

LA PLUS
SUPPORT NEEDS ASSESSMENT

A Complimentary Assessment to the AAIDD Supports Intensity Scale

SIS ID: _____

Name _____
Last First Middle

Address _____

City State Zip

Date LAPlus Completed _____

Date of Birth _____ Age _____

Interviewer _____
Last First

The LA PLUS is designed to identify support needs and related information not included in the AAIDD Supports Intensity Scale (SIS). The LA PLUS is to be administered in conjunction with the SIS

Section 1. SUPPORT NEEDS SCALE

(Place a mark by supports necessary to successfully participate in essential activities of life)

Part A:
Material Supports (mark all that apply)

H	N	SUPPORTS	H	N	SUPPORTS
<input type="checkbox"/>	<input type="checkbox"/>	1. Augmentative Communication	<input type="checkbox"/>	<input type="checkbox"/>	7. PERS Unit
<input type="checkbox"/>	<input type="checkbox"/>	2. Telecommunication display (TDD)	<input type="checkbox"/>	<input type="checkbox"/>	8. Teletypewriter (TTY) or text phone (TT)
<input type="checkbox"/>	<input type="checkbox"/>	3. Power Wheelchair	<input type="checkbox"/>	<input type="checkbox"/>	9. Manual wheelchair
<input type="checkbox"/>	<input type="checkbox"/>	4. Walker	<input type="checkbox"/>	<input type="checkbox"/>	10. Orthopedic braces
<input type="checkbox"/>	<input type="checkbox"/>	5. Vehicle modifications	<input type="checkbox"/>	<input type="checkbox"/>	11. Environmental modifications
<input type="checkbox"/>	<input type="checkbox"/>	6. Personal lift	<input type="checkbox"/>	<input type="checkbox"/>	12. Environmental accessibility
<input type="checkbox"/>	<input type="checkbox"/>	13. Other - Describe _____			
	<input type="checkbox"/>	13. Other - Describe _____			
<input type="checkbox"/>	<input type="checkbox"/>	14. None			

SIS ID: _____

Part B:

Vision Related Supports (select only one)

✓	SUPPORTS
<input type="checkbox"/>	1. None
<input type="checkbox"/>	2. Requires corrective lenses or surgery to see well
<input type="checkbox"/>	3. Requires large print and/or other modifications even with corrective lenses
<input type="checkbox"/>	4. Requires support to participate in activities requiring vision even with corrective lenses

Part C:

Hearing Related Supports (select only one)

✓	SUPPORTS
<input type="checkbox"/>	1. No support needed to hear speech
<input type="checkbox"/>	2. Requires prosthesis to hear well
<input type="checkbox"/>	3. Requires environmental modifications (e.g., increased volume, special seating), lip reading or some use of alternative communication (e.g., writing, pointing) even with prosthesis
<input type="checkbox"/>	4. Does not hear well enough to understand most or all speech even with prosthesis

Part D:

Supports for Communicating Needs (select only one)

✓	SUPPORTS
<input type="checkbox"/>	1. None; can communicate most or all essential needs
<input type="checkbox"/>	2. Requires extra time or technology to communicate essential needs
<input type="checkbox"/>	3. Requires partial assistance from familiar persons to communicate many essential needs
<input type="checkbox"/>	4. Requires full assistance from familiar persons to communicate most or all essential needs

Part E:**Positive Behavior Supports (select only one)**

✓ SUPPORTS	
<input type="checkbox"/>	1. No support needs in this area.
<input type="checkbox"/>	2. Requires support to learn about and/or avoid actions that endanger self or others (e.g., crossing the street safely) or due to lack of action by individual (e.g., no response to fire, will allow others to victimize).
<input type="checkbox"/>	3. Requires support to participate in school, work and/or recreation within established rules (e.g., refuses rules, refuses directions, disrupts or unaware of rules or social norms).
<input type="checkbox"/>	4. Requires support to participate in desired activities because of difficulties with anger control, anxiety, depression or other mental health concerns . (Does not match description in items 6 and 7.)
<input type="checkbox"/>	5. Requires support to prevent, manage or provide therapy for behaviors or conditions that can potentially cause physical harm to self or others or that may be a misdemeanor (e.g., aggression, self-injury, pica, wandering without concern for safety, window peeping, stripping in public, shoplifting) .
<input type="checkbox"/>	6. Requires a highly structured environment with specially trained staff to prevent or manage behaviors that are expected to cause serious harm to self or others if not addressed or that may be a felony (e.g., aggression or self-injury causing bleeding or broken bones, sexual behavior with a minor, felony theft, felony possession of drugs, dealing drugs).
<input type="checkbox"/>	7. Requires a highly structured environment with specially trained staff to prevent or manage behaviors that are imminently life threatening (e.g., suicidal, homicidal, sexual assaults).

Part F:**Physician Supports (mark all that apply)**

✓	PROFESSION	FREQ*	SCORE
<input type="checkbox"/>	1. General Physician		
<input type="checkbox"/>	2. Neurologist		
<input type="checkbox"/>	3. Psychiatrist		
<input type="checkbox"/>	4. Orthopedist		
<input type="checkbox"/>	5. Podiatrist		
<input type="checkbox"/>	6. Dentist		
<input type="checkbox"/>	7. Optometrist		
<input type="checkbox"/>	8. Cardiologist		
<input type="checkbox"/>	9. Other M.D. - _____		
<input type="checkbox"/>	10. Other M.D. - _____		
<input type="checkbox"/>	11. Other M.D. - _____		
<input type="checkbox"/>	12. Other M.D. - _____		
<input type="checkbox"/>	13. Other M.D. - _____		
<input type="checkbox"/>	14. Other M.D. - _____		
<input type="checkbox"/>	15. Other M.D. - _____		

Part G:**Professional Supports (mark all that apply)**

✓	PROFESSION	FREQ*	SCORE
<input type="checkbox"/>	1. Registered Nurse		
<input type="checkbox"/>	2. Licensed Practical Nurse		
<input type="checkbox"/>	3. Physical Therapist		
<input type="checkbox"/>	4. Occupational Therapist		
<input type="checkbox"/>	5. Speech Pathologist/Therapist		
<input type="checkbox"/>	6. Psychologist		
<input type="checkbox"/>	7. Nutritionist/Dietician		
<input type="checkbox"/>	8. Licensed Clinical Social Worker		
<input type="checkbox"/>	9. Other - Identify Professional _____		
<input type="checkbox"/>	10. Other - Identify Professional _____		
<input type="checkbox"/>	11. None		

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Part H:
Stress and Risk Factors (mark one per subsection)

✓	SCORE	
		<i>Factors related to illness or injuries (in past 3 months):</i>
<input type="checkbox"/>	0	a. No known health problems
<input type="checkbox"/>	1	b. Mild: non-serious; disrupts activities < 1 week
<input type="checkbox"/>	2	c. Moderate: non-serious; disrupts activities one or more weeks
<input type="checkbox"/>	3	d. Intensive: serious pain for one or more weeks; chronic and incapacitating
<input type="checkbox"/>	4	e. Extreme: very serious; life threatening
		<i>Factors related to family or group in home:</i>
<input type="checkbox"/>	0	a. None; generally a supportive environment
<input type="checkbox"/>	1	b. Mild: group works together, but interpersonal conflicts occur at least weekly
<input type="checkbox"/>	2	c. Moderate: group is often uncooperative; does not interfere with most activities
<input type="checkbox"/>	3	d. Intensive: group's conflicts interfere most days; or lead to prolonged periods of emotional upset
<input type="checkbox"/>	4	e. Extreme: group members are verbally or physically neglectful or abusive
		<i>Factors related to physical living conditions:</i>
<input type="checkbox"/>	0	a. Adequate or more than adequate
<input type="checkbox"/>	1	b. Mild: minimally adequate resources for essential health needs; or concern of imminent loss of adequate resources
<input type="checkbox"/>	2	c. Moderate: inconsistent utilities; cooking appliances, heat, air; overly crowded
<input type="checkbox"/>	3	d. Intensive: lack of food, clothes, shelter, or healthy environment
<input type="checkbox"/>	4	e. Extreme: living environment is dangerous due to structure, location, or prolonged lack of essentials for survival
		<i>Factors related to trauma or danger*</i>
<input type="checkbox"/>	0	a. No known trauma or danger
<input type="checkbox"/>	1	b. Mild: trauma/danger ; no signs of distress
<input type="checkbox"/>	2	c. Moderate: trauma/danger occurred ; minimal distress which does not interfere with current activities
<input type="checkbox"/>	3	d. Intensive: trauma/danger ; distress reactions interfere with activities
<input type="checkbox"/>	4	e. Extreme: trauma/danger in past month; or is ongoing; or person is at imminent risk

