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| Transforming Lives | AGING AND LONG-TERM SUPPORT ADMINISTRATION**Individual with Complex Behaviors** | CLIENT’S NAME |
| CLIENT ACES ID NUMBER | REGION |
| MENTAL HEALTH DIAGNOSIS**[ ]**  Yes **[ ]**  No Principle diagnosis:Current presentation in Section 1. Information can be obtained from, conversation with Psychiatrist, Nurse, Medical Physician, Social Worker, Mental Health Professional, Counselor, or Certified Peer Specialist. | CLINICAL IMPRESSIONSRISK ASSESSMENT Completed by Hospital or Behavioral Health Provider[ ]  Yes [ ]  No [ ]  NADate:  |
| INDIVIDUAL CRISIS PLANDocument within CARE the expected date Crisis Plan is to be received by provider.[ ]  Yes [ ]  No [ ]  NA |
| MEDICATION AND MEDICAL CONDITIONS MONITORINGIs the individual taking medication as directed and agreeable to medical treatment(s):[ ]  Yes [ ]  No [ ]  NALast medication review:  |
| COORDINATED BEHAVIOR SUPPORT AND TEAM MEETINGS ESTABLISHEDComplete a comment within CARE in Treatment List: Type Programs: Behavior Management Plan detailing the plan. Refer to WAC: 388-107: 388-106-0336 [ ]  Yes [ ]  No [ ]  NA |
| **Section 1. Check one or all that apply (documentation must be present in file)** |
|  HISTORY OF OCCURRENCECurrent presentation and behaviors that increase risk of behavioral crisis. INDICATE FREQUENCY AS DAILY, WEEKLY, OR MONTHLYCheck all relevant boxes below. 30/60/90 DAYS 1–2 YEARS 3-5+ YEARS |
| **[ ]**  **Assaultive** (significant aggression or physical abuse toward others)  Violent Mood Swings, Unpredictable / ImpulsiveDescribe / clarify (please list any charges related to this behavior): |  |  **[ ]  [ ]  [ ]**  |
| Frequency:  |
| **[ ]**  **Destructive** (significant property destruction which puts self or others at risk)Describe / clarify (please list any charges related to this behavior): |  |  **[ ]  [ ]  [ ]**  |
| Frequency:  |
| **[ ]  Self-Injurious** (suicidal behavior; significant self-injury, danger to self).Describe / clarify (please list any charges related to this behavior): |  |  **[ ]  [ ]  [ ]**  |
| Frequency:  |
| **[ ]**  **History of felony and/or misdemeanor type behavior. May or may not have been charged** (shoplifting, theft, trespassing, buying liquor for minors, forgery, malicious mischief, motor vehicle citations, disturbing the peace, harm to animals, stalking, etc.). Citations or related accusations against any population.Describe / clarify (please list any charges related to this behavior): |  |  **[ ]  [ ]  [ ]**  |
| Frequency:  |
| **[ ]**  **Challenging Sexualized Behavior**Describe / clarify (please list any charges related to this behavior): |  |  **[ ]  [ ]  [ ]**  |
| Frequency:  |
| **[ ]**  **History of arson.**Describe / clarify (please list any charges related to this behavior): |  |  **[ ]  [ ]  [ ]**  |
| Frequency:  |
| LEGAL STATUS**[ ]**  Current charge pending; if checked, specify:  **[ ]**  Not Guilty by Reason of Insanity (NGRI)**[ ]**  Current Less Restrictive Alternative (LRA) (attach copy of court order)[ ]  Conditional release (attach conditions of release)**[ ]**  Current incarceration status; projected release date:  [ ]  Early release**[ ]**  Convictions**[ ]**  DOC supervision**[ ]**  Registered Offender Notifications (specify):  [ ]  NA |
| CASE MIX COMPLETEDDocument findings within CARE under Relationships / Interests within comments in Electronic Case Record (ECR).[ ]  Yes [ ]  No [ ]  NA STAFFING PLAN COMPLETEDPlan must be provided and kept in the provider file and Electronic Case Records (ECR) and documented with the CARE assessment.[ ]  Yes [ ]  No [ ]  NA **Emergency situations of Individual – see definition section:** [ ]  Yes [ ]  No [ ]  NA |
| **Section 2. (Only complete if agency requires) Addendum** |
| INFORMATION VERIFICATION BY:**[ ]**  Police report **[ ]**  Court records **[ ]** Psychiatrist, Nurse**[ ]** Medical Physician**[ ]** Social Worker**[ ]** Mental Health Professional**[ ]** Counselor **[ ]** Certified Peer Specialist.**[ ]**  Self-report **[ ]**  Parent / guardian **[ ]**  Psycho-sexual assessment**[ ]**  Other (specify):  | CURRENT DAY PROGRAM**[ ]**  Employment **[ ]**  School**[ ]**  Community access **[ ]**  None**[ ]**  Other  |
| CURRENT RESIDENCE (SEE STAFF INSTRUCTIONS)**[ ]**  AFH **[ ]**  AL **[ ]**  ARC **[ ]**  CFH **[ ]**  CH **[ ]**  CPRS **[ ]**  DOC **[ ]**  EARC [ ]  ESF **[ ]**  ESH **[ ]**  GH/GTH **[ ]**  ICF/ID **[ ]**  JR **[ ]**  SL **[ ]**  WSH **[ ]**  Own home **[ ]**  Parent / relative home **[ ]**  Other (specify):  |
| SPECIFY OTHER CURRENT SERVICES (E.G., THERAPIES, COUNSELING, MPC, CFC, CFC+COPES, RSW, ETC.) |
| **This form was completed based on available information.** |
| CASE MANAGER’S SIGNATURE DATE |
| I have reviewed all information for **Name**, and upon acceptance of said individual will incorporate the information received to develop **Name’s** negotiated care plan or person-centered service plan pursuant to WAC: For detailed information regarding Adult Family Home Negotiated Care Plan refer to (WAC 388-76-10355 through 388-76-10385; Assisted Living Negotiated Service Agreement (WAC 388-78A-2130 through 388-78A-2160); and Person-centered service plan for Enhanced Service Facility (WAC 388-107-0110 through 388-107-0130)  |
| PROVIDER’S SIGNATURE DATE |
| **DISTRIBUTION:** Client Electronic Case Record Provider |

