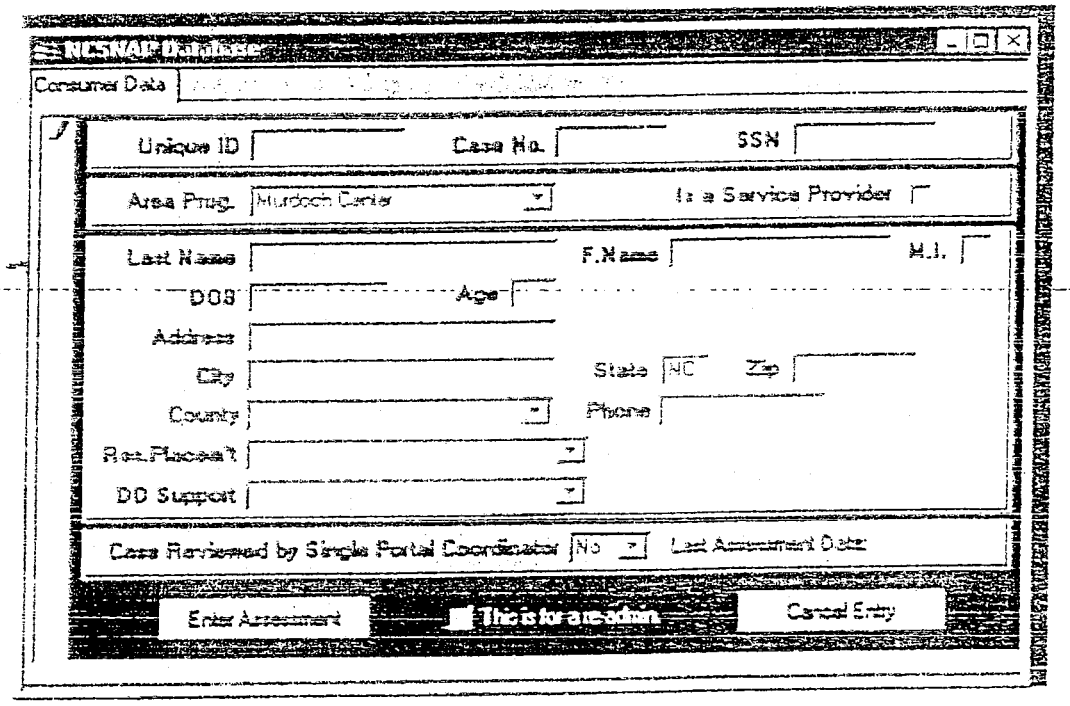
Once you have completed entering examiner information, put your cursor over the [X] button (this is in the upper right hand section of your window) and press your left mouse key to exit this screen.

Note: An examiner must be entered in this section first before you can enter in a NC-SNAP completed by that examiner.

Note: Each Area Program must enter this information for their certified examiners. After classes are completed, Instructors should ensure that MRC Outreach enters this information into its database, and then forward on to each Area Program a list containing this information for their certified examiners.

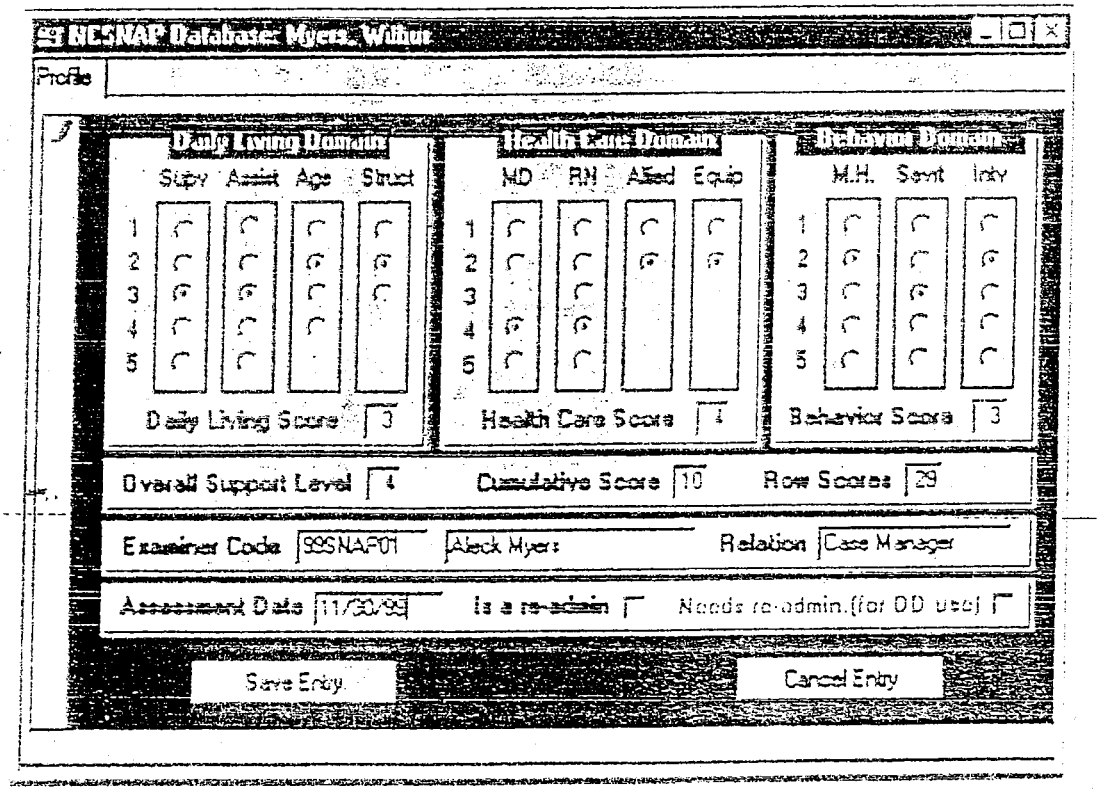
C. Entering a New *NC-SNAP* Consumer

To enter an individual's *NC-SNAP* data for the first time, press the *Add New Consumer* button at the Main Menu.



Using the *NC-SNAP* Database Coversheet and page one of the *NC-SNAP*, complete the Consumer Data form on the computer screen. You must enter all of the information before you are allowed to proceed to the assessment data [the only exceptions are "Case No." and "M.I." (middle initial) which are optional but should be entered if available]. Use the drop down menus by pressing the down arrow to complete the Area Program, County, Residential Placement, and DD Support information.

Once you enter the information, place the cursor over the Enter Assessment button and press the left mouse button. You should now see the Profile page:



- To enter the assessment profile data place the cursor over the button in each column that corresponds with the scores marked on the *NC-SNAP* page one Profile and press the left mouse key.

- You must enter the Examiner Code, Relation, and Date of Assessment. Indicate if the *NC-SNAP* you are entering is a re-administration (i.e., scheduled as part of the Look-Behind Quality Assurance procedure--See Chapter 6). Once you have done this, put the cursor over the Save Entry button on the bottom of the form and press the left mouse button.

- If at any time you make an error or simply want to get out of this screen without saving your work, put the cursor over the Cancel button and press the left mouse key.

D. Entering an Additional Administration of the *NC-SNAP* for an Existing Consumer

To enter new *NC-SNAP* data for an individual who already has data in the database, press the Add Assessment button at the Main Menu.

Add Assessment button

- This enables you to enter new *NC-SNAP* data (a subsequent assessment) without having to re-enter all of the consumer information.

- First, select the appropriate record from the list of existing entries. Note that this list can be sorted by selecting the desired column and then pressing up-or-down-arrow button on the toolbar to the right. This makes finding the record much easier.
- After selecting the appropriate record, press the "Enter Assessment" button.
- Finally, enter the NC-SNAP profile information.
- Note that you will have to enter the examiner's number.
- After entering the profile information, go to "Edit/View Data" (see below) to ensure that the Consumer Data is still accurate (revise as needed if changes have occurred since the last entry).

E. Editing/Viewing Data

To view existing consumer information and profiles, or to edit information, press the Edit/View Data button at the Main Menu.

In this section you will be able to view and/or edit consumer information or *NC-SNAP* profile data.

- To do this, press the Edit/View Data button.
- You will see a list of consumers to choose from.
- Select the person whose information you wish to view or edit. Note that this list can be sorted by selecting the desired column and then pressing up-or-down-arrow button on the toolbar to the right. This makes finding the record much easier.

- Press the Consumer Data button.
- You can make changes by simply entering in the corrections.

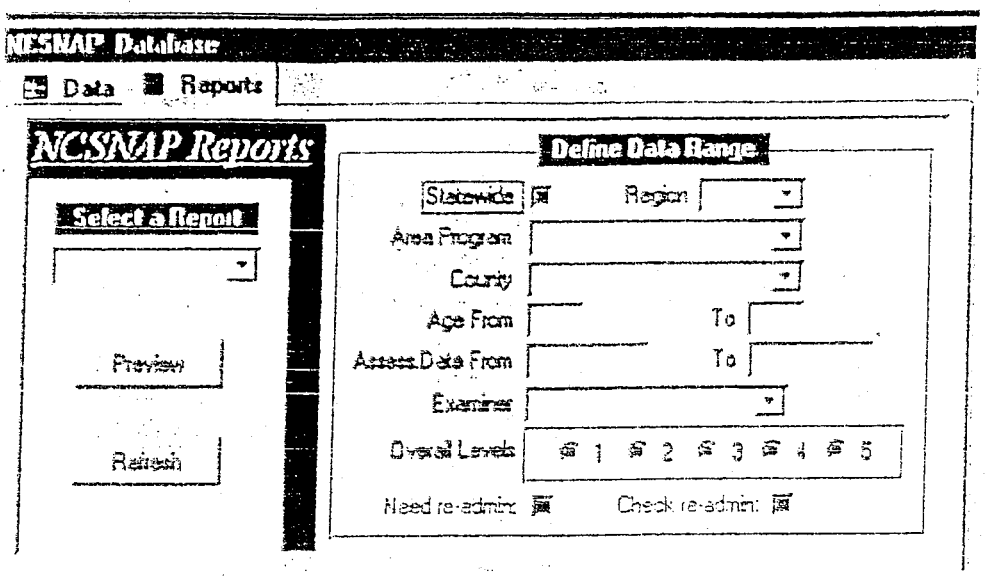
To view the *NC-SNAP* profile for this person, press the Assessments button. You should now see a list of all *NC-SNAP* profiles saved for this person.

