# NC Medicaid 1915(i) Assessment[[1]](#footnote-2)

|  |  |
| --- | --- |
| Name |  |
| MID |  |
| DOB |  |
| Relevant Diagnosis(es) (optional) |  |
| Requires Treatment Service(s) for:  *Select All that Apply* | I/DD  TBI  SMI  SED  SUD |
| Care Manager/ Agency |  |
| Tailored Plan/ LME-MCO |  |

Beneficiary reports/assessor has identified a need for services based on beneficiary having at least one functional deficit below:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Assistance Needed**  **None** | **Assistance Needed**  **Some** | **Assistance Needed**  **Total** | **Comments (e.g., who assists, equipment used, problems or issues for caregivers, type of assistance needed)** |
| **Activities of Daily Living** |  |  |  |  |
| Ambulation |  |  |  |  |
| Bathing |  |  |  |  |
| Dressing |  |  |  |  |
| Eating |  |  |  |  |
| Grooming |  |  |  |  |
| Toileting |  |  |  |  |
| Transfer |  |  |  |  |
| * To from bed |  |  |  |  |
| * To from car |  |  |  |  |
|  |  |  |  |  |
| **Instrumental Activities** |  |  |  |  |
| Home maintenance |  |  |  |  |
| Housekeeping |  |  |  |  |
| Laundry |  |  |  |  |
| Meal Prep |  |  |  |  |
| Money Management |  |  |  |  |
| Shopping/errands |  |  |  |  |
| Transportation |  |  |  |  |
| * Use of |  |  |  |  |
| * Scheduling |  |  |  |  |
|  |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Assistance Needed**  **None** | **Assistance Needed**  **Some** | **Assistance Needed**  **Total** | **Comments (e.g., who assists, equipment used, problems or issues for caregivers, type of assistance needed)** |
| **Social and Work** |  |  |  |  |
| **Interacting with others** |  |  |  |  |
| **Responding to negative feedback** |  |  |  |  |
| **Responding to change** |  |  |  |  |
| **Screening out environmental stimuli** |  |  |  |  |
| **Maintaining stamina** |  |  |  |  |
| **Handling time pressures and multiple tasks** |  |  |  |  |
| Ability to learn new tasks |  |  |  |  |
| Acceptable speed of completing tasks |  |  |  |  |
|  |  |  |  |  |
| **Cognitive/Behavior** |  |  |  |  |
| Speech/ Language/ Communication |  |  |  |  |
| Self-Direction |  |  |  |  |
| Social Development |  |  |  |  |
| Learning |  |  |  |  |
| Vocational Development |  |  |  |  |
| Maladaptive Behavior |  |  |  |  |
| Psychosis/ Hallucinations |  |  |  |  |
| Mild Memory Loss |  |  |  |  |
| Moderate Memory Loss |  |  |  |  |
|  |  |  |  |  |
| **Other:** |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Does the individual require support to manage a medical or health condition?  Yes  No

Comment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the individual need support to acquire or maintain employment?  Yes  No

Comment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the primary caregiver in need of respite?  Yes  No

Comment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the individual in need of rehabilitative/habilitative service for ADLs/IADLs/Social Skills/Employment Skills/etc.?  Yes  No

Comment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Living Arrangement (i.e., At home w/ Family, Group Home, ACH, etc.):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there plans for the individual to move to an independent living arrangement within the next 60 days?

Yes  No

Comment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Beneficiary requests the following services (please check all that apply):

Community Transition

Respite

Individual and Transitional Supports

Community Living Supports

Supported Employment/Individual Placement Supports

Beneficiary does not meet Target Population for any of the above services.

Signature of Assessor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name of Assessor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. As required for 1915(i) per 42 CFR § 441.720. [↑](#footnote-ref-2)