Organization: _____ KAMIS Number: _____ Assessment Date: _____ Assessment Time: _____ *(Initial Asmt Only)* Assessor Name: Assessor Phone:	**Kansas Department for Aging and Disability Services** **BASIS Assessment Instrument**	**Assessment Type:** ☐ Initial ☐ Annual Re-Evaluation ☐ Special Re-Evaluation With Permission ☐ Re-Admitted ☐ Transferred From Another Facility ☐ Child Reaching 5 Years Of Age

CUSTOMER INFORMATION

First: _____ M.I.: _____

Last: _____ Nickname: _____

Birth Date: _____ Age: _____

Month Day Year

Ethnicity:

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Ethnicity Missing

Race:

☐ American Indian/Alaskan Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ Reporting some other race
☐ Reporting 2 or more races
☐ White Non-Hispanic
☐ White Hispanic

Gender:

☐ Female ☐ Male

Marital Status:

☐ Single ☐ Married
☐ Widowed ☐ Divorced

ID Numbers:

Social Security #: _____
Medicare #: _____
Medicaid #: _____
☐ Customer has a Current Medicaid Card

ADDRESS INFORMATION

Residence Address: Customer's home is: ☐ Rural ☐ Urban

Street Address: _____

City: _____ County: _____ State: _____ Zip: _____

Phone: _____ Phone (alternate): _____

ASSOCIATE INFORMATION

Emergency or Alternative Contact: Relationship: _____

First Name: _____ Last Name: _____

Street Address: _____

City: _____ County: _____ State: _____ Zip: _____

Phone: _____ Phone (alternate): _____

Legal Guardian: Relationship: _____

First Name: _____ Last Name: _____

Street Address: _____

City: _____ County: _____ State: _____ Zip: _____

Phone: _____ Phone (alternate): _____

Targeted Case Manager Name: _____ TCM Phone: _____

BASIS Assessment Instrument

Customer Name: _____ KAMIS ID #: _____

ADDITIONAL INFORMATION

DISABILITIES AND ASSESSMENTS

Identified Disabilities:

☐ Autism ☐ Cerebral Palsy ☐ Epilepsy/Seizure Disorder
☐ Mental Retardation ☐ Other Other Description:

Primary Disability (Select the one developmental disability from Identified Disabilities which best applies):

☐ Autism ☐ Cerebral Palsy ☐ Epilepsy/Seizure Disorder
☐ Mental Retardation ☐ Other Other Description:

Special Population:

☐ CIP ☐ Special care rate
☐ Child in custody ☐ ICF/MR closure
☐ Self-directed care ☐ Placed from SMHH
☐ Self-determination

Psychiatric Diagnosis:

a. _____
b. _____
c. _____

Intellectual Assessment:

☐ Normal
☐ Mild
☐ Moderate
☐ Severe
☐ Profound
☐ Undetermined

Hearing Assessment:

☐ Normal
☐ Mild
☐ Moderate
☐ Severe
☐ Profound
☐ Undetermined

Vision Assessment:

☐ Undetermined
☐ Fully Sighted
☐ Moderate Impairment
☐ Severe Impairment
☐ Light Perception
☐ Total Blindness

RESIDENTIAL AND DAY PROGRAMS INFORMATION

County of Origin (Home County): _____

Residential Status:

☐ Living alone
☐ Living with 2 or less persons with MR/DD
☐ Living with 3 to 7 persons with MR/DD
☐ Living with 8 or more persons with MR/DD
☐ Living with non-relatives who are not MR/DD
☐ Living with relatives
☐ State MR Facility
☐ Private ICF/MR Facility
☐ Other
Other Description: _____

Day Programs:

