Identifying Information

Name: Case #:

Address: DOB:

Assessment Date: Placement Date (if applicable):

Natural and Community Supports

Does the consumer have natural supports assisting them with community living activities and personal care?

☐ Yes ☐ No

If yes, who are these natural supports? (Complete the CLS Net Service Analysis Map w/ consumer to determine needed coverage)

Indicate the hours per week the consumer's natural supports are providing assistance:

Does the consumer have community supports assisting them with community living activities and personal care?

☐ Yes ☐ No

If yes, who are these community supports?

Indicate the hours per week the consumer's community supports are providing assistance:

Does the consumer participate in school, work, volunteer in an independent setting (without paid supports), or attend a community activity center?

☐ Yes ☐ No

If yes, what are these activities?

Indicate the hours per week the consumer participates in these activities:

Adult Home Help

Has the consumer been assessed for Adult Home Help? (required if CLS services are requested)

☐ Yes ☐ No ☐ Assessment Requested

Approved Adult Home Help Hours per month: Estimated AHH Hours Per Week: 0.00

Additional information regarding Adult Home Help hours, if any:

Provider of Adult Home Help:

Identifying Information

Name: Case #:

Community Living Support (CLS)/ Personal Care Assessment of Functioning

This assessment is part of a process to determine medical necessity for CLS services. **Place an 'X' in the box** that corresponds to the consumer's current level of functioning (while using any adaptive equipment and/or service animal assistance).

These needs should be reflected in the consumer's plan of service goals, objectives and interventions.

1 = Independent 2 = Needs verbal direction 3 = Needs some assistance 4 = Needs much assistance 5 = Dependent
N/A = Not applicable or not age appropriate

Personal Care Needs	1	2	3	4	5	N/A
Eating/Feeding	0.00	6.00	8.00	10.00	12.00	0.00
Toileting	0.00	10.00	12.67	15.33	18.00	0.00
Bathing	0.00	5.00	5.67	6.33	7.00	0.00
Dressing	0.00	2.00	2.67	3.33	4.00	0.00
Grooming	0.00	6.00	7.33	8.67	10.00	0.00
Transferring	0.00	10.00	13.33	16.67	20.00	0.00
Ambulation/Mobility	0.00	5.00	8.33	11.67	15.00	0.00
Taking Medication	0.00	1.00	1.83	2.67	3.50	0.00

Personal Care Hrs/Wk
0

Community Living Support Needs	1	2	3	4	5	N/A
Meal Preparation	0.00	10.00	11.67	13.33	15.00	0.00
Laundry	0.00	1.00	1.67	2.33	3.00	0.00
Housekeeping	0.00	6.00	6.67	7.33	8.00	0.00
Shopping	0.00	1.00	1.67	2.33	3.00	0.00
Money Management	0.00	0.50	0.83	1.17	1.50	0.00
Socialization/Relationship Building	0.00	1.00	1.67	2.33	3.00	0.00
Community/Recreation Activities	0.00	3.00	3.67	4.33	5.00	0.00
Attendance at Medical Appointment	0.00	0.50	0.83	1.17	1.50	0.00
Community/In-Home Safety	0.00	6.00	7.33	8.67	10.00	0.00
Preventing Self-Harm	0.00	6.00	7.33	8.67	10.00	0.00
Preventing Harm to Others	0.00	6.00	7.33	8.67	10.00	0.00

Comm. Living Supp. Hrs/Wk
0

Total Assessed PC/CLS Hours Per Week	0.00
Less Natural Supports Hours	0.00
Less Community Supports Hours	0.00
Less Community Activity Hours	0.00
Less Adult Home Help Hours (estimate per week)	0.00
Potential PC/CLS Hours Per Week	**0.00**

Identifying Information

Name: Case #:

Additional PC/CLS Information

How many of the **Potential PC/CLS Hours Per Week** is the consumer seeking to cover with PC/CLS hours? Which of the **Personal Care Needs** and **Community Living Support Needs** does the consumer want PC/CLS to address?

Are there any other clinical circumstances or considerations of note?

Signature of Assessor

Completed by: Signature Date:

Supervisory Approval: Signature Date:

Review Committee Recommendation(s):

Committee Review Date: