**WARNING**

**This site contains protected health information (PHI). In accordance with the Health Insurance Portability and Accountability Act (HIPAA), unauthorized access is forbidden and may result in civil and criminal penalties.**

**IMPORTANT**

**Please take your time and consider your answers to the following questions *carefully*. You will be able to use the "previous page" button to return to a question during the survey if you wish to change a response. However, once you have completed this assessment and submitted your responses, *you will be unable to make any further changes*.**

**State Of New Jersey**
**Division Of Developmental Disabilities**
**New Jersey Comprehensive Assessment Tool (NJ CAT)**

***Conducted by Rutgers University***
***Developmental Disabilities Planning Institute (DDPI)***

**Version 1.3 April 27, 2015**

**DDPI has been asked by the New Jersey Division of Developmental Disabilities (DDD) to obtain information on [name], who is applying for services. Security measures have been taken to safeguard the confidentiality of the information provided.**

**Instructions for completing the survey:**

1. ***The person who knows [name] best* should be the respondent.**
2. **You must answer *ALL* questions on each page in order to proceed to the next page.**
3. **Questions should be answered based on the consumer's status *NOW*, not at some point in the past or future.**
4. **This survey will take approximately 30-40 minutes to complete.**
5. **If you have any questions about how to respond to a question, please contact us *before* submitting the completed survey.**

**Thank you for your time and assistance with this important endeavor.**

## CONSUMER DETAILS

**The consumer is the person who is or may receive DDD services.**

MIS_D) **MIS/Serial: (pre-populated field)**

CLName_D) **Consumer's First Name: (pre-populated field)**
**Consumer's Last Name: (pre-populated field)**

This survey is for **[Consumer's First Name (pre-populated field) / Consumer's Last Name (pre-populated field) / DDD ID # (pre-populated field)].** If this is not the correct person, please exit this survey now.

1. Please review the following information and correct any misspellings.

Again, if this is not the correct person, please exit this survey now

**Consumer's First Name: (pre-populated field)**
**Consumer's Last Name: (pre-populated field)**

1_Cons) Please provide [firstname lastname]'s current address and date of birth in the boxes below:

1_Cons _1. Permanent Street Address: _____
1_Cons _2. City: _____
1_Cons _3. State: _____
1_Cons _4. Zip Code: _____
1_Cons _5. Date of Birth (*Please use mm/dd/yyyy format.*): _____

***[Only ask VerifyDOB if the answer to 1_Cons_5 does not match file data]***

VerifyDOB) On the previous page you indicated that [firstname lastname]'s date of birth is *mm/dd/yyyy*. If this is not correct, please enter the correct information below.
_____

## RESPONDENT DETAILS

**The respondent is the person who is completing this assessment on behalf of the consumer.**

1a. Who will be filling out the information in this survey?

1. Respondent on the behalf of the consumer
2. Consumer ➔ ***Go To Question 3b***

1_Resp) Please provide the following information about the respondent:

1_Resp _1. Your First Name: _____
1_Resp _2. Your Last Name: _____
1_Resp _3. Your Phone Number (*Please use xxx-xxx-xxxx format*): _____
1_Resp _4. Your Cell/Alternate Phone Number (*Please use xxx-xxx-xxxx format*): _____
1_Resp _5. Your Email Address (e.g. abcdef@ghij.com): _____
1_Resp _6. Your Street Address: _____
1_Resp _7. Your City: _____
1_Resp _8. Your State: _____
1_Resp _9. Your Zip Code: _____

2. Are you the primary caregiver for [name]? The primary caregiver is the person who is principally responsible for the care and well-being of [name].

(*Note: If you equally share caretaking with a spouse or other person, please answer "Yes."*)

0. No
1. Yes

3a. Does [name] currently live with you?

0. No
1. Yes

3b. What best describes [names]'s current living arrangement?

1. At home alone
2. In a home with family or friend(s)
3. In a group home facility or supervised apartment
4. In a nursing home setting
98. Some other setting (please specify) _____

***[Only Ask 4 and 5 if the answer to 1a is "Respondent on the behalf of the consumer"]***

4. What is your relationship to [name]?

   1. Mother or father
   2. Grandmother or grandfather
   3. Sister or brother
   4. Son or daughter
   5. Other relative
   6. Friend of the family
   7. Agency or group home staff (Clinical)
   8. Agency or group home staff (Non-clinical)
   98. Other (please specify) _____

5. Respondent's (your) gender:

   1. Male
   2. Female

6. Who is [name]'s guardian for medical and legal decisions at this time?

   1. [name] is his/her own guardian
   2. I am (Please select this option even if you are a co-guardian with someone else)
   3. Another family member
   4. A family friend
   5. BGS (Bureau of Guardianship Services)/State guardianship
   6. Applying for guardianship/Guardianship in process
   7. Someone else/Other (Please specify relationship)_____

7. Who is likely to be [name]'s guardian for medical and legal decisions 5 years from now?

   1. [name] will be his/her own guardian
   2. I will (Please select this option even if you will be a co-guardian with someone else)
   3. Another family member
   4. A family friend
   5. BGS (Bureau of Guardianship Services)/State guardianship
   6. Someone else/Other (Please specify relationship)_____

## CONSUMER CHARACTERISTICS

8. How old is [name]?

*Please select from the drop down list below.*
[Drop down list values = "17 years old or younger" to "97 or older"]

_____

9a. What is [name]'s gender?

1. Male
2. Female

9b. Which of the following best represents [name]'s racial or ethnic heritage?

*Please select all that apply.*

1. Hispanic, Latino, or Spanish Origin
2. Black or African-American
3. White
4. Asian
5. American Indian or Alaska Native
6. Native Hawaiian or Pacific Islander
98. Some other group (Please specify) _____

9c. Does [name] have a valid drivers license?

0. No ➔ ***Go To Question 10***
1. Yes

9d. Does [name] have access to a motor vehicle and drive himself/herself as a means of regular transportation?

