

CHANCES
Of
Stone County, Missouri
Needs Based Assessment

1. What is your relationship to the person with a disability?

- | | |
|--|--|
| <input type="checkbox"/> I am the person with the disability | <input type="checkbox"/> other relative_____ |
| <input type="checkbox"/> Mother | <input type="checkbox"/> non-relative guardian |
| <input type="checkbox"/> Father | <input type="checkbox"/> other_____ |

2. What disabling condition(s) does this person have?_____

Living Arrangements

3. What zip code does this person live in?_____ What zip code do you live in?_____

4. Does this person currently live with you?

- Yes
 No

5. Describe this person's current living arrangements?

- lives in their natural home with parents and or other relatives
 lives in a supported living apartment or house
 lives in a group home or other supervised residential setting
 lives independently without supervision
 other_____

6. Does this person need any more support or assistance (from someone outside the family) than they are getting, to live successfully in this situation?

- they are not receiving any outside support or ongoing living assistance now but needs some
 they are not receiving any outside support or assistance and does not need any at this time
 they are receiving some outside support or assistance now but need more
 they are receiving about as much support and assistance as they need

7. When will this person need a change to their living arrangements? (best estimate)

- immediately
 within the next 2 years
 between 3 and 5 years from now
 6 or more years from now
 no change will likely be needed
 not sure

7a. If you think a change in living arrangements may be needed, what type will be needed?

- | | |
|---|--|
| <input type="checkbox"/> not sure at this time | <input type="checkbox"/> in a group home or other supervised situation |
| <input type="checkbox"/> with a relative | <input type="checkbox"/> independent living with little or no support |
| <input type="checkbox"/> in a supported living apartment or house | <input type="checkbox"/> other_____ |

8. If this person is currently living in his natural home (with parents or relatives), could they remain in this home longer if necessary support services were provided to the family?

- yes, with a few additional services
 yes, but only with multiple services
 additional services would not impact how long they could remain at home
 does not apply
 other_____

If "yes" what services would help most?

School

9. Is this person currently in an educational or vocational program? yes no

If yes, is this:

- | | |
|--|---|
| <input type="checkbox"/> elementary (grade) school | <input type="checkbox"/> a vocational school program |
| <input type="checkbox"/> high school | <input type="checkbox"/> a college or community college program |
| <input type="checkbox"/> other special adult program | <input type="checkbox"/> other _____ |

10a. If this person is currently in a school program. When will the program be finished? (estimate)

Month _____ Year _____

10. Would this person like to be a student in one of the following programs now or in the future?

Type of program?

- School
- a college or community college
- vocational or job skill program
- other program _____

When would they like to start?

- this year
- within the next 2 years
- within 3 to 5 years
- in 6 or more years from now

Work/Employment

11. Does this person currently have a paid job? yes no

IF YES (Has a paid job)

a. Which of the following best describes their current work situations?

- in a regular job with nondisabled co-workers with no assistance or support?
- in a regular job with nondisabled co-workers with assistance and support?
- in a sheltered workshop with other persons with disabilities?
- other, please describe _____

b. How many ours a day do they work? _____ (estimate)

c. What are their weekly earnings? _____ (estimate)

d. If they are currently seeking a change in jobs or work setting check one of the following:

- wants a different job in the same type of work setting
- wants a different job in a different type of setting
- what type of setting would they prefer? _____
- other change wanted _____

e. Is this person planning to retire soon? yes no (if yes, how soon? _____)

IF NO (does not have a paid job)

Which of the following best describe their current work or employment situation?

- in a training program preparing for work
- looking for a job
- not seeking employment now but will within the next two years
- not seeking employment now but will within 3 to 5 years
- not seeking employment now but will after 6 or more years
- Retired
- not seeking employment for other reasons _____
- other _____

12. When this person next looks for a job, which of the following will they want:

- a regular job with nondisabled co-workers (with no assistance or support if necessary)
 a job in a sheltered workplace with other persons with disabilities
 will not or most likely will not ever look for a job

13. Does this person need assistance starting a business? yes no

IF Yes, what kind of help? _____

Services Received and Services Needed Now

14. Place a checkmark in the box in front of any service this person is receiving now. Then, whether or not they are receiving a service, circle the number to the right that best describes their CURRENT level of need for each service listed.

