

Member Name:	Age:	Member ID #:
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**Section I – Household Composition**

Name	Age	Relationship	Works/Attends School
			<input type="checkbox"/> Work <input type="checkbox"/> School <input type="checkbox"/> Home
			<input type="checkbox"/> Work <input type="checkbox"/> School <input type="checkbox"/> Home
			<input type="checkbox"/> Work <input type="checkbox"/> School <input type="checkbox"/> Home
			<input type="checkbox"/> Work <input type="checkbox"/> School <input type="checkbox"/> Home
			<input type="checkbox"/> Work <input type="checkbox"/> School <input type="checkbox"/> Home
			<input type="checkbox"/> Work <input type="checkbox"/> School <input type="checkbox"/> Home

**Section II – Primary Caregiver Assessment**

Name of Primary Caregiver	Age	Relationship	Phone #

**Section III – Member Assessment**

Does the member attend school or work? <input type="checkbox"/> No <input type="checkbox"/> Yes	If YES, time: ____ a.m./p.m. to ____ a.m./p.m. Days: Mon Tues Wed Thurs Fri Sat Sun	Name of school or employer:
Does the member have an Individualized Education Plan (IEP) in place? <input type="checkbox"/> No <input type="checkbox"/> Yes	Does the member have help at school with Activities of Daily Living (ADLs)? <input type="checkbox"/> No <input type="checkbox"/> Yes	If YES, who helps member at school with ADLs?
Member is : <input type="checkbox"/> Verbal <input type="checkbox"/> Non-verbal	Does the member take medications? <input type="checkbox"/> No <input type="checkbox"/> Yes	If YES, who gives the member medications?
Is the member age 15 or older? <input type="checkbox"/> No <input type="checkbox"/> Yes	If YES, can he/she direct his/her own care? <input type="checkbox"/> No <input type="checkbox"/> Yes	If NO, who will be in the home when services are provided?
Does the member use adaptive equipment? <input type="checkbox"/> No <input type="checkbox"/> Yes	If YES, what type of equipment?	

**Section IV – Dietary Factors**

Is there a medical reason (e.g., a special diet) that requires the member’s meals to be prepared separately from the family’s meals? <input type="checkbox"/> No <input type="checkbox"/> Yes If YES, please specify:		
Who prepares the member’s meals?	What is their relationship to the member?	
Does the member use assistive devices for eating (e.g., feeding tube, etc.)? <input type="checkbox"/> No <input type="checkbox"/> Yes If YES, specify:		
Please indicate the number of meals and snacks the PCS worker will prepare for the member daily: ____ Meals ____ Snacks	Is the member able to feed him/herself without assistance? <input type="checkbox"/> No <input type="checkbox"/> Yes	If NO, specify the type of assistance required:

**Section V – Home Environment**

Describe access to home (e.g., stairs, doors, walks, etc.):
Describe home living space (e.g., number of bedrooms, bathrooms, etc.):

Describe home location (e.g., rural, urban, on bus line, etc.):

Where does the family do their laundry? (e.g., washer/dryer in home, laundromat, etc.):

**Section VI – Family Responsibilities**

Which family members assume major responsibilities for caring for the member, and what tasks so they perform?

Family Member	Tasks Performed

**Section VII – Social Support System**

List other friends, relatives or neighbors that assist in caring for the member or in giving relief to the primary caregiver.

Name	Type of Assistance Provided

**Section VII – Other Services**

<p>Does the member have a case manager/support coordinator?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>If YES, list his/her name, agency and contact number:</p>
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What other service is the member receiving at this time, and how often is the service received?

<input type="checkbox"/> Home Health	<input type="checkbox"/> Waiver	<input type="checkbox"/> OCDD (e.g., respite, family support)	<input type="checkbox"/> Other:
Days of week:	Days of week:	Days of week:	Days of week:
Times:	Times:	Times:	Times:

**Signatures**

Agency Representative:	Date:
Name of PCS Agency:	Phone #:
Parent/Guardian:	Date:
Relationship to Member:	Phone #: