Regional Center Comprehensive Assessment

Developmental Center, MHRC, IMD, DE/SP, and Out of State

Client Name		Assessment Date		Date of last IPP	
UCI#		Current Residence		Length in Placement	
DOB		Age		Sex ☐F ☐M	☐Medi-Cal ☐Medicare ☐Other:
Regional Center		Conserved ☐Y ☐N	Location of Family/ Conservator		Legal Status (6500, 1370.1)		Exp. Date	
Diagnosis		Mobile: ☐Y ☐N	Move/Mobility Program: ☐Y ☐N	Non-Ambulatory: ☐Y ☐N
Verbal Ability/ Primary Language	
Criminal Activity/Charges	

Contact Information	Name	Address Phone/Fax/Email
Service Coordinator (SC)		
Consenter / Conservator		
Physician		
Current Residential Provider		
Family Member		

Prior Transition Activities (attempted placements):

HEALTH TRANSITION PLAN					To be completed upon determination of next placement	
HEALTH CARE CONDITIONS/DIAGNOSIS	Restricted Health Condition?	Special Health Care Need?	Nursing Care Plan Required?	Specify Change(s)	Responsible Party	Completion Date
	☐Y ☐N	☐Y ☐N	☐Y ☐N			
	☐Y ☐N	☐Y ☐N	☐Y ☐N			
	☐Y ☐N	☐Y ☐N	☐Y ☐N			
	☐Y ☐N	☐Y ☐N	☐Y ☐N			
	☐Y ☐N	☐Y ☐N	☐Y ☐N			
	☐Y ☐N	☐Y ☐N	☐Y ☐N			
	☐Y ☐N	☐Y ☐N	☐Y ☐N			
	☐Y ☐N	☐Y ☐N	☐Y ☐N			
	☐Y ☐N	☐Y ☐N	☐Y ☐N			

MEDICATION (Dose/Frequency)	Indication (purpose)	MEDICATION (Dose/Frequency)	Indication (purpose)

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List all known allergies: seasonal			
List any recent medical procedures:			

To be completed upon determination of next placement

Current Health/Medical Updates			
Exam/Eval	Date	Exam/Eval	Date
Physical exam		Gyn (if applicable)	
Dental exam		OT/PT eval	
Neurology		Functional Analysis	
Psychiatry		Wheelchair eval	
Audiology/Speech		Podiatry	
Eye exam			
Sedation required ☐Y ☐N ☐Invasive ☐Non-invasive Type:			

Future Health/Medical Updates	
Name of future MD	
Phone #:	*Appt needed by:*
Name of future Dentist	
Phone #:	*Appt needed by:*
Name of Future Psychiatrist	
Phone #:	*Appt needed by:*
Future Psychologist/Behaviorist	
Phone #:	*Appt needed by:*

Other services/appointments needed to be scheduled:

IDENTIFIED RISKS (If applicable utilize Risk Assessment Tool)	Intervention Required?	Comments
	☐Y ☐N	
	☐Y ☐N	
	☐Y ☐N	
	☐Y ☐N	
	☐Y ☐N	
	☐Y ☐N	
	☐Y ☐N	

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Is client being considered for a Delayed Egress/Secured Perimeter home? ☐Y ☐N		
IDENTIFIED RISKS (If applicable utilize Risk Assessment Tool)	Intervention Required?	**Comments/description**
Does client lack impulse control and hazard awareness that poses a risk of harm to himself or herself or others by wandering off or running away from the residence?	☐Y ☐N	

Psychiatric/Behavioral Support Needs			
Behavior	Frequency	Behavior	Frequency

MEDICAL SUPPLY NEEDS	Quantity	Funding Source	Supplier Contact Information

MEDICAL EQUIPMENT NEEDS (Specify serial #, model & model #)	Funding Source	Status		Supplier/Maintenance Contact Information
		☐Purchased ☐To Be Loaned	☐To Be Purchased ☐To Be Rented	
		☐Purchased ☐To Be Loaned	☐To Be Purchased ☐To Be Rented	
		☐Purchased ☐To Be Loaned	☐To Be Purchased ☐To Be Rented	
		☐Purchased ☐To Be Loaned	☐To Be Purchased ☐To Be Rented	

ACTIVITIES OF DAILY LIVING		To be completed upon determination of next placement		
		Plan Needed?	Responsible Party	Completion Date
Bathing		☐Y ☐N		
Dressing		☐Y ☐N		
Hygiene & Grooming		☐Y ☐N		
Toileting		☐Y ☐N		

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Eating		☐Y ☐N		
Transfers		☐Y ☐N		
Sleep Habits		☐Y ☐N		
Other		☐Y ☐N		

Special Considerations and Plan of Action (if necessary):	Adaptive Equipment

Ancillary Service Needs (OT, PT, Speech, Etc.)	

Current Training/Day Program
Schedule/Preferences/Current Objective

Personal Property Needs

FINANCIAL INFORMATION					
BENEFITS	NUMBER	BENEFITS	MONTHLY AMOUNT	BENEFITS	INFORMATION
MEDI-CAL	#	SSI	$	Current Representative Payee	
MEDICARE	#	SSA	$	After Placement Representative Payee	
MEDICARE D	#	Savings I	$	Burial Plan	
Health Insurance Carrier		Savings II	$	Legal Status	
		Trust BALANCE (current)	$		
Other Eligible Services					

CLIENT'S DESIRED PLACEMENT/ CLIENT'S THOUGHTS ON COMMUNITY PLACEMENT (use client's actual words if applicable)

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CONSERVATOR/ FAMILY'S POSITION ON COMMUNITY PLACEMENT **(must be based on a current discussion; include name of family member or conservator contacted and date)**
BARRIERS TO COMMUNITY PLACEMENT
SERVICES AND SUPPORTS REQUIRED FOR SUCCESSFUL COMMUNITY PLACEMENT **(Include type of facility/program) (note if an additional assessment needs to be completed by a specialist)**

Residential	
Day Program	
Additional Assessment Recommended i.e. Nursing, Risk, Nutritional etc.	
Other	

Completed by: _____

_____

_____

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