Part I: Protective Supervision

1. How many hours a day total could the individual be left unsupervised exclusive of work and/or school?

2. How many hours a day total could the individual be left unsupervised inclusive of work and/or school?

3. Nighttime Support Needed?

Type of Support

Frequency

Daily Support Time

4. What level of monitoring does this person require during awake hours?

- ☐ a. independent ☐ e. close proximity
☐ b. remote ☐ f. onsite
☐ c. periodic ☐ g. line of sight/earshot
☐ d. monitoring

Part J: Summoning Help

Is the individual able to summon help?

- ☐ a. **not applicable**, can resolve independently
☐ b. **yes**, can resolve with remote assistance
☐ c. **no**, needs someone physically present to assist
☐ d. **no**, needs full physical assistance

Part K: Sharing Supports

1. Could this individual utilize shared supports with another individual (who requires support) in a home setting? ☐ Yes ☐ No

2. If yes, how much time in a 24 hour period would need to be devoted solely to supporting this individual?

Part L: Community Safety

Which of the following apply to the individual being assessed?

- ☐ Non-Convicted Public Safety Risk Requiring a Secure Setting.
☐ Convicted Public Safety Risk Requiring a Secure Setting.
☐ Neither

Part A: People in the Home Supports

How many people live in the home under 18 years?

How many people live in home with disabilities?

Part B: Natural Supports in the Home

How many natural supports in the home ?

How many natural supports in the community ?

Part C:

Living Environments (mark only one in "Current" section, mark all that apply in "Preferred" section)

Current ✓	Preferred ✓	Item #	
<input type="radio"/>	<input type="checkbox"/>	1	
<input type="radio"/>	<input type="checkbox"/>	2	
<input type="radio"/>	<input type="checkbox"/>	3	
<input type="radio"/>	<input type="checkbox"/>	4	
<input type="radio"/>	<input type="checkbox"/>	5	
<input type="radio"/>	<input type="checkbox"/>	6	
<input type="radio"/>	<input type="checkbox"/>	7	
<input type="radio"/>	<input type="checkbox"/>	8	
<input type="radio"/>	<input type="checkbox"/>	9	
<input type="radio"/>	<input type="checkbox"/>	10	
<input type="radio"/>	<input type="checkbox"/>	11	

Part D: Supports and Service Providers (mark all that apply)

Current ✓	Preferred ✓	Item #	
<input type="checkbox"/>	<input type="checkbox"/>	1	
<input type="checkbox"/>	<input type="checkbox"/>	2	
<input type="checkbox"/>	<input type="checkbox"/>	3	
<input type="checkbox"/>	<input type="checkbox"/>	4	
<input type="checkbox"/>	<input type="checkbox"/>	5	
<input type="checkbox"/>	<input type="checkbox"/>	6	
<input type="checkbox"/>	<input type="checkbox"/>	7	
<input type="checkbox"/>	<input type="checkbox"/>	8	
<input type="checkbox"/>	<input type="checkbox"/>	9	
<input type="checkbox"/>	<input type="checkbox"/>	10	
<input type="checkbox"/>	<input type="checkbox"/>	11	
<input type="checkbox"/>	<input type="checkbox"/>	12	
<input type="checkbox"/>	<input type="checkbox"/>	13	
<input type="checkbox"/>	<input type="checkbox"/>	14	
<input type="checkbox"/>	<input type="checkbox"/>	15	

Part E: Vocational Activities Assessment

1. Is the individual involved in

- ☐ school-related activities
- ☐ work-related activities
- ☐ neither

2. Employment Goals

- ☐ wants to work
- ☐ seeks work opportunity education
- ☐ satisfied with current employment
- ☐ wants job exploration/career counseling
- ☐ wants job training
- ☐ seeks other opportunities/job change
- ☐ seeks promotion opportunities
- ☐ does not want to work