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| **Instructions for Individual with Complex Behaviors**This form must be part of the client’s referral packet provided to residential providers.Copies will be kept in the: * Client record; and
* Client file maintained by the residential program.

Case manager/social worker responsibilities: * Provide the forms/copies to the residential provider; and

Keep the client information on the form current. Form to be reviewed at the annual CARE assessment and anytime an Interim or Significant Change is done. The form should be updated accordingly based on necessary changes. Input an SER addressing the current status of the form and indicate if additional/updated signatures were obtained.Residential provider responsibilities: * Maintain the client files;
* Ensure the safety of all clients; and
* Inform DSHS of any change of condition with regard to the person’s complex behaviors.

**Instructions:****Mental Health Diagnosis:**  A mental condition detailed in the Diagnostic and Statistical Manual of Mental Disorders. Indicate only “Yes”, “No”, or “NA”. **Principal Diagnosis:**  Clinical diagnosis, a focus for treatment. Information to be obtained from a medical doctor who treats mental illnesses, Psychiatrist, Psychologist or licensed counselor. **Current Presentation:** How are the individual’s thoughts and perceptions currently? Summarize behaviors. Indicate current status of relationships with others to include interactions healthy and unhealthy. **Individual Crisis Plan:** A plan that identifies and addresses ways to prevent escalation and intensifying behaviors that are challenging in addition to outlining supports needed when an individual is in crisis. Indicate only “Yes”, “No” or “NA”. **Medication Monitoring:**  In medicine, compliance (also adherence, capacitance) describes the degree to which a patient correctly follows medical advice. Most commonly, it refers to medication or drug compliance, but it can also apply to other situations such as medical device use, self-care, self-directed exercises, or therapy sessions. Indicate only “Yes”, “No”, or “NA”. **Medical Condition:**  Includes mental illnesses, any illness, injury, or disease. **Coordinated Behavior Support and Team Meetings:** Meetings to discuss individual support needs as to deliver quality care. Indicate only “Yes”, “No”, or “NA”. Copy of scheduled meetings to be placed in individual’s Electronic Case Record. **Risk Assessment:** The Risk Assessment is completed by the Hospital or Behavioral Health Provider. Documentation of who completed the assessment, and the outcome should be documented within comments in the Psych/Social section. Place a copy in the individual’s Electronic Case Record.**Case Mix:** Consideration of adequate resources completed. The allocation of resources to care for all residents of the facility has been assessed. Indicate only “Yes”, “No”, or “NA”. A copy must be placed in the individual’s Electronic Case Record. **For Example:** There are five residents in the home four of which have bipolar personality, or mood disorders, and one with schizophrenia. All are redirectable, and take medications as directed. Caregiver will need to note any incidents between residents to include frequency in addition to noting the caregiver to resident ratio.**Staffing Plan:** A plan developed to ensure the appropriate human resources with the necessary skills are available. This plan should indicate type of supervision (e.g. line of site, arm’s length) Indicate only “Yes”, “No”, or “NA”. Documented within “Psych/Social” screen within comments section and indicate Staffing Plan. May need to refer Provider to specific sections within “Behavior,” “Suicide,” or “Depression” comments section. A copy of the plan to be placed in the individual’s Electronic Case Record.**Emergency Situation:**  An incident in which immediate attention or aid was needed for the Individual due to the individual’s behavior that resulted in local authorities or a Designated Crisis Responder being called and the individual being detained in the community. Describe / Clarify: This section includes specific details of the situation, everyone involved limiting some details as related to HIPAA and the outcome associated with the situation or incident.  |
| **RESIDENCE TYPES:**AFH Adult Family HomeAL Assisted LivingARC Adult Residential Care facility licensed as an Assisted Living facilityCFH Children’s Foster HomeCH Companion Home (contracted with DDA)CPRS Community Protection Residential Services (Supported Living)DOC Department of CorrectionsEARC Enhanced ARC facilityESF Enhanced Services FacilityESH Eastern State HospitalGH Group Home (contracted with DDA) with an Assisted Living licenseGTH Group Training HomeICF/ID Intermediate Care Facility for Individuals with Intellectual DisabilitiesJRA Juvenile rehabilitation facilitySL Supported Living ServicesWSH Western State Hospital**SIGNATURES:**Case Manager’s signature: Signature of the staff completing the form. Provider’s Signature: Signature of Provider willing to accept Individual for admission. |