- Select the assessment date your wish to view or edit.
- Press the Assessment Profile button.
- You can make changes by simply entering in the corrections.
- Press the Consumer List or Consumer Data button.
- Next press the Main Menu button to return to the Main Menu.

Note: These procedures can only be applied to revisions to current (untransmitted) information. After submission to the database server, NC-SNAP data can only be changed by the NC-SNAP researchers (contact Aleck Myers).

F. Generating Reports

To retrieve information on individuals from your agency entered into your local database, go back to the Main Menu and select the folder tab marked "*Reports.*" You can retrieve a report on all of your data by going to the section *Select a Report*.



Reports included are:

1. Consumer List: a complete listing of all persons entered
2. Age Group: a complete listing of all consumers by age groups (0 - 1, 2 – 6, 7 – 15, 16 - ___) and their corresponding scores
3. County: a complete listing of consumers and their overall scores by county
4. Overall Levels: a complete listing of all consumers and their overall scores
5. Re-Admin: a listing of cases selected for *NC-SNAP* re-administration.
6. Class Sheet: a pre-class list that can be printed to facilitate assignment of certification numbers. (See Section G)
7. DD Report: this is where an area program submits the data they have entered to the DD Section. Data must be submitted monthly. (See Section H)

If you would like to specify certain criteria prior to generating your report, you may do so by entering the criteria in the Define Data Range section. You can complete only one section or you may complete any combination of sections to limit your report. Below is a description of each section:

1. Assess. Date: you can enter a start date and end date to limit the number of records.
2. Age: you can specify a particular age range (0-1, 2-6, 7-15, 16-__).
3. County: allows you to limit your report to a certain county of responsibility
4. Examiner: allows you to limit your report to a specific examiner
5. Overall Levels: allows you to limit your report to a specific level(s).

➢ Note: To clear criteria from the screen, press the Refresh button.

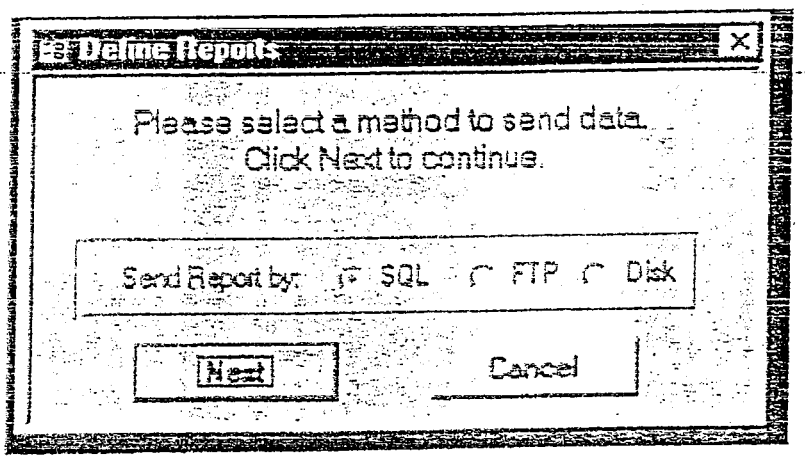
G. Instructor Class Preparation Report

To print a pre-class listing of unused certification numbers on a class sign-up sheet, select the "Instructor Class Preparation Report Form" from the Main Menu. After students sign up on this form, and successfully pass the course, you may verbally tell them their certification number and then enter their name and number into the database (see Section II above). [NOTE: The *NC-SNAP* authors will mail instructors the Examiners' Certification Cards within 2 weeks of data transmission.]

H. Sending Data to the Data Managers

- *Note: Transmit data only once each day. Repeat same-day transmissions are hard on the server. If for some reason a transmission attempt fails, you can continue to try to send data the same day.*
- *Note: If you attempt to send data via SQL or FTP but are unable to for some reason, continue trying that day. However, if you are still unable to accomplish this by the end of the day, save the data to a diskette that can be mailed in. [Once the attempt is made, your local computer will treat the data as sent and will not transmit the data the next day. This should rarely be a problem, but the data diskette will need to be mailed to Raleigh (see address below) for the server to acquire the data.]*

After finishing the data entry, return to the main menu. Select the "Report" tab. Under "Select a Report," select "DD Report." Then select one of the three options in the "Define Reports" window.



- *Note:* *Always select "SQL"* *(unless the option is unavailable).* This option allows data to be transmitted directly to the statewide server.

- If "SQL" is not an option (i.e., your internet connection does not permit it), select *"FTP."* This option will allow you to send a data file to Raleigh, where it will be stored until a staff member downloads it into the statewide server.

- Use the *"Disk"* option *only* when neither the "SQL" nor the "FTP" options are operational (e.g., you have no internet access). This option will download your data file to a floppy disk, which you must mail to Raleigh at the end of each calendar month (we recommend that you keep a backup diskette). The staff member in Raleigh will then download the data file into the server. If you must use this option, mail the diskette to :

  Vannia Cotti, DD Section
  3006 Mail Service Center
  Raleigh, NC 27699-3006

- The SQL and FTP options both specify a URL. The URL is the address where the data reports are sent. Do not change it unless you receive a notice from the central office in Raleigh.

- For all these options, the "login ID" is **ncsnapuser** (all lowercase). For the "password" use **ncsnap2000** (all lowercase).

- Whichever method of data transfer is used, a confirmation window will pop up to notify you that your records were successfully transferred.

I. Other

1. **Individual's Unique ID No.:** If unknown, this may be created by listing the first three letters of the person's last name, then the person's first initial, and then a six-digit number representing the person's birth date (2 digits for month, 2 digits for day, 2 digits for year). E.g., Tom Miller, born March 6, 1963 = MILT030663. If more than one person has an identical ID, the program will prompt the addition of a letter at the end of the ID (e.g., MILT030663A for Tom's twin sister Teri).

2. If you run into problems, contact one of these persons:

   Aleck Myers (919) 575-7742 aleck.myers@ncmail.net

   Rod Realon (919) 575-7913 rod.realon@ncmail.net

3. For program technical support, contact:

   Han Di (919) 733-4460 han.di@ncmail.net

4. **About Installation:**

   System Requirements:

   Microsoft Windows 95® or 98®. Pentium 200 MH or better CPU with 32 MB of memory recommended. An internet connection is needed for the program to send data to the central database directly. If you do not have an internet connection, you will need to store your data on a 3.5" diskette and mail it in monthly.

   Microsoft Access97® is not required to run the NCSNAP program. The Setup program installs an Access97® Runtime version program for NCSNAP to operate. However, you can run NCSNAP directly on Access97® without using the Runtime version.

Troubleshooting:

Although the program and installation procedures have been tested repeatedly on different computers, errors may still occur. The most likely cause of errors in installation is that the .DLL or .OCX files in your Windows system are not compatible with the ones used or copied to your computer by the Setup program. If an error should occur during installation, please write down the entire error message and ask your system administrator for help. A very helpful source of information is the Microsoft Support Knowledge Base on the Microsoft webpage at the following location: http://support.microsoft.com/support/kb.

File Locations:

NCSNAP contains three Access97® database files:

- NCSNAP.MDE – This is the main program file.
- NCSNAP_DATA.MDB – This is the main user's data file including consumer, examiner, and assessment data.
- NCSNAP_REF.MDB – This file contains all reference data such as area program codes, county codes, and so on.

These files can be located on a local hard drive (e.g., C:) or on a network drive and shared. However, it is best to load the NCSNAP.MDE file on a local drive to reduce network traffic and improve performance. If more than one user and computer needs to access the program, the last two files can be copied to a network location and shared. The location of the data file can be set on the "Utilities/Agency Info" screen within the program. You can use long file names for the data file path.

NCSNAP also needs a file location for creating report files to be sent to the central office in Raleigh. This location is set on the "Utilities/Agency Info" screen as "DD Report Path." It can be the same as the data file path or be at a different location. However, due to the limitation on internet FTP connection and the program component used in NCSNAP, the file path cannot contain spaces between words. For example, "My Documents" will not be acceptable but "MyNCSNAPReports" will be.

Networking Issues:

The NCSNAP program can be installed on a local area network to be shared among multiple users.

1. Install all three components (DCOM95 – for Windows 95® only, MDAC, and NCSNAP) on users' computers. NCSNAP should be installed on the C:\ drive.
2. Copy NCSNAP_DATA.MDB and NCSNAP_REF.MDB from one computer to a network location to be shared. Give all users necessary rights to this area.
3. On each user's computer, run NCSNAP. Select Utilities/Agency Info. Enter the network location where the shared NCSNAP data files are located in the Data Path box. Restart the program.

Licensing Issues:

DCOM95: This component is required by Microsoft MDAC which is required by NCSNAP. DCOM95 extends the support for Distributed Component Object Model (DCOM) for Microsoft Windows 95®. Its licensing agreement can be found on the Microsft web site at:

http://www.microsoft.com/com/dcom/dcom95/eula.asp.

MDAC: Microsoft Data Access Components (MDAC) is required by NCSNAP to transmit data to the database server. Its licensing agreement can be found on the following site:

http://www.microsoft.com/data/eulamdac21.htm.

The NCSNAP program is created with Microsoft Access97®. It can be run either with Access97® or Access97® Runtime. Microsoft Access97® Runtime is a limited version of Access97® which can be redistributed with an Access97® database application software product, such as NCSNAP. The NCSNAP Setup program installs Access97® Runtime on the computer. For further details about the End User Licensing, please see the following page on the Microsoft web site:

http://msdn.microsoft.com/xml/IE4/License.asp.

Chapter 5

Other Systems and Responsibilities

I. The *NC-SNAP* will be administered for each individual in, or on the waiting list for, the state's Developmental Disabilities Service System:

- When an individual enters the DD Service System
- Annually
- Whenever there is a significant change in the individual's need profile

II. Administration of the *NC-SNAP*: The job classification primarily responsible for the administration of the *NC-SNAP* is the Case Manager. These individuals are typically familiar with persons served by the area programs' DD service system, while also serving as an advocate for the individual. There are situations, however, where the person does not have an assigned case manager. In these cases it is most likely that a knowledgeable QMRP/QDDP will need to administer the instrument. In any event, staff in the following categories must be trained and certified as examiners for the *NC-SNAP*:

- Case Manager (DD, Thomas S., "Responsible Therapist," etc.)
- Case Manager Supervisor
- DD Coordinator
- Regional DD Coordinator
- Single Portal Coordinator
- ICF/MR QMRP/QDDP (required when there is no independent case manager)

III. Training Responsibilities:

A. Training the Trainers: The *NC-SNAP* Researchers from Murdoch Center will train MRC Outreach and Staff Development staff to teach and certify examiners, and use the statewide database program. They will also provide the following:

- Training videotapes
- Examiner's Guides
- Instructor's Manuals, including instructions for the class and for data entry procedures
- Database Software for statewide data collection
- Sampling of training classes
- Sampling of area programs', MRC Staff Development programs', MRC Outreach programs' database/record systems
- Database maintenance
- Regular reports and custom reports upon request
- Troubleshooting and quality assurance

B. The DD Section will be responsible for:

- Storage and dissemination of *NC-SNAP* forms, Data Entry Worksheets, and Examiner Guides to MRCs and area programs.
- Database program support
- Quality assurance
- Oversight of compliance, protocols, procedures

C. The MRC Staff Development Departments will train all QMRPs at the MRC. They will also maintain the MRC certification databases.

D. The MRC Outreach Departments will train all Case Managers, DD Coordinators, Single Portal Coordinators, Regional Coordinators, and QDDPs in their region. [Note: The Area Program will be responsible for identifying those individuals requiring training, and getting them registered and to the training classes.] They will also maintain the Community certification database. Additionally, they will train at least one person from each area program to use the statewide database program.

E. The Area Program Director will identify those who require training, register them for classes, and ensure they attend. (This includes one person for database program training.)

F. Initial Timelines: Immediately following certification, Examiners should begin using the *NC-SNAP*. Priorities for assessment:

- Persons entering the DD service system (ongoing, effective immediately)
- DD Waiting List (should be completed by 5/31/00 for those currently receiving no services)
- All others currently receiving services (prior to annual planning meeting)

III. Materials Needed for Class:

Examiners' Class:

- A sufficient supply of NC-SNAP forms
- A sufficient supply of Data Entry Coversheets
- A sufficient supply of each Sample Case History (#1, #2, and #3)
- One *Examiner's Guide* for each student
- At least one *Instructor's Manual*
- The training video
- A good quality television and VCR
- *Optional:* Pre-printed "Class Preparation Form Report"

Data Entry Class:

- A suitable computer (laptop may be easiest)
- For a group, a data projector may be helpful
- The *NC-SNAP Statewide Database Program* CD
- Instructions for the database program (Chapter 4)

IV. Other: For questions, comments, suggestions, or problems, please contact one of the following *NC-SNAP* Researchers:

Aleck Myers	919-575-7742 aleck.myers@ncmail.net
Rod Realon	919-575-7913 rod.realon@ncmail.net
Tom Thompson	919-575-7913 tom.thompson@ncmail.net

V. Instructions for Database Coversheet: Once you have completed a *NC-SNAP* assessment you will need to complete the Database Coversheet. This should only take you a few minutes. However, ***you must record all of this information so that the data entry person can enter the NC-SNAP profile into the computer.*** There is only one entry on this form that is optional: *Consumer Case #* (this does not apply to everybody). **All other information must be completed.**

Note that for the question "Are there significant natural supports in place?," 'significant' refers to natural supports that if no longer available would still have to be provided. E.g., if an individual lives at home with his or her parents, and the parents became incapacitated, would new supports be a necessity? If yes, circle "yes" on the coversheet. A reduced copy of a completed coversheet is included in this chapter. Note that this coversheet may be updated from time to time.

Individual's Unique ID No.: If unknown, this may be created by listing the first three letters of the person's last name, then the person's first initial, and then a six-digit number representing the person's birth date (2 digits for month, 2 digits for day, 2 digits for year). E.g., Tom Miller, born March 6, 1963 = MILT030663. If more than one person has an identical ID, the program will prompt the addition of a letter at the end of the ID (e.g, MILT030663A for Tom's twin sister Teri).

North Carolina
Support Needs Assessment Profile
(NC-SNAP)

Database Coversheet

When administering the *NC-SNAP*, complete all sections of this form. Please print neatly! When finished, staple this form to the *NC-SNAP* and then turn it in to your designated data-entry person.

Individual's Name: Miller, Tom Social Security No.: 234-56-7890
Individual's Unique ID No.: MILT030663 Individual's Case #: 467890
Examiner's Name: Aleck Myers *NC-SNAP* Certification No.: 99YK9910
Area Program: VGFW Is Area Program a provider of services? Yes (No)
County: Granville Are there significant natural supports in place? Yes (No)

Individual's Type of Residential Placement: (Check only one)

___ Independent Living
XX Family Home
___ Foster Home
___ Nursing/Rest Home
___ Skilled Nursing Home
Supervised Living:
__ EduCare
__ RhA
__ Other (Specify:_____)
Alternative Family Living:
__ Medicaid
__ Other
___ Other Resid. Placement
(Specify: _____)

Group Home:
___ DDA
___ ICF (Specify:
___ State
___ RHA
___ VOCA
___ EduCare
___ Other
(Specify: _____)
___ MRBD
___ Other (Specify: _____)
Mental Retardation Center:
___ Black Mountain Center
___ Caswell Center
___ Murdoch Center
___ O'Berry Center
___ Western Carolina Center

Current DD System Support: (Check only one)

___ This is first contact
XX Waiting list (no services)
___ Waiting list (insufficient supports)
___ Just entering system (supports started)
___ Services est. & ongoing: (mark all that apply):
____ CAP ____ TBI
____ TANF ____ CBI
____ State ____ Other
____ Medicaid

Chapter 6

"Look Behind" Quality Assurance

Occasionally, Certified Examiners will be asked to re-administer an *NC-SNAP* for an individual who was recently assessed by another examiner. This is part of the quality assurance process in place to monitor the *NC-SNAP*. Although some of the same records and sources will be used in both administrations, the re-administration should be approached openly without regard to previous scores.

I. Re-Administration Responsibilities

A. *NC-SNAP* Researchers will identify individuals from the database for re-administration.

B. The community area program will re-administer the *NC-SNAP* for:

1. Five percent of the MRC residents

2. Five percent of the community-based individuals whose previous *NC-SNAP* was administered by a certified examiner who is involved in the provision of services.

C. MRC Outreach staff will administer the *NC-SNAP* for five percent of persons in community-based supports, with an emphasis placed on those who were previously assessed by a case manager from an area program that is a service provider.

D. The *NC-SNAP* Researchers will re-administer approximately one percent of all *NC-SNAP* assessments statewide.

II. Re-administration procedures: The responsible party (i.e., area program or MRC Outreach program) will be contacted by the *NC-SNAP* authors.

A. Monthly, the MRC Outreach Director will be provided a list of individuals for whom the *NC-SNAP* should be re-administered. The Outreach Director will delegate these to certified outreach examiners. Once assigned, the responsible person should contact the community area program case manager (who completed the first *NC-SNAP*) to determine who would be the best person to contact for an independent re-administration. Preferred contacts are (in order of preference):

1. Individual, parent, guardian
2. Non-employee of agency (area program or MRC) that conducted the previous *NC-SNAP* (for example, contract professional, day program employee, etc.)
3. Other employee (of agency that conducted the previous *NC-SNAP*)

B. Monthly, the Area Program DD Coordinator will be provided a list of people for whom the *NC-SNAP* should be re-administered. The DD Coordinator will then contact the QMRP or provider (QDDP) who administered the first *NC-SNAP* to determine who would be the best person to contact for an independent re-administration. Preferred contacts are the same as noted above.

C. **Guidelines for readministering an *NC-SNAP* by phone:** The following steps are provided as general instructions on how to conduct a phone interview to complete an *NC-SNAP* readministration. The examiner should feel free to use his or her "own style" of conversation.

1. When calling the contact person you plan to interview, begin by introducing yourself as a certified *NC-SNAP* examiner, and be prepared to offer your certification number and explain the purpose of the *NC-SNAP*. Explain your role in the process and where you work. Refer to the examiner who recently administered the *NC-SNAP* (you've probably recently talked to this examiner in order to get the contact person's name and number; hopefully that examiner also called the contact person to tell them you would call).

2. If the contact person expresses reluctance to participate, don't press the issue. Thank them for their time and re-contact the original examiner to identify another contact.

3. In obtaining information needed to complete the *NC-SNAP* it is usually best to begin by asking general questions, saving specific questions for later if some areas aren't answered. **Do not** read the items from the *NC-SNAP* and ask the contact person to make a choice. Instead, ask for general information such as:

"Tell me about how _____ cares for him/herself."
"Does _____ require someone to help care for him/her?"
"What kind of health services does _____ need?"
"Does _____ have any behavior concerns?"

After obtaining general information, ask more specific questions about unanswered items, such as:

"Does _____ require nighttime supervision?"
"Can _____ stay by him/herself?"
"If so, when and for how long?"
"How many times in the past year did _____ need to visit a physician?"
"How often does someone need to repair or maintain _____'s wheelchair?"

Continue to ask increasingly specific questions until you have all of the information needed to complete the *NC-SNAP*. If you cannot obtain sufficient information to score a particular item, ask the contact person how you may acquire the information. If necessary, re-contact the original examiner to seek further assistance.

Don't forget to thank the contact person!

Chapter 7

Reliability and Validity of the *NC-SNAP*

During its development, the *NC-SNAP* was field-tested on two separate occasions. In 1997, an earlier version of the *NC-SNAP* was compared to two other assessment instruments to determine which of the three most accurately assessed level of intensity of need for North Carolina's citizens with developmental disabilities. In 1998, after being selected as North Carolina's most probable choice, the *NC-SNAP* underwent revision to maximize its effectiveness. Following this revision, the *NC-SNAP* was examined in a final field test in 1999 to ensure that its reliability and validity were sufficient to be confidently used as a statewide assessment tool.

This chapter presents a brief overview of the design and pertinent data gathered from these field tests. A more extensive report is in preparation for publication. Additionally, extensive data will be collected as the *NC-SNAP* is implemented statewide. As updated reports become available, this chapter may be expanded.

