DEVELOPMENTAL DISABILITIES SERVICES UNIT
Dane County Department of Human Services – Adult Community Services Unit
1202 Northport Drive, Madison WI 53704 • 242-6200, fax: 242- 6531

REASSESSMENT OF INDIVIDUAL SUPPORT NEEDS

(Attach ISP Individual Outcomes to this worksheet)

Section 1

Consumer Name:	**DOB:**	**ACS#:**	**Dates of Reassessment:**
Providers/Support Agency modifying support:		**Case Manager/Support Broker:**	
Waiver Program:	**Assigned County Manager:**		

Consumer Resources:
Annual Residential SDS Rate $_____ **Annual Vocational Rate $_____** **Other Rate $_____**
Monthly Earned Income $_____ **Authorized Daily MAPC Hours _____**
Monthly Federal SSI Payment $_____ **Monthly State SSI Payment $_____** **Monthly SSDI Payment $_____**
MAPP _____ Yes _____ No **Monthly MAPP Premium $_____**
Cost Share _____ Yes _____ No **Monthly Cost Share $_____**
Special Needs Trust _____ Yes _____ No **Burial Trust** _____ Yes ____ No

Who is initiating proposed reassessment? ("X")

_____ Individual	_____ Guardian or Family	_____ Support Broker	_____ Service Provider	_____ Other:

In addition to the consumer and guardian (if applicable), who participated in the reassessment?

Briefly describe the team's reassessment process:

What Specific Program Category (SPC) has been reassessed (please refer to the SPC chart on the instruction sheet for the proper SPC code):

List person's outcome measures impacted by the reassessment and the suggested change in support:

1. _____
2. _____
3. _____

Proposed change in HOURS of support as a result of the reassessment (use + for increase or - for decrease)

Home Support - #Hours:_____ **Work Support - #Hours: _____** **Day Support - #Hours: _____**
Home Support – if not hours, describe: _____
Work Support – if not hours, describe: _____
Day Support – if not hours, describe: _____
Other Supports – describe: _____

Does the proposed service change allow the individual to achieve his/her outcomes measures? ("X")

	Yes, Explain:
	No, Explain:

Does the proposed service change create any health and safety risks? ("X")

	Yes, Explain:
	No, Explain:

If health and safety risks are identified, how will the team proceed?

What is the plan to minimize these risks?

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Section 2
IF THE REASSESSMENT HAS RESULTED IN A NEED FOR *INCREASED SUPPORT SERVICES*, PLEASE COMPLETE THE FOLLOWING:

NOTE: If your request is for an increase in staff coverage, a description of the current and proposed staffing may be requested. You may want to use a *Residential/Vocational Rate Worksheet* as a guide (this worksheet is available from DD Intake at 242-6440 or in the Broker Manual, section 9).

Why is a budget increase needed for this consumer?

Proposed budget increase (Include dollar amount and hours of services it purchases):

If you are asking for an increase in residential funding, please answer the following questions:

1. What other options have been explored?

2. Can existing funds or supports be reallocated to meet outcomes?

3. Can supports be shared? Are natural supports an option?

If you are asking for an increase in vocational funding, please answer the following questions:

1. What other options have been explored?

2. Can existing funds or supports be reallocated to meet outcomes?

3. Can supports be shared? Are natural supports an option?

If you are requesting funding for one-time costs, please describe alternative resources you have explored:

What is the plan to eliminate the need for an EER?

What kinds of alternative supports have been explored, i.e. MAPC, Sounds Response, sharing staff, PASS/IRWE, Personal Resources, natural supports, generic resources?

What will happen if your request for funding is denied?

Section 3
IF THE REASSESSMENT HAS RESULTED IN A *REDUCTION, SUSPENSION, TERMINATION, OR SUBSTITUTION* OF SUPPORT SERVICES, PLEASE COMPLETE THE FOLLOWING:

Is a SPC being…

… reduced? List SPC(s): _____

… suspended? List SPC(s): _____

… terminated? List SPC(s): _____

… substituted? List SPC(s): for what SPC (s):

Does the individual or the individual's guardian object to the reduction, suspension, termination, or substitution of services? ("X") _____ Yes _____ No

When completed, send a copy of this form to Self-Directed Services Coordinator, Angie Klemm at klemm.angela@countyofdane.com so proper notice can be generated.

Below for Dane County use only

Date Reviewed:

If Legal Notification required, date sent:

Date Reduction, Suspension, Termination, or Substitution of services implemented: