PERSONAL CARE SERVICES PROGRAM
Qualified Intellectual Disabilities Professional (QIDP) Assessment
Interviewing Data

Participant Name: _____ Medicaid Identification #: _____

Address: _____ Sex: _____ DOB: _____

City: _____ Phone:_____

Primary Physician: _____

Legal Status (Guardianship): _____

The plan is:

___ Initial Assessment ___ Annual Reevaluation ___ Care Plan Change

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FUNCTIONAL ASSESSMENT

1. Indicate the highest level of prompt required for the participant to complete each skill and/or specific need identified. It may be necessary to consult other resources, such as evaluations completed by school/day program personnel, to complete the assessment.

Key:
I = Independent
V = Verbal
G = Gestural
M = Model
P = Physical

TASK	PROMPT LEVEL	SPECIFIC NEEDS, COMMENTS, RECOMMENDATIONS
Self help, personal appearance		
Feeding, eating, drinking		
Dressing		
Toileting		
Oral hygiene		
Shaving		
Bathing		
Hand washing		
Menses care		
Physical development, gross motor skills		

TASK	PROMPT LEVEL	SPECIFIC NEEDS, COMMENTS, RECOMMENDATIONS
Fine motor skills		
Communication receptive language		
Expressive language		
Personal, social skills, play skills		
Interaction skills		
Group participation		
Social amenities		
Sexual behavior		
Leisure activities		
Expression of emotions		
Cognitive functioning pre-academics (e.g., colors)		
Health care, personal welfare, treatment of injuries, health problems		
Medication administration		
Prevention of health problems		
Personal safety		
Consumer skills handling money		
Purchasing		
Banking		
Budgeting		
Domestic skills household cleaning		
Clothing care		
Kitchen skills		
Household safety		
Community orientation travel skills		
Utilization of community resources		
Telephone usage		
Community safety		

2. Does the participant exhibit any of the following inappropriate behaviors? Please describe.

	Description	Frequency per Month
☐ Pica		
☐ Aggression		
☐ Inappropriate Sexual Behavior		
☐ Self-Injurious		
☐ Self-Stimulation		
☐ Other		

3. Does the participant receive a behavior modifying drug(s)? Yes _____ No_____
If yes, answer a – d.

a. What behavior modifying drug(s) does the participant receive? Please list:
_____
_____

b. For what behavior is the drug(s) prescribed? _____
_____

c. Describe all side effects noted from the use of the drug(s)? _____
_____
_____

d. On what date was the drug(s) last reduced? _____
What was the participant's reaction to the reduction? _____
_____

4. Day program and other services necessary to meet the participant's needs:
_____
_____

5. Description of family/community supports for participant:
_____
_____
_____

6. Specify the time and frequency necessary for the personal care services (PCS) provider to address each need. An individualized training program must be developed for each priority training need and included in the plan of care.

Frequency Week	Priority Needs	Date Set	Date Met	Minutes/Day	Days/Week	Total Time/Week
	Deferred Needs					

7. Standby Assistance: All required care needs which cannot be scheduled (on-site, on-call time necessary).

_____
_____
_____
_____

Grand Total: _____

_____ _____ _____
QIDP Signature Date Contact-Phone QIDP

Mailing Address:
_____

City: _____ State: _____ Zip Code: _____

In Home Training Plan
To be Attached to the Plan of Care

Participant Name: _____ Medicaid Identification #: _____
For each priority training need identified on the QMRP assessment, an individualized training program must be developed for the personal care services (PCS) provider to implement. The individualized programs must be included as part of this plan.

QIDP Signature: _____ Date: _____

_____

SPECIAL INSTRUCTIONS/COMMENTS:
_____
_____
_____
_____
_____
_____
_____
_____