Assessment Tool for Electronic Home-Based Services

This optional assessment tool is used by planning teams to determine an individual's ability and desire to participate in and benefit from Electronic Home-Based Services. It can be completed by any member of the team except the EHBS provider. Following completion, a qualified professional must review and provide a signed statement of recommendation on the form.

Individual Name:

Date of birth:

Support Coordinator:

Completed by: _____

Date: _____ Initials: _____

The individual communicates in the following manner:

- ☐ Voice
- ☐ Images
- ☐ Other:
- ☐ Voice – nonstandard speech
- ☐ Communication Device/App
- ☐ Body Language
- ☐ Gestures/Sign Language

Individual's Primary Language:

Should it be determined that the individual has the ability to utilize, does the individual and Substitute Decision-Maker, as applicable, choose to request the addition of Electronic Home-based Services?

◯ Yes ◯ No

Will the addition of EHBS result in a decrease for the need for other Medicaid services AND/OR promote community inclusion AND/OR increase safety in the home?

◯ Yes ◯ No

Who will support the individual with the technology? Note: The technology or EHBS provider will provide the initial training on the technology and will be available for technical assistance.

List the current Assistive Technologies used in the home, work or community:

What outcomes does the individual wish to achieve as a result of using Electronic Home-Based Services?

Does the individual currently use or have previous experience using technology?

- ◯ Currently uses technology and is fully independent
- ◯ Currently uses technology but requires some assistance to operate it
- ◯ Currently uses technology but requires a high amount of assistance to operate it
- ◯ Has some but very little previous experience using technology
- ◯ Has no previous experience using technology but may or is willing to try it
- ◯ Is adverse to using technology and will need increased support/coaching

Select from the following the supports that could be beneficial based on the individual's needs:

- ☐ Controlling the environment through switches or voice activated devices
- ☐ Engaging in home leisure activities
- ☐ Preparing meals including cooking safety
- ☐ Eating
- ☐ Cleaning house, completing laundry or other household tasks
- ☐ Using household appliances
- ☐ Remembering steps in a task, planning, or keeping appointments
- ☐ Reading (in home and community)
- ☐ Computer use and access (i.e., email, internet, participation in work, social or community activites)
- ☐ Arranging transportation including public transportation
- ☐ Medication administration
- ☐ Responding appropriately to a dangerous situation
- ☐ Hearing and recognizing alarms, doorbells or other alert devices
- ☐ Calling for help
- ☐ Using a telephone
- ☐ Entering or exiting a home or answering the door
- ☐ Locking/securing doors
- ☐ Getting in and out of shower/bathtub
- ☐ Getting on/off the toilet
- ☐ Hygiene
- ☐ Regulating water temperature
- ☐ Turning the tap on/off
- ☐ Managing slippery surfaces
- ☐ Overflowing the bathtub/sink
- ☐ Getting up from the floor
- ☐ Sitting down/getting up from a chair
- ☐ Fall detection
- ☐ Seizure detection
- ☐ Overnight safety
- ☐ Wandering or getting lost in the community
- ☐ Navigating the community
- ☐ Communication
- ☐ Sensory (using technology to manage sensory needs)
- ☐ OTHER:

What accessibility features need to be considered when selecting technology (i.e., larger text, loud volume, big buttons)?

Description of how EHBS will benefit the person:

Is there any additional information that needs to be shared?

Is any technology being requested available under the Medicaid State Plan or Durable Medical Equipment?

◯ Yes ◯ No

Qualified Professional Recommendation

(Qualified professionals include: an Occupational Therapist, a Licensed Behavior Analyst or similarly licensed professionals qualified to recommend assistive technologies, such as a Primary Care Physician, Psychiatric Provider, or a Physical Therapist)

Based on my experience providing services to this individual:

I **agree** the individual has the physical and cognitive ability to participate in the provision of Electronic Home-Based Services as described above.

I **do not agree** the individual has the physical and cognitive ability to participate in the provision of Electronic Home-Based Services as described above.

Print name and profession

Clear form

Signature

Date