**COMMUNITY INTEGRATION SUPPLEMENTATION OPTIONAL CHECKLIST**

1. **Contact Information.** Please fill in the information as appropriate.

**Applicant’s Name:**

Social Security Number:

Residential Street Address:

City: State: Zip:

Mailing Address (if different):

City: State: Zip:

Phone number: Email:

**Applicant’s Authorized Representative Name (if applicable):**

Residential Street Address:

City: State: Zip:

Mailing Address (if different):

City: State: Zip:

Phone: Email:

**Applicant’s Care Coordinator Name (if applicable):**

Residential Street Address:

City: State: Zip:

Mailing Address (if different):

City: State: Zip:

Phone: Email:

1. **Permanent residence**. Please answer all questions listed below. Circle ‘Yes’ or ‘No’ or fill in the information as appropriate. (Please also provide all required verification documentation.)

Does the individual maintain a permanent residence within the community? **Yes** or **No**

Does the individual rent or own their residence? How often do they pay rent/mortgage? Please describe the arrangement:

Does the individual have a valid rental agreement provided, and if so, does it clearly state the individual’s tenancy rights? **Yes** or **No** or **N/A**

1. **Serious Mental Illness**.Please provide responses for all questions listed below. Circle ‘Yes’ or ‘No’ as appropriate. (Please also provide all required verification documentation.)

Is a signed written statement available from a Qualified Mental Health Provider verifying that the Individual has a serious mental illness? **Yes** or **No**

Does the individual have a serious mental illness which impairs or impedes the individual’s functioning in at least one major area of living? **Yes** or **No**

Does the individual have a serious mental illness which is unlikely to improve without treatment, services, or support? **Yes** or **No**

Does the individual have a serious mental illness which does not include a primary diagnosis of Alzheimer’s disease or dementia? **Yes** or **No**

1. **Services, Supports, or Other Care Needs**.Please provide information about the services, supports, or other care needs used to support the individual’s ability to remain living and integrated within the community. Please check any of the services, supports, or other care needs below that the individual is currently utilizing or intends to utilize within the next 12 months which will prevent institutionalization. Fill in the information, or Circle ‘Yes’ or ‘No’ as appropriate. Please respond to all questions for any service, support, or other care needs checked.

[ ]  **Transportation**. Is the service utilized now? **Yes** or **No**

Will the individual utilize the service in the next 12 months? **Yes** or **No**

Does the service prevent institutionalization? **Yes** or **No**

How often is the service utilized?

How much and how often does the individual pay for the service out of pocket?

What is the payment type (Examples: Private pay, In-kind, part of another service, Medicaid)?

Please describe any details of the service:

[ ]  **Housekeeping**. Is the service utilized now? **Yes** or **No**

Will the individual utilize the service in the next 12 months? **Yes** or **No**

Does the service prevent institutionalization? **Yes** or **No**

How often is the service utilized?

How much and how often does the individual pay for the service out of pocket?

What is the payment type (Examples: Private pay, In-kind, part of another service, Medicaid)?

Please describe any details of the service:

[ ]  **Meal Preparation**. Is the service utilized now? **Yes** or **No**

Will the individual utilize the service in the next 12 months? **Yes** or **No**

Does the service prevent institutionalization? **Yes** or **No**

How often is the service utilized?

How much and how often does the individual pay for the service out of pocket?

What is the payment type (Examples: Private pay, In-kind, part of another service, Medicaid)?

Please describe any details of the service:

[ ]  **Shopping**. Is the service utilized now? **Yes** or **No**

Will the individual utilize the service in the next 12 months? **Yes** or **No**

Does the service prevent institutionalization? **Yes** or **No**

How often is the service utilized?

How much and how often does the individual pay for the service out of pocket?

What is the payment type (Examples: Private pay, In-kind, part of another service, Medicaid)?

Please describe any details of the service:

[ ]  **Administering Medication**. Is the service utilized now? **Yes** or **No**

Will the individual utilize the service in the next 12 months? **Yes** or **No**

Does the service prevent institutionalization? **Yes** or **No**

How often is the service utilized?

How much and how often does the individual pay for the service out of pocket?

What is the payment type (Examples: Private pay, In-kind, part of another service, Medicaid)?

Please describe any details of the service:

[ ]  **Yard Maintenance**. Is the service utilized now? **Yes** or **No**

Will the individual utilize the service in the next 12 months? **Yes** or **No**

Does the service prevent institutionalization? **Yes** or **No**

How often is the service utilized?

How much and how often does the individual pay for the service out of pocket?

What is the payment type (Examples: Private pay, In-kind, part of another service, Medicaid)?

Please describe any details of the service:

[ ]  **Other**. Please provide thorough information about any other services, supports, or other care needs the individual currently utilizes or intends to utilize within the next 12 months that support the individual’s ability to remain living and integrated within the community. The following are some examples of other services, supports, and care needs the individual may receive. Please note this is not an all-inclusive list:

* Individual Therapy/Counseling, Group Therapy, Crisis Services
* Case Management Services, Care Coordination, Person Centered Planning
* Employment Supports, Assertive Community Treatment, Peer Support Services
* Membership to an organization such as a Bowling League, Craft-making club, Church or other place of worship attendance, Public Library membership, Health Club or Gym membership
* Service or companion animal care, out-of-pocket prescription or non-prescription medications, medical and mental health co-payments, durable and non-durable medical equipment, minor home adaptations; specific groceries, food, or supplies;
* Rent/Mortgage;

**Please specify other service, support, or care need:**

Is the service, support, or care need utilized now? **Yes** or **No**

Will the individual utilize it in the next 12 months? **Yes** or **No**

How often is it utilized?

How much and how often does the individual pay for the service out of pocket?

What is the payment type (Examples: Private pay, In-kind, part of another service, Medicaid)?

Does it prevent institutionalization? **Yes** or **No**

**Please specify other service, support, or care need:**

Is the service, support, or care need utilized now? **Yes** or **No**

Will the individual utilize it in the next 12 months? **Yes** or **No**

How often is it utilized?

How much and how often does the individual pay for the service out of pocket?

What is the payment type (Examples: Private pay, In-kind, part of another service, Medicaid)?

Does it prevent institutionalization? **Yes** or **No**

1. **Is the individual receiving 1915(c) Waiver services? Yes** or **No**

**If so, what Waiver type?**

Please provide a written statement that includes all waiver services being utilized.

1. **Is there any other information to share about the services, supports, or care needs the individual will receive in the next 12 months? If so, please share in the space below.**

1. **Please provide any additional information you believe is critical to verify care and services that prevent institutionalization and support the individual’s ability to remain integrated within the community. Please feel free to attach any other documentation which supports the information provided on this form. Documentation is any tangible proof, offered in good faith, that establishes a payment amount, whether in-kind or monetary, and frequency, and does not need to be exact documentation such as dollar-for-dollar receipts.**
2. **Signature.**

**Who is providing the information for this statement?** (Please check all that apply.)

[ ]  **Care Coordinator**

[ ]  **Caregiver**

[ ]  **Representative**

[ ]  **Applicant**

[ ]  **Other:** (Please specify)

**By signing this statement, I certify that the information provided above (or attached) is true and correct to the best of my knowledge.**

 **Signature:**

 **Date:**