

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:

The individual communicates in the following manner:

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

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?

Completed by: _____

Date: _____

Initials: _____

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:

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

Signature

Date