0. No
1. Yes

10) Please tell us whether [name] has any of the following:

| | | No | Yes |
|---|---|---|---|
| 10_1. | Autism spectrum disorder | 0 | 1 |
| 10_2. | Cerebral palsy | 0 | 1 |
| 10_3. | Spina bifida | 0 | 1 |
| 10_4. | Down's syndrome | 0 | 1 |
| 10_5. | An intellectual or cognitive disability (formerly known as mental retardation) | 0 | 1 |
| 10_6. | Prader-Willi syndrome | 0 | 1 |
| 10_7. | Any physical disabilities (including, but not limited to, any physical disability on this list) | 0 | 1 |
| 10_8. | A mental health problem with a psychiatric diagnosis (*other than an intellectual or cognitive disability, pervasive developmental disorder, or autism spectrum disorder*) | 0 | 1 |
| 10_9. | Traumatic brain injury including acquired non-degenerative brain injury | 0 | 1 |
| 10_10. | Epilepsy or a seizure disorder | 0 | 1 |

***[Only Ask 10_1a if the answer to 10_1 is "Yes"]***

10_1a. Would you describe [name]'s autism or autism spectrum disorder as mild, moderate, or severe?

1. Mild
2. Moderate
3. Severe

***[Only Ask 10_8a if the answer to 10_8 is "Yes"]***

10_8a. You indicated that [name] has a mental health problem with a psychiatric diagnosis. Please specify the diagnosis in the space below.

_____

***[Only Ask 10_10a and 10_10b if the answer to 10_10 is "Yes"]***

10_10a. You indicated that [name] has epilepsy or a seizure disorder. When was the last time that [name] had a seizure?

1. In the last 3 months
2. In the last 4-6 months
3. In the last 7-12 months
4. More than a year ago

10_10b. Does [name] currently require CONSTANT SUPERVISION at all times during waking and/or sleeping hours in order to prevent injury due to an uncontrolled seizure disorder?

0. No
1. Yes

## CONSUMER CHARACTERISTICS: SENSORY/MOTOR

11. Does [name] experience any hearing loss that cannot be corrected by hearing aids?

    0. No, hearing is in normal range or normal with aids ➔ ***Go to Question 13***
    1. Yes, has hearing loss

12. Which answer best describes [name]'s hearing in the last month?

    (*Note: If [name] uses a corrective device, such as a hearing aid, please select the response that best describes (name's) hearing while using the hearing aid.*)

    1. Mild loss: [name] often finds it difficult to hear normal speech
    2. Moderate loss: [name] has to turn up the TV or speak loudly to hear, deaf in one ear, etc.
    3. Severe loss: [name] can hear only if someone is shouting
    4. Profound loss: [name] is deaf

13. Does [name] experience any visual problems that cannot be corrected with glasses or contacts?

    0. No, vision is in normal range with or without correction ➔ ***Go to Question 15***
    1. Yes, has visual impairment that cannot be corrected

14. Which answer best describes [name]'s vision in the last month?

    (*Note: If [name] uses a corrective device, such as glasses, which answer best describes [name]'s vision using glasses?*)

    1. Mild impairment: [name] is color blind or has trouble seeing small objects
    2. Moderate impairment: [name] sees more than light or shadows, has trouble with depth perception, seeing curbs, or recognizing people by sight, or is blind in one eye, etc.
    3. Severe impairment: [name] sees only light or shadows
    4. Profound impairment: [name] is totally blind

15) Please indicate whether [name] was not able to, needed help with, or independently could do each of the following <u>in the last month</u>:

| | | Not able | Needed help | Could do Independently |
|---|---|---|---|---|
| 15_1. | Rolling from back to stomach | 0 | 1 | 2 |
| 15_2. | Pulling himself/herself to standing from a sitting position | 0 | 1 | 2 |
| 15_3. | Going <u>up</u> stairs in any house or building (*Note: If uses hand rail on his/her own, please answer "Independently."*) | 0 | 1 | 2 |
| 15_4. | Going <u>down</u> stairs in any house or building (*Note: If uses hand rail on his/her own, please answer "Independently."*) | 0 | 1 | 2 |
| 15_5. | Picking up small objects, such as a Cheerio | 0 | 1 | 2 |
| 15_6. | Transferring an object from hand to hand | 0 | 1 | 2 |
| 15_7. | Crawling, creeping, or scooting, such as getting something from under a bed or chair | 0 | 1 | 2 |
| 15_8. | Sitting without support for at least 5 minutes, such as on a piano bench or stool without a back | 0 | 1 | 2 |

16. Does [name] walk independently without difficulty, without using a corrective device, and/or without receiving assistance?

0. No
1. Yes ➔ ***Go to Question 22A***

17. Which best describes [name]'s typical level of walking mobility?

0. Cannot walk by self with a corrective device or with assistance
1. Walks only with assistance from another person
2. Walks independently with a corrective device (e.g., walker, crutches, brace)
3. Walks independently, but with difficulty (no corrective device)

18. Does [name] use a wheelchair or electric scooter?

(*Note: If [name] is temporarily using a wheelchair due to a recent injury or acute condition, please answer "No."*)

0. No, does not use ➔ ***Go to Question 22A***
1. Yes, uses at all times
2. Yes, uses for long trips or as needed

19) Please indicate which of the following is currently being used by [name].

(Note: *If prescribed, but not used by [name], please answer "No."*)

| | | No | Yes |
|---|---|---|---|
| 19a. | Non-motorized wheelchair | 0 | 1 |
| 19b. | Motorized wheelchair | 0 | 1 |
| 19c. | Electric scooter | 0 | 1 |

20. Which best describes [name]'s ability to transfer himself/herself in or out of the wheelchair or scooter?

0. Regularly requires the use of a Hoyer or other lift and/or more than one other person when transferring
1. Needs a lot of physical assistance from one other person when transferring
2. Needs only minimal assistance from one other person when transferring
3. Can transfer independently without assistance

21. Which best describes [name]'s ability to move a wheelchair from place to place?

(*Note: Response categories apply to use of both motorized and non-motorized wheelchairs.*)

0. Has no independent wheelchair mobility – needs someone to push him/her from place to place
1. Can move wheelchair back and forth with hands or feet, but requires pushing to move from place to place for any real distance
2. Can move wheelchair independently from place to place without assistance, but requires pushing for long distances
3. Can move wheelchair independently from place to place without assistance and requires no assistance even for longer trips

## CONSUMER CHARACTERISTICS: COGNITIVE ABILITIES

22A) Below are some questions about [name]'s cognitive, or mental, abilities. Please indicate whether [name] has done each of the following in the last month.

