SECTION 1: INFORMATION

1. Social Security Number										
			-			-				

Enter the individual's nine digit social security number. Since this is a key field, please double check the accuracy of this number, taking care to avoid transposed numbers, etc.

NOTE: The PERT unit of Health Care Policy can generate an SSN for the purposes of BASIS. Call Shirley at (785) 296-4576.

2. Date of Birth							

Enter two digits for the month, two digits for the day, and four digits for the year excluding slashes (e.g., 07171997). Again be careful to enter the correct date to ensure accurate data retrieval.

3. Last Name												

Enter as many letters of the last name of the individual as you have spaces for.

4. First Name												

Enter as many letters of the individual's full given first name as you have spaces for. Do not enter a nickname.

5. MI

If the individual has no middle name, leave this field blank.

6. Street Address													

Enter the house number, street name, and apartment number, if applicable, of the address where the individual currently lives. Do not enter a Post Office box or the address of the agency serving the individual; use the address of the residence.

7. City													

Enter the name of the city in which the individual currently lives.

8. State	

Enter the two letter abbreviation for the state in which the individual lives.

9. Zip Code				

Enter the five digit zip code for the individual's mailing address.

10. Phone Number												

Enter the ten digit telephone number of the residence of the individual, including area code. If the individual has no phone, leave this field blank.

11. County of Residence		

Enter the three digit code for the county in which the individual currently lives. County codes may be found in Appendix D.

12. Home County		

Enter the three digit code for the county of residence of family members, friends, or other persons who know and care about this person. If there are no known natural supports the home county may be the county in which this person resided prior to placement or the county of residence of the guardian.

13. Medicaid ID Number											

Enter the number found on the individual's Kansas medical card. If he/she does not have a medical card, leave the field blank.

14. Sex	
	1. Male
	2. Female

Mark male or female.

15. Race	
	1. White
	2. African American
	3. Native American
	4. Asian/Pacific Islander
	5. Hispanic
	6. Other

Mark the one which best describes the individual's race or ethnic origin.

16. Residential Status	
	1. Living alone
	2. Living with 2 or less persons with MR/DD
	3. Living with 3 to 7 other persons with MR/DD
	4. Living with 8 or more persons with MR/DD
	5. Living with relatives
	6. Living with non-relatives who are not MR/DD
	7. Other

Mark the one category which best describes the individual's current living arrangement. The categories are defined below:

NOTE: What if the person is married? The familial relationship takes the precedent, i.e., living with a relative.

17. Day Programs (May mark up to 3)	
	1. Attends school in a classroom 50% or more of the day with people who are not MR/DD
	2. Attends school in a classroom less than 50% of the day with people who are not MR/DD
	3. Generic community activities less than 20 hours per week
	4. Generic community activities 20 or more hours per week.
	5. Work environment designed for persons with MR/DD less than 20 hours per week.
	6. Work environment designed for persons with MR/DD 20 or more hours per week.
	7. Competitive employment less than 20 hours per week.
	8. Competitive employment 20 or more hours per week.
	9. Agency based non-work activities less than 20 hours per week.
	10. Agency based non-work activities 20 or more hours per week.
	11. Other

Mark up to three categories which best describe the individual's current activities which occur during the day. The categories are defined in the manual.

18. Identified Disabilities		
Y	N	1. Mental Retardation
Y	N	2. Autism
Y	N	3. Cerebral Palsy
Y	N	4. Epilepsy/Seizure Disorder
5. Other (description)		

Circle "yes" for all that apply.

BEST PRACTICE: Information on the disability should be documented in the consumer file.

19. Primary Disability

Enter the one digit number of the one developmental disability in number 18 above, which is considered the individual's primary disability.

NOTE: When marking this box it is important to seek the team's input. Do not show developmental delay in this box after the age of 8.

BEST PRACTICE: If developmental delay is still being shown in box 19 during the year the person turns eight, the family needs to be encouraged to work on getting a diagnosis by the next annual assessment.

20. Special Population (may mark up to 3)	
	1. CIP
	2. Child in Custody
	3. Self-Directed Care
	4. Self-Determination
	5. Special Care Rate
	6. ICF/MR Closure
	7. Placed from SMHH

Mark up to three categories, if they apply. Many individuals will have nothing marked in this field. The categories are defined below:

21. Psychiatric Diagnosis	
1.	
2.	
3.	

Enter up to three DSM-IV diagnosis codes. If the individual has no psychiatric diagnosis, leave this field blank. Do not enter a DSM-IV code for any of the identified disabilities marked in number 18 above.

NOTE: Only current diagnoses should be entered with supporting documentation that the person is receiving treatment or has refused treatment. Example: current prescription

BEST PRACTICE: Information of psychiatric diagnosis should be documented in the consumer file.

22. Intellectual Assessment	
	1. Normal
	2. Mild
	3. Moderate
	4. Severe
	5. Profound
	6. Undetermined

Enter the one category which best indicates the individual's level of intellectual functioning based on the most recent psychological assessment available. If mental retardation was entered as the primary disability in number 19, you may not enter #1 or #6.

23. Hearing: (with hearing aid if used)	
	1. Normal
	2. Mild Loss
	3. Moderate Loss
	4. Severe Loss
	5. Profound Loss
	6. Undetermined

Mark the category which best describes the person's hearing with the use of a hearing aid if one is used. If hearing levels are different for each ear, mark the category which equates to the most severe loss.

24. Vision: (with glasses or contacts if used)	
	1. Fully Sighted
	2. Moderate Impairment
	3. Severe Impairment
	4. Light Perception
	5. Total Blindness
	6. Undetermined

Mark the category which best describes the person's vision with the use of glasses or contact lenses if used. Note that legally blind may not necessarily be #5, "Total blindness". A person could be legally blind without being totally blind. For a person who is fully sighted in one eye only, mark #2, "Moderate impairment".

Guardian Information

BEST PRACTICE: In order for a guardian to be added or changed, the CDDO should be supplied a copy of the court-appointed guardianship papers.

25. Guardian Last Name													

Enter as many letters of the last name of the individual's guardian as you have spaces for. Do not complete this field unless a guardian has been legally appointed, if the individual is an adult, or unless the individual is under age 18. If a guardian has not been appointed, skip #26 - #32. For a child in custody simply put "SRS" in this field and leave the remaining guardian information blank.

26. Guardian First Name													

Enter the guardian's full, given first name. Do not enter a nickname.

27. Guardian Street Address													

Enter the house number, street name, and apartment number, if applicable, of the address where the individual's guardian currently lives.

28. Guardian City													

Enter the name of the city in which the individual's guardian currently lives.

29. State	

Enter the two letter abbreviation for the state in which the individual's guardian currently lives.

30. Zip Code				

Enter the five digit zip code for the individual's guardian's mailing address.

31. Guardian Phone Number												

Enter the ten digit phone number, including area code, for the individual's guardian.

Service Coordinator Information

32. **Service Coordinator Last Name**													

Enter the last name of the individual's service coordinator.

33. Service Coordinator First Name									

Enter the first name of the individual's service coordinator.

34. Service Coordinator Phone Number w/area code												

Enter the ten digit phone number of the individual's service coordinator, including the area code.

35. Reporting Agency				

Enter the six digit code for the agency whose staff is completing this information. (CDDO BASIS Contacts have access to these codes.) In the case of persons living in private ICFs/MR or SMRHs, this will be the agency code of the ICF/MR or the SMRH.

36. Date of Report							

Enter the date the information is completed on this section of BASIS, not the date information is entered into the computer.

SECTION 2: ASSESSMENT

Social Security Number										
			-			-				

Name													

The Social Security number and name of the individual will automatically be entered into the computer when it is entered in Section 1: Information. For your paper records, however, you may want to mark them on the Assessment form.