1997 Field Test

Design

In order to test if an assessment instrument could predict the level of intensity of support need, the authors selected participants who currently received good or ideal supports. We categorized the level of support intensity those participants received. Assessment instruments, if accurate, should predict

the level of supports being received by the participants. Therefore, the process had three steps:

1. Find individuals with developmental disabilities who were well served

2. Determine the participating individual's current support array level

3. Administer the three assessment instruments

1. Find individuals who were well served

Five area programs agreed to participate. In all, 2,332 persons receiving services and supports were identified. In order to determine whether each individual was well served, a five-point survey was administered to the individual (or guardian), his or her case manager, and his or her service provider. An individual was identified for participation when all three sources agreed he or she was receiving either good (better than adequate) or ideal services. Of the 2,332 people, 559 or 24 percent were identified as participants.

2. Determine the participating person's current support array level

Next, case managers were asked to identify the support array received by each person for whom they had responsibility. To do this, both residential and other types of supports were described. Using this information, each participant was independently assigned to one of five support array levels.

Three independent raters achieved an agreement level of 98% with regard to the assigned levels.

3. Administer the three assessment instruments

Training sessions were conducted in each area program and at three mental retardation centers. During these sessions, case managers (or Qualified Mental Retardation Professionals) were trained to complete the instruments for participants on their caseload. As an additional control procedure, an author or a research assistant interviewed a second person familiar with the participant to complete an inter-rater reliability assessment.

Results

A. Research Question 1: How well does the *NC-SNAP* predict current "good" or "ideal" support arrays?

1. Percent Exact Match (between assessment result and assigned support array):
   NC-SNAP: 30.4

2. Percent Match Within One Level
   NC-SNAP: 68.7

B. Research Question 2: What is the inter-rater reliability of the *NC-SNAP*?

1. Percent Exact Match Inter-rater Agreement
   NC-SNAP: 70.7

2. Percent Inter-rater Agreement Within One Level
   NC-SNAP: 98.3

C. Other factors

1. Mean duration of the *NC-SNAP*: 15 minutes (range: 2 – 45)

2. *NC-SNAP* performed best with individuals with high needs.

3. *NC-SNAP* tended to overestimate need.

1999 Field Test

Design

Following the first field test, the *NC-SNAP* was judged to be approximately equal, across all variables, in effectiveness to the next best alternative instrument. At that time, the authors of the *NC-SNAP* were asked by North Carolina's Developmental Disability Policy Advisory Work Group to conduct a comprehensive analysis of the instrument, using the field test data, with the goal of maximizing the validity and reliability of the *NC-SNAP* through careful revision. In brief, the *NC-SNAP* was modified by identifying items associated with errors in predictive validity, and then eliminating or modifying those items to enhance accuracy.

Following this analysis, the re-tooled *NC-SNAP* was field tested in one area program, using a stratified sample (N = 100). The design of this second field test was almost identical to the 1997 field test, with the exception that an additional analysis was conducted to identify errors in support array level determination. Results were analyzed based on both the original assigned support array and on a "corrected" support

array. That is, the support array was corrected if additional information was obtained indicating that the original support array had been determined using incomplete or erroneous information, or if a change in the individual's status had occurred since the support array was originally determined.

Results

1. Research Question 1: How well does the *NC-SNAP* predict current "good" or "ideal" support arrays?

    a. Percent Exact Match for original (no corrections) support array: 70.0

    b. Percent Exact Match when support array corrected for known errors: 92.5

2. Research Question 2: How well does the *NC-SNAP* predict current "good" or "ideal" support arrays at each Need Level (1 to 5)?

Percent Accuracy by Level		
Level	Original (Uncorrected) Support Array	Corrected for Known Support Array Errors
1	46.2	76.9
2	33.3	91.7
3	76.2	90.5
4	85.7	95.2
5	92.3	100

3. Research Question 3: How well does the *NC-SNAP* predict current "good" or "ideal" support arrays for infants and children?

Percent Accuracy for Children	
Age Range	Corrected for Known Support Array Errors
Ages 0 – 2 years	100
Ages 2.01 – 6 years	100
Ages 6.01 – 16 years	100
Children Overall	100 (Corrected) 76.5 (Uncorrected)

Chapter 8

Answers to Frequently-Asked Questions

General Information about the *NC-SNAP*

➢ *How was the NC-SNAP developed?*

The NC-SNAP was developed through a 2-½ year research project with the aim of developing an easy-to-use, reliable and valid assessment tool. This was accomplished through an extensive comparative field test.

➢ *How was the NC-SNAP validated?*

The NC-SNAP was validated by determining its predictive qualities in an extensive field test. The NC-SNAP was administered to hundreds of persons who were receiving good to ideal services with support arrays that ranged from low (Level 1) to high (Level 5). The NC-SNAP predicted the level of need or support array a high percentage of the time.

➢ *How reliable is the NC-SNAP?*

Inter-rater reliability of the NC-SNAP was very good and compared favorably with standardized assessment instruments.

➢ *How will the NC-SNAP be used?*

The NC-SNAP will be used as the standard assessment tool for persons with developmental disabilities in North Carolina

as part of the process to identify needs for support and as an initial step in the development of a support plan.

- *Will NC-SNAP results be used to determine what services are delivered to a client?*

No. The NC-SNAP **does not** specify services. It identifies needs, which can be met through a variety of services. Therefore, services will be neither added nor taken away solely on the basis of a NC-SNAP score.

- *Should the NC-SNAP be readministered each time the individual obtains a new or different service?*

No. Again, the NC-SNAP **does not** specify services. It identifies needs, which can be met through a variety of services.

- *When should the NC-SNAP be readministered?*

The NC-SNAP should be readministered at least annually or whenever there is a significant change in the individual's need profile (e.g., the individual suffers a debilitating stroke).

- *Will funding be tied to the NC-SNAP? If so, will funding be tied to individual budgets or will an Area Program be given funding to develop aggregate budgets?*

The NC-SNAP is not tied to funding on either an individual or aggregate basis. The issue of whether to do so and how to do so is, however, under consideration.

- *Must a case manager be a QDDP to become an examiner?*

Not necessarily, although this will usually be the case. There is no strict educational requirement to complete the NC-SNAP.

- *Do people living in DDA homes need a NC-SNAP?*

Yes. All persons with a diagnosis of developmental disabilities who are currently served under the North Carolina DD Service System (or on the waiting list for services) should have a NC-SNAP completed for them.

- *What about children in early intervention programs who do not have a formal diagnosis of developmental disability?*

In the absence of a formal diagnosis of developmental disability, children will receive a NC-SNAP only if there has been an application made on their behalf for CAP funding, they are receiving CAP funding, or they are receiving residential supports specifically designed for persons with developmental disabilities.

- *If an individual has no assigned case manager, who will be responsible for administering the NC-SNAP?*

The Area Program Director, or designee, is responsible for the identification of appropriate persons to assume this responsibility.

- *Will everyone on the DD Waiting List have a NC-SNAP administered?*

Yes. Those currently receiving no services will have a NC-SNAP completed by May 31, 2000. Those currently receiving services (i.e., but awaiting additional services) should have a NC-SNAP administered prior to their annual planning meeting (i.e., IEP, PCC, IPP, etc.)

- *If an individual is not receiving supports or services and has no case manager, who should serve as the examiner?*

Unless the individual is on the DD Waiting List, the NC-SNAP will not be administered to individuals not receiving supports or services from the North Carolina Service System.

- *Will examiners be issued a certificate card and certification number after successfully completing the training?*

Yes. They should receive their certification number at the completion of the training. After the training, a laminated certification card will be sent to them. It looks pretty cool!

- *What if someone fails the training?*

In order to be certified, students must meet the certification criteria. If someone can not successfully meet these criteria, he or she should repeat the training.

- *Will I need to be recertified as an examiner if I move to another part of the state?*

No. You may continue to use your original NC-SNAP Examiner number anywhere in North Carolina. Also, there is no plan to require recertification of examiners.

- *I'm a certified examiner. May I show my assistant how to administer the NC-SNAP and let her use my number?*

No. Only certified instructors may train and certify examiners.

- *How can I become an instructor?*

At this time, only Outreach and Staff Development staff from the Mental Retardation Centers can be trained to become instructors. They must be certified by the NC-SNAP researchers.

- *Will the NC-SNAP replace any other forms?*

Hopefully, yes. It is anticipated that the LOE and MR2 will be replaced. However, these forms should continue to be used until notification is received from the DD Section.

- *Can I make copies of the NC-SNAP?*

No. The NC-SNAP and all related materials (i.e., database software, instructional video, Instructor's Manual, Examiner's Guide) are copyrighted. However, these materials are available free of charge when used by the state of North Carolina in accordance to policy. Please contact one of the NC-SNAP authors if you need further clarification.

- *Where will the NC-SNAP be stored?*

Store the completed NC-SNAP in the individual's permanent record, in a centralized records location, or wherever official eligibility records are maintained.

- *Should I use a pencil or pen (blue or black ink) when I fill out the NC-SNAP?*

We recommend using a pen. Black ink is sometimes preferred or even required.

- *Where do we get blank forms when our supply runs low?*

Each of the MRCs have an established procedure to distribute NC-SNAP forms and related materials. Contact your regional MRC for further information. When the regional MRC's supplies run low, they should notify the DD Section in Raleigh.

- *Will a registration fee be charged for the Examiner's Training?*

No. The Mental Retardation Centers' Outreach Departments do not charge registration for required training.

Specifics about the *NC-SNAP*

- *Section I of the NC-SNAP asks whether the case has been reviewed by the Single Portal Coordinator. How do I know if this has occurred?*

The short answer is that if you don't know, answer "No." However, if any member of the InterAgency Council has reviewed the case, answer "yes" and write in their name.

- *Sometimes a person lives in one county but is from another county. Which county should be listed on the Data Cover Sheet (and entered into the database)?*

Enter the name of the "responsible" county (i.e., the county with formal responsibility for the individual).

- *How are the "cumulative scores" used?*

The cumulative domain scores and the cumulative raw scores are calculated for research purposes only at this time.

