Washington State Department of Social & Health Services
Transforming lives

AGING AND LONG-TERM SUPPORT ADMINISTRATION

Individual with Complex Behaviors

CLIENT'S NAME	
CLIENT ACES ID NUMBER	REGION

MENTAL HEALTH DIAGNOSIS
☐ Yes ☐ No
Principle diagnosis:

Current presentation in Section 1.

Information can be obtained from, conversation with Psychiatrist, Nurse, Medical Physician, Social Worker, Mental Health Professional, Counselor, or Certified Peer Specialist.

CLINICAL IMPRESSIONS

RISK ASSESSMENT Completed by Hospital or Behavioral Health Provider
☐ Yes ☐ No ☐ NA
Date:

INDIVIDUAL CRISIS PLAN
Document within CARE the expected date Crisis Plan is to be received by provider.
☐ Yes ☐ No ☐ NA

MEDICATION AND MEDICAL CONDITIONS MONITORING
Is the individual taking medication as directed and agreeable to medical treatment(s):
☐ Yes ☐ No ☐ NA
Last medication review:

COORDINATED BEHAVIOR SUPPORT AND TEAM MEETINGS ESTABLISHED
Complete a comment within CARE in Treatment List: Type Programs: Behavior Management Plan detailing the plan. Refer to WAC: 388-107: 388-106-0336 ☐ Yes ☐ No ☐ NA

Section 1. Check one or all that apply (documentation must be present in file)

Current presentation and behaviors that increase risk of behavioral crisis.

Check all relevant boxes below.

	HISTORY OF OCCURRENCE INDICATE FREQUENCY AS DAILY, WEEKLY, OR MONTHLY		
	30/60/90 DAYS	1–2 YEARS	3-5+ YEARS
☐ **Assaultive** (significant aggression or physical abuse toward others) Violent Mood Swings, Unpredictable / Impulsive Describe / clarify (please list any charges related to this behavior): Frequency:	☐	☐	☐
☐ **Destructive** (significant property destruction which puts self or others at risk) Describe / clarify (please list any charges related to this behavior): Frequency:	☐	☐	☐
☐ **Self-Injurious** (suicidal behavior; significant self-injury, danger to self). Describe / clarify (please list any charges related to this behavior): Frequency:	☐	☐	☐
☐ **History of felony and/or misdemeanor type behavior. May or may not have been charged** (shoplifting, theft, trespassing, buying liquor for minors, forgery, malicious mischief, motor vehicle citations, disturbing the peace, harm to animals, stalking, etc.). Citations or related accusations against any population. Describe / clarify (please list any charges related to this behavior): Frequency:	☐	☐	☐
☐ **Challenging Sexualized Behavior** Describe / clarify (please list any charges related to this behavior): Frequency:	☐	☐	☐
☐ **History of arson.** Describe / clarify (please list any charges related to this behavior): Frequency:	☐	☐	☐

LEGAL STATUS

☐ Current charge pending; if checked, specify: _____

☐ Not Guilty by Reason of Insanity (NGRI)

☐ Current Less Restrictive Alternative (LRA) (attach copy of court order)

☐ Conditional release (attach conditions of release)

☐ Current incarceration status; projected release date: _____

☐ Early release

☐ Convictions

☐ DOC supervision

☐ Registered Offender Notifications (specify): _____ ☐ NA

CASE MIX COMPLETED

Document findings within CARE under Relationships / Interests within comments in Electronic Case Record (ECR).

☐ Yes ☐ No ☐ NA

STAFFING PLAN COMPLETED

Plan must be provided and kept in the provider file and Electronic Case Records (ECR) and documented with the CARE assessment.

☐ Yes ☐ No ☐ NA

Emergency situations of Individual – see definition section: ☐ Yes ☐ No ☐ NA

Section 2. (Only complete if agency requires) Addendum

INFORMATION VERIFICATION BY:

☐ Police report ☐ Court records ☐ Psychiatrist, Nurse

☐ Medical Physician

☐ Social Worker

☐ Mental Health Professional

☐ Counselor

☐ Certified Peer Specialist.

☐ Self-report ☐ Parent / guardian

☐ Psycho-sexual assessment

☐ Other (specify):

CURRENT DAY PROGRAM

☐ Employment ☐ School

☐ Community access ☐ None

☐ Other

CURRENT RESIDENCE (SEE STAFF INSTRUCTIONS)

☐ AFH ☐ AL ☐ ARC ☐ CFH ☐ CH ☐ CPRS ☐ DOC ☐ EARC ☐ ESF ☐ ESH ☐ GH/GTH ☐ ICF/ID

☐ JR ☐ SL ☐ WSH ☐ Own home ☐ Parent / relative home

☐ Other (specify):

SPECIFY OTHER CURRENT SERVICES (E.G., THERAPIES, COUNSELING, MPC, CFC, CFC+COPES, RSW, ETC.)

This form was completed based on available information.