☐ Attends school in a classroom 50% or more of the day with people who are not MR/DD
☐ Attends school in a classroom less than 50% of the day, with people who are not MR/DD
☐ Generic community activities less than 20 hours per week
☐ Generic community activities 20 hours or more per week
☐ Work environment designed for persons with MR/DD less than 20 hours per week
☐ Work environment designed for persons with MR/DD 20 or more hours per week
☐ Competitive employment less than 20 hours per week
☐ Competitive employment 20 or more hours per week
☐ Agency based non-work activities less than 20 hours per week
☐ Agency based non-work activities 20 or more hours per week
☐ Other Day Program Other Description: _____

BASIS Assessment Instrument

Customer Name: _____ KAMIS ID #: _____

HEALTH

Medical Conditions – Indicate Yes or No for each of the following:

Respiratory	☐ Yes	☐ No	Genito-Urinary	☐ Yes	☐ No
Cardiovascular	☐ Yes	☐ No	Neoplastic Disease	☐ Yes	☐ No
Gastro-Intestinal	☐ Yes	☐ No	Neurological Disease	☐ Yes	☐ No

SEIZURE INFORMATION

Does individual have a history of seizures? ☐ Yes ☐ No

Which type of Seizures has the individual experienced in the 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 (Gran Mal)

☐ Had some type of seizure - not sure of type

Frequency in the past year:

How frequently has the individual experienced seizures that involve loss of awareness and/or loss of consciousness.

☐ None during past year ☐ Less than once a month ☐ About once a month

☐ About once a week ☐ Several times a week ☐ Once a day or more

MEDICATION INFORMATION

Is Individual currently taking prescription medication? ☐ Yes ☐ No

Medications - Mark all prescription medications the individual receives:

Antipsychotic	☐ Currently	☐ Not Currently
Antianxiety	☐ Currently	☐ Not Currently
Antidepressant	☐ Currently	☐ Not Currently
Anticonvulsant	☐ Currently	☐ Not Currently
Diabetes	☐ Currently	☐ Not Currently
Sedative/Hypnotic	☐ Currently	☐ Not Currently
Other Maintenance Medication	☐ Currently	☐ Not Currently

Multiple Medications ☐ Yes ☐ No

Does Individual receive medication by injection? ☐ Yes ☐ No

Level of Medication Support

(Which best describes the level of support the individual receives when taking prescription medications)

☐ No Medications ☐ Independent ☐ Assistance ☐ Supervision ☐ Total Support

Indicate whether or not the individual:

Missed more than a total of two weeks of a day programing due to a medical condition during the last year:	☐ Yes	☐ No
Was hospitalized for medical problem in the last year:	☐ Yes	☐ No
Presently requires caregiver be trained in special health care procedures:	☐ Yes	☐ No
Presently requires special diet planned by dietician, nutritionist, or nurse:	☐ Yes	☐ No

BASIS Assessment Instrument

Customer Name: _____ KAMIS ID #: _____

ADAPTIVE

MOBILITY

Indicate which one response best describes the individual's typical level of mobility:

- ☐ Walks Independently
- ☐ Walks Independently but with difficulty (no corrective devices)
- ☐ Walks Independently with corrective devices
- ☐ Walks only with assistance from another person
- ☐ Can not Walk

Does the individual use a Wheelchair? ☐ Yes ☐ No

Indicate the one response that best describes wheelchair mobility (may be motorized):

- ☐ Can use wheelchair independently - including transferring
- ☐ Can us wheelchair independently with assistances in transferring
- ☐ Requires assistance in transferring and moving
- ☐ No Mobility - Must be transferred and moved
- ☐ Does Not Use Wheelchair

INDIVIDUAL ABILITIES

Indicate whether or not the individual:

Rolls Back to Stomach	☐ Yes	☐ No
Pulls self to standing	☐ Yes	☐ No
Walks up and down stairs by alternating feet	☐ Yes	☐ No
Picks up small object	☐ Yes	☐ No
Transfers an object from hand to hand	☐ Yes	☐ No
Marks with pencil, crayon or chalk	☐ Yes	☐ No
Turns pages of a book one at a time	☐ Yes	☐ No
Copies a circle from an example	☐ Yes	☐ No
Cuts with scissors along a straight line	☐ Yes	☐ No