<u>Services</u>	not a need	minor need	major need	critical need
√ the services they receive now				

<input type="checkbox"/> Day care while you attend school	0	1	2	3
<input type="checkbox"/> Extended day care before or after consumer's program	0	1	2	3
<input type="checkbox"/> Day care on weekends or nights while you go to work or school	0	1	2	3
<input type="checkbox"/> Occasional out-of-home care when you need a break (respite care)	0	1	2	3
<input type="checkbox"/> Occasional in-home care when you need a break (respite care)	0	1	2	3
<input type="checkbox"/> Out -of-home medical care (respite care)	0	1	2	3
<input type="checkbox"/> In-home medical care (respite care)	0	1	2	3
<input type="checkbox"/> Medical services	0	1	2	3
<input type="checkbox"/> Dental services	0	1	2	3
<input type="checkbox"/> Nursing services	0	1	2	3
<input type="checkbox"/> Daily in-home personal care assistance	0	1	2	3
<input type="checkbox"/> Occasional in-home personal care assistance	0	1	2	3
<input type="checkbox"/> Special equipment or assistive devices (braces, wheel chairs, etc.)	0	1	2	3
<input type="checkbox"/> Home modification	0	1	2	3
<input type="checkbox"/> Vehicle modification	0	1	2	3
<input type="checkbox"/> Legal services and guardianship information	0	1	2	3
<input type="checkbox"/> Advocacy services	0	1	2	3
<input type="checkbox"/> Counseling services	0	1	2	3
<input type="checkbox"/> Behavioral management services	0	1	2	3
<input type="checkbox"/> Adult development services	0	1	2	3
<input type="checkbox"/> Special therapies (occupational, speech, physical, etc.)	0	1	2	3
<input type="checkbox"/> Training for living in the community	0	1	2	3
<input type="checkbox"/> Adult day programming services	0	1	2	3
<input type="checkbox"/> Weekend recreational activities	0	1	2	3
<input type="checkbox"/> Summer recreational activities	0	1	2	3
<input type="checkbox"/> Summer camp	0	1	2	3
<input type="checkbox"/> Camp during school breaks	0	1	2	3
<input type="checkbox"/> Group recreational activities	0	1	2	3
<input type="checkbox"/> Individual supported recreational activities	0	1	2	3
<input type="checkbox"/> Getting financial assistance from government agencies	0	1	2	3
<input type="checkbox"/> Transportation services	0	1	2	3
<input type="checkbox"/> Case management services	0	1	2	3
<input type="checkbox"/> Other _____	0	1	2	3
<input type="checkbox"/> Family support groups	0	1	2	3
<input type="checkbox"/> Information about available services for persons with disabilities	0	1	2	3
<input type="checkbox"/> Planning for future service needs	0	1	2	3
<input type="checkbox"/> Learning about options for their out-of-home living arrangements	0	1	2	3
<input type="checkbox"/> Learning more about their employment options	0	1	2	3
<input type="checkbox"/> Planning for their future financial needs and security	0	1	2	3
<input type="checkbox"/> Services for the family _____	0	1	2	3

15. What agencies are currently providing services to this person? _____

Future Service Needs

16. Please tell us if you believe this person will need any of the following services in the future and whether or not they receive them now. Place a checkmark in a box to indicate when the service(s) will be needed. (Within the 2 years, in 3 to 5 years, or in 6 or more years.)

<u>Services</u> the services they will be needing	Within 2 yrs	In 3-5 yrs	In 6 + yrs
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Day care while you attend school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Extended day care before or after consumer's program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Day care on weekends or nights while you go to work or school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Occasional out-of-home care when you need a break (respite care)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Occasional in-home care when you need a break (respite care)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Out-of-home medical care (respite care)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In-home medical care (respite care)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nursing services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Daily in-home personal care assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Occasional in-home personal care assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Special equipment or assistive devices (braces, wheel chairs, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Home modification	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vehicle modification	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Legal services and guardianship information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Advocacy services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Counseling services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behavioral management services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adult development services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Special therapies (occupational, speech, physical, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Training for living in the community	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adult day programming services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weekend recreational activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Summer recreational activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Summer camp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Camp during school breaks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Group recreational activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Individual supported recreational activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting financial assistance from government agencies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transportation services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Case management services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family support groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Information about available services for persons with disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Planning for future service needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning about options for their out-of-home living arrangements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning more about their employment options	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Planning for their future financial needs and security	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Services for the family _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

17. What sources of income does this person have other than employment?

- SSI (Supplemental Security Income)
- financial support from family
- SSDI (Social Security Disability Insurance)
- other _____

Background Questions (For statistical analysis only)

a. Is this a two-parent or single parent household?	<input type="checkbox"/> two parents	<input type="checkbox"/> single-parent	<input type="checkbox"/> other
b. What is the total number of persons under 18 in the household?	_____	over 18	_____
c. How many others in the household, if any, have developmental disabilities? _____			
d. What is your education	<input type="checkbox"/> did not finish high school	<input type="checkbox"/> high school/GED	
	<input type="checkbox"/> some college	<input type="checkbox"/> college degree	
e. What is your age? _____			
f. Total family income:	<input type="checkbox"/> Under \$20,000.	<input type="checkbox"/> \$20,000-39,999	<input type="checkbox"/> \$40,000-59,999 <input type="checkbox"/> \$60,000 +

Name _____

Address _____

City _____ Zip _____

Phone _____ E-mail _____

Family member with developmental disabilities: Name _____ Age _____

Does this individual live with you? YES NO Type of disability _____

Address if not living with you _____

Do you know of Stone County residents with developmental disabilities?

YES NO Please list their name and address if available _____

May we contact you about future meetings or information? YES NO