | ☐ | Member may benefit from mental health therapy now. |
| ☐ | ☐ | Member is aware of the potential effects of alcohol or drug use on their TBI |

Notes (If Applicable):

R. Criminal History

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| Yes | No | |
|---|---|---|
| ☐ | ☐ | None. Member has never been charged or convicted of a misdemeanor or felony charge of any kind. |
| ☐ | ☐ | Member has been arrested but not convicted of a crime(s). |
| ☐ | ☐ | Member has been arrested and convicted of a misdemeanor. If yes, describe (e.g. domestic violence, drug, DUI, etc.): |
| ☐ | ☐ | Member has been arrested and convicted of a felony. If yes, describe (e.g. domestic violence, drug, DUI, etc.): |
| ☐ | ☐ | Unknown |
| Notes (If Applicable): | | |



| S. If Participant is not Connected to a Primary Care Provider (PCP) (If Applicable) | |
|---|---|
| ☐ Applicable ☐ Not Applicable | |
| Why is the participant not connected to a PCP? (Select all that apply) | |
| ☐ | Needs new provider |
| ☐ | Assistance needed to identify new provider |
| ☐ | Afraid |
| ☐ | Declines service |
| ☐ | Transportation |
| ☐ | Insurance |
| ☐ | Other (provide explanation): |

| T. Resources Provided to Address Barriers Identified in Section S. (If Applicable) | |
|---|---|
| ☐ Applicable ☐ Not Applicable | |
| Resources provided (Select all that apply) | |
| ☐ | CC connected member to CCNC through Carolina Access |
| ☐ | CC provided Medicaid PCP list |
| ☐ | CC will submit request for Community Navigator (to assist member complete new patient paperwork) |

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| | |
|---|---|
| ☐ | Other (provide explanation): |