Indicate whether or not the individual can perform each of the following:

Sort objects by size	☐ Yes	☐ No
Correctly spells first and last name	☐ Yes	☐ No
Tells time to nearest five minute	☐ Yes	☐ No
Distinguishes between right and left	☐ Yes	☐ No
Counts ten or more objects	☐ Yes	☐ No
Understand simple functional signs (exit, restroom)	☐ Yes	☐ No
Do simple addition and subtraction of figures	☐ Yes	☐ No
Reads and comprehends simple sentences	☐ Yes	☐ No
Reads and comprehends newspaper or magazine articles	☐ Yes	☐ No

BASIS Assessment Instrument

Customer Name: _____ KAMIS ID #: _____

COMMUNICATION SKILLS

Indicate whether or not the individual typically displays each of the follow receptive and expressive communication skills:

Understands meaning of "No"	☐ Yes	☐ No
Understands one-step directions	☐ Yes	☐ No
Understands two-step directions	☐ Yes	☐ No
Understands a joke or story	☐ Yes	☐ No
Responds "Yes" or "No" to a simple question	☐ Yes	☐ No
Asks simple questions	☐ Yes	☐ No
Relates experiences when asked	☐ Yes	☐ No
Tells a story, joke or plot of television show	☐ Yes	☐ No
Describes realistic plans in detail	☐ Yes	☐ No

SELF-CARE SKILLS

Indicate how independently the individual typically performs each activity:

Toileting/Bowels	
Toileting/Bladder	
Shower/Bath	
Brushes Teeth/Cleans Dentures	
Brushes/Combs Hair	
Selects Clothes appropriate to weather	
Putting on Clothes	
Undresses self	
Drinks from a cup or glass	
Chews and swallows food	
Feeds self	

DAILY LIVING SKILLS

Indicate how independently the individual typically performs each task:

Makes Bed	
Cleans Room	
Does Laundry	
Uses Telephone	
Shops for simple Meal	
Prepares Food that do not require cooking	
Uses Stove or Microwave	
Cross Street in Residential Neighborhood	
Uses Public Transportation for simple direct trip	
Manages own Money	

Self-Care and Daily Living Skills Scoring Guide

Code	Description
1	Total Support - Completely Dependent
2	Assistance - Requires hands-on help
3	Supervision - Requires mainly verbal prompts
4	Independent – Starts and finishes without prompts or help

BASIS Assessment Instrument

Customer Name: _____ KAMIS ID #: _____

MALADAPTIVE

BEHAVIOR FREQUENCY

Indicate the frequency of each behavior over the last twelve months:

Has tantrums or emotional outbursts	
Damages own or others property	
Physically assaults others	
Disrupts others' activities	
Is verbally or gesturally abusive	
Is self-injurious	
Teases or harasses peers	
Resists supervision	
Runs or wanders away	
Steals	
Eats inedible objects	
Displays sexually inappropriate behavior	
Smears feces	

Behavior Frequency Scoring Guide

Code	Description
1	Not this year
2	Occasionally - Less than once a month
3	Monthly - About once a month
4	Weekly - Account once a week
5	Frequently - Several times a week
6	Daily - Once a day or more

RESULTS OF BEHAVIORS

As a result of any behavior problem(s) consider whether or not each of the following:

Behavior problems prevents individual from moving to a less restrictive setting	☐ Yes	☐ No
Has a written behavior intervention plan	☐ Yes	☐ No
Individual's environment must be carefully structured to avoid behavior problems	☐ Yes	☐ No
Staff sometimes intervenes physically with individual	☐ Yes	☐ No
Supervised "Time Out" period is needed at least once a week	☐ Yes	☐ No
Requires one-on-one supervision for many program activities	☐ Yes	☐ No