New Jersey Department of Children and Families
Division of Children's System of Care

#3 - Adaptive Behavior/Health/Safety/Risk Summary (ABS/HSRS)

Adaptive Behavior Summary			
Individuals Name		Date Completed	
DOB		MIS #	
ABS Completed By:			
Relationship: ☐ Parent- Phone #:	☐ Sibling/ Other Family Relative- Phone #:	☐ Paid Care Giver- Phone #:	
Case Manager: Phone #:			
Residential Type Select Phone #:		Address:	
Day Program Type Select Phone #:		Address:	

Legally Appointed Guardian(s), if applicable:	Is the guardianship status appropriate?
Name: type:Select	Name: type:Select
Home Address:	Home Address:
Work Location :	Work Location :
Phone#:	Phone#:

MEDICAL INSURANCE INFORMATION				
Medicaid #:	Medicare #:	Private Insurance:		Other:
EMERGENCY CONTACT INFORMATION				
Name:	Relationship:	Phone #:	Alternate #:	Address:
Name:	Relationship:	Phone #:	Alternate #:	Address:
Name:	Relationship:	Phone #:	Alternate #:	Address:

Eating	**Y**	**N**	**I**	**R**	**VD**	**PA**	**N/O**	**Comments**
Feeds self with a spoon	☐	☐	☐	☐	☐	☐	☐	
Feeds self with a fork	☐	☐	☐	☐	☐	☐	☐	
Cuts food with a knife	☐	☐	☐	☐	☐	☐	☐	
Eats with fingers	☐	☐	☐	☐	☐	☐	☐	
Drinks from a cup or glass	☐	☐	☐	☐	☐	☐	☐	
Favorite foods? Strong food dislikes?								
Religious/Cultural preferences/ restrictions?								
Toileting								
Does this person use adult incontinence products:	☐	☐	☐	☐	☐	☐	☐	
Day	☐	☐	☐	☐	☐	☐	☐	
Night	☐	☐	☐	☐	☐	☐	☐	
Toilets Self	☐	☐						
Wipes self with toilet paper.	☐	☐	☐	☐	☐	☐	☐	
Washes hands after toileting.	☐	☐	☐	☐	☐	☐	☐	
(Women) Takes care of menstrual needs.	☐	☐	☐	☐	☐	☐	☐	
Appropriate toilet habits?	☐	☐						
Any bladder accidents?	☐	☐		Day ☐	Night ☐	Frequency		
Any bowel accidents?	☐	☐		Day ☐	Night ☐	Frequency		

Hygiene	**Y**	**N**	**I**	**R**	**VD**	**PA**	**N/O**	**Comments**
Washing and Bathing								
Turns on/regulates water temperature			☐	☐	☐	☐	☐	
Washes and dries hands			☐	☐	☐	☐	☐	
Washes and dries face			☐	☐	☐	☐	☐	
Bathes self in bathtub			☐	☐	☐	☐	☐	
Showers self			☐	☐	☐	☐	☐	
Washes hair			☐	☐	☐	☐	☐	
Dries self			☐	☐	☐	☐	☐	

Key: **Y**-Yes **N**-No **I**-Independent **R**-Needs Reminders **VD**-Needs Verbal Direction
PA-Needs Physical Assistance **N/O**-No Opportunity to Observe

Hygiene, Cont.	**Y**	**N**	**I**	**R**	**VD**	**PA**	**N/O**	**Comments**
Uses deodorant			☐	☐	☐	☐	☐	
Combs/brushes hair			☐	☐	☐	☐	☐	
Tooth and mouth care								
Puts toothpaste on brush			☐	☐	☐	☐	☐	
Brushes own teeth			☐	☐	☐	☐	☐	
Dentures	☐	☐						
Worn regularly			☐	☐	☐	☐	☐	
Cares for own Dentures			☐	☐	☐	☐	☐	
Blows and wipes nose with tissue			☐	☐	☐	☐	☐	
Shaving Uses:								
safety razor	☐	☐	☐	☐	☐	☐	☐	
electric razor	☐	☐	☐	☐	☐	☐	☐	