- *In the "Allied Health Professional" column of the "Health Care Supports" domain, the options are 'less than weekly' or 'weekly or more.' Does less than weekly mean the individual sees the professional less often (e.g., once a month)?*

Yes. For some reason, this has been confusing to some examiners. When we reprint the NC-SNAP we will change the wording to 'less than once per week' and 'once a week or more often.'

- *How should an examiner score an item when there is conflicting information?*

Ultimately, the examiner should score the item based on his or her own judgment after reviewing all available information. If two sources disagree, the examiner should seek additional information (e.g., from other persons or evaluations, direct observation) to make an accurate decision.

- *Instructions for the NC-SNAP state that the examiner should assess the individual's 'need' as opposed to the services currently delivered. However, the "physician's services" column under "Health Care Supports" suggests that the examiner should average the number of physician visits during the previous year. Is this a contradiction?*

Not really, although we can see why this might seem unclear. When gauging the intensity of need associated with an individual's chronic health care need it is helpful to assess the frequency of required physician intervention. If, however, the examiner feels that the previous year's average does not accurately reflect the individual's most current needs (e.g., due to a very recent significant change in medical status), the score that best represents these most current needs should be marked.

- *Does "Equipment Supports" refer to the purchase of equipment?*

No. Score this item based on the amount of support that is required to maintain or service an individual's equipment. The purchase of the equipment should not be considered. For

instance, some communication devices are very costly to purchase. If the individual does not require frequent (i.e., less often than once per month) support to maintain the equipment, score Level 1.

- *What is the "Pre-printed Class Preparation Form Report?"*

This is a form that can be printed prior to an Examiner's Training Class. It can be found in the *NC-SNAP* Database Program, in the "Reports" folder. This can be very useful in organizing the class roster and assigning examiner numbers.

- *How is the NC-SNAP to be used as part of a personal plan for support?*

Page 4 of the NC-SNAP can be used as a worksheet for the development of a personal support plan.

- *Why doesn't the NC-SNAP include a category specifically for vocation (or communication)?*

Remember that the *NC-SNAP* is designed to functionally assess an individual's level of intensity of need. Some areas such as vocation and communication, while extremely important aspects of an individual's life, do not easily fit into need levels. During our field testing of the *NC-SNAP* we found that including a category for vocational support needs actually hurt the predictive validity of the instrument. We speculate that this is because of the wide range of supports needed at all levels.

Questions about the statewide database

- *What computer specifications are needed to use the database program?*

The program is written in *Microsoft Access*. Installation is done via a CD. Therefore, the computer must have a CD-Drive and *Microsoft Windows 95* or *98*. However, the computer does not require *Access* itself. Finally, there are three ways to download data to the statewide server. The preferred method is through SQL download, directly to the server via the internet. Another option is through an FTP file transfer. The final option, for those who do not have internet access, is to store the data on a diskette, and mail it to Raleigh.

- *Is the database program compatible with the Single Portal (Waiting List) program?*

The NC-SNAP database program was written for ease of use and is 'compatible' with both the Single Portal program and the Centralized Data Warehouse. However, this does not mean that they are the same. It is hoped that these will eventually be merged to eliminate or reduce the necessary data entry redundancy.

- *Is there a plan in place to modify the Data Entry Coversheet?*

Yes. We anticipate adding more information in the near future. Also, a redesign of the form is planned to facilitate data entry.

MAP-552K
(01/01)

APPENDIX I

DEPARTMENT FOR COMMUNITY BASED SERVICES
NOTICE OF AVAILABILITY OF INCOME FOR LONGTERM CARE/WAIVER AGENCY/HOSPICE

MAID NUMBER:
PROGRAM: COUNTY:

( ) INITIAL ( ) CORRECTION
( ) CHANGE ( ) SPECIAL CIRCUMSTANCE
( ) SSN CHANGE ( ) DISCHARGE

CLIENT'S NAME: BIRTH DATE:

PROVIDER NUMBER:
ADMISSION DATE: DISCHARGE DATE: DEATH DATE:
LEVEL OF CARE: LTC INELIGIBLE DATE:
FAMILY STATUS: SINGLE SPOUSE STATUS:

INCOME COMPUTATION

UNEARNED INCOME SOURCE	AMOUNT
RSDI	$
SSI	$
RR	$
VA	$
STATE SUPPLEMENTATION	$
OTHER	$
SUB-TOTAL UNEARNED INC.	$

EARNED INCOME	AMOUNT
WAGES	$
EARNED INCOME DEDUCTION	$
SUB-TOTAL EARNED INC.	$

TOTAL INCOME $

DEDUCTIONS	AMOUNT
PERSONAL NEEDS ALLOWANCE	$
INCREASE PNA	$
SPOUSE/FAMILY MAINT.	$
SMI	$
HEALTH INSURANCE	$
INCURRED MEDICAL EXPENSES	$
TOTAL DEDUCTION	$

THIRD PARTY PAYMENTS $

AVAILABLE INCOME $
AVAILABLE INCOME (ROUNDED) $
AVAILABLE MONTHLY INCOME: $

CASE STATUS
ACTIVE CASE: NO
IF ACTIVE, EFF. MA DATE:
IF DISC, EFF. MA DISC:

NOTIF. FORM: CONFIRMATION NOTICE
DATE PATIENT STATUS MET:

EFF. DATE OF CORR:
ENDING DATE OF CORR:

PRIVATE PAY PATIENT
FROM: THRU:

EFFECTIVE DATE:

WORKER CODE: CASELOAD CODE: UPDATE DATE:

Revised 3/03

ABI ☐
SCL ☐
SGF ☐

INCIDENT REPORT

Incident Class
Class I ☐
Class II ☐
Class III ☐

IDENTIFYING INFORMATION:

MAID/SS#:_____ Name:_____

DOB:___/___/___ Reporting Agency:_____ Provider #_____

Reporting Person:_____ Title:_____ Phone:_____

Support Coordination Provider:_____ Support Coordinator:_____

INCIDENT INFORMATION:

Date of Incident:___/___/___ Time:____:____AM PM

Location (where occurred):
☐ CH ☐ Group Home ☐ FHP ☐ Respite ☐ Staffed Residence ☐ In-Home ☐ Community
☐ Community Job ☐ Other _____

DESCRIPTION OF INCIDENT: (To be completed by staff witnessing or discovering the incident)

Who was involved? What happened? Where did it happen? Action Taken?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ ___/___/___

Signature of Person Reporting **Title** **Date**

	NOTIFICATIONS			FINAL REPORT		
Reported to:	Class I 24 hours	Class II 24 hours	Class III 8 hours	Class I 10 days	Class II 10 days	Class III 7 days
Support Coordinator	Date:___/___/___ Time:____am pm By whom:	Date:___/___/___ Time:____am pm By whom:	Date:___/___/___ Time:____am pm By whom:	Date:___/___/___ Time:____am pm By whom:	Date:___/___/___ Time:____am pm By whom:	Date:___/___/___ Time:____am pm By whom:
DMR	N/A	N/A	Date:___/___/___ Time:____am pm By whom:	N/A	Date:___/___/___ Time:____am pm By whom:	Date:___/___/___ Time:____am pm By whom:
Guardian/ Individual	Date:___/___/___ Time:____am pm By whom:	Date:___/___/___ Time:____am pm By whom:	Date:___/___/___ Time:____am pm By whom:	Date:___/___/___ Time:____am pm By whom:	Date:___/___/___ Time:____am pm By whom:	Date:___/___/___ Time:____am pm By whom:
DCBS	N/A	N/A	**IMMEDIATE** Date:___/___/___ Time:____am pm By whom:	N/A	N/A	Date:___/___/___ Time:____am pm By whom:
Other	Date:___/___/___ Time:____am pm By whom:	Date:___/___/___ Time:____am pm By whom:	Date:___/___/___ Time:____am pm By whom:	Date:___/___/___ Time:____am pm By whom:	Date:___/___/___ Time:____am pm By whom:	Date:___/___/___ Time:____am pm By whom:

INSTRUCTIONS FOR COMPLETING INCIDENT REPORT

Page 1: The approved form must be used as written and not altered in any way.

Complete all blanks on the form.

Check appropriate funding box and incident class. (SCL, ABI or SGF)

Check appropriate incident class.

Description of Incident: The person witnessing or discovering the incident must complete this section. The incident analysis must be detailed and include all participants and their involvement in the incident. Where appropriate, individual's actions and staff response should be documented.

SUMMARY OF REPORTING REQUIREMENTS:

Who Reports:	***Reportable to:***	**Class I**	**Class II**	**Class III**
Provider Agency	Support Coordinator or Case Manager	24 hours	24 hours	Immediately
Provider Agency	DMR	Not reportable	10 calendar days	Phone or fax – 8 hours Written report – 7 calendar days
Provider Agency	Guardian	Report as indicated By guardian	Within 24 hours (follow provider agency policy)	Phone or fax – 8 hours Written report – 7 calendar days
Provider Agency	DCBS	N/A	N/A	Phone or fax – 8 hours Written report – 7 calendar days

Page 2: Code sheet: Mark all relevant areas to fully describe the incident.
If an abuse code is used-the Incident must be a Class III.
If "unknown" or "other" is checked-please provide details in narrative.
Do not write in changes to items checked. If it does not apply as stated on the form-do not check it.

Page 3: The information in this section summarizes the results of follow-up needed for Class I incidents or the investigations conducted for Class II and Class III incidents.

The follow-up should include a critique of staff response and action taken. This critique should analyze what occurred before and after the incident to help determine if staff responded appropriately.

Also included should be a plan to ensure that the incident does not occur again as well as stating who was involved in developing this plan. Preferably actual or planned dates of completion would be included.

Staff training needs identified as a result of incident follow-up/investigation, along with a training plan, would be included in this section.

Also included should be a statement about the current situation of the individual involved in the incident.

Person completing the follow-up form the provider agency shall sign along with the Case Manager or Support Coordinator and other relevant parties.

MAID/SS# _____ Name: _____ Date of Incident:_____

SUPERVISOR/SUPPORT COORDINATOR REVIEW

INCIDENT FOLLOW-UP:

Analysis of incident, staff action taken and incident follow-up:_____

_____

_____

_____

_____

How could this incident have been prevented and how can this incident be avoided in the future? (Who made this decision)_____

_____

_____

_____

_____

Staff training needs identified (include training plan and who's responsible):_____

_____

_____

_____

_____

Individual support needs identified:_____

_____

_____

_____

_____

Current Status:_____

_____

_____

_____

Submitted by:_____ Title:_____ Date:___/___/___

Additional Signatures:

_____ Title: Support Coordinator Date:___/___/____

_____ Title:_____ Date:___/___/____

_____ Title:_____ Date:___/___/____

MAID/SS#:_____ Name:_____ Date of Incident:___/___/___

Incident Codes (Check ALL that apply)

A SUSPECTED/ALLEGED ABUSE
- ☐ 1 Emotional, Community Person to Individual
- ☐ 2 Emotional, Parent/Family to Individual
- ☐ 3 Emotional, Individual to Individual
- ☐ 4 Emotional, Staff to Individual
- ☐ 5 Physical, Community Person to Individual
- ☐ 6 Physical, Parent/Family to Individual
- ☐ 7 Physical, Individual to Individual
- ☐ 8 Physical, Staff to Individual
- ☐ 9 Sexual, Community Person to Individual
- ☐ 10 Sexual, Parent/Family to Individual
- ☐ 11 Sexual, Individual to Individual
- ☐ 12 Sexual, Staff to Individual
- ☐ 13 Verbal, Community Person to Individual
- ☐ 14 Verbal, Parent/Family to Individual
- ☐ 15 Verbal, Individual to Individual
- ☐ 16 Verbal, Staff to Individual
- ☐ 17 Unknown

B SUSPECTED/ALLEGED NEGLECT
- ☐ 1 Community Person to Individual
- ☐ 2 Parent/Family to Individual
- ☐ 3 Staff to Individual
- ☐ 4 Unknown

C SUSPECTED/ALLEGED EXPLOITATION
- ☐ 1 Community Person to Individual
- ☐ 2 Parent/Family to Individual
- ☐ 3 Individual to Individual
- ☐ 4 Staff to Individual
- ☐ 5 Unknown

D DEATH OF PERSON
- ☐ 1 Accident
- ☐ 2 Criminal Act
- ☐ 3 Illness
- ☐ 4 Natural Causes
- ☐ 5 Suicide

E RESTRAINT
- ☐ 1 Unnecessary Restraint
- ☐ 2 Emergency Chemical Restraint
- ☐ 3 Emergency Physical Restraint
- ☐ 4 Emergency Mechanical Restraint

F SEVERE BEHAVIORAL ISSUES
- ☐ 1 Sexual Contact
- ☐ 2 Threatened Suicide
- ☐ 3 Attempted Suicide
- ☐ 4 Severe Behavior Outburst
- ☐ 5 Property Damage
- ☐ 6 Self Abuse
- ☐ 7 Individual aggressed to Staff
- ☐ 8 Peer to Peer aggression

G SERVICE SITE/RESIDENCE UNINHABITABLE
- ☐ 1 Loss of Electric
- ☐ 2 Loss of Heat
- ☐ 3 Loss of Water
- ☐ 4 Other Safety Issues

H SERVICE SITE/RESIDENTIAL FIRE
- ☐ 1 Requiring Relocation
- ☐ 2 Resulting in Personal Injury
- ☐ 3 Resulting in Property Loss

I ACT UNACCEPTABLE BY PUBLIC
- ☐ 1 Individual
- ☐ 2 Staff

J HOSPITAL VISIT/ADMISSION
- ☐ 1 Emergency Room
- ☐ 2 In-patient
- ☐ 3 Medical
- ☐ 4 Medical, Medication Therapy IV
- ☐ 5 Medical, Surgery
- ☐ 6 Psychiatric, Behavior reasons
- ☐ 7 Psychiatric, Medication Adjustment
- ☐ 8 Psychiatric, Suicidal
- ☐ 9 Psychiatric, Threat to Others
- ☐ 10 Physician's Office/Clinic

K PERSON MISSING FROM
- ☐ 1 Community Habilitation Site
- ☐ 2 Residence
- ☐ 3 Community
- ☐ 4 Other

L ADMISSION TO NURSING FACILITY
- ☐ 1 Medical Needs
- ☐ 2 Rehabilitative Needs

M SERIOUS INJURY RESULTING IN
- ☐ 1 Cast Applied
- ☐ 2 Medical Procedure (MRI, Xray)
- ☐ 3 Medication
- ☐ 4 Referral to other Physician
- ☐ 5 Splints
- ☐ 6 Stitches/Staples
- ☐ 7 Wrapping
- ☐ 8 Other

N MEDICATION ERROR
- ☐ 1 Dose(s) Missed Entirely
- ☐ 2 Not within admin window when due
- ☐ 3 Wrong Dose Given
- ☐ 4 Wrong Medication Given
- ☐ 5 Wrong Route
- ☐ 6 Other

O CRIMINAL ACTION AS VICTIM/PERPETRATOR
- ☐ 1 Arrested
- ☐ 2 Victim of a Crime
- ☐ 3 Other

P INJURED PART OF BODY
- ☐ 1 Abdomen
- ☐ 2 Ankle Left
- ☐ 3 Ankle Right
- ☐ 4 Anus
- ☐ 5 Arm Left
- ☐ 6 Arm Right
- ☐ 7 Back Left
- ☐ 8 Back Right
- ☐ 9 Buttocks
- ☐ 10 Chest Left
- ☐ 11 Chest Right
- ☐ 12 Chin
- ☐ 13 Collarbone
- ☐ 14 Ears
- ☐ 15 Eyes
- ☐ 16 Face
- ☐ 17 Fingers Left Hand
- ☐ 18 Fingers Right Hand
- ☐ 19 Foot Left
- ☐ 20 Foot Right
- ☐ 21 Genitals
- ☐ 22 Groin Area
- ☐ 23 Hand Left
- ☐ 24 Hand Right
- ☐ 25 Head Back
- ☐ 26 Head Front
- ☐ 27 Knee Left
- ☐ 28 Knee Right
- ☐ 29 Leg Left
- ☐ 30 Leg Right
- ☐ 31 Lips
- ☐ 32 Mouth
- ☐ 33 Neck
- ☐ 34 Nose
- ☐ 35 Rib
- ☐ 36 Shoulder Left
- ☐ 37 Shoulder Right
- ☐ 38 Teeth
- ☐ 39 Throat
- ☐ 40 Toes Left
- ☐ 41 Toes Right
- ☐ 42 Other
- ☐ 43 Hip
- ☐ 44 Wrist Left
- ☐ 45 Wrist Right

Q CAUSE OF INJURY
- ☐ 1 Accident
- ☐ 2 Bite/Sting
- ☐ 3 Equipment Failure
- ☐ 4 Equipment Operator Error
- ☐ 5 Fall
- ☐ 6 Individual's Behavior
- ☐ 7 Lift/Transfer Error
- ☐ 8 Medical Condition
- ☐ 9 Scalding
- ☐ 10 Staff Person
- ☐ 11 Unsafe Condition, Service Site
- ☐ 12 Unsafe Condition, Home
- ☐ 13 Other

R TYPE OF INJURY/EMERGENCY CONDITIONS
- ☐ 1 No Apparent Injury
- ☐ 2 Abrasions
- ☐ 3 Allergic Reaction
- ☐ 4 Angina/Chest Pain
- ☐ 5 Aspiration
- ☐ 6 Asthma
- ☐ 7 Bedsores
- ☐ 8 Blister
- ☐ 9 Blood Clot
- ☐ 10 Bone Breaks/Fractures
- ☐ 11 Bowel Blockage
- ☐ 12 Bronchitis
- ☐ 13 Bruises/contusions
- ☐ 14 Burns
- ☐ 15 Chafed/Chapped
- ☐ 16 Choking
- ☐ 17 Communicable Disease
- ☐ 18 Concussion
- ☐ 19 Constipation
- ☐ 20 Cracked/Missing Tooth
- ☐ 21 Dehydration
- ☐ 22 Diarrhea
- ☐ 23 Dislocation
- ☐ 24 Gout
- ☐ 25 Heart Rhythm Irregularities
- ☐ 26 Hematoma
- ☐ 27 Hepatitis
- ☐ 28 High Blood Pressure
- ☐ 29 High Blood Sugar
- ☐ 30 Irritation/Rash
- ☐ 31 Laceration
- ☐ 32 Lesion
- ☐ 33 Low Blood Sugar
- ☐ 34 Malnutrition
- ☐ 35 Nausea/Vomiting
- ☐ 36 Pneumonia
- ☐ 37 Puncture
- ☐ 38 Scabies
- ☐ 39 Seizures
- ☐ 40 Significant Infection
- ☐ 41 Skin Ulcers
- ☐ 42 Soft Tissue Swelling
- ☐ 43 Spasms
- ☐ 44 Sprains
- ☐ 45 Strains
- ☐ 46 Stroke
- ☐ 47 Sunburn
- ☐ 48 Swallowing Objects
- ☐ 49 Ulcers
- ☐ 50 Upper Respiratory Infection
- ☐ 51 Urinary Tract Infection
- ☐ 52 Other
- ☐ 53 pain

INDIVIDUAL SUPPORT PLAN

1. **Name:** _____
   Last Middle First

2. **Medicaid Number:** _____
   (10) Digits

3. **Date of Birth:** _____

5. **Individual's Current Address:** _____
   _____
   _____
   _____
   _____
   County: _____

4. **Residential Status:**
   In-Home _____
   Family Home _____
   Group Home _____
   Staffed Residence _____
   Adult Foster Care Home _____

6. **Support Coordination Provider:**
   Provider Name _____
   Provider Number _____
   Name of Area Development District _____
   _____

7. **Legal Status:** _____ **Adjudicated** _____ **Non-Adjudicated** _____
   Legal Representative Name and Address: _____
   _____
   _____
   _____

8. **Confirmation Notice/Service Plan**
   Effective Dates: **From** _____ **Through** _____

9. **Supports**

Service Code	Provider Number	Frequency	Duration

Support Coordinator: _____ **Individual/Guardian:** _____

Cost Worksheet

Support Coordination Provider: _____ **Provider #:** _____

Individual's Name: _____ **Medicaid #:** _____

Waiver/Service Code	Units Per Week Column A	Cost Per Unit Column B	Cost Per Week (Column AxB) Column C	Total Cost Monthly (4.3xColumn C) Column D
ON-GOING SERVICES				
			COST PER MONTH: $	
ONE-TIME ONLY SERVICE				

ONE-TIME ONLY COSTS $_____

INDIVIDUAL SUPPORT PLAN

This part of the individual support plan will be submitted for review upon request. Otherwise, it shall be maintained in the individual record for review during onsite visits by the monitoring team. A copy shall be at each individual service site.

Individual's Name: _____ **Medicaid #:** _____

Address: _____ **Legal Status:** _____

_____

_____

_____

DSM IV Diagnoses

Axis I _____

Axis II _____

Axis III _____

DD Diagnosis _____

Personal Profile: Summarize information regarding the individual's vision, likes and preferences/talents, non-negotiables, interests and how the person expresses choices.

Present Situation/Supports: Summary information regarding home, work/school/daytime involvement, social inclusion, support to exercise rights and responsibilities, satisfaction with services and personal life situation. Provide specific information regarding behavior issues, health issues, medications and safety issues.

Individual's Name: _____ **Medicaid #:** _____

Behavior Issues: (be specific); Date of Functional Analysis and/or Behavior Plan: _____

Mental Health Issues: (be specific)

Health Issues: (be specific)

Safety Issues: (be specific)

Medication:

Current Medications **Name, Dosage/Frequency, Purpose**	**Allergies**

INDIVIDUAL SUPPORT PLAN COMPONENT

Individual's Name: _____ **Medicaid #:** _____

Statement of Anticipated Individual Outcomes	Processes for Supported Outcomes	Name of Service/Support Service Codes	Responsible Provider Name and Number

The Agency is expected to determine the following information about the individual, which shall be used as the basis for the development of the support plan and its addenda. All information shall be maintained by the agency either within the body of the support plan document or in the individual's record. All records shall include detailed information in each area. Some areas may be summarized in the support plan as indicated. Other areas of the support plan shall be detailed.

INDIVIDUAL SUPPORT PLAN - PART II

Personal Information	
(Basic Demographics and Legal Status)	**Detailed**
Personal Profile	**Summarize**
a. Vision	
b. Likes and Preferences/Talents	
c. Non-Negotiables	
d. Interests	
e. How the Person Expresses Choices	
Present Situation/Supports	
a. Home	Summarize
b. Work/School/Daytime Involvement	Summarize
c. Social Inclusion	Summarize
d. Communication	Summarize
e. Support to Exercise Rights and Responsibilities (indicate restrictions/due process)	Summarize
f. Satisfaction with Services	Summarize
g. Satisfaction with Personal Life Situation	Summarize
Support Plan Components	
a. Individual's Outcome	Detailed
1. Support/Activity/Goal	Detailed
2. Skill Building Goal	Detailed
b. Behavioral Support Plan, if needed	Detailed
c. Name of Service/Support	Detailed
d. Frequency of Service/Support	Detailed
e. Duration of Service/Support	Detailed
f. Responsible Party	Detailed
Signature Page	

FREEDOM OF CHOICE OF HOME AND COMMUNITY BASED WAIVER FOR PERSONS WITH MR/DD SERVICES PROVIDERS

The home and community waiver for persons with MR/DD offers people freedom to choose from any and all service providers available. Attached is a listing of all providers enrolled with the State Medicaid Agency who can provide waiver services. Please indicate below the providers of your choice and sign and date the form.

SERVICES REQUESTED	PROVIDER REQUESTED
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Signature _____ Date _____

Kentucky Medicaid

LONG TERM CARE FACILITIES AND HOME AND COMMUNITY BASED PROGRAM CERTIFICATION FORM

I. ESTATE RECOVERY

Pursuant to the Omnibus Budget Reconciliation Act (OBRA) of 1993, states are required to recover from an individual's estate the amount of Medicaid benefits paid on the individual's behalf during a period of institutionalization or during a period when an individual is receiving community based services as an alternative to institutionalization.

In compliance with Section 1917 (b) of the Social Security Act, estate recovery will apply to nursing facility long term care services (NF, NF/BI, ICF/MR/DD), home and community based services that are an alternative to long term care facility services and related hospital and prescription drug services.

Recovery will only be made from an estate if there is no surviving spouse, or children under age 21, or children of any age who are blind or disabled.

I certify that I have read and understand the above information.

_____ _____
Signature Date

II. HOME AND COMMUNITY BASED WAIVER SERVICES FOR THE AGED AND DISABLED, PEOPLE WITH MENTAL RETARDATION OR DEVELOPMENTAL DISABILITIES, MODEL WAIVER II, BRAIN INJURY WAIVER

A. HCBS - This is to certify that I/legal representative have been informed of the HCBS waiver for the aged and disabled. Consideration for the HCBS program as an alternative to NF placement is requested _____; is not requested _____.

_____ _____
Signature Date

B. This is to certify that I/legal representative have been informed of the home and community based waiver program for people with mental retardation/ developmental disabilities. Consideration for the waiver program as an alternative to ICF/MR/DD is requested _____; is not requested _____.

_____ _____
Signature Date

C. MODEL WAIVER II - This is to certify that I/legal representative have been informed of the Model Waiver II program. Consideration for the Model Waiver II program as an alternative to NF placement is requested _____; is not requested _____.

_____ _____
Signature Date

D. BRAIN INJURY (BI) WAIVER - This is to certify that I/legal representative have been informed of the BI Waiver Program. Consideration for the BI Waiver Program as an alternative to NF or NF/BI placement is requested _____; is not requested _____.

_____ _____
Signature Date

III. FREEDOM OF CHOICE OF PROVIDER

I understand that under the waiver programs, I may request services from any Medicaid provider qualified to provide the service and that a listing of currently enrolled Medicaid providers may be obtained from Medicaid Services.

_____ _____
Signature Date

IV. RESOURCE ASSESSMENT CERTIFICATION

This is to certify that I/legal representative have been informed of the availability, without cost, of resource assessments to assist with financial planning provided by the Department for Community Based Services.

_____ _____
Signature Date

V. RECIPIENT INFORMATION

Medicaid Recipient's Name: _____

Address of Recipient: _____

_____

Phone: _____

Medicaid Number: _____

Responsible Party/Legal Representative: _____

Address: _____

_____

Phone: _____

Signature and Title of Person Assisting with Completion of Form:

_____

Agency/Facility: _____

Address: _____

COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

REQUEST FOR EQUIPMENT FORM

RECIPIENT'S NAME _____ MAID # _____ BIRTHDATE _____
Mo Day Yr

List Other Insurance Coverage _____

Estimated Time Needed # Months_____ Indefinitely _____ Permanently _____

Specific Equipment Item Requested: Please include Medicare codes for parts to items such as Braces, Prostheses, and Wheelchairs (if applicable). Otherwise, group parts together under Code E1399 or appropriate miscellaneous code for braces/prostheses.

PURCHASES:

ITEM	CODE	MANUFACTURER'S SUGGESTED LIST PRICE (IC ITEMS ONLY)	AGENCY'S ACQUISITION COST (ALL ITEMS)

Trade Name/Model Number of Equipment item (if applicable) _____

_____

Manufacturer's Name _____

RENTAL:

If Rental is Requested, Please Specify Amount $_____

Supplier of Equipment _____

Address _____

Date of Delivery if Equipment Item is Already Place in Home – Date _____

Agency Name _____ Provider # _____

Authorized Signature _____ Date _____

MAP-620
Revised 3/03

APPENDIX VII

APPLICATION FOR SCL WAIVER AND ICF/MR SERVICES

THIS FORM MUST BE COMPLETED ENTIRELY

1. **Name** _____
First Middle Last

Social Security Number: _____ **Sex: M** ☐ **or F** ☐

Medical Assistance Number _____

Date of Birth: _____ **Phone Number: (_____)** _____
month day year

Present Address _____
Street

_____ _____
City County State Zip Code

IF THIS SECTION IS COMPLETED, SIGNATURE OF GUARDIAN OR LEGAL REPRESENTATIVE IS REQUIRED BELOW.

2. **Legal Representative/Guardian (if applicable)** _____

Address _____

_____
City County State Zip Code

Phone Number _____ **Relationship to Applicant** _____

3. **Case Management Provider Name and Address (if applicable)**

Name _____

Address _____

_____
City County State Zip Code Phone Number

_____ _____ _____
Applicant's Signature Legal Rep./Guardian (if applicable) Date
MUST BE SIGNED BY APPLICANT IF THERE IS NO GUARDIAN

4. **DSM Diagnosis:**

Axis I (Mental Health): _____

Axis II (Mental Retardation/Developmental Disability) : _____

Axis III (Physical Health): _____

Age Disability Identified: _____

Please designate desired services:

☐ **SCL Waiver:** _____ _____
Physician/QMRP Signature **Date**

☐ **ICF/MR:** _____ _____
CMHC MR/DD Director Signature **Date**

*** For ICF/MR application, Please attach a copy of the current Individual Support Plan, current psychological, social history, and a current needs assessment.**

PLEASE TELL US ABOUT THE APPLICANT BY CHECKING ONE BOX UNDER EACH HEADING

6. MOBILITY

☐ Walks independently
☐ Walks with supportive devices
☐ Walks unaided with difficulty
☐ Uses wheelchair operated by self
☐ Uses wheelchair & needs help
☐ No mobility
Comments:_____

COMMUNICATION

☐ Speaks and can be understood
☐ Speaks and is difficult to understand
☐ Uses gestures
☐ Uses sign language
☐ Uses communication board or device
☐ Does not communicate
Comments:_____

7. HOW MUCH TIME IS REQUIRED FOR ASSURING SAFETY?

☐ Requires less than 8 hours per day on average
☐ Requires 9-16 hours daily on average
☐ Requires 24 hours (does not require awake person overnight)
☐ Requires 24 hours with awake person overnight
☐ **Extreme Need:** Requires 24 hours, awake person trained to meet individual's particular needs; continuous monitoring

COMMENTS:_____

8. HOW MUCH ASSISTANCE IS NEEDED FOR DAILY LIVING TASKS?

☐ **No assistance** needed in **most** self-help and daily living areas, and
Minimal assistance ***(use of verbal prompts or gestures as reminders)*** needed **in some** self-help and daily living areas, and
Minimal to complex assistance needed to complete complex skills such as financial planning and health planning.

