Individual Name:____Date:___________________

Service Funding Needs Assessment

It is the policy of the Board to provide its Programs, Services and Supports in the most efficient and effective manner to as many eligible individuals as possible (Section 8.19). Level of support shall be reflective of the needs in accordance with the ISP in the areas of:

Individual need and medical necessity:

What services are provided that address a specific diagnosis or treatment of a specific condition?____

____

____

Have these services been provided at a staffing ratio other than 1:1 or 1:2? _______other staffing ratio?_____________

If yes, what were the outcomes of services being provided at a staffing ratio of 1:3 or 1:4?

____

____

____

Attach supporting documentation - i.e. individual sort report, medical reports, counselor notes

Assurance of health and safety

What systemic efforts are in place to maintain individual's well being?

____

____

____

What systemic efforts have been made to develop procedures to identify hazards in order to minimize risk, potential damage, harm or adverse health effects?

____

____

____

Have these services been provided at a staffing ratio other than 1:1 or 1:2? _______other staffing ratio?_____________

If yes, what were the outcomes of services being provided at a staffing ratio of 1:3 or 1:4?

____

____

____

Individual Name:____Date:_________________

Attach supporting documentation - i.e. individual sort report, medical reports, counselor notes

Does this individual currently have any alone time? ____________

If yes, what are the parameters of that alone time? _______________________________________

____

After review of current medical, health and safety needs, the individual / parent / guardian feels services need be provided at a rate of 1:1 or 1:2 regardless of outcome of Residential Review Committee.

Yes___no____ Individual / parent / guardian signature___________________________date_______

If yes, and Residential Review Committee does not see conditions being met necessitating 1:1 or 1:2 staffing, this individual will be considered a "preferential" case that will not be supported by Board resources. The Board will assist individuals / parents / guardians to develop voluntary and natural supports, shared funding opportunities to reach their preferred support level.

Team signatures:

Signature	Printed Name	Title	Date

Residential Review Committee:

___conditions **meet** the criteria to necessitate 1:1 or 1:2 staffing ratios for the medical health and safety needs of this individual.

___conditions **do not meet** the criteria to necessitate 1:1 Or 1:2 staffing ratios for the medical health and safety needs of this individual.

Committee signatures:

Signature	Printed Name	Title	Date