3. Phase of Employment

- ☐ working/stable
- ☐ seeking more/different employment
- ☐ just starting a new job
- ☐ planning to retire within 1 year
- ☐ job change
- ☐ at risk of losing employment
- ☐ not working

4. Employment Limitations

- ☐ transportation
- ☐ little work history
- ☐ frequent job changes
- ☐ others not supportive of employment goals
- ☐ lacks social skills
- ☐ unable to regularly get to work on time
- ☐ hygiene issues unresolved
- ☐ behaviors impact workplace
- ☐ high turnover of natural supports
- ☐ uncertain about work
- ☐ uncooperative/lacks motivation
- ☐ fearful/scared of new situations
- ☐ needs support arranging childcare
- ☐ none of these

Diagnoses (mark all that apply; add diagnoses not listed in blanks provided)

✓	DIAGNOSIS	ICD-9 CODE
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		

Medications and Dosages

Is this person receiving medication ? ☐ Yes ☐ No

Is this person receiving medication for a behavioral or psychological disorder? ☒ Yes ☐ No

Is this person receiving medication for a seizure ☐ Yes ☐ No

Example 2			
Name		Dosage	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Part B:
Medications and Dosages (continued)

	Name	Dosage	Frequency
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			

How many ER visits/911 calls has the individual had in the past year?

Part C : Sleep Assessment

Does this person exhibit difficulty sleeping at night? ☐ Yes ☐ No

☐ Yes ☐ No

How many hours does this person sleep over a typical 24 hour period?

Part D : Need for Relief from Pain or Illness

☐ None Apparent

☐ Check if a person verbally complains of pain or illness or shows apparent signs.

(e.g., statements, grimaces, moans, holds or hits specific parts of body)

If complaints of pain or illness, mark the frequency and intensity that best describes the person's pain.

✓	Frequency	✓	Intensity
<input type="radio"/>	1 < Monthly	<input type="radio"/>	1 Bothersome for periods < 15 minutes
<input type="radio"/>	2 Monthly	<input type="radio"/>	2 Bothersome for periods > 15 minutes
<input type="radio"/>	3 Weekly	<input type="radio"/>	3 Overwhelming for periods < 15 minutes
<input type="radio"/>	4 Daily	<input type="radio"/>	4 Overwhelming for periods > 15 minutes
<input type="radio"/>	5 > Daily		

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Section 4. Personal Satisfaction

Select the rating 0 to 3 that best describes your level of satisfaction. Ideally this form will be completed by or with the person but may be completed by people close to the person if necessary (e.g., family, friends, long-term staff)

Personal Satisfaction	Score	
1. Supports Provided at Home		
2. Work Day Programs, or Daily Activities (rate 0 if desired but not available)		
3. Living Environment		
4. Family Relationships		
5. Social Relationships		

Comments/Notes:

SIS ID: _____

LAPLUS Summary of Scored Items

Summary of Section 1: LA Plus Support Needs Scale

	PART	SUPPORTS	HIGHEST SCORE	
	E	Positive Behavior Supports		
	F	Physician Supports		
	G	Professional Supports		
	H	Stress and Risk Factors		
TOTAL			<input type="text"/>	

Summary of Section 2: Living Arrangements and Programs

Part A - People in the Home:

How many people live in the home under 18 years?

How many people live in home with disabilities?

Part B - Natural Supports in the Home :

How many natural supports in the home ?

How many natural supports in the community ?

Part C - Current Living Environment:

Part C - Preferred Living Environment:

1	<input type="text"/>
2	<input type="text"/>
3	<input type="text"/>

Part D - Current Programs:

1	<input type="text"/>
2	<input type="text"/>
3	<input type="text"/>

Part D - Preferred Programs:

1	<input type="text"/>
2	<input type="text"/>
3	<input type="text"/>

LA PLUS DATA SUMMARY (CONTINUED)

Summary of Section 3: Diagnostics and Medical Information

Part A - Diagnoses

ICD-9 Code

LA PLUS DATA SUMMARY (CONTINUED)

Summary of Section 3: Diagnostics and Medical Information (Continued)

Part B - Medications:

Medicine Name	Dosage	Frequency

Part D - Need for Relief from Pain or Illness

Summary of Section 4: Personal Satisfaction Rating