CASE MANAGER'S SIGNATURE DATE

I have reviewed all information for **Name**, and upon acceptance of said individual will incorporate the information received to develop **Name's** negotiated care plan or person-centered service plan pursuant to WAC: For detailed information regarding Adult Family Home Negotiated Care Plan refer to (WAC 388-76-10355 through 388-76-10385; Assisted Living Negotiated Service Agreement (WAC 388-78A-2130 through 388-78A-2160); and Person-centered service plan for Enhanced Service Facility (WAC 388-107-0110 through 388-107-0130)

PROVIDER'S SIGNATURE DATE

DISTRIBUTION: Client Electronic Case Record Provider

Instructions for Individual with Complex Behaviors

This form must be part of the client's referral packet provided to residential providers.

Copies will be kept in the:

- Client record; and
- Client file maintained by the residential program.

Case manager/social worker responsibilities:

- Provide the forms/copies to the residential provider; and

  Keep the client information on the form current. Form to be reviewed at the annual CARE assessment and anytime an Interim or Significant Change is done. The form should be updated accordingly based on necessary changes. Input an SER addressing the current status of the form and indicate if additional/updated signatures were obtained.

Residential provider responsibilities:

- Maintain the client files;
- Ensure the safety of all clients; and
- Inform DSHS of any change of condition with regard to the person's complex behaviors.

Instructions:

Mental Health Diagnosis: A mental condition detailed in the Diagnostic and Statistical Manual of Mental Disorders. Indicate only "Yes", "No", or "NA".

Principal Diagnosis: Clinical diagnosis, a focus for treatment. Information to be obtained from a medical doctor who treats mental illnesses, Psychiatrist, Psychologist or licensed counselor. **Current Presentation:** How are the individual's thoughts and perceptions currently? Summarize behaviors. Indicate current status of relationships with others to include interactions healthy and unhealthy.

Individual Crisis Plan: A plan that identifies and addresses ways to prevent escalation and intensifying behaviors that are challenging in addition to outlining supports needed when an individual is in crisis. Indicate only "Yes", "No" or "NA".

Medication Monitoring: In medicine, compliance (also adherence, capacitance) describes the degree to which a patient correctly follows medical advice. Most commonly, it refers to medication or drug compliance, but it can also apply to other situations such as medical device use, self-care, self-directed exercises, or therapy sessions. Indicate only "Yes", "No", or "NA".

Medical Condition: Includes mental illnesses, any illness, injury, or disease.

Coordinated Behavior Support and Team Meetings: Meetings to discuss individual support needs as to deliver quality care. Indicate only "Yes", "No", or "NA". Copy of scheduled meetings to be placed in individual's Electronic Case Record.

Risk Assessment: The Risk Assessment is completed by the Hospital or Behavioral Health Provider. Documentation of who completed the assessment, and the outcome should be documented within comments in the Psych/Social section. Place a copy in the individual's Electronic Case Record.

Case Mix: Consideration of adequate resources completed. The allocation of resources to care for all residents of the facility has been assessed. Indicate only "Yes", "No", or "NA". A copy must be placed in the individual's Electronic Case Record. **For Example:** There are five residents in the home four of which have bipolar personality, or mood disorders, and one with schizophrenia. All are redirectable, and take medications as directed. Caregiver will need to note any incidents between residents to include frequency in addition to noting the caregiver to resident ratio.

Staffing Plan: A plan developed to ensure the appropriate human resources with the necessary skills are available. This plan should indicate type of supervision (e.g. line of site, arm's length) Indicate only "Yes", "No", or "NA". Documented within "Psych/Social" screen within comments section and indicate Staffing Plan. May need to refer Provider to specific sections within "Behavior," "Suicide," or "Depression" comments section. A copy of the plan to be placed in the individual's Electronic Case Record.

Emergency Situation: An incident in which immediate attention or aid was needed for the Individual due to the individual's behavior that resulted in local authorities or a Designated Crisis Responder being called and the individual being detained in the community. Describe / Clarify: This section includes specific details of the situation, everyone involved limiting some details as related to HIPAA and the outcome associated with the situation or incident.

RESIDENCE TYPES:

AFH	Adult Family Home
AL	Assisted Living
ARC	Adult Residential Care facility licensed as an Assisted Living facility
CFH	Children's Foster Home
CH	Companion Home (contracted with DDA)
CPRS	Community Protection Residential Services (Supported Living)
DOC	Department of Corrections
EARC	Enhanced ARC facility
ESF	Enhanced Services Facility
ESH	Eastern State Hospital
GH	Group Home (contracted with DDA) with an Assisted Living license
GTH	Group Training Home
ICF/ID	Intermediate Care Facility for Individuals with Intellectual Disabilities
JRA	Juvenile rehabilitation facility
SL	Supported Living Services
WSH	Western State Hospital

SIGNATURES:

Case Manager's signature: Signature of the staff completing the form.

Provider's Signature: Signature of Provider willing to accept Individual for admission.