Dressing Skills	**Y**	**N**	**I**	**R**	**VD**	**PA**	**N/O**	**Comments**
Undresses self			☐	☐	☐	☐	☐	
Buttons			☐	☐	☐	☐	☐	
Snaps			☐	☐	☐	☐	☐	
Zippers			☐	☐	☐	☐	☐	
Fastens a buckle			☐	☐	☐	☐	☐	
(Women) Hooks own bra			☐	☐	☐	☐	☐	
Ties shoes			☐	☐	☐	☐	☐	
Dresses self completely			☐	☐	☐	☐	☐	
Changes clothing regularly			☐	☐	☐	☐	☐	
Matches colors/patterns			☐	☐	☐	☐	☐	
Selects seasonal clothing			☐	☐	☐	☐	☐	

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COMMUNICATION SKILLS:	**Y**	**N**	**I**	**R**	**VD**	**PA**	**N/O**	**Comments**
Please select the languages used by this person:								LIST:
Understands the spoken word?	☐	☐						
Follows simple directions?	☐	☐						
Communicates through:								
Verbal Speech	☐	☐						
Communication Device	☐	☐	☐	☐	☐	☐	☐	LIST:
Gestures	☐	☐	☐	☐	☐	☐	☐	LIST:
Signs	☐	☐	☐	☐	☐	☐	☐	LIST:
Gestures and Signs Known	LIST:							
Telephone Use								
Can dial phone	☐	☐	☐	☐	☐	☐	☐	
Can answer /speak on the phone	☐	☐	☐	☐	☐	☐	☐	
Can use Cellular phone	☐	☐	☐	☐	☐	☐	☐	
Can this person read?	☐	☐						
Can this person write?	☐	☐						

SOCIAL BEHAVIORS	**Y**	**N**	**Comments**
What does this person enjoy doing?	LIST:		
How are emotions such as anger or frustration displayed?	LIST:		
Is this person sexually active?	☐	☐	☐ Chooses not to answer
How are symptoms of illness communicated?	LIST		
Does this person smoke?	☐	☐	
Does this person vote?	☐	☐	
Does this person advocate for him/herself?	☐	☐	
Are there any unusual fears? LIST	☐	☐	LIST:
Does this person have any unusual sleep patterns?	☐	☐	LIST:
Can this person be in a home with children?	☐	☐	LIST Precautions (Supervision needs):

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COMMUNITY AWARENESS	**Y**	**N**						
What community activities are enjoyed?	LIST:							
Does the person demonstrate appropriate behavior during these activities?	☐	☐	LIST Precautions (Supervision needs):					
Is this person aware of ordinary household dangers, such as stairs, heaters, electric outlets, household cleaners, ovens, wood burning stoves and fireplaces?	☐	☐	LIST Precautions (Supervision needs):					
Does this person demonstrate awareness of community dangers: a) including traffic,	☐	☐	LIST Precautions (Supervision needs):					
b) being overly friendly with strangers, etc.?	☐	☐	LIST Precautions (Supervision needs):					
Can the person make purchases?			☐	☐	☐	☐	☐	
With cash money, count and make change			☐	☐	☐	☐	☐	
With debit/credit card			☐	☐	☐	☐	☐	
How much money can the person independently manage?	$							
Describe the assistance this person needs to handle his/her finances (paying bills, budgeting, etc)								
Can this person tell time?	☐	☐						
Is this person visually impaired?	☐	☐	LIST Capacity:					
Height , Weight (if relevant to support needs)		Ft	Ins	Lbs				
Does this person self-medicate?	☐	☐	If yes, attach assessment. If no, describe level of assistance needed :					
Method of Administering medication:			Describe Methods:					
Can this person be left alone/unsupervised for any length of time?	☐	☐	If yes, attach assessment. If no, describe level of assistance needed :					

Physician Type	Name	Address	Telephone #:

Key: **Y**-Yes **N**-No **I**-Independent **R**-Needs Reminders **VD**-Needs Verbal Direction
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Instructions for Health/Safety/Risk section: Use the checklist to initiate conversations about health, medical, supervision and other supports the person may need. Incorporate into the plan of care the services and supports needed to keep the person safe and mitigate risk.

