



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

CHO Area:

PIN/ UNIQUE IDENTIFIER:

Date Completed:

Disability Supports Application Management Tool

Section 1: Individual Information and Home Circumstances

** Instruction to complete – Please tick relevant box*

1.1. PIN or Unique Identifier	
1.3. Age	

1.2. Date of Birth	
1.4. Sex	
Male	
Female	

1.5. Current Living at Home Circumstances	
At home with two parents	
At home with one parent	
At Home with Sibling	
At home with relative	
Lives with non relative (eg neighbour or family friend)	
Vagrant / Homeless	
Existing Residential Service	
Living Independently (no funded supports)	
Living Semi independently – Maximum 25 hours Funded Support Weekly	
Living Semi Independently – No Paid Support (Natural Supports)	
Acute Care Setting	
Nursing Home	
In Care of Tusla	
Foster Care/After Care	
Not Applicable	

1.6 Age Range of NOK	
Less than 30	
30-39	
40-49	
50-59	
60-69	
70-79	
Greater than 80	

1.7. Date of Application	
Date	

1.8. Reason for Application	
Changing Needs in the Home	
Changing needs in existing Service	
Death of Main Carer	
Incapacity of Main Carer	
Future Needs	
Other – please specify in 1.11	

1.9 No of Additional Dependents (Adults & Children) in the Household with a Disability or High Support Needs	

1.10 No of Dependents in the Household under 18 Yrs	



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1.11. Additional Relevant Information

(Narrative to be added to give context of Client's situation)

2. Existing Funded Provision prior to application for Service and/or Additional Services



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2.1. Current Respite Provision Type. (Select Main provision if multiple types)	
Crisis or planned respite (centre based)	
Occasional respite with host family	
Overnight respite in the home	
Holiday residential placement	
Shared care or guardianship[
Regular part time care (2/3 days per week)	
Regular part time care (every weekend)	
Regular part time care (alternate weeks)	
Other residential service	

2.2 List other Respite Types availed of (if applicable)

2.3 Total No. of Respite Nights per month

2.4 Total No of Respite Days/Evenings per month

2.5 Total No. of Home Help Hours per week

**List only Hours Funded for use of the Person with Disability*

2.6 No of PA Hours per week

2.7 No. of Home Support Hours per week

**List only Hours Funded for use of the Person with Disability*

2.8 Current Residential Placements	
Not applicable	
<i>**Community Home Group**</i>	
5 Day Community Home Group	
7 Day Community Home Group	
7 day (52 wk) Community Home Group	
<i>** Residential Centre**</i>	
5 Day Residential Centre	
7 Day Residential Centre	
7 Day (52 wk) Day Residential Centre	
<i>**Other Placements**</i>	
Acute Hospital	
Mental Health Community Residence	
Psychiatric Hospital	
Intensive Placement (challenging behaviour)	
Intensive Placement (profound or multiple handicap)	
Nursing Home	
Other full time Residential Service	

2.9 Current Day Program	
None	
Day Service	
Day Activation	
Work-like-Work	
RT Program	
New Directions	

2.10 No of other persons resident in Residential Unit

3. Individual Profile Information



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3.1. Primary Disability	
Intellectual Disability	
Physical & Sensory Disability	
Autism	

3.2 Level of ID	
N/A	
Borderline	
Mild	
Moderate	
Severe/Profound	
Not Verified	

3.4 Confirmed Autism Diagnosis	
Yes	
No	

** NB (Answer only if confirmed diagnosis)*

3.5 Confirmed Mental Health Diagnosis	
Yes	
No	

** NB (Answer only if confirmed diagnosis)*

3.7 Epilepsy	
Controlled	
Uncontrolled	
None	

3.9 Incontinent (Full time Pads)	
By Night Only	
Full Time Pads	

3.11 Enteral Feed Required	
Non Relevant	
Nasogastric	
PEG Feed	

** Answer only if "non verbal" selected in 3.12*

3.1 (a). Secondary Disability	
Intellectual Disability	
Physical & Sensory Disability	
Autism	

3.3 Physical/Sensory Disability	
N/A	
Paraplegia	
Quadriplegia	
Neurological Conditions (ie MS, Parkinsons etc)	
Hemiplegia	
Cerebral Palsy	
Dystrophy	
Absent limb/reduced limb function	
Spina Bifida / Hydrocephalus	
Polio / Post-Polio	
Other P&S Diagnosis	