☐ **No assistance** in **some** self-help, daily living areas, and
Minimal assistance for many skills, and
Complete assistance (*caregiver completes all parts of task)* needed in **some** basic skills and all **complex** skills.

☐ **Partial** ***(use of hands on guidance for part of task)*** **to complete assistance** needed **in most** areas of self-help, daily living, and decision making, and
Cannot complete **complex** skills.

☐ **Partial to complete assistance** is needed **in all areas** of self-help, daily living, decision-making, and complex skills

☐ **Extreme Need:** All tasks must be done for the individual, with no participation from the individual

COMMENTS:_____

APPLICATION FOR SCL WAIVER AND ICF/MR SERVICES

THIS FORM MUST BE COMPLETED ENTIRELY

1. **Name:** _____
First Middle Last

Social Security Number: _____ **Sex: M** ☐ **or F** ☐

Medical Assistance Number: _____

Date of Birth: _____ **Phone Number:** (_____) _____
month day year

Present Address: _____
Street

_____ _____
City County State Zip Code

IF THIS SECTION IS COMPLETED, SIGNATURE OF GUARDIAN OR LEGAL REPRESENTATIVE IS REQUIRED BELOW.

2. **Legal Representative/Guardian (if applicable)** _____

Address: _____

_____
City County State Zip Code

Phone Number: _____ **Relationship to Applicant:** _____

3. **Case Management Provider Name and Address (if applicable)**

Name: _____

Address: _____

_____
City County State Zip Code Phone Number

_____ _____ _____
Applicant's Signature Legal Rep./Guardian (if applicable) Date
MUST BE SIGNED BY APPLICANT IF THERE IS NO GUARDIAN

4. **DSM Diagnosis:**

Axis I (Mental Health): _____

Axis II (Mental Retardation/Developmental Disability): _____

Axis III (Physical Health): _____

Age Disability Identified: _____

5. **Please designate desired services:**

☐ **SCL Waiver:** _____ _____
Physician/QMRP Signature **Date**

☐ **ICF/MR:** _____ _____
CMHC MR/DD Director Signature **Date**

*** For ICF/MR application, Please attach a copy of the current Individual Support Plan, current psychological, social history, and a current needs assessment.**

PLEASE TELL US ABOUT THE APPLICANT BY CHECKING ONE BOX UNDER EACH HEADING

6. MOBILITY

☐ Walks independently
☐ Walks with supportive devices
☐ Walks unaided with difficulty
☐ Uses wheelchair operated by self
☐ Uses wheelchair & needs help
☐ No mobility

Comments:_____

COMMUNICATION

☐ Speaks and can be understood
☐ Speaks and is difficult to understand
☐ Uses gestures
☐ Uses sign language
☐ Uses communication board or device
☐ Does not communicate

Comments:_____

7. HOW MUCH TIME IS REQUIRED FOR ASSURING SAFETY?

☐ Requires less than 8 hours per day on average
☐ Requires 9-16 hours daily on average
☐ Requires 24 hours (does not require awake person overnight)
☐ Requires 24 hours with awake person overnight
☐ **Extreme Need:** Requires 24 hours, awake person trained to meet individual's particular needs; continuous monitoring

Comments:_____

8. HOW MUCH ASSISTANCE IS NEEDED FOR DAILY LIVING TASKS?

☐ **No assistance** needed in **most** self-help and daily living areas, and
Minimal assistance ***(use of verbal prompts or gestures as reminders)*** needed **in some** self-help and daily living areas, and
Minimal to complex assistance needed to complete complex skills such as financial planning and health planning.

☐ **No assistance** in **some** self-help, daily living areas, and
Minimal assistance for many skills, and
Complete assistance (***caregiver completes all parts of task)*** needed in **some** basic skills and all **complex** skills.

☐ **Partial** ***(use of hands on guidance for part of task)*** **to complete assistance** needed **in most** areas of self-help, daily living, and decision making, and
Cannot complete **complex** skills.

☐ **Partial to complete assistance** is needed **in all areas** of self-help, daily living, decision-making, and complex skills

☐ **Extreme Need:** All tasks must be done for the individual, with no participation from the individual

Comments:_____

9. HOW OFTEN ARE DOCTOR VISITS NEEDED?

- ☐ For routine health care only/once per year
- ☐ 2-4 times per year for consultation or treatment for chronic health care need
- ☐ More than 4 times per year for consultation or treatment
- ☐ **Extreme Need:** Chronic medical condition requires immediate availability and frequent monitoring

Comments:_____

10. HOW OFTEN ARE NURSING SERVICES NEEDED?

- ☐ Not at all
- ☐ For routine health care only
- ☐ 1-3 times per month
- ☐ Weekly
- ☐ Daily
- ☐ **Extreme Need:** Several times daily or continuous availability

Comments:_____

11. ARE THERE BEHAVIORAL PROBLEMS? Yes ☐ No ☐

IF YES-PLEASE CHECK ALL THAT APPLY.

- ☐ Self-Injury
- ☐ Aggressive towards others
- ☐ Inappropriate sexual behavior
- ☐ Property destruction
- ☐ Life threatening (threat of death or severe injury to self or others)
- ☐ Takes prescribed medications for behavior control

PLEASE CHECK ONE ANSWER UNDER EACH QUESTION, UNLESS OTHERWISE INDICATED.

12. WHERE IS THE INDIVIDUAL CURRENTLY LIVING?

- ☐ Living with family/relative
- ☐ Group home or personal care home
- ☐ ICF/MR (Intermediate Care Facility)
- ☐ Living in own home or apartment
- ☐ Nursing home
- ☐ Living with a friend

13. DOES THE INDIVIDUAL CURRENTLY RECEIVE ANY OF THE FOLLOWING SERVICES? (CHECK ALL THAT APPLY)

- ☐ Supported Living
- ☐ Medicaid Acquired Brain Injury
- ☐ Supported Employment
- ☐ Home Health
- ☐ Other Medicaid Services
- ☐ Day Program
- ☐ School
- ☐ Behavior Support
- ☐ Transportation
- ☐ Speech Therapy
- ☐ Physical Therapy
- ☐ Medicaid EPSDT (if under 21)
- ☐ Medicaid Home & Community Based Waiver
- ☐ Mental Health Counseling or Medication for a mental health condition
- ☐ In home Support
- ☐ Residential KRS 216.015 (26) Sexual Assault Exam Facility
- ☐ Respite
- ☐ Occupational Therapy
- ☐ Support Coordination
- ☐ Other

14. WHAT SERVICES ARE NEEDED NOW OR IN THE FUTURE?

- ☐ Day Program
- ☐ School
- ☐ Respite
- ☐ Transportation
- ☐ Speech Therapy
- ☐ Physical Therapy
- ☐ Other
- ☐ In home Support
- ☐ Residential
- ☐ Behavior Support
- ☐ Occupational Therapy
- ☐ Support Coordination
- ☐ Supported Employment

15. THE FOLLOWING ARE 5 CHOICES FOR FUTURE LIVING ARRANGEMENTS. WHERE WOULD THE INDIVIDUAL CURRENTLY ON THE WAITING LIST PREFER TO LIVE IN THE FUTURE? CHOOSE ONLY ONE (1):

- ☐ At home with a family member with someone to come in and help
- ☐ In the person's own home with minimal supports
- ☐ In a 24 hour staffed residence in the community
- ☐ In a 24 hour supervised family home in the community
- ☐ In an ICF/MR

16. WHO IS THE PRIMARY CAREGIVER?

☐ Mother ☐ Father ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle
☐ Sister ☐ Brother ☐ Friend ☐ Neighbor ☐ Other: Who? _____

WHAT IS THE AGE OF THE PRIMARY CAREGIVER?

☐ Less than 30 years old ☐ 31-50 years old ☐ 51-60 years old ☐ 61-70 years old
☐ 71-80 years old ☐ Over 80 years old

18. THE PRIMARY CAREGIVER'S HEALTH STATUS COULD BE CLASSIFIED AS:

☐ Poor ☐ Stable ☐ Very Good

Comments: _____

_____

_____

Person Completing Application: _____
Print Name

_____
Relationship to Individual (if not individual)

_____
Phone Number

_____ _____
Signature Date

Additional Comments: _____

Mail to: Division of Mental Retardation 100 Fair Oaks Ln. 4E-E Frankfort, KY. 40621

Supports for Community Living
Individual Placement Form

Support Coordination Provider Name: _____
Support Coordination Provider Number: _____

Check the One That Applies:

1. Admission: _____
2. Transfer: _____
3. Change in Address: _____
4. Hospitalization: _____
5. Facility(Other than hospital) _____
   _____
6. Termination: _____

A. Identifying Information:

1. Name: _____
2. SSN: _____
3. Medicaid #: _____
4. Legal Status: _____
   a. Adjudicated: _____
   b. Nonadjudicated: _____
5. Responsible Party Name and Address:
   (If Adjudicated or a Minor)
   _____
   _____
   _____
   _____

B. In-Home Services:

1. Date: _____
2. Home Address: _____
   _____
   _____
   _____
3. Phone:(____) _____

C. Residential Placement:

1. FH _____ SR _____ GH _____ AFCH _____
2. Date: _____
3. Name of Residential Provider: _____
   _____
4. Provider #: _____
5. Address: _____
   _____
   _____
   _____
6. Phone:(____) _____

D. Hospital or Facility Admission:

1. Hospital or Facility Name: _____
2. Admission Date: _____ Discharge Date: _____
3. Reason for Admission: _____
   _____
   _____
   _____

E. Termination From the Supports for Community Living Waiver Program:

1. Voluntary: _____ Involuntary: _____
2. Date of Termination: _____
3. Reason For Termination: _____
   _____
   _____

F. Submitted By/Title: _____

G. Today's Date: _____

SUPPORT PLAN ADDENDUM

Effective Date of Requested Change: _____

Support Coordinator: _____
Name **Phone**

Individual's Name: _____ **MAID #:** _____

What has happened to the individual which necessitates a plan change?

_____

_____

_____

_____

_____

Changes Requested:

	Service/Code	Provider Number	Frequency/Duration
A. Addition			
B. Deletion			
C. Change			

Who participated in the decision-making which determined the need for a plan change?

_____

_____

_____

_____

_____

_____ _____
Support Coordinator Signature **Date**

Attach a revised cost worksheet.