Health/Safety/Risk

Medical	Current	History	Medical	Current	History
Asthma	Y☐ N☐	Y☐ N☐	Diabetes	Y☐ N☐	Y☐ N☐
Frequent Colds	Y☐ N☐	Y☐ N☐	Pneumonia	Y☐ N☐	Y☐ N☐
Respiratory/Lung/ Breathing Problems	Y☐ N☐	Y☐ N☐	Uses Catheter, colostomy	Y☐ N☐	Y☐ N☐
Feeding Issues	Y☐ N☐	Y☐ N☐	GER (gastro esophageal reflux)	Y☐ N☐	Y☐ N☐
• At risk for Aspiration	Y☐ N☐	Y☐ N☐	Allergies (Medication, Food, Seasonal)	Y☐ N☐	Y☐ N☐
• Uses G-Tube	Y☐ N☐	Y☐ N☐	Ear infections	Y☐ N☐	Y☐ N☐
• Coughs or chokes while eating or drinking	Y☐ N☐	Y☐ N☐	Frequent Headaches	Y☐ N☐	Y☐ N☐
• Someone else puts food/liquids in your mouth	Y☐ N☐	Y☐ N☐	Serious Skin condition	Y☐ N☐	Y☐ N☐
• Mechanically altered diet *(thickened, chopped/ puréed)*	Y☐ N☐	Y☐ N☐	Hypertension/ High Blood Pressure	Y☐ N☐	Y☐ N☐
Medically Prescribed Diet *(fat, sodium, cholesterol)*	Y☐ N☐	Y☐ N☐	Heart/ Circulatory	Y☐ N☐	Y☐ N☐
Extreme food/ liquid seeking behavior that may cause injury (Prader-Willi Syndrome)	Y☐ N☐	Y☐ N☐	Stomach/Digestive	Y☐ N☐	Y☐ N☐
Dehydration Risk/ Regularly Refuses Liquids	Y☐ N☐	Y☐ N☐	Needs assistance ambulating	Y☐ N☐	Y☐ N☐
Constipation *Routinely takes bowel medications, Requires suppository or enema, Routinely takes fiber*	Y☐ N☐	Y☐ N☐	Seizure Disorder *Loss of Consciousness/Gran Mal, Absence/Petit Mal, Other Seizure*	Y☐ N☐	Y☐ N☐
Kidney/Urinary	Y☐ N☐	Y☐ N☐	Other Medical Not Listed :	Y☐ N☐	Y☐ N☐
Hepatitis B	Y☐ N☐	Y☐ N☐	I do not have any identified medical conditions.	Y☐ N☐	Y☐ N☐
Use of Adaptive Equipment	**Current**	**History**	**Use of Adaptive Equipment**	**Current**	**History**
Wheelchair *(Manual requires assistance, manual self propels, motorized requires assistance, motorized self propels)*	Y☐ N☐	Y☐ N☐	Elastic Stocking	Y☐ N☐	Y☐ N☐
Eyeglasses	Y☐ N☐	Y☐ N☐	Modified Eating Utensils	Y☐ N☐	Y☐ N☐
Walker/Crutches/Cane	Y☐ N☐	Y☐ N☐	PERS-Personal Emergency Response System	Y☐ N☐	Y☐ N☐

Comments:

Use of Adaptive Equipment, cont.	**Current**	**History**	**Use of Adaptive Equipment, cont.**	**Current**	**History**
Corrective shoes/braces	Y☐ N☐	Y☐ N☐	Helmet	Y☐ N☐	Y☐ N☐
Hearing Aide	Y☐ N☐	Y☐ N☐	Other:	Y☐ N☐	Y☐ N☐
Augmentative Communication Device	Y☐ N☐	Y☐ N☐	Other:	Y☐ N☐	Y☐ N☐
Use of Environmental Modifications	**Current**	**History**	**Use of Environmental Modifications**	**Current**	**History**
Wheelchair Accessible VAN	Y☐ N☐	Y☐ N☐	Accessible Bathroom Facilities	Y☐ N☐	Y☐ N☐
Ramp	Y☐ N☐	Y☐ N☐	Other:	Y☐ N☐	Y☐ N☐
Lifts: Porch, Hoyer, Stair	Y☐ N☐	Y☐ N☐	Other:	Y☐ N☐	Y☐ N☐
Behavioral Health	**Current**	**History**	**Behavioral Health**	**Current**	**History**
Aggressive injurious behavior to others	Y☐ N☐	Y☐ N☐	Pica- consumption of non edibles	Y☐ N☐	Y☐ N☐
Aggressive injurious behavior to self	Y☐ N☐	Y☐ N☐	Other behavior that requires intervention	Y☐ N☐	Y☐ N☐
Property destruction	Y☐ N☐	Y☐ N☐	Mental health condition or illness *(depression, loss of capacity, dementia, psychiatric admissions, psychosocial stressors, etc)*	Y☐ N☐	Y☐ N☐
Unsafe/criminal behavior	Y☐ N☐	Y☐ N☐	Substance use/abuse	Y☐ N☐	Y☐ N☐
• Sexual behavior	Y☐ N☐	Y☐ N☐	Other Behavioral:	Y☐ N☐	Y☐ N☐
• Fire setting	Y☐ N☐	Y☐ N☐	Other Behavioral:	Y☐ N☐	Y☐ N☐
Emergency	**Current**	**History**	**Emergency**	**Current**	**History**
Can the person identify what an emergency is?	Y☐ N☐	Y☐ N☐	Requires assistance or supervision to evacuate the home	Y☐ N☐	Y☐ N☐
Supervision Needs In the Home	**Current**	**History**	**Supervision Needs in the Community**	**Current**	**History**
In the home:			In the community:		
• 24 Hour supervision	Y☐ N☐	Y☐ N☐	• Restrictions	Y☐ N☐	Y☐ N☐
• Line of sight, close supervision	Y☐ N☐	Y☐ N☐	• Line of sight, close supervision	Y☐ N☐	Y☐ N☐
• Daily on-site support, limited hours	Y☐ N☐	Y☐ N☐	• Can be left alone at specific venues	Y☐ N☐	Y☐ N☐
• Scheduled, less frequently than daily support	Y☐ N☐	Y☐ N☐	• Travels in community independently	Y☐ N☐	Y☐ N☐
• As needed visitation & phone contact	Y☐ N☐	Y☐ N☐	Can be left unsupervised in a vehicle	Y☐ N☐	Y☐ N☐
Financial exploitation vulnerable	Y☐ N☐	Y☐ N☐		Y☐ N☐	Y☐ N☐
Staff require specialized/ individualized training for:	**Current**	**History**	**Staff require specialized/ individualized training for:**	**Current**	**History**
• Self care (hygiene, eating)	Y☐ N☐	Y☐ N☐	• Safety (adaptive equipment, transfers, community, mobility, emergencies)	Y☐ N☐	Y☐ N☐
• Health (medication administration, seizure care, treatments)	Y☐ N☐	Y☐ N☐	▪ Positive supports, supervision, restrictions, environmental modifications, etc	Y☐ N☐	Y☐ N☐

Comments:			
Section D: Choice (to be completed for waiver participants)			
Are you satisfied with:	**Yes**	**No**	**Comments**
• Current services?	☐	☐	
• Current provider?	☐	☐	
Are you requesting a change in:	**Yes**	**No**	
• Services?	☐	☐	
• Provider?	☐	☐	

Section E: Current Medication (Optional)

Medication	Use for	Dosage	Times	Side Effects	Doctor Info