RESIDENTIAL PROGRAM: _____ **DATE:** _____

Quarterly review: Select One

Name: _____ **Admit Date:** _____ **Anticipated D/C Date:** _____ **Current Length of stay:** _____ **Current Service Authorization:** Select _____ **Diagnosis:** _____	(1) Requires 100% watchful oversight.	(2) Requires frequent prompts and assistance.	(3) Often requires or requests assistance.	(4) Rarely requests or requires assistance.	(5) Does not require or request assistance.
	Intensive		Semi Independent		Independent
Ability to prepare and cook meals					
Turns off stove/oven upon cooking completion					
Remains present and attentive during cooking					
Safe use of household appliances, tools, chemicals					
Operating washer and dryer					
Dressing appropriate to weather					
Maintains appropriate hygiene and grooming practices					
Extinguishes and disposes of cigarette butts safely					
Able to exit living arrangement in emergency					
Use of community resources					
Self-administers medications as prescribed					
Symptom management/identification, use of coping skills					
Self-care for medical needs/issues (PCP, dentist)					
Keeps medical appointments / Attend to medical needs					
Understands finances, leases, work with payee if needed					
Aggression (Verbal, Physical or Sexual Aggression)					
Socialization Skills					

Housing Goal: (Include available housing options, resources, and supports that promote opportunities for continued growth and independence.)

_____

_____

_____

Primary Discharge Plan: _____

Secondary Discharge Plan: _____

Barriers to Transition (This includes skill deficits):	**Interventions to Address Barriers:**
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____
5. _____	5. _____
6. _____	6. _____

Comprehensive Needs Assessment:

1. Vital Documentation: (Please check if individual currently has any of the below items. If items are not secured, please identify how staff will assist with obtaining prior to discharge from Residential Services.)

☐ Birth Certificate ☐ Social Security Card ☐ State ID Other: _____

_____

2. Benefits status: (Please check item applicable below and provide additional information as needed, especially Payee status.)

☐ Active Benefits (Please list below) ☐ Applied for Benefits (Please specify date and status) ☐ None (Please explain)

_____

3. Identification of Natural Supports: (Please list below and describe level of involvement. This includes guardianship statuses.)

_____

_____

4. Supportive Services Needed: (Please indicate when referral was made and status)

Outpatient Services: ☐ CMS ☐ PSR-I ☐ ADSS ☐ Individual Counseling

_____

Specialty Services: ☐ ACT ☐ CST ☐ ICM ☐ Supported Employment

_____

Primary Care: _____ Dental: _____

Other: _____

5. Needs Supported Housing (NSH) Survey Completion date and status: _____

6. Does individual have a current Notice to Proceed (NTP) for a Georgia Housing Voucher (GHV)? If so, please list approval date and Housing Support Program Specialist: _____

7. Medical Diagnosis / Needs: _____

8. Sensory Impairments / Modification needs: _____

9. Primary Language / Literacy deficits (Can they read/write): _____

10. Legal involvement: (Please include if individual has a Forensic Status/Outpatient Commitment Order with expiration date/Enrolled in AOT/Probation. If individual is involved with any of the listed services, ensure to invite contact to this meeting.)

    _____

    _____

Clinical Necessity:

Crisis Interventions in the past 90 days (i.e. ACT/CST/ICM, GCAL/Mobile Crisis): _____

_____

Hospitalizations in past 90 days (i.e. ER/CSU/BHCC/State): _____

_____

Changes made to IRP as a result of the Clinical Review required after a Crisis Intervention, Hospitalization, and/or inability to participate in Rehabilitative Skill Building: (Part II, Section III: Documentation Requirements, item #5, sub-item E)

_____

_____

_____

_____

_____

Residential Crisis Plan: This is the Provider's response to an individual's crisis episode while receiving residential services that diverts the loss of housing and promotes housing stability.

1. What is a potential crisis episode that I may face that will place me at risk for losing housing stability (i.e. aggression, elopement)?

_____ _____

_____ _____

2. What are my triggers in the home that may impact my housing (i.e. loud noises, people, activities)?

_____ _____

_____ _____

3. When I am in a crisis at home, what are some things that Residential Staff can do to help me to de-escalate so I don't lose my housing?

_____ _____

_____ _____

4. When I am in a crisis, who can Residential Staff call to help me to de-escalate so I don't lose my housing?

_____ _____

_____ _____

5. Clinical interventions to be implemented by Residential Staff **before** a crisis to promote stabilization of housing.

6. Clinical interventions to be implemented by Residential Staff **after** a crisis to promote stabilization of housing.

_____ _____ _____

Individual's Printed Name Individual's Signature Date

_____ _____ _____

Name and Title of Staff Completing Form Signature Date