**22A) Associating Time with Events and Actions**

| | | No | Yes |
|---|---|---|---|
| 22A_1. | Remembers events that happened a month or more ago (*Note: Would [name] remember someone he/she hasn't seen in a month or since a special occasion?*) | 0 | 1 |
| 22A_2. | Knows daily routine, such as what occurs in the morning, afternoon, and evening | 0 | 1 |
| 22A_3. | Associates events with time in past, present, or future, such as knowing the difference between yesterday, today, and tomorrow | 0 | 1 |

***[Only Ask 22A_2a if the answer to 22A_2 is "Yes"]***

22A_2a. Associates regular events with a specific hour, such as knowing 6:00 PM is time for dinner

0. No
1. Yes

***[Only Ask 22A_3a if the answer to 22A_3 is "Yes"]***

22A_3a. Tells time to nearest five minutes, such as knowing the difference between 5 minutes to 6:00 PM and 5 minutes after 6:00 PM, or understands the difference between 5 minutes and 10 minutes from now

0. No
1. Yes

**22B) Spatial/Perceptual Abilities**

| | | No | Yes |
|---|---|---|---|
| 22B_1. | Knows difference between red, blue, green, and yellow | 0 | 1 |
| 22B_2. | Knows difference between big and small | 0 | 1 |
| 22B_3. | Knows difference between a circle, square, and triangle | 0 | 1 |
| 22B_4. | Finds way around the home by himself/herself (*Note: If mobility issues prevent moving from room to room by himself/herself, but he/she knows where different rooms are located, please answer "Yes."*) | 0 | 1 |

**22C) Number Awareness**

| | | No | Yes |
|---|---|---|---|
| 22C_1. | Uses numbers, even if inaccurately (*Note: Please answer "Yes" whether [name] uses numbers accurately or inaccurately.*) | 0 | 1 |
| 22C_2. | Counts to 10 without help | 0 | 1 |

***[Only Ask 22C_2a if the answer to 22C_2 is "Yes"]***

22C_2a. Does simple addition without use of a calculator or computer

0. No ➔ ***Go to Question 22D_1***
1. Yes

22C_2b. Does simple subtraction without use of a calculator or computer

0. No
1. Yes

**22D) Writing Skills (Include Braille or Typing)**

| | | No | Yes |
|---|---|---|---|
| 22D_1. | Prints or writes single letters without a model or tracing | 0 | 1 |

***[Only Ask 22D_1a and 22D_1b if the answer to 22D_1 is "Yes"]***

22D_1a. Prints or writes own first name without a model or tracing

0. No
1. Yes

22D_1b. Prints or writes single words, other than his/her name, without a model or tracing

0. No
1. Yes

***[Only Ask 22D_1ba if the answer to 22D_1b is "Yes"]***

22D_1ba. Prints or writes simple sentences without a model or tracing

0. No
1. Yes

**22E) Reading and Sign Skills**

| | | No | Yes |
|---|---|---|---|
| 22E_1. | Recognizes his/her own first and last name when it is written | 0 | 1 |
| 22E_2. | Reads and understands simple words | 0 | 1 |

***[Only Ask 22E_2a if the answer to 22E_2 is "Yes"]***

22E_2a. Reads and understands simple sentences

0. No
1. Yes

***[Only Ask 22E_2aa if the answer to 22E_2a is "Yes"]***

22E_2aa. Reads and understands a simple story

0. No
1. Yes

## CONSUMER CHARACTERISTICS: COMMUNICATION

23) Please think about [name]'s ability to communicate. Please indicate whether [name] has done the following <u>in the last month</u>.

**23A) Expressive Verbal Communication**

| | | No | Yes |
|---|---|---|---|
| 23A_1. | Uses at least a few simple words, signs, or picture symbols | 0 | 1 |

***[Only Ask 23A_1a if the answer to 23A_1 is "Yes"]***

23A_1a. Uses 10 or more simple words or signs in his/her entire vocabulary

0. No
1. Yes

***[Only Ask 23A_1aa – 23A_1ac if the answer to 23A_1a is "Yes"]***

| | | No | Yes |
|---|---|---|---|
| 23A_1aa. | Asks simple questions using words or signs | 0 | 1 |
| 23A_1ab. | Uses complete sentences when carrying on a conversation | 0 | 1 |
| 23A_1ac. | Tells a simple story, such as about a television show | 0 | 1 |

**23B) Clarity of Speech**

| | | No | Yes |
|---|---|---|---|
| 23B_1. | Clearly says "Yes" or "No" to a simple question | 0 | 1 |
| 23B_2. | Speech is readily understood by strangers | 0 | 1 |

***[Only Ask 23B_1a if the answer to 23B_1 is "Yes"]***

23B_1a. Is English [name]'s primary language?

0. No
1. Yes

***[Only Ask 23B_1aa if the answer to 23B_1a is "No"]***

23B_1aa. What is [name]'s primary language? (*Please specify in the box below.*)

_____

***[Only Ask 23B_2a if the answer to 23B_2 is "No"]***

23B_2a. Speech is understood by those who know [name] well

0. No
1. Yes

**23C) Receptive Verbal Communication**

| | | No | Yes |
|---|---|---|---|
| 23C_1. | Does [name] respond to his/her name when it is spoken or signed? | 0 | 1 |
| 23C_2. | Does [name] understand the meaning of "Yes" and "No"? | 0 | 1 |

***[Only Ask 23C_2a if the answer to 23C_2 is "Yes"]***

23C_2a. Does [name] understand a one-step direction, such as "Look at me"?

