

FUNCTIONAL COMMUNITY ASSESSMENT

INDIVIDUAL'S NAME _____

STAFF PERSON COMPLETING ASSESSMENT _____

MONTH/YEAR ORIGINAL ASSESSMENT COMPLETED _____

A. MEDICATION

1. Does this person take prescribed medication? Yes No
(If YES, complete remaining questions in Section A. If NO, respond to question 2 only and proceed to Section B).
2. How will the person obtain and self-administer over-the-counter medications not prescribed by a physician?

3. Can the person independently place an order for and obtain a prescription from the physician?
 Yes No - If NO, describe support or training needed:

4. Can the person independently notify their physician and/or pharmacist of all over-the-counter medications being used? Yes No - If NO, describe support or training needed:

5. Check which one of the following apply:
 Individual is capable of handling his/her own medications without supervision.
 Individual will need supervision with the self-administration of medication according to APD's Rule Chapter 65G-7, Florida Administrative Code.

Explanation:

Which staff will be providing supervision? _____

Individual will need staff to administer his/her medication according to the APD's Rule Chapter 65G-7, Florida Administrative Code.

Explanation:

6. Can the individual independently take proper medications to work, on vacation, or to activities away from home? Yes No

If NO, describe support or training needed:

B. NUTRITION

1. Can the person plan his/her own menus? Yes No

If NO, describe support or training needed:

2. Is the person on a special diet monitored by a physician? Yes No

If YES, describe the diet:

Explain medical condition that prompted the diet:

3. Can the person independently purchase his/her own groceries? Yes No

If NO, describe support or training needed:

4. Can the person independently prepare his/her own meals? Yes No

If NO, describe support or training needed:

5. Can the person independently set the table for dining? Yes No

If NO, describe support or training needed:

6. Can the person eat his/her meals without assistance? Yes No

If NO, describe support or training needed:

C. SEXUALITY

1. Can the person differentiate between a casual relationship and an intimate relationship?

Yes No

Describe any areas of concern:

2. Does the person have understanding of sexually transmitted diseases (e.g., HIV/AIDS, etc.)?

Yes No

If NO, describe support or training needed:

3. Is the person aware of their right to say, "No"? (Does the person understand the difference between consensual and non-consensual sex?) Yes No

Describe any areas of concern:

4. If applicable, does the person have a functional understanding of protected sex and birth control? Yes No

Describe any areas of concern:

D. FIRST AID

1. Can the person administer basic first aid to himself/herself and access/use a first aid kit?

Yes No -- If NO, describe support or training needed:

E. SERIOUS ACCIDENTS AND ILLNESS

1. Can the person recognize when he/she is ill or injured and requires outside help or attention?

Yes No -- If NO, describe support or training needed:

2. Can the person access the following emergency assistance if needed:

Dial 911? Yes No

Access his/her waiver support coordinator or service provider 24-hours? Yes No

Summon a roommate or neighbor? Yes No

If NO, describe support or training needed:

F. SEVERE WEATHER AND OTHER NATURAL DISASTERS

1. Does the person know how to respond to severe weather and other natural disasters?

Yes No -- If NO, describe support or training needed:

G. FIRE AND SAFETY CONSIDERATIONS

1. Did the person demonstrate the proper use of a fire extinguisher? Yes No

2. Can the person self-evacuate through an accessible exit? Yes No

If NO, describe support or training needed:

3. Does the person know where to go if they need to be temporarily relocated? Yes No

If YES, where? _____

If NO, describe support or training needed:

H. PERSONAL CARE

1. Is the person independent in his/her self-care? Yes No

If NO, describe support or training needed:

If NO, will the person need personal supports? Yes No

If YES, has this service been arranged by the support coordinator? Yes No

I. HOUSEHOLD MAINTENANCE/MANAGEMENT

1. Is the person able to independently maintain his/her home? Yes No

If NO, describe specific areas of support or training needed:

2. Can the person monitor his/her household for basic repairs needed and safety concerns such as leaky faucets, frayed electrical cords, etc.? Yes No

If NO, describe specific areas of support or training needed:

3. Can the person contact the landlord and/or service technicians for needed repairs?

Yes No -- If NO, describe support or training needed:

4. Does the person know how to secure exterior doors and windows, etc. at night or when he/she leaves the house? Yes No

If YES, do they consistently remember to do so? Yes No

5. Is the person aware of their right to ask would be visitors to identify themselves and to refuse entry if they so desire? Yes No

J. MONEY MANAGEMENT

1. Can the person make simple purchases (up to \$10)? Yes No

2. Can the person count change? Yes No

3. Can the person write checks to pay bills or make purchases? Yes No

4. Can the person sign their checks? Yes No

5. Can the person make bank transactions independently? Yes No

If NO, describe areas of concern:

6. Can the person prepare a basic budget? Yes No

7. Can the person follow a basic budget? Yes No

If NO, describe areas of concern:

8. Can the person exercise appropriate assertiveness when others ask him/her for some/all of their money? Yes No

If NO, describe areas of concern:

K. COMMUNITY MOBILITY

1. What will be the person's routine method of mobility in the community?

2. Can they access transportation services independently? Yes No

If NO, describe areas of concern:

3. Can the person cross streets safely? Yes No

If NO, describe areas of concern:

4. Does the person practice community safety (awareness of others, handling strangers, etc.)?

Yes No

If NO, describe areas of concern:

L. INTERPERSONAL /RECREATION / LEISURE

1. Can the person engage in casual, friendly conversation in person with others? Yes No

If NO, describe areas of concern:

2. Can the person call people on the telephone? Yes No

3. Can the person plan/participate in their own community activities (shopping, movies, shows, sporting events, health clubs, parks, etc.) Yes No

Which activities do they participate in routinely?

Describe areas of concern:

4. Can the person manage their own free time? Yes No

Describe areas of concern:
