NAME OF PERSON APPLYING FOR HSW: _____

MEDICAID ID # _____ DATE OF BIRTH: _____

PERSON'S ADDRESS: _____

DEVELOPMENTAL DISABILITY: _____ DATE OF ONSET OF DD:_____

COMPLETED BY: _____ DATE: _____

PERFORMANCE ON AREAS OF MAJOR LIFE ACTIVITY-

0. **INDEPENDENT** - No help or oversight - or- Help/oversight provided only 1 or 2 times during the last 7 days.
1. **SUPERVISION** - Oversight, encouragement or cuing provided 3+ times during last 7 days - OR - Supervision plus physical assistance provided only 1 or 2 times during last 7 days**.**
2. **LIMITED ASSISTANCE** - Resident highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3+ times - or- More help provided only 1 or 2 times during last 7 days.
3. **EXTENSIVE ASSISTANCE** - While resident performed part of activity, over last 7 day period, help of following type(s) provided 3 or more times:
    - Weight Bearing Support
    - Full staff performance during part (but not all) of last 7 days.
4. **TOTAL DEPENDENCE -** Full staff performance of activity during entire 7 days.

**** Specify any devices or equipment needed for any area of major life activity in the space below each description and indicate performance (0-4 as described above) in the box to the right of each activity..**

a.	**BED MOBILITY**	**How person moves to and from lying position, turns side-to-side, and positions body while in bed**	
b.	**TRANSFER**	**How person moves between surfaces B to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)**	
c.	**DRESSING**	**How person puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis**	
d.	**EATING**	**How person eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)**	
e.	**TOILET USE**	**How person uses the toilet room (or commode, bedpan, urinal), transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes**	
f.	**PERSONAL HYGIENE**	**How person maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands and perineum (EXCLUDE baths and showers)**	
g.	**BATHING**	**How person takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower.**	

h.	**RECEPTIVE & EXPRESSIVE LANGUAGE**	**How person communicates with others to express his desires and needs, including understanding verbal, pictorial, or written communication. Specify any devices used to communicate:**	
i.	**LEARNING**	**How person learns new information, generalizes what he has learned to new situations. If there is a diagnosis of Intellectual disability, please specify below:**	
j.	**MOBILITY**	**How person moves between locations on even surfaces. If in wheelchair, self-sufficient once in chair. Specify any mobility devices used:**	
k.	**SELF-DIRECTION**	**How person directs his own life. If there is a guardian, please specify the areas in which person continues to make decisions.**	
l.	**CAPACITY FOR INDEPENDENT LIVING**	**How person manages a household and schedule, including financial affairs (e.g., bill paying, money management), domestic responsibility (e.g., housekeeping, chores, maintenance), nutritional status (e.g., menu planning, shopping, cooking), arranging transportation if applicable, medication management and managing own health status.**	
m.	**ECONOMIC SELF-SUFFICIENCY**	**How person is employed and whether his income is sufficient to support himself. If working toward economic self-sufficiency, when does person expect to achieve this?**	

1. Describe any behavioral issues and the approaches agreed to during person-centered planning or attach supporting documentation with this area highlighted.

2. Describe any health issues and the approaches agreed to during person-centered planning or attach supporting documentation with this area highlighted.

3. Please enclose the following documentation:
   Signed HSW Certification Form
   Copy of the Individual Plan of Services.
   Any other pertinent information related to services, treatment, or supports needed by the person.