0. No
1. Yes

***[Only Ask 23C_2aa and 23C_2ab if the answer to 23C_2a is "Yes"]***

23C_2aa. Does [name] understand a two-step direction, such as "Turn your head and look at me"?

0. No
1. Yes

23C_2ab. Does [name] understand a joke or story?

0. No
1. Yes

## CONSUMER CHARACTERISTICS: SOCIAL INTERACTION

24. The following questions concern [name]'s ways of acting (or behaving) in different social situations -- with family members and others -- in the last month. Please tell us, based on your own knowledge, about [name]'s behavior in the following situations.

24a. Does [name] make direct eye contact when you or others are talking to him/her -- or does he/she tend to look away?

1. Makes eye contact
2. Looks away

24b. Can you tell by [name]'s facial expression how he/she is feeling -- or is it difficult to tell what he/she is feeling?

1. Can tell
2. Cannot tell

24c. Does [name] primarily prefer spending time with other people -- or would he/she rather be alone?

1. With others
2. Alone

24d. Is [name] comfortable being part of a group -- or does he/she find it uncomfortable to be a part of a group?

1. Comfortable
2. Uncomfortable

24e. Does [name] show enjoyment/sadness about what he/she is doing -- or does [name] keep feelings of enjoyment/sadness to himself/herself (i.e., you can't tell if he/she is happy or sad)?

1. Shows enjoyment/sadness
2. Keeps enjoyment/sadness to self

24f. Does [name] like to do things with others -- or would he/she rather do things alone?

1. With others
2. Alone

24g. Does [name] easily take turns -- or is taking turns difficult for him/her?

1. Takes turns easily
2. Has difficulty taking turns

24h. Does [name] notice when others are upset or feeling bad -- or is it difficult for him/her to tell if others are upset or feeling bad?

1. Notices when others are upset or feeling bad
2. Has difficulty telling when others are upset or feeling bad

24i. Does [name] tend to use the same words or sounds over and over -- or does his/her use of different words or sounds vary by subject matter?

1. Varies by subject
2. Uses same words or sounds

24j. Does [name] like to do one activity over and over -- or does he/she like a variety of activities?

1. Varies activities
2. Repeats activities

24k. Does [name] have special rituals or repetitive behaviors that have to be expressed a number of times -- or does he/she not have special rituals or repetitive behaviors?

1. Does not use repetition or special rituals
2. Uses repetition or rituals

## CONSUMER CHARACTERISTICS: SELF DIRECTION

25) The following questions concern to what extent [name] makes decisions about his/her everyday activities. Please indicate whether [name] decides, others decide, or both decide the following.

*(Note: These items are about decision making, so please do not answer based on physical assistance [name] may need. Please base your responses on [name]'s current everyday decision making.)*

**25) Everyday Activities**

| | | Others Decide | Both Decide | [name] Decides |
|---|---|---|---|---|
| 25_1. | How to spend time during weekdays | 0 | 1 | 2 |
| 25_2. | How to spend time on weekends | 0 | 1 | 2 |
| 25_3. | How to spend his/her own money | 0 | 1 | 2 |
| 25_4. | When to spend time with friends or others (other than family) | 0 | 1 | 2 |
| 25_5. | When to go out of or leave the house for leisure | 0 | 1 | 2 |
| 25_6. | Whether to have someone over to the home | 0 | 1 | 2 |
| 25_7. | Whether to go for a visit to someone's home with or without someone else | 0 | 1 | 2 |
| 25_8. | Whether to go to the movies with or without someone else | 0 | 1 | 2 |
| 25_9. | Whether to go to a library, museum, or other public building with or without someone else | 0 | 1 | 2 |
| 25_10. | Whether to go to a beach or park with or without someone else | 0 | 1 | 2 |

## CONSUMER CHARACTERISTICS: SELF-CARE/INDEPENDENT LIVING SKILLS

26) Please take a moment to think about [name]'s ability to do self-care tasks. Please indicate how independently [name] typically performed each task in the last month: Whether he/she was not able or has had no opportunity; required hands on assistance; required mainly supervision; or was independent in completing each task in the last month.

**26A) Basic Self-Care Needs**

| | | Has Not Done (Had no opportunity or is not able) | Lots of Assistance (Requires lots of hands on) | Mainly Supervision (Requires mainly verbal prompts) | Independent (Starts and finishes without prompt or help) |
|---|---|---|---|---|---|
| 26A_1. | Feeding himself/herself | 0 | 1 | 2 | 3 |
| 26A_2. | Drinking from a glass or cup (*Note: Can be using a sippy cup or with a straw.*) | 0 | 1 | 2 | 3 |
| 26A_3. | Chewing and swallowing bite-size food | 0 | 1 | 2 | 3 |
| 26A_4. | Toileting with regards to bladder | 0 | 1 | 2 | 3 |
| 26A_5. | Toileting with regards to bowels | 0 | 1 | 2 | 3 |
| 26A_6. | Physically dressing himself/herself (*Note: Do not include picking out clothing.*) | 0 | 1 | 2 | 3 |
| 26A_7. | Moving around in familiar settings, such as home | 0 | 1 | 2 | 3 |
| 26A_8. | Washing hands | 0 | 1 | 2 | 3 |
| 26A_9 | Washing face | 0 | 1 | 2 | 3 |
| 26A_10. | Brushing or combing hair | 0 | 1 | 2 | 3 |
| 26A_11. | Wiping or blowing nose with tissue | 0 | 1 | 2 | 3 |
| 26A_12. | Adjusting water temperature for washing hands or bathing | 0 | 1 | 2 | 3 |
| 26A_13. | Tying laces or fastening Velcro on own shoes | 0 | 1 | 2 | 3 |
| 26A_14. | Drying entire body after bathing | 0 | 1 | 2 | 3 |