1. Type of Report (mark only one)	
	1. Initial Assessment
	2. Annual Re-evaluation
	3. Special Re-evaluation w/HCP Permission
	4. Re-admitted from same facility
	5. Transferred From Another Facility
	6. Child Reaching 5 years of age
	7. Correcting Social Security Number

If this is first time assessment information is being entered into BASIS for the individual, mark 'Initial'. Thereafter, mark 'Annual Re-evaluation' when the individual's re-evaluation is completed. If the person left services altogether (e.g., to go to a nursing facility, mental health facility, decided he/she did not need services, etc.) and came back to the same CDDO area (regardless of which agency actually served the person in the area) mark 'Readmitted'. If the person moved from CDDO area to another, mark 'Transferred'. 'Special Re-evaluation' is only marked when you have permission from the HCP Administrator of Program Support to revise the Assessment (see page 10 of this manual). When a Social Security number has been entered incorrectly and the record must be deleted and re-entered, use 'Correcting Social Security Number.'

2. Date Assessment Completed							

Mark the date that the Assessment is completed for the person. Do not mark the date Assessment data is entered into the computer.

3. Medical Conditions - Indicate yes or no for each of the following:		
Y	N	1. Respiratory
Y	N	2. Cardiovascular
Y	N	3. Gastro-intestinal
Y	N	4. Genito-urinary
Y	N	5. Neoplastic Disease
Y	N	6. Neurological Diseases

Mark 'yes' only if the individual actually has had any of the conditions any time within the last 12 months. Otherwise, mark 'no'. The following is a brief explanation/example of each category; when there is doubt about whether an individual has any of these, check the medical record or interview a medical professional:

See manual guidance regarding the specific Medical conditions.

NOTE: The Neurological diseases category does **not** include neurological **conditions** which are reported in #18 of Section 1.

NOTE: To answer 'yes', documentation should be available that the person has been receiving on-going medical treatment as part of a treatment plan prescribed by a physician.

4a. Does individual have a history of seizures?	
Yes (1)	No (2)

Mark 'yes' if the person has any documented history of seizure activity and proceed to questions 4b and 4c. If the person has no seizure history, mark 'no' and skip to question 5a.

NOTE: Consider only seizures of an epileptic nature. Do not include seizures that may have occurred as the result of high blood pressure or another medical reason.

BEST PRACTICE: Seizure history should be documented in the consumer file.

4b. Which type of seizure has the individual experienced in the last twelve months? (Mark all that apply)	
	No seizures this year
	Simple partial (Simple motor movements affected no loss of awareness)
	Complex partial (loss of awareness)
	Generalized - absence (Petit Mal)
	Generalized - tonic-clonic (Grand Mal)
	Had some type of seizure-not sure of type

Mark all types of seizures the person has experienced in the last twelve months. If the person has not had any seizures in the last twelve months, mark 'no seizures this year' and skip to question 5a. If you know the person has had seizures in the last twelve months but are unsure of the type of seizure, mark 'had some type.....' but ask for some information to be collected during the next year..

4c. Frequency - In the past year, how frequently has the individual experienced seizures that involve loss of awareness and/or loss of consciousness?	
	1. None during the past year
	2. Less than once a month
	3. About once a month
	4. About once a week
	5. Several times a week
	6. Once a day or more

Mark the one category which indicates how frequently the person has experienced seizures that involve a loss of awareness and/or consciousness in the last twelve months. If ta person's seizures are very episodic or cyclical in nature, report the frequency of episodes over the last twelve months rather than individual occurrences. See example in manual.

5a. Is Individual currently taking prescription medication?	
Yes (1)	No (2)

Mark 'yes' if the individual is taking any of the medications listed (by any route, including injections) on an ongoing, scheduled basis for a period of 12 months or more, which is prescribed by a physician and cannot be purchased without a prescription. See guidance regarding prescription v. non-prescription.