3.6 Wheelchair User	
Permanent Wheelchair User	
Wheelchair for Transfers & Community	
No	

3.8 Hoisting Required	
Yes	
No	

3.10 Feeding Support Needs	
Unable	
Needs Help	
None	

3.12 Communication	
Verbal	
Non Verbal	

** i.e Able to communicate all needs with no supports*



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3.13 Required Communication Support	
Able to communicate all needs with no supports	
Able to communicate basic needs with some supports	
Able to communicate with use of gestures	
Unable to communicate	

** Answer only if "non verbal" selected in 3.12*

3.16 Psychotropic Medication	
Yes	
No	

3.18 Cardiac Issues	
Yes	
No	

3.20 Dementia	
Yes (Indicate Query or Confirmed)	
No	

3.14 Visual Impairment	
Yes	
No	

3.15 Total Hearing Loss	
Yes	
No	

3.17 Type 1 Diabetes/Insulin Dependent	
Type 1	
Type 2	
Type 2 – Insulin Dependent	

3.19 Personal Activities of Daily Living	
Independent with all PADL's	
Requires support with up to three PADL's	
Requires support more than three PADL's	
Requires full support across all PADL's	

** Personal Activities of Daily Living includes: Toileting, Showering, Bathing, Dressing, Personal Grooming (Shaving/Hair/Make-Up), Domestic Shores*



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Subscales

3.21 Medical Support Needs	Non Relevant	Low	Medium	High	Intensive
Maintenance of Skin Integrity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Open Pressure Sore Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suctioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest/Postural Drainage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tracheostomy Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oxygen Therapy (Nebuliser, Oxygen & C-Pap)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immuno-compromised support needs (C-Diff, MRSA, Hep C, Chemotherapy, etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ostomy Care (Colostomy or other Stoma Care)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Please refer to Appendix 1*

3.22 Challenging Behaviour	Fully Independent	Largely Independent	Partial Independence	Limited Independence	High Support Needs	Very High Support Needs
Level of support required to avoid Emotional Outbursts.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Level of support required to avoid self-injurious behaviour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Level of Support required to avoid ingesting inedible substances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Level of support required to prevents attempts at suicide.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Level of support required to avoid instances of substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Level of support required to enable the person to cooperate with mental health treatment plan.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Level of support required to avoid episodes of physical assault or injury to other persons.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Level of support required to avoid nonaggressive but inappropriate sexual behaviour to self and others.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Level of support required to prevent sexual aggression towards other persons.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Level of support required to avoid the destruction of property and or the physical environment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Level of support required to guard against absconding and/or wandering behaviour.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Level of support required to guard against stealing behaviour.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Refer to Appendix 1*

Risk & Safeguarding Issues

3.23 Known to Safeguarding Team	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3.24 If Yes to above, is Safeguarding Plan in place?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3.25 Forensic Risk	Yes <input type="checkbox"/>	No <input type="checkbox"/>

5.1. Completed By:

5.2. Job Title:

5.3. Date:

** If the Person is classified as a forensic risk, it is assumed that the behaviour/incidents is of such intensity/significance that it is reportable to An Garda Síochána*



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Appendix 1 – Subscales Rating Keys for Medical Support Needs & Challenging Behaviour

Medical Support Needs (3.21)

Rating Key	
Not Relevant	This person does not require any supports or interventions for the management of this presenting need
Low	This person requires no more than two nursing intervention across a 24 hour period for the support and management of this presenting need.
Medium	This person requires nursing intervention on three occasions across a 24 hour period for the support and management of this presenting need.
High	This person requires nursing intervention on four occasions across a 24 hour period for the support and management of this presenting need.
Intensive	This person requires maximum and consistent nursing support and intervention across a 24 hour period for the management of the presenting need

Challenging Behaviour (3.22)

Rating Key	
Fully Independent	The person requires no support from another person, they are independent in the management of their behaviours.
Largely Independent	The person requires little or no support, they might need support at different points across the life span especially at times of transition (e.g. changes in education, employment and accommodation) or significant life events.
Partial Independence	The person requires prompting or coaching to manage the behaviours that challenge, the person can use different strategies to deescalate the behaviour.
Limited Independence	The person requires supervision, prompting or assistance to manage the behaviours that challenge.
High Support Needs	The person requires support in managing and addressing the presenting behaviours that challenge.
Very High Support Needs	The behaviour is of such an intensity, frequency or duration as to threaten the quality of life and/or the physical safety of the individual or others and is likely to lead to responses that are restrictive, aversive or result in exclusion. The person requires significant support.