**26B) Being Independent**

| | | Has Not Done (Had no opportunity or is not able) | Lots of Assistance (Requires lots of hands on) | Mainly Supervision (Requires mainly verbal prompts) | Independent (Starts and finishes without prompt or help) |
|---|---|---|---|---|---|
| 26B_1. | Making his/her bed | 0 | 1 | 2 | 3 |
| 26B_2. | Cleaning his/her room | 0 | 1 | 2 | 3 |
| 26B_3. | Doing his/her laundry | 0 | 1 | 2 | 3 |
| 26B_4. | Caring for his/her own clothes, such as folding them or putting them away | 0 | 1 | 2 | 3 |

**26C) Household Activities**

| | | Has Not Done (Had no opportunity or is not able) | Lots of Assistance (Requires lots of hands on) | Mainly Supervision (Requires mainly verbal prompts) | Independent (Starts and finishes without prompt or help) |
|---|---|---|---|---|---|
| 26C_1. | Using public transportation for a simple direct trip other than ACCESS link or other medical transports | 0 | 1 | 2 | 3 |
| 26C_2. | Choosing food when shopping for a simple meal | 0 | 1 | 2 | 3 |
| 26C_3. | Preparing foods that do not require cooking, such as making a sandwich or bowl of cereal | 0 | 1 | 2 | 3 |
| 26C_4. | Using the stove | 0 | 1 | 2 | 3 |
| 26C_5. | Using the microwave | 0 | 1 | 2 | 3 |
| 26C_6. | Washing dishes or using a dishwasher | 0 | 1 | 2 | 3 |
| 26C_7. | Ordering food in public | 0 | 1 | 2 | 3 |
| 26C_8. | Choosing items he/she wants to buy | 0 | 1 | 2 | 3 |
| 26C_9. | Using money, such as handing it to a cashier | 0 | 1 | 2 | 3 |

***[Only Ask 26C_9a and 26C_9b if the answer to 26C_9 is "Lots of Assistance", "Mainly Supervision", or "Independent"]***

| | | Has Not Done (Had no opportunity or is not able) | Lots of Assistance (Requires lots of hands on) | Mainly Supervision (Requires mainly verbal prompts) | Independent (Starts and finishes without prompt or help) |
|---|---|---|---|---|---|
| 26C_9a. | Making small routine purchases | 0 | 1 | 2 | 3 |
| 26C_9b. | Making or counting change | 0 | 1 | 2 | 3 |

## CONSUMER CHARACTERISTICS: SPECIAL BEHAVIORS

27) Please tell us whether [name] has engaged in any of the following special behaviors in the last 6 months.

**27A) Behaviors Dangerous to Self**

| | | No | Yes |
|---|---|---|---|
| 27A_1. | Runs away or wanders off without you knowing | 0 | 1 |
| 27A_2. | Repeatedly gets out of bed at night other than for going to the bathroom | 0 | 1 |
| 27A_3. | Eats or mouths inedible objects | 0 | 1 |
| 27A_4. | Scratches own body to the point of causing harm | 0 | 1 |
| 27A_5. | Hits his/her own body | 0 | 1 |
| 27A_6. | Hits his/her own face or head | 0 | 1 |
| 27A_7. | Bangs his/her head | 0 | 1 |
| 27A_8. | Bites self | 0 | 1 |

***[Only Ask 27A_3a to 27A_3c if the answer to 27A_3 is "Yes"]***

27A_3a. How often does [name] eat or mouth inedible objects?

1. Once a day or more
2. Several times per week
3. Once a week
4. Once a month
5. Less than once a month

| | | No | Yes |
|---|---|---|---|
| 27A_3b. | Has [name] ever been hospitalized due to this behavior? | 0 | 1 |
| 27A_3c. | Did this behavior occur while [name] was being supervised? | 0 | 1 |

***[Only Ask 27A_8a to 27A_8c if the answer to 27A_8 is "Yes"]***

27A_8a. How often does [name] bite himself/herself?

1. Once a day or more
2. Several times per week
3. Once a week
4. Once a month
5. Less than once a month

| | | No | Yes |
|---|---|---|---|
| 27A_8b. | Has [name] ever been hospitalized due to this behavior? | 0 | 1 |
| 27A_8c. | Did this behavior occur while [name] was being supervised? | 0 | 1 |

**27B) Behaviors Dangerous to Others**

| | | No | Yes |
|---|---|---|---|
| 27B_1. | Verbally threatens others | 0 | 1 |
| 27B_2. | Physically threatens others | 0 | 1 |
| 27B_3. | Hits or punches others | 0 | 1 |
| 27B_4. | Kicks others | 0 | 1 |
| 27B_5. | Uses objects to harm others | 0 | 1 |
| 27B_6. | Bites others | 0 | 1 |
| 27B_7. | Grabs or scratches others | 0 | 1 |
| 27B_8. | Head-butts others | 0 | 1 |
| 27B_9. | Pulls hair of others | 0 | 1 |
| 27B_10. | Chokes or attempts to choke others | 0 | 1 |
| 27B_11. | Aggression toward personal property (*i.e., breaks or harms objects*) | 0 | 1 |

***[Only Ask 27B_5a to 27B_5c if the answer to 27B_5 is "Yes"]***

27B_5a. How often does [name] use objects to harm others?

1. Once a day or more
2. Several times per week
3. Once a week
4. Once a month
5. Less than once a month

| | | No | Yes |
|---|---|---|---|
| 27B_5b. | Has [name] ever been hospitalized due to this behavior? | 0 | 1 |
| 27B_5c. | Did this behavior occur while [name] was being supervised? | 0 | 1 |

***[Only Ask 27B_6a to 27B_6c if the answer to 27B_6 is "Yes"]***

27B_6a. How often does [name] bite others?

1. Once a day or more
2. Several times per week
3. Once a week
4. Once a month
5. Less than once a month

| | | No | Yes |
|---|---|---|---|
| 27B_6b. | Has [name] ever been hospitalized due to this behavior? | 0 | 1 |
| 27B_6c. | Did this behavior occur while [name] was being supervised? | 0 | 1 |

***[Only Ask 27B_8a to 27B_8c if the answer to 27B_8 is "Yes"]***

27B_8a. How often does [name] head-butt others?

1. Once a day or more
2. Several times per week
3. Once a week
4. Once a month
5. Less than once a month

| | | No | Yes |
|---|---|---|---|
| 27B_8b. | Has [name] ever been hospitalized due to this behavior? | 0 | 1 |
| 27B_8c. | Did this behavior occur while [name] was being supervised? | 0 | 1 |

***[Only Ask 27B_10a to 27B_10c if the answer to 27B10 is "Yes"]***

27B_10a. How often does [name] choke or attempt to choke others?

1. Once a day or more
2. Several times per week
3. Once a week
4. Once a month
5. Less than once a month

| | | No | Yes |
|---|---|---|---|
| 27B_10b. | Has [name] ever been hospitalized due to this behavior? | 0 | 1 |
| 27B_10c. | Did this behavior occur while [name] was being supervised? | 0 | 1 |

**27C) Inappropriate or Rule-Violating Behaviors**

| | | No | Yes |
|---|---|---|---|
| 27C_1. | Has tantrums or outbursts | 0 | 1 |
| 27C_2. | Displays repetitive behavior, such as body rocking or hand flapping | 0 | 1 |
| 27C_3. | Smears feces | 0 | 1 |
| 27C_4. | Makes noises, curses, or other inappropriate vocalizations | 0 | 1 |
| 27C_5. | Disrupts activities of others | 0 | 1 |
| 27C_6. | Defies known directions or rules | 0 | 1 |
| 27C_7. | Takes off clothes in public | 0 | 1 |
| 27C_8. | Masturbates in public | 0 | 1 |
| 27C_9. | Sexually touches others without their consent | 0 | 1 |
| 27C_10. | Displays sexually predatory behavior (*For example, forcing himself/herself on others in a sexual manner.*) | 0 | 1 |

**27D) Other Special Behaviors**

| | | No | Yes |
|---|---|---|---|
| 27D_1. | Has [name] been a target or victim of inappropriate behavior by others? | 0 | 1 |

| 27E. | Please indicate which of the following have occurred as a result of any behavior problem with [name] <u>in the last 6 months</u>. | No | Yes |
|---|---|---|---|
| ***[Only Ask 27E_1 if respondent answers "Yes" to any of these questions 27A_1, 27A_3-27A_8, 27B_1 to 27B_10, 27C_3, or 27C_7 to 27C_10]*** | | | |
| 27E_1. | Has it required one-on-one supervision due to behavioral issues? | 0 | 1 |
| ***[Only Ask 27E_2 to 27E_6 if respondent answers "Yes" to any of these questions 27A_1 to 27A_8, 27B_1 to 27B_10, or 27C_1 to 27C_10]*** | | | |
| 27E_2. | Have any specific behavioral modification/support procedures <u>actually</u> been used? | 0 | 1 |
| 27E_3. | Has [name]'s environment been carefully structured due to behaviors? | 0 | 1 |
| 27E_4. | Has physical intervention sometimes been required? | 0 | 1 |
| 27E_5. | Was a supervised time-out needed to an area within or outside the room? | 0 | 1 |
| 27E_6. | Were any medications increased or used as needed (prn) to reduce/control behaviors? | 0 | 1 |

## HEALTH

28) Please indicate whether [name] currently has any of the following diagnosed conditions or illnesses.

| | | No | Yes |
|---|---|---|---|
| 28_1. | Respiratory or Breathing Conditions, such as asthma, emphysema, or cystic fibrosis | 0 | 1 |
| 28_2. | Heart or Circulatory Conditions, such as heart disease, high blood pressure, anemia, or other blood disorders | 0 | 1 |
| 28_3. | Digestive Conditions, such as ulcers, colitis, liver/bowel disorders, or tube feeding | 0 | 1 |
| 28_4. | Swallowing Conditions, such as difficulty swallowing, gastric reflux, or aspiration | 0 | 1 |
| 28_5. | Bladder or Kidney Conditions | 0 | 1 |
| 28_6. | Conditions of the Nervous System, such as multiple sclerosis, organic brain syndrome, Parkinson's disease, or seizures | 0 | 1 |
| 28_7. | Hormone or Endocrine Conditions, such as diabetes, thyroid problems, or hormone replacement therapy | 0 | 1 |
| 28_8. | Chronic Conditions related to Skin, Hair, or Nails, such as thick toenails, eczema, psoriasis, or dermatitis | 0 | 1 |
| 28_9. | Musculoskeletal Conditions, such as muscular difficulties with the arms and/or legs, arthritis, osteoporosis, or cerebral palsy | 0 | 1 |
| 28_10. | Allergies, such as those to foods, medications, or seasonal | 0 | 1 |
| 28_11. | Other Conditions (Please specify) _____ | 0 | 1 |

29) Please indicate whether [name] has been to or utilized any of the following health services in the last 3 months in any setting for routine or non-routine care.

| | | No | Yes |
|---|---|---|---|
| 29_1. | Been to an emergency clinic or emergency room in a hospital | 0 | 1 |
| 29_2. | Stayed overnight in a hospital | 0 | 1 |
| 29_3. | Seen a podiatrist (*i.e., a specialist for the feet*) | 0 | 1 |
| 29_4. | Seen a psychiatrist | 0 | 1 |
| 29_5. | Seen a psychologist for counseling or behavior management | 0 | 1 |
| 29_6. | Seen any other behavior specialist (*such as a behavioral analyst*) | 0 | 1 |
| 29_7. | Received physical therapy | 0 | 1 |
| 29_8. | Received speech therapy | 0 | 1 |
| 29_9. | Received occupational therapy | 0 | 1 |

30) Please indicate whether any of the following special medical treatments or services have been received by [name] in this home or residence in the last 3 months.

| | | No | Yes |
|---|---|---|---|
| 30_1. | Use of special bowel equipment or enemas | 0 | 1 |
| 30_2. | Catheterization | 0 | 1 |
| 30_3. | Suctioning at least once a day to remove internal fluids | 0 | 1 |
| 30_4. | Special breathing or respiratory care, such as the use of an inhaler or nebulizer | 0 | 1 |
| 30_5. | Turning or positioning to protect skin integrity | 0 | 1 |
| 30_6. | Dressing and wound care | 0 | 1 |
| 30_7. | Dialysis or use of a kidney machine | 0 | 1 |
| 30_8. | Any medication via injection by others or intravenously at home **other than insulin via an auto-injector** (which is similar to an epi pen or flex pen) | 0 | 1 |
| 30_8a. | Insulin administered with an auto-injector (which is similar to a flex pen or epi pen) | 0 | 1 |
| 30_9. | Is [name] tube fed? | 0 | 1 |

***[Only Ask 30_9a if the answer to 30_9 is "Yes".]***

| | | No | Yes |
|---|---|---|---|
| 30_9a. | Does [name] eat any food by mouth? | 0 | 1 |

***[Go to 30_11 if the answer to 30_9a is "No"]***

***[Only Ask 30_10a – 30_10e if the answer to 30_9 is "No" or if the answer to 30_9a is "Yes"]***

| | | No | Yes |
|---|---|---|---|
| 30_10a. | Has [name] used adaptive eating equipment, such as a plate guard and special utensils (not a feeding tube)? | 0 | 1 |
| 30_10b. | Has [name] required assistance due to choking incident(s), such as requiring food to be cleared from the mouth with hand or the Heimlich Maneuver? | 0 | 1 |
| 30_10c. | Is [name] physically fed by others? | 0 | 1 |
| 30_10d. | Does [name] require special food preparation, such as pureed or chopped? | 0 | 1 |
| 30_10e. | Does [name] have any special dietary foods or restrictions, such as low salt? | 0 | 1 |
| 30_11. | Were any increases in fluids required? | 0 | 1 |

31) Please indicate whether any of the following adaptive or special equipment has been used by [name] at any time in the last 3 months.

(*Note: If prescribed, but not used in the last 3 months, answer "No."*)

| | | No | Yes |
|---|---|---|---|
| 31_1. | Glasses or other visual aids | 0 | 1 |
| 31_2. | Walker | 0 | 1 |
| 31_3. | Crutches or cane | 0 | 1 |
| 31_4. | Brace or splint | 0 | 1 |
| 31_5. | Hearing aid | 0 | 1 |
| 31_6. | Picture symbols or any other communication device | 0 | 1 |
| 31_7. | A helmet not used for biking or horseback riding | 0 | 1 |
| 31_8. | Prescribed orthotics or orthopedic shoes | 0 | 1 |
| 31_9. | Special bed or bed modifications, such as side rails, special mattress, elevated bed, or hospital bed | 0 | 1 |
| 31_10. | Other (Please specify)_____ | 0 | 1 |

## SCHOOL EXPERIENCE

32. Did [name] ever attend any type of public or private school, including a special school for persons with disabilities?

0. No ➔ ***Go To Question 37***
1. Yes
98. Don't know ➔ ***Go To Question 37***

33. Is [name] currently enrolled in a high school or some other special school for persons with disabilities?

(*Note: Please answer "No" if [name] is attending college or a post-high school technical program*.)

0. No ➔ ***Go To Question 37***
1. Yes

34. Is [name] participating in any school-sponsored work activities like a work-study job, internships, or a school-based business?

0. No ➔ ***Go To Question 36***
1. Yes
98. Don't know ➔ ***Go To Question 36***

35. Is [name] paid for this work?

1. Yes, for all
2. Yes, for some
3. No, for all
98. Don't know

36) What do you think [name] will do during the day after leaving school?

| | | No | Yes |
|---|---|---|---|
| 36_1. | Get a job for pay (making at least minimum wage) | 0 | 1 |
| 36_2. | College or junior college | 0 | 1 |
| 36_3. | Vocational training or technical school | 0 | 1 |
| 36_4. | Day program | 0 | 1 |
| 36_5. | Other (Please specify) _____ | 0 | 1 |

## CURRENT EMPLOYMENT

37. Does [name] currently have a paid job?

0. No ➔ ***Go To Question 41***
1. Yes
98. Don't know ➔ ***Go To Question 41***

38. About how many hours per week did [name] work at this paid job in the past 2 weeks?

*Please select from the drop down list below.*

_____ hours
*[Drop down list values = 1 hour or less to 40 or more, Don't know = 98]*

39. About how much per hour was [name] paid? *(If you are unsure of the exact amount, please enter your best estimate.)*

(*Please provide approximate amount in US dollars only. Do not include a dollar sign ($).*)

$_____

40. Does [name] have a job coach or someone special from an agency who helps him/her at this paid job?

0. Yes, usually ➔ ***Go To Question 48***
1. Sometimes ➔ ***Go To Question 48***
2. Occasionally ➔ ***Go To Question 48***
3. No, does not need one ➔ ***Go To Question 48***

## PAST EMPLOYMENT

41. Has [name] had a paid job in the past 2 years?

0. No ➔ ***Go To Question 45***
1. Yes
98. Don't know ➔ ***Go To Question 45***

42. About how many hours per week on average did [name] work for pay?

*Please select from the drop down list below.*

_____ hours

*[Drop down list values = 1 hour or less to 40 or more, Don't know = 98]*

43. About how much per hour was [name] paid? *(If you are unsure of the exact amount, please enter your best estimate.)*

(*Please provide approximate amount in US dollars only. Do not include a dollar sign ($).*)

Approximate amount paid per hour $_____

44. Did [name] have a job coach or someone special from an agency who helped him/her on this paid job?

0. Yes, usually
1. Sometimes
2. Occasionally
3. No, does not need one

## FUTURE EMPLOYMENT

45. Was [name] actively looking and trying to get a paid job in the past 2 weeks?

    0. No
    1. Yes

46. How likely do you think it is that [name] will have a paid job next year?

    0. Definitely will not ➔ ***Go To Question 48***
    1. Probably will not
    2. Probably will
    3. Definitely will

47. If [name] had a paid job next year, about how much do you think [name] would make per hour?

    (*Please provide your best estimate. Please provide approximate amount in US dollars only. Do not include a dollar sign ($).*)

    $_____

## CONTACT WITH DIVISION OF VOCATIONAL REHABILITATION (DVR)

48. Have you had any contact with anyone who works for the Division of Vocational Rehabilitation (DVR) within the last two years?

    0. No ➔ ***Go To Question 50***
    1. Yes

49. How helpful were the services or information provided by DVR?

    1. Very helpful
    2. Somewhat helpful
    3. Not very helpful
    4. Not at all helpful
    98. Don't know

## CAREGIVER CHARACTERISTICS

**Please Note: The following questions apply to the primary caregiver of [name]. If you are not [name]'s primary caregiver (Question 2 is "No" or Question 4 is "Agency or group home staff (Clinical)" or (Non-clinical), Go To Question 60.**

As the Division of Developmental Disabilities is concerned about the experiences of the whole family, including those providing support, we now want to find out more about YOU. Please note that these questions are asked for record keeping purposes only and to learn more about who we are serving.

50. How many years of schooling have you had a chance to complete?

1. No formal schooling
2. 1st through 8th grade
3. Attended high school, but did NOT graduate
4. Graduated from high school/obtained GED
5. Trade, technical, or vocational school after high school
6. Some college (Have not yet earned degree)
10. Completed a 2-year Associates Degree (AA, AS, or AAS) or a 3-year RN degree
7. Completed a 4-year degree (BA, BS, Bachelors)
8. Currently working on post-graduate work or post-graduate degree (e.g., Doctorate or Master's Degree)
9. Completed post-graduate work or post-graduate degree (e.g., Doctorate or Master's Degree)

51. Are you currently employed?

0. No ➔ ***Go To Question 54***
1. Yes

52. Is this employment inside or outside of your home?

1. Inside the house
2. Outside the house
3. Both inside and outside the house

53. On average, how many hours per week do you work for <u>pay</u>?

(*Include lunch, but not travel time to and from your job*.)

*Please select from the drop down list below.*

_____

*[Drop down list values = 1 hour or less to 40 or more, Don't know = 98]*

54. In total, how many persons under 18 currently live in your home?

(*Enter 0 if there are none*.)

*Please select from the drop down list below.*

_____
*[Drop down list values = 0 to 10 or more]*

55. In total, how many persons 18 or older currently live in your home, including you and [name]?

*Please select from the drop down list below.*

_____
*[Drop down list values = 1 to 10 or more]*

56. Besides caring for [name], are you currently the primary caregiver for anyone else inside or outside of your home who needs special care, such as a disabled child, elderly parent, disabled spouse, etc.?

0. No ➔ ***Go To Question 58***
1. Yes

57. Does this individual live with you?

0. No
1. Yes

58. Which of the following best represents your racial or ethnic heritage?

*Please select all that apply.*

1. Hispanic, Latino, or Spanish Origin
2. Black or African-American
3. White
4. Asian
5. American Indian or Alaska Native
6. Native Hawaiian or Pacific Islander
98. Some other group (Please specify) _____

59. How old were you on your last birthday?

*Please select from the drop down list below.*

_____
*[Drop down list values = 18 to 97 or older, Prefer not to say = 3]*

60. Is [name] or are you on [name]'s behalf currently receiving any of the following?

| | | No | Yes |
|---|---|---|---|
| 60_1. | SSI (Supplemental Security Income) | 0 | 1 |
| 60_2. | Medicaid or New Jersey Family Care | 0 | 1 |
| 60_3. | Social Security Benefits (Retirement, Disability, or Survivor) | 0 | 1 |
| 60_4. | Medicare | 0 | 1 |
| 60_5. | Food Stamps | 0 | 1 |
| 60_6. | Unemployment | 0 | 1 |
| 60_7. | Any other form of state or local public assistance, other than those mentioned above (Please specify) _____ | 0 | 1 |

***[Only Ask Question 61 if the answer to 1a is "Respondent on the behalf of the consumer", and if Q4 equals 7, 8 or 98]***

61. From which of the following sources have you obtained information to complete this evaluation?

| | | No | Yes |
|---|---|---|---|
| 61_1. | Medical records/ISP (Individualized Service Plan) | 0 | 1 |
| 61_2. | Legal guardian | 0 | 1 |
| 61_3. | Family member | 0 | 1 |
| 61_4. | [name] | 0 | 1 |
| 61_5. | Other professionals | 0 | 1 |
| 61_6. | Own knowledge of [name] | 0 | 1 |
| 61_7. | Other (Please specify) _____ | 0 | 1 |

**IMPORTANT: The survey is almost complete. If you wish to verify your answers or make any corrections, *please do so now*.**

**Once you have completed this assessment and submitted your responses, *you will be unable to make any further changes*.**

Initials) Are you a DDPI staff member?

1. Yes (If "Yes") Please enter your intitials in the box below _____.
2. No

***[Only Ask Intervw_As_1 and Intervw_As_2 if the answer to Initials is "No"]***

Intervw_As_1) Did anyone assist you in completing this survey?

1. Yes
2. No ➔ ***Go To End***

Intervw_As_2) Please provide the name of the person who assisted you, and his or her agency, in the boxes below.

Name _____

Agency _____

**When you have finished, please press the submit button in the lower right corner to submit your responses.**

**Thank you very much for completing this survey.**

***Your responses have been recorded and submitted*.**

**The NJ DDD will be contacting you in the near future in regard to the next steps in this process.**