5b. Is individual currently taking prescription medication?	Not Currently	Currently
Antipsychotic Medication		
Antianxiety Medication		
Antidepressant Medication		
Anticonvulsant Medication		
Diabetes Medication		
Sedative/hypnotic Medication		
Other maintenance Medication		

For each type of medication, mark the number which indicates whether the person is taking a medication in that class.

1. Not currently taking this type of medication

2. Is currently taking this type of medication.

NOTE: Although an individual may be taking a medication in a particular class, they may be taking it for another purpose, yet the class type still needs to be recorded (i.e., individual may be taking an antipsychotic drug to regulate their heart, or taking an antidepressant to help with sleeping. The class type should still be recorded as antipsychotic or antidepressant respectively).

BEST PRACTICE: A list of current medications should be available at the screening for review.

5c. Does individual receive medication by injection?	
Yes (1)	No (2)

Mark 'yes' if the person receives **any ongoing** medication by injection. Examples of these would include Depo-Provera given once every three months, haloperidol decanoate given monthly, allergy medications injected weekly, and insulin given daily.

NOTE: This would not include PRN injections and would also not include annual flu shots, dialysis, blood transfusions, baclophen pumps, or injections by feeding tubes.

5d. Level of Support – Which best describes the level of support the individual receives when taking prescription medications.	
	1. No medications
	2. Total Support
	3. Assistance
	4. Supervision
	5. Independent

Indicate the level of support the person receives when taking prescription medication. Please read the descriptions of the levels of support carefully. Refer to the manual for descriptions of levels of support.

NOTE: If the person takes more than one medication and the support is provided at different levels (e.g., tablets and injections), mark the one that indicates more support. Mark only one response.

NOTE: This section has nothing to do with the consumer's ability to order medications.

6. Indicate whether or not the individual:		
Y	N	Missed more than a total of two weeks of regular activities due to medical conditions during the last year
Y	N	Was hospitalized for a medical problem in the last year
Y	N	Presently requires care giver be trained in special health care procedures (e.g., ostomy care, positioning, adaptive devices)
Y	N	Presently requires special diet planned by dietitian, nutritionist, nurse, e.g., high fiber, low calories, low sodium, pureed

This question relates to the consequences of a person's medical condition. In determining whether or not the person missed two weeks of regular activities due to medical conditions in the past 12 months, please consider all aspects of the person's medical condition.. Exclude routine examinations or assessments. Include only days missed due to actual medical problems. Hospitalization only refers to in-patient overnight stay during which the person was actually admitted to a hospital. It does not include out-patient procedures nor psychiatric hospitalization. When answering whether or not the person requires the care giver to have training in special health care procedures, include the following special procedures and equipment. Refer to manual for additional guidance.

NOTE: "Two weeks" should be interpreted as 14 calendar days.

NOTE: Special Healthcare Procedures does not include CPR, Heimlich Maneuver, Seizure Training, or Behavior Management.

NOTE: A special diet is only one that has been specially planned by a nutritionist, dietician, nurse, or physician specifically for that person. Mark this question 'yes' ONLY if additional staff support is needed.

BEST PRACTICE: Documentation should exist that the diet is related to some type of medical condition.

7. Indicate which one response best describes the individual's typical level of mobility.	
	1. Walks independently
	2. Walks independently but with difficulty (no corrective device)
	3. Walks independently with corrective device
	4. Walks only with assistance from another person.
	5. Can not walk

Mark the one response that best describes the person's typical level of mobility. Note that 'walks independently but with difficulty' involves walking unaided; 'walks independently with corrective device' involves the use of a corrective device such as a cane or walker, 'walks only with assistance from another person' means the person needs some help from another person when walking. Include sensory deficits in your assessment if they are a significant impediment to mobility.

NOTE: For number 3, a gait belt would be considered a corrective device.

8a. Does individual use a wheelchair?	
Yes (1)	No (2)

Mark 'yes' if the person uses a wheelchair. If the person does not use a wheelchair, mark 'no' and skip to question 9.

NOTE: This does NOT include very infrequent use. Answer 'yes' only if the person uses a wheelchair more than 50% of the time.

8b. Indicate the one response that best describes wheelchair (may be motorized) mobility.	
	1. Can use wheelchair independently, including transferring
	2. Can use wheelchair independently with assistance in transferring
	3. Requires assistance in transferring and moving
	4. No Mobility – Must be transferred and moved.

Mark the one response that best describes the person's wheelchair mobility. Note that the wheelchair may be motorized.

9. Indicate whether or not the individual:		
Y	N	Can roll from back to stomach
Y	N	Can pull self to standing
Y	N	Can walk up and down stairs by alternating feet from step to step
Y	N	Can pick up a small object
Y	N	Can transfer an object from hand to hand
Y	N	Can mark with pencil, crayon or chalk
Y	N	Can turn pages of a book one at a time
Y	N	Can copy a circle from an example
Y	N	Can cut with scissors along a straight line

Mark 'yes' or 'no for each item. Try here to base your response primarily on personal knowledge and observation of the person and only secondarily on the person's record. These questions should be viewed as whether or not the person is presently capable of doing these things, not on his/her willingness/unwillingness to do the activity.. See manual for additional guidance.

NOTE: Pulling self to standing from a chair would be a 'yes' response

10. Indicate whether or not the individual can perform each of the following:		
Y	N	Sort objects by size
Y	N	Correctly spell first and last name
Y	N	Tell time to nearest five minutes (digital or analog)
Y	N	Distinguish between right and left
Y	N	Count ten or more objects
Y	N	Understand simple functional signs (e.g., EXIT, restrooms)
Y	N	Do simple addition and subtraction of figures
Y	N	Read and comprehend simple sentences
Y	N	Read and comprehend newspaper or magazine articles

Mark 'yes' or 'no' for each item. This question is attempting to determine cognitive abilities. The person may have to be prompted verbally, but base your answers only on the person's capabilities as in the previous question. **Persons should be able to perform the tasks a majority (not necessarily 100%) of the time. For each of the items the person should be able to generalize their ability to other settings.**

11. Indicate whether or not the individual typically displays each of the following receptive and expressive communication skills.		
Y	N	Understands the meaning of "No"
Y	N	Understands one-step directions (e.g. "Put on your coat")
Y	N	Understands two-step directions (e.g., "Put on your coat, then go outside")
Y	N	Understands a joke or story
Y	N	Indicates a "Yes" or "No" response to a simple question
Y	N	Asks simple questions
Y	N	Relates experiences when asked
Y	N	Tells a story, joke, or the plot of a television show
Y	N	Describes realistic plans in detail

Mark 'yes' or 'no' for each item. In this item the word 'typically' means most of the time. Also, note that the method of communication can be written, verbal, sign, or symbolic and should typically occur naturally for the person.

BEST PRACTICE: The persons' communication style must be considered, so be prepared to accept responses in written, verbal, sign or symbolic forms.

1. Not this year; 2. Occasionally (Less than once a month); 3. Monthly (About once a month); 4. Weekly (About once a week); 5. Frequently (Several times a week); 6. Daily (Once a day or more)

12. Indicate the frequency of each behavior over the last twelve months.						
Has tantrums or emotional outbursts	1	2	3	4	5	6
Damages own or others property	1	2	3	4	5	6
Physically assaults others	1	2	3	4	5	6
Disrupts others' activities	1	2	3	4	5	6
Is verbally or gesturally abusive	1	2	3	4	5	6
Is self-injurious	1	2	3	4	5	6
Teases or harasses peers	1	2	3	4	5	6
Resists supervision	1	2	3	4	5	6
Runs or wanders away	1	2	3	4	5	6
Steals	1	2	3	4	5	6
East inedible objects	1	2	3	4	5	6
Displays sexually inappropriate behavior	1	2	3	4	5	6
Smears feces	1	2	3	4	5	6

Mark the appropriate frequency for each of the items, over the course of the past twelve months. If the person has not exhibited a certain behavior in the past twelve months, enter 1 for that behavior. If a certain behavior is very episodic or cyclical in nature, report the frequency of the episodes over the last twelves months rather than individual occurrences. See manual for more guidance.

NOTE: Restrict your answers here to behaviors which have been observed at the person's current situation only, even if you are aware of behavior problems exhibited in the past by the person in other settings.

NOTE: Think of behaviors in terms of being "beyond socially acceptable".

13. As a result of any behavior problem(s) consider whether or not each of the following presently apply:		
Y	N	Behavior problems currently prevent this individual from moving to a less restrictive setting
Y	N	Has a written behavior intervention plan
Y	N	Individual's environment must be carefully structured to avoid behavior problems
Y	N	Because of behavior problems, staff must sometimes intervene physically with individual (e.g., physically restrain individual or guide individual from)
Y	N	Because of behavior problems, a supervised "time-out" period is needed at least once a week
Y	N	Because of behavior problems, the individual requires one-on-one supervision for many program activities

Mark 'yes' or 'no' for each consequence of a person's behavior as it is currently exhibited. Respond based on what has happened as a result of any behavior on the part of the individual, not just those listed in the previous question.

To answer the first item "yes" the person must be exhibiting some aberrant behavior which his/her current environment is helping to lessen, however the behavior must be occurring at some frequency. It is not appropriate to answer "yes" to this item because you believe the person would display some aberrant behavior in a different environment.

Answer "yes" to the second item if there is **a written plan** and the following conditions are met:

- there is a clear definition of the behavior(s) at issue;
- there is a clear definition of what support staff are doing with regard to the behavior (prevention and support strategies, responses);
- there is collection of information as to the frequency and objective severity of the behavior at issue (as required by regulation); and,
- the plan ensures that the supports are specific to the individual involved (i.e. person-centered).

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SELF-CARE/DAILY LIVING SKILLS
1. Total Support (Completely Dependent); 2. Assistance (Requires lots of hands-on-help), 3. Supervision (requires mainly verbal prompts), 4. Independent (Starts and finishes without prompts or help)

14. As best you can, indicate how independently the individual typically performs each activity:				
Toileting/bowels	1	2	3	4
Toileting/bladder	1	2	3	4
Taking aa shower/bath	1	2	3	4
Brushing teeth/cleaning dentures	1	2	3	4
Brushing/combing hair	1	2	3	4
Selecting clothes appropriate to weather	1	2	3	4
Putting on clothes	1	2	3	4
Undressing self	1	2	3	4
Drinking from a cup or glass	1	2	3	4
Chewing and swallowing food	1	2	3	4
Feeding self	1	2	3	4

Mark the appropriate number (1-4) for each item. **We are interested here in how well the person performs these activities as stated in each item from start to finish at a reasonably acceptable level**. Refer to the manual for specific examples and definitions of the specific descriptors.

15. As best you can, indicate how independently the individual typically performs each task				
Making bed	1	2	3	4
Cleaning room	1	2	3	4
Doing laundry	1	2	3	4
Using telephone	1	2	3	4
Shopping for a simple meal	1	2	3	4
Preparing foods that do not require cooking	1	2	3	4
Using stove or microwave	1	2	3	4
Crossing street in residential neighborhood	1	2	3	4
Using public transportation for a simple direct trip	1	2	3	4
Managing own money	1	2	3	4

These items use the same rating scale listed for question 14. Where the individual's situation does not really allow him or her to perform a certain activity, we would like an estimate of the person's ability to perform this task independently. For example, 'Crossing street in residential neighborhood' - If the situation doesn't allow someone to do this on their own, estimate their ability to do this independently.

Assessment completed by:

16. Last Name											

First Name											

Phone Number (area code)
( ) –

Fill in the last and first names and phone number of the person who completed the assessment. This may or may not be the Service Coordinator listed in the Information Section.