WellSky Human Services

Participant Assessment/Form 6-month

An asterisk (*) indicates a required field

*Participant Name: _____ *DOB: _____

Review: As needed *Worker: _____

*Review Date: _____ *Assessment/Form Status:

Open/Close: LTSS **State Agency/Program:** BHDDH/IDD/HCBS

Contact Form

*Attempted Contact Outcome:
(If contact is unsuccessful,
complete section 1 and 5 only)

*Type of Contact: 6-month

*Opt Out of Monthly Contacts:

Section 1: General Information

1. *Date of Contact: _____
2. *Person(s) Contacted Type:
3. *Person Contacted Name: _____

4. *Duration of contact: _____

5. If completed by someone other than the assigned case manager, please explain:

Section 2: Person-Centered Plan

1. *Are services, supports, and resources being delivered according to your person-centered plan?

    a. If no, please explain:

2. *Are you satisfied with your service providers?

    a. If no, please explain:

3. *Are there services you would like to change, add or remove from your person-centered plan?

    a. If yes, please explain:

Section 3: Health and Safety

1. *Have there been any changes to your health, functional capacity, social or physical environment, or support system since our last contact?

    a. If yes, please explain:

2. *Have you visited a physician, urgent care, emergency room or been hospitalized since our last discussion?

    a. If yes, please explain:

3. *Has anything happened that has made you feel unsafe at home, in your neighborhood, at work/day program, or during a community activity?

    a. If yes, please explain:

4. *Have you felt down or lost interest in doing things?

    a. If yes, please explain:

5. *Have you encountered any additional difficulties or improvements in your daily activities?

    a. If yes, please explain:

6. *Do you have access to food and resources in needed (i.e., are you eating regularly)?

    a. If no, please explain:

7. *Has there been any changes to your emergency plans?

a. If yes, please explain:

Section 4: Goals

1. *Are you making progress towards goals?

    a. If not met, please explain:

Section 5: Continuity and Stability with Living Arrangement

1. *Do you like where you live?

    a. If no, please explain:

2. *Can you have snacks/food when you like?

    a. If no, please explain:

3. *Do you need anything to stay in your home (e.g., equipment to get around)?

    a. If yes, please explain:

Section 6: Community Connections

1. *What have you been doing outside the home/in the community in the past few months?

2. *Do you like the things you are currently doing in the community?

    a. If no, please explain:

3. *Do you decide, or with necessary support decide, the community activities you do and with whom you do them (including people you do not live with)?

    a. If no, please explain:

4. *Are there things you are doing now that you would like to do more often, and/or things you are not doing now that you like to do?

    a. If yes, please explain:

Section 7: Employment

1. *If you are not working now, are you interested in work?

    a. If yes, is a referral needed for employment services?

    b. If yes, please explain:

2. *If you are working now, would you like to explore ways to further your career goals, employment goals, or work more hours?

    a. If yes, are you currently working with a supported employment provider?

        i. If yes, is that provider able to supply you with the employment services you need?

i. If no, do you want a referral?

b. Comments:

3. *Have you had any changes to your employment status?

   a. If yes, what are the changes?

      i. If increase/decrease in pay, increase/decrease in hours, new job, or job loss, have you reported this change to Medicaid and/or DHS, BHDDH, or another agency?

      ii. If job loss, is a referral needed for employment services?

      iii. For any answer: please explain:

   b. If no, do you need assistance with reporting?

Section 8: Participant Satisfaction and Rights

1. *Are your caregivers or providers treating you with dignity and respect?

   a. If no, please explain:

2. *Are providers listening to you and your needs?

   a. If no, please explain:

3. *Are you satisfied with your services?

    a. If no, please explain:

4. *Are you pleased with the way your life is going?

    a. If no, please explain:

Section 9: Closing Question

1. *Is there anything else you would like me to know right now, or anything else you need assistance with?

    a. If yes, please explain:

Section 10: Questions to be Answered by the Case Manger

1. *The participant's place of residence appears to be safe.

    a. If no, please explain:

2. * (For participants under self-direction): Will the current rate of budget expenditure allow services to continue as needed through the entire plan term?

    a. If no, please explain:

Section 11: Contact Summary and Required Follow-up

Contact Comments / Additional Notes: