This form should accompany all NC-SNAP assessments. Pleasecomplete **all** applicable sections of the form. A copy of this form, along with a copy of the *NC-SNAP* assessment, should be forwarded to the responsible LME-MCO for keying into the *NC-SNAP* database. After data entry, the forms should be filed and maintained per documentation requirements.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date of *NC-SNAP* Assessment:** | | | | | | | | | | |  | | | | **Individual’s Name:** | | | |  | | | | |
| **Type of Assessment (c*heck only one)*** | | | | | | | | | | | | | | | **Individual’s Unique ID No.** | | | | | | |  | |
|  | | | **Initial Assessment** | | | | | |  | | **Special Update** | | | | **Individual’s Case No.** | | | | | |  | | |
|  | | | **Annual Update** | | | | | | | | | | | | **Medicaid ID No.** | | |  | | | | | |
| **State funded Services  Money Follows Person  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | **Change in DD Support Status (*if applicable,* c*heck only one)*** | | | | | | | | | | | | | | | | | | | | |
|  | | |  | | | **Deceased** | | |  | | **Refused Services** | | |  | **Unable to Locate** | | |  | | | **Moved to Another**  **LME-MCO** | | |
|  | | |  | | | **Moved Out-of-State** | | | | |  | **No Longer Receiving Services (other)** | | | | | | | | | | | |
|  | | |  | | | **Changed Provider (name):** | | | | | | | | | **SIS Assessment (date completed)** | | | | | | | | |

Current *NC-SNAP* Scores

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Daily Living:** |  | **Health Care:** |  | **Behavioral Supports:** |  | **Overall Level:** |  |

Examiner/Agency Information

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Examiner’s Name:** |  | | | **Agency Name:** |  |
| **NC-SNAP Certification No.** | | |  | **Agency Address:** |  |
| **Examiner’s Email:** | |  | | **Agency Phone:** |  |

**Individual’s Type of Residential Placement** ***(check only one)***

|  |  |  |
| --- | --- | --- |
|  | Independent Living (lives by self or with roommate) | |
|  | Family Home (lives with family member or guardian) | |
|  | Foster Home | |
|  | 1 Bed Alternative Family Living (AFL) | |
|  | 2 - 6 Bed Alternative Family Living (AFL) | |
| **Supervised Living DD Adult Group Home (state funded)** | | |
|  | 1 - 3 Bed Supervised Living DD Adult | |
|  | 4 - 6 Bed Supervised Living DD Adult | |
|  |  | |
| **Supervised Living DD Minor Group Home (state funded)** | | |
|  | 1 - 3 Bed Supervised Living DD Minor | |
|  | 4 - 6 Bed Supervised Living DD Minor | |
|  |  | |
| **ICF/ID Group Home (Medicaid funded)** | | |
|  | 1 - 6 Bed ICF/ID Group Home | |
|  | 7 - 15 Bed ICF/ID Group Home | |
|  | > 15 Bed ICF/ID Group Home | |
| **Adult Care/Nursing/Rest Homes (homes for aged/disabled)** | | |
|  | 1 - 6 Bed Adult Care/Nursing/Rest Home | |
|  | 7- 15 Bed Adult Care/Nursing/Rest Home | |
|  | > 15 Bed Adult Care/Nursing/Rest Home | |
| **Large Congregate Care (> 15 Bed)** | | |
|  | State Developmental Center | |
|  | Psychiatric Hospital | |
|  | Neuro Med Treatment Center | |
| **Other Residential Not Listed Above (Specify Below)** | | |
|  | 1 - 6 Bed Other Residential | |
|  | 7-15 Bed Other Residential | |
|  | > 15 Bed Other Residential | |
| Specify Other Residential | |  |

Oct 2017