



# Arkansas Independent Assessment (ARIA)

## Arkansas Independent Assessment (ARIA)

### Filling this form with Adobe Acrobat

#### What you need

In order to **fill in and save** the data on this form you need one of the following:

- Adobe Acrobat Standard 7 or higher
- Adobe Acrobat Professional 7 or higher

If you only have Adobe Reader you will be able to fill in but **not** save the form data.

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1. Open one of the forms on the web page
2. Click on the “disc” icon found on the toolbar
3. Save the document to your hard drive.

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1. Open the form (saved on your hard drive) on the following page. Select the Hand tool.
2. Move the cursor inside the first field and click. The I-beam pointer allows you to type text. The arrow pointer allows you to select a button, a check box, a radio button, or an item from a list. After entering text do one of the following:
  - Press *Tab* to go to the next form field to enter data.
  - Press *Shift-Tab* to go to the previous form field.
  - Press *Enter* (Windows) or *Return* (Mac) to travel down the page.
  - Use the *Space Bar* for fields that need a check mark.

#### To save the completed form with the data

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Click the *Clear Form Data* button at the top of the form. This will erase all the data from all the fields of the form, creating a blank form.

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#### To enlarge or reduce the view of the page

Press *Ctrl-0* (Windows) or *Command-0* (Mac) to fit the page on the screen. Press *Ctrl-2* (Windows) or *Command-2* (Mac) to fit the width of the page on the screen.



# Arkansas Independent Assessment (ARIA)

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## Arkansas Independent Assessment (ARIA)

### A. Assessment Information

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A.1

Last four of Social Security Number (SSN)

### B. Demographic

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B.1 Legal Name

First

Middle

Last and Suffix

B.2

Date of Birth (MM/DD/YYYY)

B.3 Gender

☐ Male

☐ Female

☐ Other - **If “Other”, indicate how the individual self- identifies:**

Comments

B.4 Marital Status:

☐ Now married

☐ Separated

☐ Widowed/Widower

☐ Never Married

☐ Divorced

B.5 Are you a veteran?

☐ Yes ☐ No

B.6 What is your race?

☐ White

☐ Native American/Alaskan Native

☐ Black or African American

☐ Native Hawaiian or other Pacific Islander

☐ Asian

B.7 Ethnicity:

☐ Hispanic or Latino

☐ Unknown

☐ Other

B.8 Safety Risk?

☐ Yes ☐ No

**↓IF YES, ANSWER RISK CATEGORY BELOW. ↓**

B.9 Safety Risk Categories.

☐ Physical

☐ Animal

☐ Connectivity Issues

☐ Road Conditions

☐ Health

B.10

Safety Risk Comments



## Arkansas Independent Assessment (ARIA)

B.11 Does the person to be assessed need any additional accommodations?

☐ No

☐ Yes -If yes, please describe:

Comments

B.12 Type of Telephone Service Used:

☐ Voice ☐ TTY ☐ Videophone

B.13 Is an interpreter needed?

☐ No

☐ Yes -If yes, please describe:

Comments

B.14 Address: Mailing

Street Address

City

State

Zip

County

B.15 Phone Numbers

Home Number

Work Number

Cell Number

B.16 Email

Home Email

Work Email

B.17 Preference to be contacted:

☐ Email ☐ Mail ☐ Telephone



## Arkansas Independent Assessment (ARIA)

### C. Current Services and Supports

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#### C.1 What current services and supports is the individual currently receiving?

*Check all that apply:*

- |   |  |
|---|--|
| <input type="checkbox"/> None   | <input type="checkbox"/> Home Health Aide                                      |
| <input type="checkbox"/> Adaptive Equipment   | <input type="checkbox"/> Mental Health Assessment and/or Treatment             |
| <input type="checkbox"/> Adult Day Services   | <input type="checkbox"/> Mental Health Targeted Case Management                |
| <input type="checkbox"/> Adult Day Health Services                                  | <input type="checkbox"/> Nurse Visits  |
| <input type="checkbox"/> Adult Family Homes   | <input type="checkbox"/> Occupational Therapy                                  |
| <input type="checkbox"/> Assisted Living  | <input type="checkbox"/> Personal Care Attendant (PCA)                         |
| <input type="checkbox"/> Attendant Care   | <input type="checkbox"/> Personal Emergency Response System (PERS)             |
| <input type="checkbox"/> Case Management/Care Coordination                          | <input type="checkbox"/> Physical Therapy                                      |
| <input type="checkbox"/> Children's Health Medical Services (CHMS)                  | <input type="checkbox"/> Program for All-Inclusive Care for the Elderly (PACE) |
| <input type="checkbox"/> Community Transitions                                      | <input type="checkbox"/> Respite   |
| <input type="checkbox"/> Consultation Services                                      | <input type="checkbox"/> Specialized Medical Services                          |
| <input type="checkbox"/> Crisis Intervention  | <input type="checkbox"/> Speech Therapy  |
| <input type="checkbox"/> Developmental Disability Day Treatment Services (DDTCS)    | <input type="checkbox"/> Supplemental Supports                                 |
| <input type="checkbox"/> Environmental Accessibility Adaptations/Adaptive Equipment | <input type="checkbox"/> Supported Employment                                  |
| <input type="checkbox"/> Environmental Modifications                                | <input type="checkbox"/> Supportive Living                                     |
| <input type="checkbox"/> Foster Care  | <input type="checkbox"/> Targeted Case Management                              |
| <input type="checkbox"/> Home Delivered Meals                                       | <input type="checkbox"/> Substance Abuse Assessment and/or Treatment           |
|   | <input type="checkbox"/> Other – If “Other”, please specify service            |

---

#### Comments



## Arkansas Independent Assessment (ARIA)

### D. Housing

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#### D.1 Current Housing Type:

- |   |   |
|---|---|
| <input type="checkbox"/> Adult Family Home  | <input type="checkbox"/> Noncertified boarding care                           |
| <input type="checkbox"/> Licensed Level 1 Assisted Living   | <input type="checkbox"/> Provider-Owned Group Home                            |
| <input type="checkbox"/> Licensed Level 2 Assisted Living   | <input type="checkbox"/> Provider-Owned Supported Apartment                   |
| <input type="checkbox"/> Certified Level 1 Therapeutic Community (Long Term Residential)                            | <input type="checkbox"/> Provider-Owned Supported Housing (Max 4 individuals) |
| <input type="checkbox"/> Certified Level 2 Therapeutic Community (Long Term Residential)                            | <input type="checkbox"/> Residential Care Facility (RCF)                      |
| <input type="checkbox"/> Foster Care  | <input type="checkbox"/> Supported Living Arrangement (with Paid Staff)       |
| <input type="checkbox"/> Homeless   |   |
| <input type="checkbox"/> ICF State Operated   |   |
| <input type="checkbox"/> ICF Private  |   |
| <input type="checkbox"/> Individual Owned/Controlled Apartment  |   |
| <input type="checkbox"/> Individual Owned/Controlled Home   |   |
| <input type="checkbox"/> Individual Owned/Controlled Family Home  |   |
| <input type="checkbox"/> Institution Hospital   |   |
| <input type="checkbox"/> Institution, NF   Certified boarding care  |   |
| <input type="checkbox"/> In someone else's home/apt. <b>-IF YES, PLEASE SPECIFY RELATIONSHIP TO OWNER/RESIDENT:</b> |   |

---

Relationship to Owner





## Arkansas Independent Assessment (ARIA)

### E. Emergency Contacts

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E.1

**Name**

E.2

**Relationship**

☐

Spouse/Caregiver/Child

☐

Friend Neighbor

☐

Parent

☐

Other

☐

Guardian/Legal Representative

E.3

**Address**

Street Address

City

State

Zip Code

E.4

Directions/Comments

E.5

**Telephone Numbers**

Home Number

Work Number

Cell Number

E.6

**Email**

Home Email

Work Email



## Arkansas Independent Assessment (ARIA)

### F. Activities of Daily Living (ADLs)

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#### Eating

F.1 **Do you have any difficulties with eating or require support or assistance with eating?**

☐ Yes ☐ No ☐ Chose not to answer

**↓IF F.1 IS YES, COMPLETE THE REMAINDER OF THE EATING SECTION:↓**

F.2 **What assistance does the client need to eat by themselves for **ages >=18?****

- ☐ Can eat without help of any kind
- ☐ Needs and/or gets minimal reminding or supervision
- ☐ Needs and/or gets help in cutting food, buttering food or arranging food
- ☐ Needs and/or gets some personal help with feeding or someone needs to be sure that you don't choke
- ☐ Needs to be fed completely or tube feeding or IV feeding

F.3 **What assistance does the client need to eat by themselves for **ages <=17?****

- ☐ Independent
- ☐ Intermittent supervision or reminders
- ☐ Needs constant supervision and/or assistance in setting up meals, i.e. cutting meat, pouring fluids
- ☐ Needs physical assistance. Child can partially feed self (N/A for child 0-24M)
- ☐ Needs and receives total oral feeding from another. Child is physically unable to participate (N/A for child 0-12M)
- ☐ Receives tube feeding. Child has documented incidents of choking or reflux on a weekly basis or more that is related to diagnosis or disability.

F.4 **Cuing and Supervision:**

- ☐ Independent ☐ Intermittently during the task
- ☐ To initiate the task ☐ Constantly throughout the task

F.5 **Physical Assistance:**

- ☐ Independent ☐ Limited
- ☐ Setup/prep ☐ Extensive/total dependence



## Arkansas Independent Assessment (ARIA)

### F.6 Challenges while eating?

What inhibits the client from performing the task? (Select all that apply):

- |  |  |
|--|--|
| <input type="checkbox"/> Behavioral issues                               | <input type="checkbox"/> Mouth pain                      |
| <input type="checkbox"/> Cannot cut food                                 | <input type="checkbox"/> Poor appetite                   |
| <input type="checkbox"/> Chewing problem                                 | <input type="checkbox"/> Poor hand to mouth coordination |
| <input type="checkbox"/> Choking problem                                 | <input type="checkbox"/> Problems with taste             |
| <input type="checkbox"/> Disease/symptoms interfere with performing task | <input type="checkbox"/> Swallowing problem              |
|  | <input type="checkbox"/> Other                           |

Other challenges while eating:

---

*Provide supporting documentation (e.g., per client, due to, needs, what, by who, how often):*

### F.7 Strengths:

What does the person do well while eating? (Select all that apply):

- |   |   |
|---|---|
| <input type="checkbox"/> Cooperates with caregivers             | <input type="checkbox"/> No swallowing problems         |
| <input type="checkbox"/> Has a good appetite                    | <input type="checkbox"/> Person is motivated            |
| <input type="checkbox"/> Independent with equipment/adaptations | <input type="checkbox"/> Takes occasional food by mouth |
| <input type="checkbox"/> Manages own tube feeding               | <input type="checkbox"/> Other                          |

Other strengths while eating:

---

*What additional part of the task can the client do well?*

### F.8 Eating Equipment:

Does the client identify that they need, or they have equipment to assist with eating?

- ☐ Yes ☐ No ☐ Chose not to answer

**↓IF F.8 IS YES, SELECT ALL THAT APPLY FOR F.9 BELOW. ↓**

### F.9 Document what equipment client currently uses:

- |   |  |
|---|--|
| <input type="checkbox"/> Adaptive Cup     | <input type="checkbox"/> Jejunostomy Tube              |
| <input type="checkbox"/> Adapted Utensils | <input type="checkbox"/> Nasogastric Tube              |
| <input type="checkbox"/> Dentures         | <input type="checkbox"/> Plate Guard                   |
| <input type="checkbox"/> Dycem Mat        | <input type="checkbox"/> Specialized Medical Equipment |
| <input type="checkbox"/> Gastrostomy Tube | <input type="checkbox"/> Straw                         |
| <input type="checkbox"/> Hickman Catheter | <input type="checkbox"/> Other                         |
| <input type="checkbox"/> IV               |  |



## Arkansas Independent Assessment (ARIA)

- F.10 Document if client reports they need adaptive equipment but currently do not have or has but does not use – If “other” was selected describe other equipment utilized.

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### Eating Notes/Comments

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#### Bathing

- F.11 Do you have any difficulties with bathing or require support or assistance during bathing?  
☐ Yes ☐ No ☐ Chose not to answer  
↓IF F.11 IS YES, COMPLETE THE REMAINDER OF THE BATHING SECTION:↓
- F.12 What assistance does client need to bath by themselves for **ages >= 18?**  
☐ Can bathe or shower without any help ☐ Needs and/or gets help getting in and out of the tub  
☐ Needs and/or gets minimal supervision or reminding ☐ Needs and/or gets help washing and drying their body  
☐ Needs and/or gets supervision only ☐ Cannot bathe or shower, needs complete help
- F.13 What assistance does client need to bath by themselves for **ages <= 17?**  
☐ Independent ☐ Constant supervision, but child does not need physical assistance  
☐ Intermittent supervision or reminders ☐ Physical assistance of another, but child is physically able to participate (N/A 0-72M)  
☐ Needs help in and out of tub ☐ Totally dependent on another for all bathing. Child is physically unable to participate. (N/A 0-60M)
- F.14 **Cuing and Supervision:**  
☐ Independent ☐ Intermittently during the task  
☐ To initiate the task ☐ Constantly throughout the task
- F.15 **Physical Assistance:**  
☐ Independent ☐ Limited  
☐ Setup/prep ☐ Extensive/total dependence



## Arkansas Independent Assessment (ARIA)

### F.16 Challenges while bathing?

**What inhibits the client from performing the task? (Select all that apply):**

- |   |  |
|---|--|
| <input type="checkbox"/> Behavioral issues              | <input type="checkbox"/> Disease/symptoms interfere with performing task |
| <input type="checkbox"/> Afraid of bathing              | <input type="checkbox"/> Unable to shampoo hair                          |
| <input type="checkbox"/> Cannot be left unattended      | <input type="checkbox"/> Unable to stand alone                           |
| <input type="checkbox"/> Cannot judge water temperature | <input type="checkbox"/> Other   |

**Other challenges while bathing:**

---

*Provide supporting documentation (e.g., per client, due to, needs, what, by who, how often):*

### F.17 Strengths:

**What does the person do well while bathing? (Select all that apply):**

- |   |   |
|---|---|
| <input type="checkbox"/> Able to direct caregiver   | <input type="checkbox"/> Person is weight bearing |
| <input type="checkbox"/> Bathes self with cuing     | <input type="checkbox"/> Safe when unattended     |
| <input type="checkbox"/> Cooperates with caregivers | <input type="checkbox"/> Shampoos hair            |
| <input type="checkbox"/> Enjoys bathing             | <input type="checkbox"/> Other                    |

**Other strengths while bathing:**

---

*What additional part of the task can the client do well?*

### F.18 Bathing Equipment:

**Does the client identify that they need, or they have equipment to assist with Bathing?**

- ☐ Yes ☐ No ☐ Chose not to answer

**↓IF F.18 IS YES, SELECT ALL THAT APPLY FOR F.19 BELOW. ↓**

### F.19 Document what equipment client currently uses:

- |   |  |
|---|--|
| <input type="checkbox"/> Bath Bench           | <input type="checkbox"/> Shower Chair                  |
| <input type="checkbox"/> Grab Bars            | <input type="checkbox"/> Specialized Medical Equipment |
| <input type="checkbox"/> Hand-Held Shower     | <input type="checkbox"/> Transfer Bench                |
| <input type="checkbox"/> Hoyer Lift           | <input type="checkbox"/> Other                         |
| <input type="checkbox"/> Roll-in Shower Chair |  |

### F.20 Document if client reports they need adaptive equipment but currently do not have or has but does not use – If “other” was selected describe other equipment utilized.

---

**Bathing Notes/Comments:**

## Dressing

### F.21 Do you have any difficulties with dressing or require support or assistance during dressing?

- ☐ Yes ☐ No ☐ Chose not to answer

**↓IF F.21 IS YES, COMPLETE THE REMAINDER OF THE DRESSING SECTION↓**



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F.22 **What assistance does the client need to dress by themselves for ages  $\geq 18$ ?**

- |  |  |
|--|--|
| <input type="checkbox"/> Can dress without any help  | <input type="checkbox"/> Cannot dress themselves, somebody else dresses them |
| <input type="checkbox"/> Needs and/or gets minimal supervision                             | <input type="checkbox"/> Is never dressed                                    |
| <input type="checkbox"/> Needs and/or gets some help from another person to put clothes on |  |

F.23 **What assistance does the client need to dress by themselves for ages  $\leq 17$ ?**

- |  |   |
|--|---|
| <input type="checkbox"/> Independent   | <input type="checkbox"/> Physical assistance or presence of another at all times, but child is able to physically participate (N/A for child 0-36M) |
| <input type="checkbox"/> Intermittent supervision or reminders, may need physical assistance with fasteners, shoes or layout out clothes | <input type="checkbox"/> Totally dependent on another for all dressing. Child is unable to physically participate (N/A if child 0-12M)              |
| <input type="checkbox"/> Constant supervision, but no physical assistance (N/A for child 0-48M)  |   |

F.24 **Cuing and Supervision:**

- |   |   |
|---|---|
| <input type="checkbox"/> Independent          | <input type="checkbox"/> Intermittently during the task |
| <input type="checkbox"/> To initiate the task | <input type="checkbox"/> Constantly throughout the task |

F.25 **Physical Assistance:**

- |                                      |   |
|--------------------------------------|---|
| <input type="checkbox"/> Independent | <input type="checkbox"/> Limited                    |
| <input type="checkbox"/> Setup/prep  | <input type="checkbox"/> Extensive/total dependence |

F.26 **Challenges while dressing?**

**What inhibits the client from performing the task? (Select all that apply):**

- |  |  |
|--|--|
| <input type="checkbox"/> Behavioral issues                               | <input type="checkbox"/> Unable to lie                   |
| <input type="checkbox"/> Cannot button clothing                          | <input type="checkbox"/> Unable to undress independently |
| <input type="checkbox"/> Cannot dress lower extremities                  | <input type="checkbox"/> Unable to zip                   |
| <input type="checkbox"/> Cannot lift arms                                | <input type="checkbox"/> Will wear dirty clothes         |
| <input type="checkbox"/> Cannot put on shoes/socks                       | <input type="checkbox"/> Other                           |
| <input type="checkbox"/> Disease/symptoms interfere with performing task |  |

**Other challenges while dressing:**

---

***Provide supporting documentation (e.g., per client, due to needs, what by who, how often):***



## Arkansas Independent Assessment (ARIA)

### F.27 Strengths:

**What does the person do well while dressing?** (Select all that apply):

- |   |  |
|---|--|
| <input type="checkbox"/> Able to direct caregiver   | <input type="checkbox"/> Person is motivated     |
| <input type="checkbox"/> Buttons clothing           | <input type="checkbox"/> Puts on shoes and socks |
| <input type="checkbox"/> Cooperates with caregivers | <input type="checkbox"/> Uses assistive devices  |
| <input type="checkbox"/> Gets dressed with cuing    | <input type="checkbox"/> Other                   |

**Other strengths while dressing:**

---

*What additional part of the task can the client do well?*

### F.28 Dressing Equipment: Does the client identify that they need or they have equipment to assist with dressing?

- ☐ Yes ☐ No ☐ Chose not to answer

**↓IF F.28 IS YES, SELECT ALL THAT APPLY FOR F.29 BELOW↓**

### F.29 Document what equipment client currently uses:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Adaptive Clothing  | <input type="checkbox"/> Orthotics       | <input type="checkbox"/> Sock Aid                      |
| <input type="checkbox"/> Button Hook        | <input type="checkbox"/> Prosthesis      | <input type="checkbox"/> Specialized Medical Equipment |
| <input type="checkbox"/> Elastic Shoe Laces | <input type="checkbox"/> Protective Gear | <input type="checkbox"/> TED Hose                      |
| <input type="checkbox"/> Helmet             | <input type="checkbox"/> Reacher         | <input type="checkbox"/> Other                         |

### F.30 Document if client reports they need adaptive equipment but currently do not have, or has but does not use – If “other” was selected describe other equipment utilized.

---

### Dressing Notes/Comments

#### Personal Hygiene/Grooming

### F.31 Does the person have any difficulties with or require support or assistance to take care of their grooming and hygiene needs?

- ☐ Yes ☐ No ☐ Chose not to answer

**↓IF F.31 IS YES, COMPLETE THE REMAINDER OF THE PERSONAL HYGIENE/GROOMING SECTION↓**

### F.32 What assistance does client need to groom by themselves for **ages >= 18?**

- ☐ Can comb hair, wash face, shave or brush teeth without any help of any kind
- ☐ Needs and/or gets supervision or reminding about grooming activities
- ☐ Needs and/or gets daily help from another person
- ☐ Is completely groomed by somebody else



## Arkansas Independent Assessment (ARIA)

F.33 **What assistance does client need to groom by themselves for ages  $\leq 17$ ?**

- ☐ Independent
- ☐ Intermittent supervision or reminders
- ☐ Help of another to complete the task, but child is able to physically participate (N/A if child 0-48M)
- ☐ Totally dependent on another for all dressing. Child is unable to physically participate (N/A if child 0-12M)
- ☐ Child is unable to physically participate (N/A if child 0-24M)

F.34 **Cuing and Supervision:**

- ☐ Independent
- ☐ Intermittently during the task
- ☐ To initiate the task
- ☐ Constantly throughout the task

F.35 **Physical Assistance:**

- ☐ Independent
- ☐ Limited
- ☐ Setup/prep
- ☐ Extensive/total dependence

F.36 **Challenges while grooming/hygiene?**

**What inhibits the client from performing the task? (Select all that apply):**

- ☐ Behavioral issues
- ☐ Disease/symptoms interfere with performing task
- ☐ Cannot brush/comb hair
- ☐ Unaware of grooming needs
- ☐ Cannot brush teeth
- ☐ Other
- ☐ Cannot raise arms

**Other challenges while grooming/hygiene:**

---

*Provide supporting documentation (e.g., per client, due to, needs, what, by who, how often):*

F.37 **Strengths:**

**What does the person do well in taking care of their own grooming/hygiene needs? (Select all that apply):**

- ☐ Able to apply makeup, lotions, etc.
- ☐ Brushes teeth/dentures
- ☐ Able to brush/comb hair
- ☐ Can shave themselves
- ☐ Able to trim nails
- ☐ Cooperates with caregiver
- ☐ Able to wash hands/face
- ☐ Person is motivated
- ☐ Other

**Other strengths while grooming:**

---

*What additional part of the task can the client do well?*

F.38 **Personal Hygiene/Grooming Equipment: Does the client identify that they need or they have equipment to assist with grooming?**

- ☐ Yes
- ☐ No
- ☐ Chose not to answer

**↓ IF F.38 IS YES, SELECT ALL THAT APPLY FOR F.39 BELOW:↓**





## Arkansas Independent Assessment (ARIA)

### F.39 Document what equipment client currently uses:

- |   |   |
|---|---|
| <input type="checkbox"/> Adapted Toothbrush                 | <input type="checkbox"/> Special Type of Toothbrush |
| <input type="checkbox"/> Dental Floss Holder   Flossing Aid | <input type="checkbox"/> Splint                     |
| <input type="checkbox"/> Dentures                           | <input type="checkbox"/> Other                      |
| <input type="checkbox"/> Electric Razor                     |   |

### F.40 Document if client reports they need adaptive equipment but currently do not have, or has but does not use – If “other” was selected describe other equipment utilized.

### *Personal Hygiene/Grooming Notes/Comments:*

#### Toilet Use/Continence

### F.41 Does the person have any difficulty with toileting or need assistance or support with toileting?

- ☐ Yes ☐ No ☐ Chose not to answer

**↓ If F.41 IS YES, COMPLETE THE REMAINDER OF THE TOILET USE/CONTINENCE SUPPORT SECTION: ↓**

### F.42 What assistant does the client need to manage using the toilet by themselves for **ages >=18?**

- |  |   |
|--|---|
| <input type="checkbox"/> Can use the toilet without help, including adjusting clothing                       | <input type="checkbox"/> Has accidents more than once a week  |
| <input type="checkbox"/> Needs and/or gets some help to get to and on the toilet, but doesn't have accidents | <input type="checkbox"/> Wets their pants and has bowel movement in their clothes very often                                  |
| <input type="checkbox"/> Has accidents sometimes but not more than once a week                               | <input type="checkbox"/> Needs assistance with bowel and bladder programs, or appliances (i.e. ostomies or urinary catheters) |
| <input type="checkbox"/> Only has accidents at night   |   |

### F.43 What assistant does the client need to manage using the toilet by themselves for **ages <=17?**

- ☐ Independent
- ☐ Intermittent supervision, cuing or minor physical assistance such as clothes adjustments or hygiene. No Incontinence (N/A for child 0-60M)
- ☐ Usually continent of bowel and bladder, but has occasional accidents requiring physical assistance (N/A for child 0-60M)
- ☐ Usually continent of bowel and bladder, but needs physical assistance or constant supervision for all parts of the task (N/A for child 0-60M)
- ☐ Incontinent of bowel or bladder. Diapered. (N/A for child 0-48M)
- ☐ Needs assistance with bowel and bladder programs, or appliances (i.e. ostomies or urinary catheters)

### F.44 Cuing and Supervision:

- |   |   |
|---|---|
| <input type="checkbox"/> Independent          | <input type="checkbox"/> Intermittently during the task |
| <input type="checkbox"/> To initiate the task | <input type="checkbox"/> Constantly throughout the task |

### F.45 Physical Assistance:

- |                                      |   |
|--------------------------------------|---|
| <input type="checkbox"/> Independent | <input type="checkbox"/> Limited                    |
| <input type="checkbox"/> Setup/prep  | <input type="checkbox"/> Extensive/total dependence |



## Arkansas Independent Assessment (ARIA)

### F.46 Challenges with toileting?

**What inhibits the client from performing the task? (Select all that apply):**

- |  |  |
|--|--|
| <input type="checkbox"/> Behavioral issues   | <input type="checkbox"/> Painful urination                   |
| <input type="checkbox"/> Cannot always find bathroom                               | <input type="checkbox"/> Refuses to use pads/briefs          |
| <input type="checkbox"/> Cannot change incontinence pads. Cannot do own peri care. | <input type="checkbox"/> Requires peri-care after toilet use |
| <input type="checkbox"/> Cannot empty ostomy/catheter bag                          | <input type="checkbox"/> Unaware of need                     |
| <input type="checkbox"/> Experiences urgency                                       | <input type="checkbox"/> Wets/soils bed/furniture            |
|  | <input type="checkbox"/> Other                               |

**Other challenges while toileting:**

---

*Provide supporting documentation (e.g., per client, due to, needs, what, by who, how often):*

### F.47 Strengths:

**What does the person do well with toileting and staying dry and clean? (Select all that apply):**

- |  |  |
|--|--|
| <input type="checkbox"/> Able to use incontinence products | <input type="checkbox"/> Cooperates with caregivers        |
| <input type="checkbox"/> Assists caregiver with transfer   | <input type="checkbox"/> Does not need assistance at night |
| <input type="checkbox"/> Aware of need to use toilet       | <input type="checkbox"/> Empties own ostomy/catheter bag   |
| <input type="checkbox"/> Can toilet with cuing             | <input type="checkbox"/> Other                             |

**Other strengths while toileting:**

---

*What additional part of the task can the client do well?*

### F.48 Toilet Use/Continence Support Equipment: Does the client identify that they need or they have equipment to assist with toileting?

- ☐ Yes ☐ No ☐ Chose not to answer

**↓ IF F.48 IS YES, SELECT ALL THAT APPLY FOR F.49 BELOW: ↓**

### F.49 Document what equipment client currently uses:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Barrier Cream       | <input type="checkbox"/> Disinfectant Spray | <input type="checkbox"/> Mattress Cover                |
| <input type="checkbox"/> Bed Pan             | <input type="checkbox"/> External Catheter  | <input type="checkbox"/> Raised Toilet Seat            |
| <input type="checkbox"/> Incontinence Briefs | <input type="checkbox"/> Gloves             | <input type="checkbox"/> Specialized Medical Equipment |
| <input type="checkbox"/> Pads                | <input type="checkbox"/> Grab Bars          | <input type="checkbox"/> Urinal                        |
| <input type="checkbox"/> Colostomy Bag       | <input type="checkbox"/> Ileostomy Bag      | <input type="checkbox"/> Other                         |
| <input type="checkbox"/> Commode             | <input type="checkbox"/> Internal Catheter  |  |

### F.50 Document if client reports they need adaptive equipment but currently do not have, or has but does not use – If “other” was selected describe other equipment utilized.

---

*Toilet Use/Continence Support Notes/Comments*



## Arkansas Independent Assessment (ARIA)

### Mobility – Walking and Wheeling

F.51 **Does the person have any difficulty with mobility or require support or assistance to get around?**

☐ Yes ☐ No ☐ Chose not to answer

**↓ If F.51 is YES, COMPLETE THE REMAINDER OF THE MOBILITY-WALKING AND WHEELING SECTION:↓**

F.52 **What assistance does the client need to walk by themselves for ages  $\geq 18$ ?**

- ☐ Walks without help of any kind
- ☐ Can walk with help of a cane, walker crutch or push wheelchair
- ☐ Needs and/or gets help from one person to help walk
- ☐ Needs and/or gets help from two people to help walk
- ☐ Cannot walk at all

F.53 **What assistance does client need to walk by themselves for ages  $\leq 17$ ?**

- ☐ Independent. Ambulatory without device.
- ☐ Can mobilize with the assist of a device but does not need personal assistance.
- ☐ Intermittent physical assistance of another (n/a 0-24 M). (this does not include supervision for safety of a child underage)
- ☐ Needs constant physical assistance of another. Includes child who remains bedfast (n/a 0-12M)

F.54 **Cuing and Supervision:**

- ☐ Independent ☐ Intermittently during the task
- ☐ To initiate the task ☐ Constantly throughout the task

F.55 **Physical Assistance:**

- ☐ Independent ☐ Limited
- ☐ Setup/prep ☐ Extensive/total dependence

F.56 **Challenges getting around their home.**

**What inhibits the client from performing the task? (Select all that apply):**

- ☐ Behavioral issues
- ☐ Activity limited; afraid of falling
- ☐ Cannot propel wheelchair
- ☐ Disease/symptoms interfere with performing task
- ☐ Leans to one side
- ☐ Misplaces/forgets assistive device
- ☐ Poor navigation
- ☐ Unable to exit in emergency
- ☐ Unable to walk/bear weight
- ☐ Will not use assistance devices
- ☐ Other

**Other challenges getting around home:**

---

***Provide supporting documentation (e.g., per client, due to, needs, what, by who, how often):***



## Arkansas Independent Assessment (ARIA)

---

**F.57 Challenges getting around community.**

**What inhibits the client from performing the task? (Select all that apply):**

- |  |  |
|--|--|
| <input type="checkbox"/> Behavioral issues                               | <input type="checkbox"/> Difficulty navigating unfamiliar environments |
| <input type="checkbox"/> Cannot open doors                               | <input type="checkbox"/> Gets lost outside residence                   |
| <input type="checkbox"/> Disease/symptoms interfere with performing task | <input type="checkbox"/> Needs assistance to evacuate                  |
| <input type="checkbox"/> Needs assistance with stairs                    | <input type="checkbox"/> Needs wheelchair for distance                 |
| <input type="checkbox"/> activity limited afraid of falling              | <input type="checkbox"/> Poor safety awareness                         |
|  | <input type="checkbox"/> Other   |

**Other challenges around community:**

---

*Provide supporting documentation (e.g., per client, due to, needs, what, by who, how often):*

**F.58 Strengths:**

**What does the person do well when getting around their home? (Select all that apply):**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Able to exit in emergency  | <input type="checkbox"/> Has a steady gait      | <input type="checkbox"/> Sees well enough to navigate independently |
| <input type="checkbox"/> Aware of own safety        | <input type="checkbox"/> Motivated              | <input type="checkbox"/> Other                                      |
| <input type="checkbox"/> Cooperates with caregivers | <input type="checkbox"/> Propels own wheelchair |   |

**Other strengths in mobility at home:**

---

*What additional part of the task can the client do well?*

**F.59 Strengths**

**What does the person do well when getting around their community? (Select all that apply):**

- |  |  |
|--|--|
| <input type="checkbox"/> Can evacuate in emergency     | <input type="checkbox"/> Residence has ramp      |
| <input type="checkbox"/> Has good endurance            | <input type="checkbox"/> Will ask for assistance |
| <input type="checkbox"/> Independent with stairs       | <input type="checkbox"/> Other                   |
| <input type="checkbox"/> Navigates safely in community |  |

**Other strengths in mobility in community:**

---

*What additional part of the task can the client do well?*

**F.60 Mobility:**

**Walking and Wheeling Equipment: Does the person have or need any adaptive equipment to assist with mobility?**

- ☐ Yes   ☐ No   ☐ Chose not to answer



## Arkansas Independent Assessment (ARIA)

**IF F.60 IS YES, SELECT ALL THAT APPLY FOR F.61 BELOW:**

F.61 Document what equipment client currently uses:

- |  |  |
|--|--|
| <input type="checkbox"/> Air Pad                     | <input type="checkbox"/> Ramps                         |
| <input type="checkbox"/> Cane                        | <input type="checkbox"/> Repositioning Wheelchair      |
| <input type="checkbox"/> Crutch                      | <input type="checkbox"/> Room Monitor                  |
| <input type="checkbox"/> Gait Belt                   | <input type="checkbox"/> Scooter                       |
| <input type="checkbox"/> Gel Pad                     | <input type="checkbox"/> Service Animal                |
| <input type="checkbox"/> Manual Wheelchair           | <input type="checkbox"/> Specialized Medical Equipment |
| <input type="checkbox"/> Motorized Wheelchair        | <input type="checkbox"/> Splint   Braces               |
| <input type="checkbox"/> Medical Response Alert      | <input type="checkbox"/> Walker                        |
| <input type="checkbox"/> Medical Response Alert Unit | <input type="checkbox"/> Walker with Seat              |
| <input type="checkbox"/> Prostheses                  | <input type="checkbox"/> Other                         |
| <input type="checkbox"/> Quad Cane                   |  |

F.62 Document if client reports they need adaptive equipment but currently do not have or has but does not use – If “other” was selected describe other equipment utilized.

### *Mobility – Walking and Wheeling Comments/Notes*

#### Positioning

F.63 Does the person have any difficulties with positioning or require support or assistance when positioning?

- ☐ Yes ☐ No ☐ Chose not to answer

↓ **IF F.63 IS YES, COMPLETE THE REMAINDER OF THE POSITIONING SECTION: ↓**

F.64 What assistance does client need to manage sitting up or moving around by themselves for ages **>= 18?**

- ☐ Can move in bed without any help  
☐ Needs and/or gets help sometimes to sit up  
☐ Always needs and/or gets help to sit up at least daily  
☐ Always needs and/or gets help to be turned or change positions

F.65 What assistance does client need to manage turning and positioning by themselves for ages **<=17?**

- ☐ Independent. Ambulatory without Device  
☐ Needs occasional assistance of another person or device to change position less than daily.  
☐ Needs intermittent assistance of another on a daily basis to change positions. Child is physically able to participate  
☐ Needs total assistance in turning and positioning. Child is unable to participate

F.66 Cuing and Supervision:

- |   |   |
|---|---|
| <input type="checkbox"/> Independent          | <input type="checkbox"/> Intermittently during the task |
| <input type="checkbox"/> To initiate the task | <input type="checkbox"/> Constantly throughout the task |



## Arkansas Independent Assessment (ARIA)

### F.67 Physical Assistance:

- ☐ Independent      ☐ Limited  
☐ Setup/prep      ☐ Extensive/total dependence

### F.68 Challenges while positioning?

**What inhibits the client from performing the task?** (Select all that apply):

- |  |  |
|--|--|
| <input type="checkbox"/> Behavioral issues                                 | <input type="checkbox"/> Slides down in chair          |
| <input type="checkbox"/> Bedridden all   most of the time                  | <input type="checkbox"/> Slips down in bed             |
| <input type="checkbox"/> Cannot elevate legs   feet                        | <input type="checkbox"/> Unable to use trapeze         |
| <input type="checkbox"/> Disease   Symptoms interfere with performing task | <input type="checkbox"/> Unaware of need to reposition |
| <input type="checkbox"/> Chair fast all   most of the time                 | <input type="checkbox"/> Other                         |
| <input type="checkbox"/> Falls out of bed                                  |  |

**Other challenges while positioning:**

---

*Provide supporting documentation (e.g., per client, due to, needs, what, by who, how often):*

### F.69 Strengths:

**What does the person do well when repositioning?** (Select all that apply):

- |  |   |
|--|---|
| <input type="checkbox"/> Able to elevate legs        | <input type="checkbox"/> Directs caregiver to assist with tasks |
| <input type="checkbox"/> Asks for assistance         | <input type="checkbox"/> Motivated                              |
| <input type="checkbox"/> Aware of need to reposition | <input type="checkbox"/> Uses Trapeze                           |
| <input type="checkbox"/> Cooperates with Caregiver   | <input type="checkbox"/> Other                                  |

**Other strengths while positioning:** (If other is selected provide supporting documentation)

---

*What additional part of the task can the client do well?*

### F.70 Positioning Equipment: Does the client identify that they need, or they have equipment to assist with positioning?

- ☐ Yes    ☐ No    ☐ Chose not to answer

**↓ IF F.70 IS YES, SELECT ALL THAT APPLY FOR F.71 BELOW: ↓**

### F.71 Document what equipment client currently uses:

- |  |  |
|--|--|
| <input type="checkbox"/> Alternating pressure mattress | <input type="checkbox"/> Posey or other enclosed bed   |
| <input type="checkbox"/> Bubble mattress               | <input type="checkbox"/> Side rails                    |
| <input type="checkbox"/> Brace                         | <input type="checkbox"/> Specialized Medical Equipment |
| <input type="checkbox"/> Electronic bed                | <input type="checkbox"/> Water mattress                |
| <input type="checkbox"/> Flotation mattress            | <input type="checkbox"/> Other                         |
| <input type="checkbox"/> Manual bed                    |  |

### F.72 Document if client reports they need adaptive equipment but currently do not have, or has but does not use – If “other” was selected describe other equipment utilized.

---

*Positioning Comments/Notes*



## Arkansas Independent Assessment (ARIA)

### Transfer

- F.73 **Does the person have any difficulties with transfers or require support or assistance when making transfers?**  
☐ Yes ☐ No ☐ Chose not to answer  
**↓ IF F.73 IS YES, COMPLETE THE REMAINDER OF THE TRANSFERS SECTION: ↓**
- F.74 **What assistance does the client need to transfer in/out of bed and in/out of chair, by themselves for **ages >=18**)?**  
☐ Can get in and out of a bed or chair without help of any kind  
☐ Needs somebody to be there to guide them but they can move in and out of a bed or chair  
☐ Needs and/or gets one other person to help  
☐ Needs and/or gets two other people or a mechanical aid to help
- F.75 **What assistance does client need to manage transfers, by themselves for **ages <=17**)?**  
☐ Independent  
☐ Needs intermittent supervision or reminders (i.e. cuing or guidance only).  
☐ Needs physical assistance, but child is able to participate. Excludes car seat, highchair, crib for toddler age child. (N/A for child 0-30 months)  
☐ Needs total assistance of another and child is physically unable to participate. (N/A for child 0-18 months)  
☐ Must be transferred using a mechanical device (i.e. Hoyer lift)
- F.76 **Cuing and Supervision:**  
☐ Independent ☐ Intermittently during the task  
☐ To initiate the task ☐ Constantly throughout the task
- F.77 **Physical Assistance:**  
☐ Independent ☐ Limited  
☐ Setup/prep ☐ Extensive/total dependence
- F.78 **Challenges with making transfers.**  
**What inhibits the client from performing the task? (Select all that apply)**  
☐ Behavioral issues ☐ Two -Person transfer  
☐ Afraid of falling ☐ Unable to transfer without assistance  
☐ Afraid of Hoyer lift ☐ Unsteady during transfer  
☐ Disease | Symptoms interfere with performing task ☐ Other  
**Other challenges with making transfers:**

---

*Provide supporting documentation (e.g., per client, due to, needs, what, by who, how often):*



## Arkansas Independent Assessment (ARIA)

---

**F.79 Strengths:**

**What does the person do well when transferring? (Select all that apply):**

- |   |   |
|---|---|
| <input type="checkbox"/> Ask for assistance             | <input type="checkbox"/> Has good upper body strength |
| <input type="checkbox"/> Aware of safety                | <input type="checkbox"/> Motivated                    |
| <input type="checkbox"/> Can transfer self-using a lift | <input type="checkbox"/> Transfers with some support  |
| <input type="checkbox"/> Cooperates with Caregiver      | <input type="checkbox"/> Other                        |

**Other strengths while transferring:**

---

**What additional part of the task can the client do well?**

**F.80 Transfers Equipment:**

**Does the client identify that they need, or they have equipment to assist with transferring?**

- ☐ Yes ☐ No ☐ Chose not to answer

**↓If F.80 IS YES, SELECT ALL THAT APPLY FOR F.81 BELOW:↓**

**F.81 Document what equipment client currently uses:**

- |   |  |
|---|--|
| <input type="checkbox"/> Bed rail                     | <input type="checkbox"/> Hoyer or similar device       |
| <input type="checkbox"/> Brace                        | <input type="checkbox"/> Lift Chair                    |
| <input type="checkbox"/> Ceiling lift tracking system | <input type="checkbox"/> Slide Board                   |
| <input type="checkbox"/> Electronic bed               | <input type="checkbox"/> Specialized Medical Equipment |
| <input type="checkbox"/> Gait Belt                    | <input type="checkbox"/> Other                         |

**F.82 Document if client reports they need adaptive equipment but currently do not have or has but does not use – If “other” was selected describe other equipment utilized.**

---

*Transfers Comments/Notes*





## Arkansas Independent Assessment (ARIA)

### G. Instrumental Activities of Daily Living (IADLs)

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#### Medication Management (Age >= 18)

**G.1 Do you take any medication(s)?**

(This question is asking if the client is taking any medications, not if the client has any difficulties with medications.)

☐ Yes ☐ No ☐ Chose not to answer

↓ **IF G.1 IS YES, COMPLETE THE REMAINDER OF THE MEDICATIONS SECTION:** ↓

**G.2 Does the person need assistance with medication management?**

- ☐ Needs no help or supervision
- ☐ Needs medication setup
- ☐ Needs visual or verbal reminders
- ☐ Needs medication administration

**G.3 Challenges:**

**What difficulties does the person have with medication management?**

- |  |  |
|--|--|
| <input type="checkbox"/> Behavioral issues                                 | <input type="checkbox"/> Forgets to take medication            |
| <input type="checkbox"/> Cannot crush pills                                | <input type="checkbox"/> Has multiple prescriptions            |
| <input type="checkbox"/> Cannot open containers                            | <input type="checkbox"/> Takes outdated or expired medications |
| <input type="checkbox"/> Cannot fill syringe                               | <input type="checkbox"/> Unable to read labels                 |
| <input type="checkbox"/> Disease   Symptoms interfere with performing task | <input type="checkbox"/> Unaware of dosages                    |
| <input type="checkbox"/> Doesn't take medications due to cost              | <input type="checkbox"/> Use multiple pharmacies               |
| <input type="checkbox"/> Does not use correct dosage                       | <input type="checkbox"/> Other                                 |

**Other challenges with medication:**

---

*Provide supporting documentation (e.g., per client, due to, needs, what, by who, how often):*

**G.4 Strengths**

**What does the person do well when managing medications? (Select all that apply):**

- |  |   |
|--|---|
| <input type="checkbox"/> Able to manage multiple medications | <input type="checkbox"/> Can crush pills                    |
| <input type="checkbox"/> Able to open containers             | <input type="checkbox"/> Can fill   use syringe             |
| <input type="checkbox"/> Able to put medications in mouth    | <input type="checkbox"/> Takes medications as prescribed    |
| <input type="checkbox"/> Able to use   give own injections   | <input type="checkbox"/> Understands purpose of medications |
| <input type="checkbox"/> Aware of frequency & dosages        | <input type="checkbox"/> Other                              |
| <input type="checkbox"/> Aware of potential side effects     |   |

**Other strengths in medication:**

---

*Provide supporting documentation (e.g., per client, due to, needs, what, by who, how often):*

**G.5 Medication Management Equipment:**

**Does the person have or need any adaptive equipment to assist with medication management?**

☐ Yes ☐ No ☐ Chose not to answer



## Arkansas Independent Assessment (ARIA)

↓ **IF G.5 IS YES, SELECT ALL THAT APPLY FOR G.6 BELOW:** ↓

G.6 **Medication Equipment Status?** (select all that apply):

- |                                       |  |
|---------------------------------------|--|
| <input type="checkbox"/> CompuMed     | <input type="checkbox"/> Pill Cutter                   |
| <input type="checkbox"/> Medi-Minder  | <input type="checkbox"/> Specialized Medical Equipment |
| <input type="checkbox"/> Medi-Set     | <input type="checkbox"/> Syringe                       |
| <input type="checkbox"/> Pill Crusher | <input type="checkbox"/> Other                         |

G.7 **Document if client reports they need adaptive equipment but currently do not have or has but does not use – If “other” was selected describe other equipment utilized.**

---

### *Medication Management Comments/Notes*

### Meal Preparation (>=18)

G.8 **Does the person have any difficulty preparing meals?**

- ☐ Yes ☐ No ☐ Chose not to answer

↓ **IF G8 IS YES, COMPLETE THE REMAINDER OF THE MEAL PREPARATION SECTION:** ↓

G.9 **Does the person need assistance with meal preparation?**

- ☐ Needs no help or supervision  
☐ Sometimes needs assistance or occasional supervision  
☐ Often needs assistance or constant supervision  
☐ Always or nearly always needs assistance

G.10 **Challenges:**

**What difficulties does the person have with preparing meals?** (Select all that apply):

- |  |   |
|--|---|
| <input type="checkbox"/> Behavioral issues         | <input type="checkbox"/> Diseases/symptoms interfere with performing task |
| <input type="checkbox"/> Cannot cut/peel/chop      | <input type="checkbox"/> Keeps spoiled food                               |
| <input type="checkbox"/> Does not know how to cook | <input type="checkbox"/> Leaves burners on                                |
| <input type="checkbox"/> cannot plan meals         | <input type="checkbox"/> Special diet                                     |
| <input type="checkbox"/> Cannot reach stove        | <input type="checkbox"/> Other  |

**Other challenges with preparing meal:**

---

*Provide supporting documentation (e.g., per client, due to, needs, what, by who, how often):*



## Arkansas Independent Assessment (ARIA)

### G.11 Strengths:

**What does the person do well when preparing simple meals?** (Select all that apply):

- |   |  |
|---|--|
| <input type="checkbox"/> Able to follow special dietary needs | <input type="checkbox"/> Can use the microwave             |
| <input type="checkbox"/> Assists with meals                   | <input type="checkbox"/> Directs caregiver to prepare meal |
| <input type="checkbox"/> Aware of food allergies              | <input type="checkbox"/> Has accessible kitchen            |
| <input type="checkbox"/> Can prepare a simple meal            | <input type="checkbox"/> Makes good meal choices           |
| <input type="checkbox"/> Can prepare food with cueing         | <input type="checkbox"/> Plans own menus                   |
|   | <input type="checkbox"/> Other                             |

Other strengths in meal preparation:

---

*Provide supporting documentation (e.g., per client, due to, needs, what, by who, how often):*

### Transportation (Age >= 16)

### G.12 Does the person have difficulty with transportation?

- ☐ Yes ☐ No ☐ Chose not to answer

**↓ If G.12 TO YES, COMPLETE THE REMAINDER OF THE TRANSPORTATION SECTION: ↓**

### G.13 Does the person need assistance with transportation?

- ☐ Needs no help or supervision  
☐ Sometimes needs assistance or occasional supervision  
☐ Often needs assistance or constant supervision  
☐ Always or nearly always needs assistance

### G.14 Challenges

**What difficulties does the person have with transportation?** (Select all that apply):

- |  |   |
|--|---|
| <input type="checkbox"/> Behavioral issues                               | <input type="checkbox"/> Needs to take walker/ wheelchair     |
| <input type="checkbox"/> Difficult to transfer                           | <input type="checkbox"/> Needs to use vehicle with lift       |
| <input type="checkbox"/> Difficulty communicating with drivers           | <input type="checkbox"/> No car                               |
| <input type="checkbox"/> Disease/symptoms interfere with performing task | <input type="checkbox"/> Unable to arrange own transportation |
| <input type="checkbox"/> Needs escort if public transportation is used   | <input type="checkbox"/> Will not ride a bus                  |
|  | <input type="checkbox"/> Other                                |

Other challenges with transportation:

---

*Provide supporting documentation (e.g., per client, due to, needs, what, by who, how often):*

### G.15 Strengths:

**What does the person do well related to transportation?** (Select all that apply):

- |  |   |
|--|---|
| <input type="checkbox"/> Can find and read schedules, phone #s       | <input type="checkbox"/> Has own car                          |
| <input type="checkbox"/> Can ride bus without assistance             | <input type="checkbox"/> Has handicap parking sticker/license |
| <input type="checkbox"/> Communicates needed information with driver | <input type="checkbox"/> Knows bus routes                     |
| <input type="checkbox"/> Has a vehicle with a lift                   | <input type="checkbox"/> Other                                |

Other strengths with transportation:

---

*Provide supporting documentation (e.g., per client, due to, needs, what, by who, how often):*



## Arkansas Independent Assessment (ARIA)

### Housework (Age >=18)

G.16 **Does the person need assistance with housework?**

☐ Yes ☐ No ☐ Chose not to answer

**↓ If G.16 YES, COMPLETE THE REMAINDER OF THE HOUSEWORK SECTION: ↓**

G.17 **Amount of assistance with “light” housekeeping:**

- ☐ Needs no help or supervision
- ☐ Sometimes needs assistance or occasional supervision
- ☐ Often needs assistance or constant supervision
- ☐ Always or nearly always needs assistance

G.18 **Amount of assistance with “heavy” housekeeping:**

- ☐ Needs no help or supervision
- ☐ Sometimes needs assistance or occasional supervision
- ☐ Often needs assistance or constant supervision
- ☐ Always or nearly always needs assistance

G.19 **Amount of assistance with doing their own laundry:**

- ☐ Needs no help or supervision
- ☐ Sometimes needs assistance or occasional supervision
- ☐ Often needs assistance or constant supervision
- ☐ Always or nearly always needs assistance

G.20 **Challenges:**

**What difficulties does the person have with housework? (Select all that apply):**

- |   |  |
|---|--|
| <input type="checkbox"/> Behavioral issues                      | <input type="checkbox"/> Does not have vacuum cleaner                    |
| <input type="checkbox"/> Allergies to dust, pollen, etc.        | <input type="checkbox"/> Disease/symptoms interfere with performing task |
| <input type="checkbox"/> Cannot make or change bedding          | <input type="checkbox"/> Has chemical sensitivities                      |
| <input type="checkbox"/> Cannot operate washer/dryer            | <input type="checkbox"/> Unaware of need                                 |
| <input type="checkbox"/> Cannot see when surfaces need cleaning | <input type="checkbox"/> Other   |
| <input type="checkbox"/> Does not have lawnmower                |  |

**Other challenges with housework:**

---

*Provide supporting documentation (e.g., per client, due to, needs, what, by who, how often):*

G.21 **Strengths:**

**What does the person do well related to housework? (Select all that apply):**

- |  |   |
|--|---|
| <input type="checkbox"/> Able to make bed              | <input type="checkbox"/> Can instruct caregiver     |
| <input type="checkbox"/> Able to sweep                 | <input type="checkbox"/> Can take out garbage       |
| <input type="checkbox"/> Can do dishes                 | <input type="checkbox"/> Can wash windows           |
| <input type="checkbox"/> Can do light housekeeping     | <input type="checkbox"/> Does housework with cueing |
| <input type="checkbox"/> Can do light personal laundry | <input type="checkbox"/> Other                      |
| <input type="checkbox"/> Can fold clothes              |   |

**Other strengths doing housework:**

---

*Provide supporting documentation (e.g., per client, due to, needs, what, by who, how often):*



## Arkansas Independent Assessment (ARIA)

### Telephone Use (Age >=16)

G.22 **Does the person need assistance to use the telephone?**

☐ Yes ☐ No ☐ Chose not to answer

↓ **If G.22 IS YES, COMPLETE THE REMAINDER OF THE TELEPHONE USE SECTION:↓**

G.23 **Amount of assistance using the telephone:**

- ☐ Needs no help or supervision  
☐ Sometimes needs assistance or occasional supervision  
☐ Often needs assistance or constant supervision  
☐ Always or nearly always needs assistance

G.24 **Challenges- What difficulty does the person have with using the telephone? (Select all that apply):**

- |   |  |
|---|--|
| <input type="checkbox"/> Behavioral issues                          | <input type="checkbox"/> Disease   Symptoms interfere with performing task |
| <input type="checkbox"/> Cannot dial phone                          | <input type="checkbox"/> No telephone                                      |
| <input type="checkbox"/> Cannot get to phone                        | <input type="checkbox"/> Other   |
| <input type="checkbox"/> Cannot hear phone ringing                  |  |
| <input type="checkbox"/> Difficulty hearing   understanding callers |  |

**Other challenges using telephone:**

---

**Provide supporting documentation** (e.g., per client, due to, needs, what, by who, how often):

G.25 **Strengths:**

**What does the person do well when using the telephone? (Select all that apply):**

- |   |  |
|---|--|
| <input type="checkbox"/> Can dial phone                   | <input type="checkbox"/> Can use relay service |
| <input type="checkbox"/> Can take messages                | <input type="checkbox"/> Can use speaker phone |
| <input type="checkbox"/> Can use PERS                     | <input type="checkbox"/> Other                 |
| <input type="checkbox"/> Can use phone book   411 service |  |

**Other strengths using telephone:**

---

**Provide supporting documentation** (e.g., per client, due to, needs, what, by who, how often):

### Shopping (Age >=16)

G.26 **Does the person need assistance with shopping?**

☐ Yes ☐ No ☐ Chose not to answer

↓ **If G.26 YES, complete the remainder of the Shopping section:↓**

G.27 **Amount of assistance with shopping for food or other items:**

- ☐ Needs no help or supervision  
☐ Sometimes needs assistance or occasional supervision  
☐ Often needs assistance or constant supervision  
☐ Always or nearly always needs assistance



## Arkansas Independent Assessment (ARIA)

G.28 **Challenges – What difficulties does the person have with shopping? (Select all that apply):**

- |   |  |
|---|--|
| <input type="checkbox"/> Behavioral issues        | <input type="checkbox"/> Cannot shop online                              |
| <input type="checkbox"/> Cannot carry heavy items | <input type="checkbox"/> Disease/symptoms interfere with performing task |
| <input type="checkbox"/> Cannot reach items       | <input type="checkbox"/> Other   |
| <input type="checkbox"/> Cannot read labels       |  |
| <input type="checkbox"/> Cannot see/locate items  |  |

**Other challenges with shopping:**

---

*Provide supporting documentation (e.g., per client, due to, needs, what, by who, how often):*

G.29 **Strengths – What is the person able to do when shopping? (Select all that apply):**

- |   |  |
|---|--|
| <input type="checkbox"/> Able to arrange transportation           | <input type="checkbox"/> Can carry small items         |
| <input type="checkbox"/> Able to budget income and expenses       | <input type="checkbox"/> Can navigate within the store |
| <input type="checkbox"/> Able to communicate with store personnel | <input type="checkbox"/> Can see/identify needed items |
| <input type="checkbox"/> Able to make shopping lists              | <input type="checkbox"/> Other                         |

Other strengths while shopping:

---

*Provide supporting documentation (e.g., per client, due to, needs, what, by who, how often):*

### Finances (Age ≥ 16)

G.30 **Does the person need assistance with finances and/or healthcare or financial paperwork?**

- ☐ Yes ☐ No ☐ Chose not to answer

**↓ IF G.30 IS YES, COMPLETE THE REMAINDER OF THE FINANCES SECTION: ↓**

G.31 **Amount of assistance with finances:**

- ☐ Needs no help or supervision  
☐ Sometimes needs assistance or occasional supervision  
☐ Often needs assistance or constant supervision  
☐ Always or nearly always needs assistance



## Arkansas Independent Assessment (ARIA)

---

### G.32 Challenges:

**What difficulty does the person have with finances? (Select all that apply):**

- |  |  |
|--|--|
| <input type="checkbox"/> Behavioral issues   | <input type="checkbox"/> Has no POA/needs                                |
| <input type="checkbox"/> Cannot budget   | <input type="checkbox"/> Hides money                                     |
| <input type="checkbox"/> Cannot see/read bills or account information  | <input type="checkbox"/> Disease/symptoms interfere with performing task |
| <input type="checkbox"/> Difficulty keeping up with paperwork to maintain eligibility for health care and other benefits | <input type="checkbox"/> Vulnerable to financial exploitation            |
| <input type="checkbox"/> Difficulty differentiating between needs /wants   | <input type="checkbox"/> Will not pay bills                              |
|  | <input type="checkbox"/> Other:  |

**Other challenges with finances:**

---

*Provide supporting documentation (e.g., per client, due to, needs, what, by who, how often):*

### G.33 Strengths – What does the person do well related to finances? (Select all that apply):

- |   |   |
|---|---|
| <input type="checkbox"/> Can budget income and expenses | <input type="checkbox"/> Has auto payment plan                |
| <input type="checkbox"/> Can use EBT card               | <input type="checkbox"/> Has direct deposit                   |
| <input type="checkbox"/> Can write checks and pay bills | <input type="checkbox"/> Has guardian/Power of Attorney (POA) |
| <input type="checkbox"/> Has a payee                    | <input type="checkbox"/> Other                                |

**Other strengths with finances:**

---

*Provide supporting documentation (e.g., per client, due to, needs, what, by who, how often):*



## Arkansas Independent Assessment (ARIA)

### H. Health

[Return to Index](#)

#### Eating Habits and Nutrition

H.1 **Does the person have any concerns about their eating habits?**

**Note:** This relates to nutritional concerns.

☐ Yes ☐ No ☐ Chose not to answer

**Please provide supporting documentation.**

---

#### Comments

↓ **IF H.1 IS YES, CHECK ALL THAT APPLY IN H.2 BELOW:** ↓

H.2 **Check all that apply:**

☐ Anorexia

☐ Bulimia

☐ Complains about taste of food

☐ Obesity

☐ Overeating

☐ Polydipsia

☐ Recent weight gain

☐ Recent weight loss

☐ Other- Please provide supporting documentation for "other"

H.3 **Please provide supporting documentation for other eating habits.**

---

#### Endocrine

H.4 **Does the person have a thyroid problem?**

☐ Yes ☐ No ☐ Chose not to answer

**Please provide supporting documentation.**

---

#### Comments

↓ **IF H.4 IS YES, CHECK ALL THAT APPLY IN H.5 BELOW:** ↓

H.5 **Check all that apply:**

☐ Hyperthyroid

☐ Hypothyroid

☐ Other

H.6 **Other Endocrine:**

Thyroid problem. Please provide supporting documentation for other endocrine-thyroid problems.





## Arkansas Independent Assessment (ARIA)

- H.7 **Does the person have diabetes?**  
☐ Yes ☐ No ☐ Chose not to answer  
**Please provide supporting documentation.**

---

### Comments

**↓IF H.7 IS YES, CHECK ALL THAT APPLY IN H.8 BELOW:↓**

- H.8 **Check all that apply:**  
☐ Diet and exercise (controlled)  
☐ Non-insulin dependent diabetes  
☐ Type 1-insulin dependent  
☐ Type 2 - insulin dependent  
☐ Other.
- H.9 **Other Endocrine-**Diabetes problem. Please provide supporting documentation for other endocrine-diabetes problems.

---

## Gastrointestinal

- H.10 **Does the person have any stomach problems or problems with constipation, diarrhea, gastrointestinal disorders, or elimination (e.g. ostomy care, bowel program)?**  
☐ Yes ☐ No ☐ Chose not to answer  
**↓IF H.10 YES, CHECK ALL THAT APPLY IN H.11 BELOW: ↓**
- H.11 **Check all that apply:**
- |   |   |
|---|---|
| <input type="checkbox"/> Blood in stool                         | <input type="checkbox"/> Hepatitis C              |
| <input type="checkbox"/> Constipation                           | <input type="checkbox"/> Irritable bowel syndrome |
| <input type="checkbox"/> Crohn's Disease                        | <input type="checkbox"/> Ulcerative Colitis       |
| <input type="checkbox"/> Diarrhea                               | <input type="checkbox"/> Frequent nausea          |
| <input type="checkbox"/> Gastrointestinal Ulcers                | <input type="checkbox"/> Vomiting                 |
| <input type="checkbox"/> Gastrointestinal Reflux Disease (GERD) | <input type="checkbox"/> Other                    |
| <input type="checkbox"/> Heartburn                              |   |
- H.12 **Other stomach problems.** Please provide supporting documentation for other stomach problems.



## Arkansas Independent Assessment (ARIA)

### Genitourinary

H.13 **Does the person have problems with urination or elimination (e.g. catheters, bladder program, etc.)?**

☐ Yes ☐ No ☐ Chose not to answer

**Please provide supporting documentation.**

---

#### Comments

**↓IF H.13 YES, CHECK ALL THAT APPLY ON H.14 BELOW: ↓**

H.14 **Check all that apply:**

- |   |  |
|---|--|
| <input type="checkbox"/> Blood in urine     | <input type="checkbox"/> Renal failure                 |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Urinary Tract Infection (UTI) |
| <input type="checkbox"/> Incontinence       | <input type="checkbox"/> Other                         |
| <input type="checkbox"/> Kidney stones      |  |
| <input type="checkbox"/> Pain on urination  |  |

H.15 **Other urination problem. Please provide supporting documentation for other urination problems.**

---

### Heart/Circulation

H.16 **Does the person have any heart or circulation problems?**

☐ Yes ☐ No ☐ Chose not to answer

**Please provide supporting documentation.**

---

#### Comments

**↓IF H.16 IS YES, CHECK ALL THAT APPLY IN H.17 BELOW: ↓**

H.17 **Check all that apply:**

- |   |  |
|---|--|
| <input type="checkbox"/> Anemia                         | <input type="checkbox"/> Hypotension                 |
| <input type="checkbox"/> Angina   Chest Pain            | <input type="checkbox"/> Heart palpitations          |
| <input type="checkbox"/> Atherosclerotic heart disease  | <input type="checkbox"/> Peripheral vascular disease |
| <input type="checkbox"/> Cardiac arrest (heart attack)  | <input type="checkbox"/> Reynaud's Syndrome          |
| <input type="checkbox"/> Cardiac Arrhythmias            | <input type="checkbox"/> Shortness of breath         |
| <input type="checkbox"/> Clotting issues                | <input type="checkbox"/> Other                       |
| <input type="checkbox"/> Congestive heart failure (CHF) |  |
| <input type="checkbox"/> Deep vein thrombosis           |  |
| <input type="checkbox"/> Hypertension                   |  |



## Arkansas Independent Assessment (ARIA)

- H.18 **Other heart or circulation problems. Please provide supporting documentation for other heart or circulation problems.**

### Mental Health

- H.19 **Does the person have a mental disorder diagnosable under the Diagnostic and Statistical Manual of Mental Disorders (DSM), current edition excluding a primary diagnosis of dementia, Alzheimer's disease, or other related cognitive conditions?**

☐ Yes ☐ No ☐ Chose not to answer

**Please provide supporting documentation.**

#### Comments

- H.20 **Check all that apply:**

- |   |   |
|---|---|
| <input type="checkbox"/> Anxiety                                  | <input type="checkbox"/> Panic Disorder                 |
| <input type="checkbox"/> Attention Deficit/Hyperactivity Disorder | <input type="checkbox"/> Post-Traumatic Stress Disorder |
| <input type="checkbox"/> Bipolar Disorder                         | <input type="checkbox"/> Schizoaffective Disorder       |
| <input type="checkbox"/> Borderline Personality Disorder          | <input type="checkbox"/> Schizophrenia                  |
| <input type="checkbox"/> Dysthymia                                | <input type="checkbox"/> Seasonal Affective Disorder    |
| <input type="checkbox"/> Eating Disorders                         | <input type="checkbox"/> Other                          |
| <input type="checkbox"/> Major Depression                         |   |
| <input type="checkbox"/> Obsessive-Compulsive Disorder (OCD)      |   |

**Please provide supporting documentation.**

#### Comments

- H.21 **Has the mental disorder resulted in significantly impaired functioning in major life activities that would be appropriate for the person's developmental stage within the past 3 to 6 months? (Age ≥ 18)**

☐ Yes ☐ No

### Musculoskeletal

- H.22 **Does the person have any muscle, bone or joint conditions (including loss of limb)?**

☐ Yes ☐ No ☐ Chose not to answer

**Please provide supporting documentation.**

#### Comments



## Arkansas Independent Assessment (ARIA)

### H.23 Check all that apply:

- |   |   |
|---|---|
| <input type="checkbox"/> Amputation               | <input type="checkbox"/> Hip fracture         |
| <input type="checkbox"/> Arthritis/Osteoarthritis | <input type="checkbox"/> Hip/Knee replacement |
| <input type="checkbox"/> Arthritis/Rheumatoid     | <input type="checkbox"/> Missing limb         |
| <input type="checkbox"/> Bursitis                 | <input type="checkbox"/> Osteoporosis         |
| <input type="checkbox"/> Contractures             | <input type="checkbox"/> Post-polio syndrome  |
| <input type="checkbox"/> Degenerative disease     | <input type="checkbox"/> Scleroderma          |
| <input type="checkbox"/> Fractures                | <input type="checkbox"/> Other                |
| <input type="checkbox"/> Gout                     |   |

### H.24 Other Musculoskeletal issues. Please provide supporting documentation for other musculoskeletal issues.

#### Comments

### Neurodevelopmental Disorder

### H.25 Does the person have any neurodevelopmental disorders or conditions?

- ☐ Yes ☐ No ☐ Chose not to answer

### H.26 Check all that apply:

- |   |   |
|---|---|
| <input type="checkbox"/> Autism Spectrum Disorder (ASD)     | <input type="checkbox"/> Intellectual or Developmental Disability |
| <input type="checkbox"/> Brain Injury onset prior to age 22 | <input type="checkbox"/> Spina Bifida                             |
| <input type="checkbox"/> Cerebral Palsy                     | <input type="checkbox"/> Other related condition                  |
| <input type="checkbox"/> Down Syndrome                      |   |
| <input type="checkbox"/> Epilepsy/Seizure Disorder          |   |

### H.27 Other Neurodevelopmental Disorder.

Please provide supporting documentation for other neurodevelopmental disorder.

#### Comments

### Neurological/Central Nervous System

### H.28 Does the person have any neurological conditions?

- ☐ Yes ☐ No ☐ Chose not to answer

### H.29 Check all that apply:

- |  |  |
|--|--|
| <input type="checkbox"/> Alzheimer's                         | <input type="checkbox"/> Muscular Dystrophy Paraplegia         |
| <input type="checkbox"/> Amyotrophic Lateral Sclerosis (ALS) | <input type="checkbox"/> Parkinson's Disease                   |
| <input type="checkbox"/> Brain Injury/Head Injury            | <input type="checkbox"/> Quadriplegia                          |
| <input type="checkbox"/> Dementia                            | <input type="checkbox"/> Stroke-Cerebrovascular Accident (CVA) |
| <input type="checkbox"/> Epilepsy                            | <input type="checkbox"/> Swallowing Disorders                  |
| <input type="checkbox"/> Friederich's Ataxia                 | <input type="checkbox"/> Transient Ischemic Attack (TIA)       |
| <input type="checkbox"/> History of concussions              | <input type="checkbox"/> Other                                 |
| <input type="checkbox"/> Huntington's Chorea                 |  |
| <input type="checkbox"/> Migraine Headaches                  |  |
| <input type="checkbox"/> Multiple Sclerosis                  |  |



## Arkansas Independent Assessment (ARIA)

H.30 **Other neurological conditions. Please provide supporting documentation for other neurological conditions.**

Comments

### Reproductive Female (Age 14-55)

H.31 **Are you pregnant?** (This question is only for females that are between the ages of 14-55.)  
☐ Yes ☐ No ☐ Chose not to answer  
**Please provide supporting documentation.**

Comments

### Respiratory

H.32 **Does the person have any breathing problems?**  
☐ Yes ☐ No ☐ Chose not to answer  
**Please provide supporting documentation.**

Comments

H.33 **Check all that apply Breathing.**  
☐ Asthma ☐ Chronic Obstructive Pulmonary Disease (COPD)  
☐ Bronchitis ☐ Pneumonia  
☐ Chronic emphysema ☐ Productive cough  
☐ Other

### Skin

H.34 **Does the person have any skin conditions or problems with the skin?**  
☐ Yes ☐ No ☐ Chose not to answer

H.35 **Check all that apply:**  
☐ Bruises ☐ Eczema ☐ Stasis ulcers  
☐ Burns - 2 degree or greater ☐ Open lesions, abrasions, cuts or skin tears ☐ Surgical site  
☐ Decubitus ulcer ☐ Psoriasis ☐ Other

H.36 **Does the client report the condition is healing or non-healing?**  
☐ Healing  
☐ Non-healing

H.37 **Other skin problem. Please provide supporting documentation for other skin problems:**

Comments



## Arkansas Independent Assessment (ARIA)

### Treatment/Monitoring

#### LEGEND TABLE

| Treatment/Monitoring   | Performed By:   | Frequency   |
|--|---|---|
| The treatment and monitoring section contain several tables all structured the same. The first column lists the type of treatment being monitored. Each cell has a checkbox to select the treatment. | The second column in each table contains a drop-down list to indicate who performs or monitors the corresponding treatment.<br>The choices include: <ul style="list-style-type: none"> <li>Caregiver/Parent</li> <li>Nurse/OT/PT/Physician</li> <li>Direct Care Worker/ST/Certified Nurse Aide</li> <li>Self</li> </ul> | The third column in each table contains a drop-down list that indicates the frequency that the corresponding treatment or monitoring occurs.<br>The choices include: <ul style="list-style-type: none"> <li>Daily &gt; 21 Day Duration for DAAS Only</li> <li>Daily &lt;= 21 Day Duration</li> <li>&gt;= 30 Days for DDS Only</li> <li>Weekly but not daily</li> <li>Monthly but not daily</li> </ul> |

### H.38 CARDIAC TABLE

| Treatment/Monitoring   | Performed By  | Frequency  |
|--|---|--|
| <input type="checkbox"/> Cardioverter-Defibrillator -wearable  | <input type="checkbox"/> Caregiver/Parent<br><input type="checkbox"/> Nurse/OT/PT/Physician<br><input type="checkbox"/> Direct Care Worker/ST/Certified Nurse Aide<br><input type="checkbox"/> Self | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only<br><input type="checkbox"/> Daily <= 21 Day Duration<br><input type="checkbox"/> >= 30 Days for DDS Only<br><input type="checkbox"/> Weekly but not daily<br><input type="checkbox"/> Monthly but not daily |
| <input type="checkbox"/> Cardioverter-Defibrillator -implanted | <input type="checkbox"/> Caregiver/Parent<br><input type="checkbox"/> Nurse/OT/PT/Physician<br><input type="checkbox"/> Direct Care Worker/ST/Certified Nurse Aide<br><input type="checkbox"/> Self | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only<br><input type="checkbox"/> Daily <= 21 Day Duration<br><input type="checkbox"/> >= 30 Days for DDS Only<br><input type="checkbox"/> Weekly but not daily<br><input type="checkbox"/> Monthly but not daily |
| <input type="checkbox"/> Pacemaker                             | <input type="checkbox"/> Caregiver/Parent<br><input type="checkbox"/> Nurse/OT/PT/Physician<br><input type="checkbox"/> Direct Care Worker/ST/Certified Nurse Aide<br><input type="checkbox"/> Self | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only<br><input type="checkbox"/> Daily <= 21 Day Duration<br><input type="checkbox"/> >= 30 Days for DDS Only<br><input type="checkbox"/> Weekly but not daily<br><input type="checkbox"/> Monthly but not daily |
| <input type="checkbox"/> Vital Signs                           | <input type="checkbox"/> Caregiver/Parent<br><input type="checkbox"/> Nurse/OT/PT/Physician<br><input type="checkbox"/> Direct Care Worker/ST/Certified Nurse Aide<br><input type="checkbox"/> Self | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only<br><input type="checkbox"/> Daily <= 21 Day Duration<br><input type="checkbox"/> >= 30 Days for DDS Only<br><input type="checkbox"/> Weekly but not daily<br><input type="checkbox"/> Monthly but not daily |



## Arkansas Independent Assessment (ARIA)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Blood Pressure   | <input type="checkbox"/> Caregiver/Parent      | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only |
|   | <input type="checkbox"/> Nurse/OT/PT/Physician | <input type="checkbox"/> Daily <= 21 Day Duration              |
|   | <input type="checkbox"/> Direct Care           | <input type="checkbox"/> >= 30 Days for DDS Only               |
|   | Worker/ST/Certified Nurse Aide                 | <input type="checkbox"/> Weekly but not daily                  |
|   | <input type="checkbox"/> Self                  | <input type="checkbox"/> Monthly but not daily                 |
| <br>                                      |  |  |
| <input type="checkbox"/> Other Treatments |  |  |

---

**Please provide supporting documentation.**

### H.39 ELIMINATION

| <b>Treatment/Monitoring</b>                 | <b>Performed By</b>  | <b>Frequency</b>   |
|---|--|--|
| <input type="checkbox"/> Bladder Irrigation | <input type="checkbox"/> Caregiver/Parent<br><input type="checkbox"/> Nurse/OT/PT/Physician<br><input type="checkbox"/> Direct Care<br>Worker/ST/Certified Nurse Aide<br><input type="checkbox"/> Self | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only<br><input type="checkbox"/> Daily <= 21 Day Duration<br><input type="checkbox"/> >= 30 Days for DDS Only<br><input type="checkbox"/> Weekly but not daily<br><input type="checkbox"/> Monthly but not daily |
| <br>  |  |  |
| <input type="checkbox"/> Bowel Program      | <input type="checkbox"/> Caregiver/Parent<br><input type="checkbox"/> Nurse/OT/PT/Physician<br><input type="checkbox"/> Direct Care<br>Worker/ST/Certified Nurse Aide<br><input type="checkbox"/> Self | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only<br><input type="checkbox"/> Daily <= 21 Day Duration<br><input type="checkbox"/> >= 30 Days for DDS Only<br><input type="checkbox"/> Weekly but not daily<br><input type="checkbox"/> Monthly but not daily |
| <br>  |  |  |
| <input type="checkbox"/> Enemas             | <input type="checkbox"/> Caregiver/Parent<br><input type="checkbox"/> Nurse/OT/PT/Physician<br><input type="checkbox"/> Direct Care<br>Worker/ST/Certified Nurse Aide<br><input type="checkbox"/> Self | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only<br><input type="checkbox"/> Daily <= 21 Day Duration<br><input type="checkbox"/> >= 30 Days for DDS Only<br><input type="checkbox"/> Weekly but not daily<br><input type="checkbox"/> Monthly but not daily |
| <br>  |  |  |
| <input type="checkbox"/> Other Treatments   |  |  |

---

**Please provide supporting documentation.**



## Arkansas Independent Assessment (ARIA)

### H.40 CATHETER INSERTION AND | OR MAINTENANCE

| Treatment/Monitoring                                | Performed By   | Frequency  |
|---|--|--|
| <input type="checkbox"/> Sterile catheter changes   | <input type="checkbox"/> Caregiver/Parent<br><input type="checkbox"/> Nurse/OT/PT/Physician<br><input type="checkbox"/> Direct Care<br>Worker/ST/Certified Nurse Aide<br><input type="checkbox"/> Self | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only<br><input type="checkbox"/> Daily <= 21 Day Duration<br><input type="checkbox"/> >= 30 Days for DDS Only<br><input type="checkbox"/> Weekly but not daily<br><input type="checkbox"/> Monthly but not daily |
| <input type="checkbox"/> Clean self-catheterization | <input type="checkbox"/> Caregiver/Parent<br><input type="checkbox"/> Nurse/OT/PT/Physician<br><input type="checkbox"/> Direct Care<br>Worker/ST/Certified Nurse Aide<br><input type="checkbox"/> Self | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only<br><input type="checkbox"/> Daily <= 21 Day Duration<br><input type="checkbox"/> >= 30 Days for DDS Only<br><input type="checkbox"/> Weekly but not daily<br><input type="checkbox"/> Monthly but not daily |
| <input type="checkbox"/> Intermittent catheter      | <input type="checkbox"/> Caregiver/Parent<br><input type="checkbox"/> Nurse/OT/PT/Physician<br><input type="checkbox"/> Direct Care<br>Worker/ST/Certified Nurse Aide<br><input type="checkbox"/> Self | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only<br><input type="checkbox"/> Daily <= 21 Day Duration<br><input type="checkbox"/> >= 30 Days for DDS Only<br><input type="checkbox"/> Weekly but not daily<br><input type="checkbox"/> Monthly but not daily |
| <input type="checkbox"/> Other Treatments           |  |  |

**Please provide supporting documentation.**





## Arkansas Independent Assessment (ARIA)

### H.41 OSTOMY CARE

| Treatment/Monitoring                                 | Performed By   | Frequency  |
|--|--|--|
| <input type="checkbox"/> Colostomy                   | <input type="checkbox"/> Caregiver/Parent<br><input type="checkbox"/> Nurse/OT/PT/Physician<br><input type="checkbox"/> Direct Care<br>Worker/ST/Certified Nurse Aide<br><input type="checkbox"/> Self | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only<br><input type="checkbox"/> Daily <= 21 Day Duration<br><input type="checkbox"/> >= 30 Days for DDS Only<br><input type="checkbox"/> Weekly but not daily<br><input type="checkbox"/> Monthly but not daily |
| <input type="checkbox"/> Ileostomy                   | <input type="checkbox"/> Caregiver/Parent<br><input type="checkbox"/> Nurse/OT/PT/Physician<br><input type="checkbox"/> Direct Care<br>Worker/ST/Certified Nurse Aide<br><input type="checkbox"/> Self | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only<br><input type="checkbox"/> Daily <= 21 Day Duration<br><input type="checkbox"/> >= 30 Days for DDS Only<br><input type="checkbox"/> Weekly but not daily<br><input type="checkbox"/> Monthly but not daily |
| <input type="checkbox"/> Scheduled Toileting program | <input type="checkbox"/> Caregiver/Parent<br><input type="checkbox"/> Nurse/OT/PT/Physician<br><input type="checkbox"/> Direct Care<br>Worker/ST/Certified Nurse Aide<br><input type="checkbox"/> Self | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only<br><input type="checkbox"/> Daily <= 21 Day Duration<br><input type="checkbox"/> >= 30 Days for DDS Only<br><input type="checkbox"/> Weekly but not daily<br><input type="checkbox"/> Monthly but not daily |
| <input type="checkbox"/> Other Treatments            |  |  |

**Please provide supporting documentation.**



## Arkansas Independent Assessment (ARIA)

### H.42 FEEDING AND NUTRITION FEEDING TUBE

| Treatment/Monitoring                                 | Performed By  | Frequency  |
|--|---|--|
| <input type="checkbox"/> Gastrojejunostomy (GJ tube) | <input type="checkbox"/> Caregiver/Parent<br><input type="checkbox"/> Nurse/OT/PT/Physician<br><input type="checkbox"/> Direct Care<br><input type="checkbox"/> Worker/ST/Certified Nurse Aide<br><input type="checkbox"/> Self | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only<br><input type="checkbox"/> Daily <= 21 Day Duration<br><input type="checkbox"/> >= 30 Days for DDS Only<br><input type="checkbox"/> Weekly but not daily<br><input type="checkbox"/> Monthly but not daily |
| <input type="checkbox"/> Gastrostomy                 | <input type="checkbox"/> Caregiver/Parent<br><input type="checkbox"/> Nurse/OT/PT/Physician<br><input type="checkbox"/> Direct Care<br><input type="checkbox"/> Worker/ST/Certified Nurse Aide<br><input type="checkbox"/> Self | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only<br><input type="checkbox"/> Daily <= 21 Day Duration<br><input type="checkbox"/> >= 30 Days for DDS Only<br><input type="checkbox"/> Weekly but not daily<br><input type="checkbox"/> Monthly but not daily |
| <input type="checkbox"/> Jejunostomy                 | <input type="checkbox"/> Caregiver/Parent<br><input type="checkbox"/> Nurse/OT/PT/Physician<br><input type="checkbox"/> Direct Care<br><input type="checkbox"/> Worker/ST/Certified Nurse Aide<br><input type="checkbox"/> Self | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only<br><input type="checkbox"/> Daily <= 21 Day Duration<br><input type="checkbox"/> >= 30 Days for DDS Only<br><input type="checkbox"/> Weekly but not daily<br><input type="checkbox"/> Monthly but not daily |
| <input type="checkbox"/> Nasogastric                 | <input type="checkbox"/> Caregiver/Parent<br><input type="checkbox"/> Nurse/OT/PT/Physician<br><input type="checkbox"/> Direct Care<br><input type="checkbox"/> Worker/ST/Certified Nurse Aide<br><input type="checkbox"/> Self | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only<br><input type="checkbox"/> Daily <= 21 Day Duration<br><input type="checkbox"/> >= 30 Days for DDS Only<br><input type="checkbox"/> Weekly but not daily<br><input type="checkbox"/> Monthly but not daily |
| <input type="checkbox"/> Levin tubes                 | <input type="checkbox"/> Caregiver/Parent<br><input type="checkbox"/> Nurse/OT/PT/Physician<br><input type="checkbox"/> Direct Care<br><input type="checkbox"/> Worker/ST/Certified Nurse Aide<br><input type="checkbox"/> Self | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only<br><input type="checkbox"/> Daily <= 21 Day Duration<br><input type="checkbox"/> >= 30 Days for DDS Only<br><input type="checkbox"/> Weekly but not daily<br><input type="checkbox"/> Monthly but not daily |
| <input type="checkbox"/> Intravenous feedings        | <input type="checkbox"/> Caregiver/Parent<br><input type="checkbox"/> Nurse/OT/PT/Physician<br><input type="checkbox"/> Direct Care<br><input type="checkbox"/> Worker/ST/Certified Nurse Aide<br><input type="checkbox"/> Self | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only<br><input type="checkbox"/> Daily <= 21 Day Duration<br><input type="checkbox"/> >= 30 Days for DDS Only<br><input type="checkbox"/> Weekly but not daily<br><input type="checkbox"/> Monthly but not daily |



## Arkansas Independent Assessment (ARIA)

☐ Other Treatments

**Please provide supporting documentation.**

### H.43 FEEDING AND NUTRITION: SWALLOWING DISORDERS

| Treatment/Monitoring   | Performed By  | Frequency  |
|--|---|--|
| <input type="checkbox"/> Oral Stimulation Program              | <input type="checkbox"/> Caregiver/Parent<br><input type="checkbox"/> Nurse/OT/PT/Physician<br><input type="checkbox"/> Direct Care<br><input type="checkbox"/> Worker/ST/Certified Nurse Aide<br><input type="checkbox"/> Self | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only<br><input type="checkbox"/> Daily <= 21 Day Duration<br><input type="checkbox"/> >= 30 Days for DDS Only<br><input type="checkbox"/> Weekly but not daily<br><input type="checkbox"/> Monthly but not daily |
| <input type="checkbox"/> Special Diet                          | <input type="checkbox"/> Caregiver/Parent<br><input type="checkbox"/> Nurse/OT/PT/Physician<br><input type="checkbox"/> Direct Care<br><input type="checkbox"/> Worker/ST/Certified Nurse Aide<br><input type="checkbox"/> Self | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only<br><input type="checkbox"/> Daily <= 21 Day Duration<br><input type="checkbox"/> >= 30 Days for DDS Only<br><input type="checkbox"/> Weekly but not daily<br><input type="checkbox"/> Monthly but not daily |
| <input type="checkbox"/> Special Diet Management               | <input type="checkbox"/> Caregiver/Parent<br><input type="checkbox"/> Nurse/OT/PT/Physician<br><input type="checkbox"/> Direct Care<br><input type="checkbox"/> Worker/ST/Certified Nurse Aide<br><input type="checkbox"/> Self | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only<br><input type="checkbox"/> Daily <= 21 Day Duration<br><input type="checkbox"/> >= 30 Days for DDS Only<br><input type="checkbox"/> Weekly but not daily<br><input type="checkbox"/> Monthly but not daily |
| <input type="checkbox"/> Other Swallowing Disorders Treatments |   |  |

**Please provide supporting documentation.**



## Arkansas Independent Assessment (ARIA)

### H.44 NEUROLOGICAL: OBSERVATION AND ASSISTANCE FOR SEIZURES

| Treatment/Monitoring  | Performed By   | Frequency  |
|---|--|--|
| <input type="checkbox"/> Requires only observation; no physical assistance and   or intervention. | <input type="checkbox"/> Caregiver/Parent<br><input type="checkbox"/> Nurse/OT/PT/Physician<br><input type="checkbox"/> Direct Care<br>Worker/ST/Certified Nurse Aide<br><input type="checkbox"/> Self | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only<br><input type="checkbox"/> Daily <= 21 Day Duration<br><input type="checkbox"/> >= 30 Days for DDS Only<br><input type="checkbox"/> Weekly but not daily<br><input type="checkbox"/> Monthly but not daily |
| <input type="checkbox"/> Requires minimal physical assistance and   or intervention               | <input type="checkbox"/> Caregiver/Parent<br><input type="checkbox"/> Nurse/OT/PT/Physician<br><input type="checkbox"/> Direct Care<br>Worker/ST/Certified Nurse Aide<br><input type="checkbox"/> Self | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only<br><input type="checkbox"/> Daily <= 21 Day Duration<br><input type="checkbox"/> >= 30 Days for DDS Only<br><input type="checkbox"/> Weekly but not daily<br><input type="checkbox"/> Monthly but not daily |
| <input type="checkbox"/> Requires significant physical assistance and   or intervention.          | <input type="checkbox"/> Caregiver/Parent<br><input type="checkbox"/> Nurse/OT/PT/Physician<br><input type="checkbox"/> Direct Care<br>Worker/ST/Certified Nurse Aide<br><input type="checkbox"/> Self | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only<br><input type="checkbox"/> Daily <= 21 Day Duration<br><input type="checkbox"/> >= 30 Days for DDS Only<br><input type="checkbox"/> Weekly but not daily<br><input type="checkbox"/> Monthly but not daily |
| <input type="checkbox"/> Other Treatments   |  |  |

**Please provide supporting documentation.**



## Arkansas Independent Assessment (ARIA)

### H.45 RESPIRATORY

| Treatment/Monitoring                    | Performed By   | Frequency  |
|---|--|--|
| <input type="checkbox"/> Apnea Monitor  | <input type="checkbox"/> Caregiver/Parent<br><input type="checkbox"/> Nurse/OT/PT/Physician<br><input type="checkbox"/> Direct Care<br>Worker/ST/Certified Nurse Aide<br><input type="checkbox"/> Self | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only<br><input type="checkbox"/> Daily <= 21 Day Duration<br><input type="checkbox"/> >= 30 Days for DDS Only<br><input type="checkbox"/> Weekly but not daily<br><input type="checkbox"/> Monthly but not daily |
| <input type="checkbox"/> CPAP-Via mask  | <input type="checkbox"/> Caregiver/Parent<br><input type="checkbox"/> Nurse/OT/PT/Physician<br><input type="checkbox"/> Direct Care<br>Worker/ST/Certified Nurse Aide<br><input type="checkbox"/> Self | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only<br><input type="checkbox"/> Daily <= 21 Day Duration<br><input type="checkbox"/> >= 30 Days for DDS Only<br><input type="checkbox"/> Weekly but not daily<br><input type="checkbox"/> Monthly but not daily |
| <input type="checkbox"/> Nebulizer      | <input type="checkbox"/> Caregiver/Parent<br><input type="checkbox"/> Nurse/OT/PT/Physician<br><input type="checkbox"/> Direct Care<br>Worker/ST/Certified Nurse Aide<br><input type="checkbox"/> Self | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only<br><input type="checkbox"/> Daily <= 21 Day Duration<br><input type="checkbox"/> >= 30 Days for DDS Only<br><input type="checkbox"/> Weekly but not daily<br><input type="checkbox"/> Monthly but not daily |
| <input type="checkbox"/> Oxygen Therapy | <input type="checkbox"/> Caregiver/Parent<br><input type="checkbox"/> Nurse/OT/PT/Physician<br><input type="checkbox"/> Direct Care<br>Worker/ST/Certified Nurse Aide<br><input type="checkbox"/> Self | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only<br><input type="checkbox"/> Daily <= 21 Day Duration<br><input type="checkbox"/> >= 30 Days for DDS Only<br><input type="checkbox"/> Weekly but not daily<br><input type="checkbox"/> Monthly but not daily |
| <input type="checkbox"/> Pulse Oximeter | <input type="checkbox"/> Caregiver/Parent<br><input type="checkbox"/> Nurse/OT/PT/Physician<br><input type="checkbox"/> Direct Care<br>Worker/ST/Certified Nurse Aide<br><input type="checkbox"/> Self | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only<br><input type="checkbox"/> Daily <= 21 Day Duration<br><input type="checkbox"/> >= 30 Days for DDS Only<br><input type="checkbox"/> Weekly but not daily<br><input type="checkbox"/> Monthly but not daily |
| <input type="checkbox"/> CPAP-Via trach | <input type="checkbox"/> Caregiver/Parent<br><input type="checkbox"/> Nurse/OT/PT/Physician<br><input type="checkbox"/> Direct Care<br>Worker/ST/Certified Nurse Aide<br><input type="checkbox"/> Self | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only<br><input type="checkbox"/> Daily <= 21 Day Duration<br><input type="checkbox"/> >= 30 Days for DDS Only<br><input type="checkbox"/> Weekly but not daily<br><input type="checkbox"/> Monthly but not daily |



## Arkansas Independent Assessment (ARIA)

☐ Other Treatments

**Please provide supporting documentation.**

### Administration of medical gases

INITIAL phases of a regimen involving administration of medical gases

☐ Yes ☐ No

If **YES** is selected answer the **Performed By** and **Frequency** questions.

#### Performed By

☐ Caregiver/Parent  
☐ Nurse/OT/PT/Physician  
☐ Direct Care  
 Worker/ST/Certified Nurse  
 Aide  
☐ Self

#### Frequency

☐ Daily > 21 Day Duration  
 for DAAS Only  
☐ Daily <= 21 Day Duration  
☐ >= 30 Days for DDS Only  
☐ Weekly but not daily  
☐ Monthly but not daily

**Please provide supporting documentation.**

### H.46 BRONCHIAL DRAINAGE

#### Treatment/Monitoring

☐ Respiratory Vest

#### Performed By

☐ Caregiver/Parent  
☐ Nurse/OT/PT/Physician  
☐ Direct Care  
 Worker/ST/Certified Nurse  
 Aide  
☐ Self

#### Frequency

☐ Daily > 21 Day Duration  
 for DAAS Only  
☐ Daily <= 21 Day Duration  
☐ >= 30 Days for DDS Only  
☐ Weekly but not daily  
☐ Monthly but not daily

☐ Postural Drainage |  
 Pummeling

☐ Caregiver/Parent  
☐ Nurse/OT/PT/Physician  
☐ Direct Care  
 Worker/ST/Certified Nurse  
 Aide  
☐ Self

☐ Daily > 21 Day Duration  
 for DAAS Only  
☐ Daily <= 21 Day Duration  
☐ >= 30 Days for DDS Only  
☐ Weekly but not daily  
☐ Monthly but not daily

☐ Bi-Level

☐ Caregiver/Parent  
☐ Nurse/OT/PT/Physician  
☐ Direct Care  
 Worker/ST/Certified Nurse  
 Aide  
☐ Self

☐ Daily > 21 Day Duration  
 for DAAS Only  
☐ Daily <= 21 Day Duration  
☐ >= 30 Days for DDS Only  
☐ Weekly but not daily  
☐ Monthly but not daily

☐ Other Treatments

**Please provide supporting documentation.**



## Arkansas Independent Assessment (ARIA)

### H.47 SUCTIONING

| Treatment/Monitoring                               | Performed By   | Frequency  |
|--|--|--|
| <input type="checkbox"/> Nasopharyngeal aspiration | <input type="checkbox"/> Caregiver/Parent<br><input type="checkbox"/> Nurse/OT/PT/Physician<br><input type="checkbox"/> Direct Care<br>Worker/ST/Certified Nurse Aide<br><input type="checkbox"/> Self | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only<br><input type="checkbox"/> Daily <= 21 Day Duration<br><input type="checkbox"/> >= 30 Days for DDS Only<br><input type="checkbox"/> Weekly but not daily<br><input type="checkbox"/> Monthly but not daily |
| <input type="checkbox"/> Oral                      | <input type="checkbox"/> Caregiver/Parent<br><input type="checkbox"/> Nurse/OT/PT/Physician<br><input type="checkbox"/> Direct Care<br>Worker/ST/Certified Nurse Aide<br><input type="checkbox"/> Self | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only<br><input type="checkbox"/> Daily <= 21 Day Duration<br><input type="checkbox"/> >= 30 Days for DDS Only<br><input type="checkbox"/> Weekly but not daily<br><input type="checkbox"/> Monthly but not daily |
| <input type="checkbox"/> Trach aspiration          | <input type="checkbox"/> Caregiver/Parent<br><input type="checkbox"/> Nurse/OT/PT/Physician<br><input type="checkbox"/> Direct Care<br>Worker/ST/Certified Nurse Aide<br><input type="checkbox"/> Self | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only<br><input type="checkbox"/> Daily <= 21 Day Duration<br><input type="checkbox"/> >= 30 Days for DDS Only<br><input type="checkbox"/> Weekly but not daily<br><input type="checkbox"/> Monthly but not daily |
| <input type="checkbox"/> Tracheostomy Care         | <input type="checkbox"/> Caregiver/Parent<br><input type="checkbox"/> Nurse/OT/PT/Physician<br><input type="checkbox"/> Direct Care<br>Worker/ST/Certified Nurse Aide<br><input type="checkbox"/> Self | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only<br><input type="checkbox"/> Daily <= 21 Day Duration<br><input type="checkbox"/> >= 30 Days for DDS Only<br><input type="checkbox"/> Weekly but not daily<br><input type="checkbox"/> Monthly but not daily |
| <input type="checkbox"/> Other Treatments          |  |  |

**Please provide supporting documentation.**



## Arkansas Independent Assessment (ARIA)

H.48 VENTILATOR

| Treatment/Monitoring   | Performed By  | Frequency  |
|--|---|--|
| <input type="checkbox"/> Continuous - expected to be or has been dependent for 3 consecutive days                            | <input type="checkbox"/> Caregiver/Parent<br><input type="checkbox"/> Nurse/OT/PT/Physician<br><input type="checkbox"/> Direct Care<br><input type="checkbox"/> Worker/ST/Certified Nurse Aide<br><input type="checkbox"/> Self | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only<br><input type="checkbox"/> Daily <= 21 Day Duration<br><input type="checkbox"/> >= 30 Days for DDS Only<br><input type="checkbox"/> Weekly but not daily<br><input type="checkbox"/> Monthly but not daily |
| <input type="checkbox"/> Intermittent - at least 6 hours per day and expected to   has been dependent for 3 consecutive days | <input type="checkbox"/> Caregiver/Parent<br><input type="checkbox"/> Nurse/OT/PT/Physician<br><input type="checkbox"/> Direct Care<br><input type="checkbox"/> Worker/ST/Certified Nurse Aide<br><input type="checkbox"/> Self | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only<br><input type="checkbox"/> Daily <= 21 Day Duration<br><input type="checkbox"/> >= 30 Days for DDS Only<br><input type="checkbox"/> Weekly but not daily<br><input type="checkbox"/> Monthly but not daily |
| <input type="checkbox"/> Intermittent - not 6 hours per day or not expected to   not been dependent for 3 consecutive days.  | <input type="checkbox"/> Caregiver/Parent<br><input type="checkbox"/> Nurse/OT/PT/Physician<br><input type="checkbox"/> Direct Care<br><input type="checkbox"/> Worker/ST/Certified Nurse Aide<br><input type="checkbox"/> Self | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only<br><input type="checkbox"/> Daily <= 21 Day Duration<br><input type="checkbox"/> >= 30 Days for DDS Only<br><input type="checkbox"/> Weekly but not daily<br><input type="checkbox"/> Monthly but not daily |
| <input type="checkbox"/> Other Treatments  |   |  |

☐ Ventilator Care/Maintenance

**Please provide supporting documentation.**  
☐ Yes ☐ No  
**Please provide supporting documentation**

Comments.

| Performed By  | Frequency  |
|---|--|
| <input type="checkbox"/> Caregiver/Parent<br><input type="checkbox"/> Nurse/OT/PT/Physician<br><input type="checkbox"/> Direct Care<br><input type="checkbox"/> Worker/ST/Certified Nurse Aide<br><input type="checkbox"/> Self | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only<br><input type="checkbox"/> Daily <= 21 Day Duration<br><input type="checkbox"/> >= 30 Days for DDS Only<br><input type="checkbox"/> Weekly but not daily<br><input type="checkbox"/> Monthly but not daily |





## Arkansas Independent Assessment (ARIA)

### H.49 VASCULAR: BLOOD DRAW

| Treatment/Monitoring  | Performed By   | Frequency  |
|---|--|--|
| <input type="checkbox"/> Blood Glucose - cannula                        | <input type="checkbox"/> Caregiver/Parent<br><input type="checkbox"/> Nurse/OT/PT/Physician<br><input type="checkbox"/> Direct Care<br>Worker/ST/Certified Nurse Aide<br><input type="checkbox"/> Self | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only<br><input type="checkbox"/> Daily <= 21 Day Duration<br><input type="checkbox"/> >= 30 Days for DDS Only<br><input type="checkbox"/> Weekly but not daily<br><input type="checkbox"/> Monthly but not daily |
| <input type="checkbox"/> Protimel  INR (International normalized ratio) | <input type="checkbox"/> Caregiver/Parent<br><input type="checkbox"/> Nurse/OT/PT/Physician<br><input type="checkbox"/> Direct Care<br>Worker/ST/Certified Nurse Aide<br><input type="checkbox"/> Self | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only<br><input type="checkbox"/> Daily <= 21 Day Duration<br><input type="checkbox"/> >= 30 Days for DDS Only<br><input type="checkbox"/> Weekly but not daily<br><input type="checkbox"/> Monthly but not daily |
| <input type="checkbox"/> Dialysis                                       | <input type="checkbox"/> Caregiver/Parent<br><input type="checkbox"/> Nurse/OT/PT/Physician<br><input type="checkbox"/> Direct Care<br>Worker/ST/Certified Nurse Aide<br><input type="checkbox"/> Self | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only<br><input type="checkbox"/> Daily <= 21 Day Duration<br><input type="checkbox"/> >= 30 Days for DDS Only<br><input type="checkbox"/> Weekly but not daily<br><input type="checkbox"/> Monthly but not daily |
| <input type="checkbox"/> Other  | <input type="checkbox"/> Caregiver/Parent<br><input type="checkbox"/> Nurse/OT/PT/Physician<br><input type="checkbox"/> Direct Care<br>Worker/ST/Certified Nurse Aide<br><input type="checkbox"/> Self | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only<br><input type="checkbox"/> Daily <= 21 Day Duration<br><input type="checkbox"/> >= 30 Days for DDS Only<br><input type="checkbox"/> Weekly but not daily<br><input type="checkbox"/> Monthly but not daily |
| <input type="checkbox"/> Other Treatments                               |  |  |

**Please provide supporting documentation.**



## Arkansas Independent Assessment (ARIA)

### H.50 VASCULAR: IV THERAPY

| Treatment/Monitoring  | Performed By   | Frequency  |
|---|--|--|
| <input type="checkbox"/> Blood Transfusions                         | <input type="checkbox"/> Caregiver/Parent<br><input type="checkbox"/> Nurse/OT/PT/Physician<br><input type="checkbox"/> Direct Care<br>Worker/ST/Certified Nurse Aide<br><input type="checkbox"/> Self | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only<br><input type="checkbox"/> Daily <= 21 Day Duration<br><input type="checkbox"/> >= 30 Days for DDS Only<br><input type="checkbox"/> Weekly but not daily<br><input type="checkbox"/> Monthly but not daily |
| <input type="checkbox"/> Chemotherapy                               | <input type="checkbox"/> Caregiver/Parent<br><input type="checkbox"/> Nurse/OT/PT/Physician<br><input type="checkbox"/> Direct Care<br>Worker/ST/Certified Nurse Aide<br><input type="checkbox"/> Self | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only<br><input type="checkbox"/> Daily <= 21 Day Duration<br><input type="checkbox"/> >= 30 Days for DDS Only<br><input type="checkbox"/> Weekly but not daily<br><input type="checkbox"/> Monthly but not daily |
| <input type="checkbox"/> Medications                                | <input type="checkbox"/> Caregiver/Parent<br><input type="checkbox"/> Nurse/OT/PT/Physician<br><input type="checkbox"/> Direct Care<br>Worker/ST/Certified Nurse Aide<br><input type="checkbox"/> Self | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only<br><input type="checkbox"/> Daily <= 21 Day Duration<br><input type="checkbox"/> >= 30 Days for DDS Only<br><input type="checkbox"/> Weekly but not daily<br><input type="checkbox"/> Monthly but not daily |
| <input type="checkbox"/> Total Parenteral Nutrition                 | <input type="checkbox"/> Caregiver/Parent<br><input type="checkbox"/> Nurse/OT/PT/Physician<br><input type="checkbox"/> Direct Care<br>Worker/ST/Certified Nurse Aide<br><input type="checkbox"/> Self | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only<br><input type="checkbox"/> Daily <= 21 Day Duration<br><input type="checkbox"/> >= 30 Days for DDS Only<br><input type="checkbox"/> Weekly but not daily<br><input type="checkbox"/> Monthly but not daily |
| <input type="checkbox"/> Intravenous injections and hypodermoclysis | <input type="checkbox"/> Caregiver/Parent<br><input type="checkbox"/> Nurse/OT/PT/Physician<br><input type="checkbox"/> Direct Care<br>Worker/ST/Certified Nurse Aide<br><input type="checkbox"/> Self | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only<br><input type="checkbox"/> Daily <= 21 Day Duration<br><input type="checkbox"/> >= 30 Days for DDS Only<br><input type="checkbox"/> Weekly but not daily<br><input type="checkbox"/> Monthly but not daily |
| <input type="checkbox"/> Other Treatments                           |  |  |

**Please provide supporting documentation.**



## Arkansas Independent Assessment (ARIA)

☐ **Intermuscular or subcutaneous injections** if the use of licensed medical personnel is necessary TO TEACH an individual or the individual's caregiver the procedure.

☐ Yes ☐ No

**Please provide supporting documentation**

Comments.

| Performed By  | Frequency  |
|---|--|
| <input type="checkbox"/> Caregiver/Parent               | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only |
| <input type="checkbox"/> Nurse/OT/PT/Physician          | <input type="checkbox"/> Daily <= 21 Day Duration              |
| <input type="checkbox"/> Direct Care                    | <input type="checkbox"/> >= 30 Days for DDS Only               |
| <input type="checkbox"/> Worker/ST/Certified Nurse Aide | <input type="checkbox"/> Weekly but not daily                  |
| <input type="checkbox"/> Self                           | <input type="checkbox"/> Monthly but not daily                 |

### H.51 WOUNDS

| Treatment/Monitoring  | Performed By  | Frequency  |
|---|---|--|
| <input type="checkbox"/> 2 or 3 Degree burns that require specialized treatment | <input type="checkbox"/> Caregiver/Parent               | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only     |
|   | <input type="checkbox"/> Nurse/OT/PT/Physician          | <input type="checkbox"/> Daily <= 21 Day Duration                  |
|   | <input type="checkbox"/> Direct Care                    | <input type="checkbox"/> >= 30 Days for DDS Only                   |
|   | <input type="checkbox"/> Worker/ST/Certified Nurse Aide | <input type="checkbox"/> Weekly but not daily                      |
|   | <input type="checkbox"/> Self                           | <input type="checkbox"/> Monthly but not daily                     |
| <br><input type="checkbox"/> Drainage tubes                                     | <br><input type="checkbox"/> Caregiver/Parent           | <br><input type="checkbox"/> Daily > 21 Day Duration for DAAS Only |
|   | <input type="checkbox"/> Nurse/OT/PT/Physician          | <input type="checkbox"/> Daily <= 21 Day Duration                  |
|   | <input type="checkbox"/> Direct Care                    | <input type="checkbox"/> >= 30 Days for DDS Only                   |
|   | <input type="checkbox"/> Worker/ST/Certified Nurse Aide | <input type="checkbox"/> Weekly but not daily                      |
|   | <input type="checkbox"/> Self                           | <input type="checkbox"/> Monthly but not daily                     |
| <br><input type="checkbox"/> Dressing Changes (sterile or clean)                | <br><input type="checkbox"/> Caregiver/Parent           | <br><input type="checkbox"/> Daily > 21 Day Duration for DAAS Only |
|   | <input type="checkbox"/> Nurse/OT/PT/Physician          | <input type="checkbox"/> Daily <= 21 Day Duration                  |
|   | <input type="checkbox"/> Direct Care                    | <input type="checkbox"/> >= 30 Days for DDS Only                   |
|   | <input type="checkbox"/> Worker/ST/Certified Nurse Aide | <input type="checkbox"/> Weekly but not daily                      |
|   | <input type="checkbox"/> Self                           | <input type="checkbox"/> Monthly but not daily                     |



## Arkansas Independent Assessment (ARIA)

☐ Open Lesions such as  
fistulas, tube sites, tumors

☐ Caregiver/Parent  
☐ Nurse/OT/PT/Physician  
☐ Direct Care  
Worker/ST/Certified Nurse  
Aide  
☐ Self

☐ Daily > 21 Day Duration  
for DAAS Only  
☐ Daily <= 21 Day Duration  
☐ >= 30 Days for DDS Only  
☐ Weekly but not daily  
☐ Monthly but not daily

☐ Open Surgical site

☐ Caregiver/Parent  
☐ Nurse/OT/PT/Physician  
☐ Direct Care  
Worker/ST/Certified Nurse  
Aide  
☐ Self

☐ Daily > 21 Day Duration  
for DAAS Only  
☐ Daily <= 21 Day Duration  
☐ >= 30 Days for DDS Only  
☐ Weekly but not daily  
☐ Monthly but not daily

☐ Stage III or IV Decubitus  
Ulcer

☐ Caregiver/Parent  
☐ Nurse/OT/PT/Physician  
☐ Direct Care  
Worker/ST/Certified Nurse  
Aide  
☐ Self

☐ Daily > 21 Day Duration  
for DAAS Only  
☐ Daily <= 21 Day Duration  
☐ >= 30 Days for DDS Only  
☐ Weekly but not daily  
☐ Monthly but not daily

☐ Wound vac

☐ Caregiver/Parent  
☐ Nurse/OT/PT/Physician  
☐ Direct Care  
Worker/ST/Certified Nurse  
Aide  
☐ Self

☐ Daily > 21 Day Duration  
for DAAS Only  
☐ Daily <= 21 Day Duration  
☐ >= 30 Days for DDS Only  
☐ Weekly but not daily  
☐ Monthly but not daily

☐ Other Treatments

**Please provide supporting documentation.**

### H.52 SKIN CARE

#### Treatment/Monitoring

☐ Application of dressings  
involving prescription  
medication and aseptic  
techniques

#### Performed By

☐ Caregiver/Parent  
☐ Nurse/OT/PT/Physician  
☐ Direct Care  
Worker/ST/Certified Nurse  
Aide  
☐ Self

#### Frequency

☐ Daily > 21 Day Duration  
for DAAS Only  
☐ Daily <= 21 Day Duration  
☐ >= 30 Days for DDS Only  
☐ Weekly but not daily  
☐ Monthly but not daily

☐ Dry Bandage Change

☐ Caregiver/Parent  
☐ Nurse/OT/PT/Physician  
☐ Direct Care  
Worker/ST/Certified Nurse  
Aide  
☐ Self

☐ Daily > 21 Day Duration  
for DAAS Only  
☐ Daily <= 21 Day Duration  
☐ >= 30 Days for DDS Only  
☐ Weekly but not daily  
☐ Monthly but not daily



## Arkansas Independent Assessment (ARIA)

☐ Pressure Relieving Device

☐ Caregiver/Parent  
☐ Nurse/OT/PT/Physician  
☐ Direct Care  
Worker/ST/Certified Nurse  
Aide  
☐ Self

☐ Daily > 21 Day Duration  
for DAAS Only  
☐ Daily <= 21 Day Duration  
☐ >= 30 Days for DDS Only  
☐ Weekly but not daily  
☐ Monthly but not daily

☐ Turning | Repositioning  
Program

☐ Caregiver/Parent  
☐ Nurse/OT/PT/Physician  
☐ Direct Care  
Worker/ST/Certified Nurse  
Aide  
☐ Self

☐ Daily > 21 Day Duration  
for DAAS Only  
☐ Daily <= 21 Day Duration  
☐ >= 30 Days for DDS Only  
☐ Weekly but not daily  
☐ Monthly but not daily

☐ Other Treatments

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**Please provide supporting documentation.**

### H.53 **DIAGNOSED MEDICAL CONDITION**

Does the individual have a diagnosed medical condition, which requires monitoring or assessment on a daily basis by a licensed medical professional and does NOT include one of the 11 skilled conditions listed in the Treatment & Monitoring section above?

☐ Yes ☐ No

---

**INPUT CONDITION. THIS MUST BE ANSWERED IF CHOSEN "YES" FOR THE ABOVE  
DIAGNOSED MEDICAL CONDITION/ MONITORING QUESTION**



## Arkansas Independent Assessment (ARIA)

### Therapies

H.54 **Is the person receiving any therapies?** *(This question is related to long term maintenance, not acute therapies.)*

☐ Yes ☐ No ☐ Chose not to answer

**Please provide supporting documentation.**

### Comments

**IF H.54 IS YES SELECT THE TYPE OF SKILLED/SPECIALIZED THERAPIES THE CLIENT IS RECEIVING FROM BELOW**

### LEGEND TABLE

| Therapy   | Performed By   | Frequency   |
|---|--|---|
| The treatment and monitoring section contain a table. The first column lists the type of therapy performed. Each cell has a checkbox to select the treatment. | The second column in each table contains a drop-down list to indicate who performs or monitors the corresponding treatment.<br><b>The choices in the dropdown list include:</b> <ul style="list-style-type: none"><li>Caregiver/Parent</li><li>Nurse/OT/PT/Physician</li><li>Direct Care Worker/ST/Certified Nurse Aide</li><li>Self</li></ul> | The third column in each table contains a drop-down list that indicates the frequency that the corresponding treatment or monitoring occurs.<br><b>The choices in the dropdown list include:</b> <ul style="list-style-type: none"><li>Daily &gt; 21 Days <b>for DAAS Only</b></li><li>Daily &lt;=21 Days</li><li>&gt;=30 Days <b>for DDS Only</b></li><li>Weekly but not daily</li><li>Monthly but not daily</li></ul> |



## Arkansas Independent Assessment (ARIA)

### H.55 SKILLED/SPECIALIZED THERAPIES

| Therapy  | Performed By   | Frequency  |
|--|--|--|
| <input type="checkbox"/> Alternative Therapies | <input type="checkbox"/> Caregiver/Parent<br><input type="checkbox"/> Nurse/OT/PT/Physician<br><input type="checkbox"/> Direct Care<br>Worker/ST/Certified Nurse Aide<br><input type="checkbox"/> Self | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only<br><input type="checkbox"/> Daily <= 21 Day Duration<br><input type="checkbox"/> >= 30 Days for DDS Only<br><input type="checkbox"/> Weekly but not daily<br><input type="checkbox"/> Monthly but not daily |
| <input type="checkbox"/> Occupational Therapy  | <input type="checkbox"/> Caregiver/Parent<br><input type="checkbox"/> Nurse/OT/PT/Physician<br><input type="checkbox"/> Direct Care<br>Worker/ST/Certified Nurse Aide<br><input type="checkbox"/> Self | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only<br><input type="checkbox"/> Daily <= 21 Day Duration<br><input type="checkbox"/> >= 30 Days for DDS Only<br><input type="checkbox"/> Weekly but not daily<br><input type="checkbox"/> Monthly but not daily |
| <input type="checkbox"/> Pain management       | <input type="checkbox"/> Caregiver/Parent<br><input type="checkbox"/> Nurse/OT/PT/Physician<br><input type="checkbox"/> Direct Care<br>Worker/ST/Certified Nurse Aide<br><input type="checkbox"/> Self | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only<br><input type="checkbox"/> Daily <= 21 Day Duration<br><input type="checkbox"/> >= 30 Days for DDS Only<br><input type="checkbox"/> Weekly but not daily<br><input type="checkbox"/> Monthly but not daily |
| <input type="checkbox"/> Physical Therapy      | <input type="checkbox"/> Caregiver/Parent<br><input type="checkbox"/> Nurse/OT/PT/Physician<br><input type="checkbox"/> Direct Care<br>Worker/ST/Certified Nurse Aide<br><input type="checkbox"/> Self | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only<br><input type="checkbox"/> Daily <= 21 Day Duration<br><input type="checkbox"/> >= 30 Days for DDS Only<br><input type="checkbox"/> Weekly but not daily<br><input type="checkbox"/> Monthly but not daily |
| <input type="checkbox"/> Range of Motion       | <input type="checkbox"/> Caregiver/Parent<br><input type="checkbox"/> Nurse/OT/PT/Physician<br><input type="checkbox"/> Direct Care<br>Worker/ST/Certified Nurse Aide<br><input type="checkbox"/> Self | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only<br><input type="checkbox"/> Daily <= 21 Day Duration<br><input type="checkbox"/> >= 30 Days for DDS Only<br><input type="checkbox"/> Weekly but not daily<br><input type="checkbox"/> Monthly but not daily |



## Arkansas Independent Assessment (ARIA)

|  |  |  |
|--|--|--|
| <input type="checkbox"/> Respiratory Therapy                 | <input type="checkbox"/> Caregiver/Parent<br><input type="checkbox"/> Nurse/OT/PT/Physician<br><input type="checkbox"/> Direct Care<br>Worker/ST/Certified Nurse Aide<br><input type="checkbox"/> Self | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only<br><input type="checkbox"/> Daily <= 21 Day Duration<br><input type="checkbox"/> >= 30 Days for DDS Only<br><input type="checkbox"/> Weekly but not daily<br><input type="checkbox"/> Monthly but not daily |
| <input type="checkbox"/> Speech Therapy                      | <input type="checkbox"/> Caregiver/Parent<br><input type="checkbox"/> Nurse/OT/PT/Physician<br><input type="checkbox"/> Direct Care<br>Worker/ST/Certified Nurse Aide<br><input type="checkbox"/> Self | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only<br><input type="checkbox"/> Daily <= 21 Day Duration<br><input type="checkbox"/> >= 30 Days for DDS Only<br><input type="checkbox"/> Weekly but not daily<br><input type="checkbox"/> Monthly but not daily |
| <input type="checkbox"/> Other                               | <input type="checkbox"/> Caregiver/Parent<br><input type="checkbox"/> Nurse/OT/PT/Physician<br><input type="checkbox"/> Direct Care<br>Worker/ST/Certified Nurse Aide<br><input type="checkbox"/> Self | <input type="checkbox"/> Daily > 21 Day Duration for DAAS Only<br><input type="checkbox"/> Daily <= 21 Day Duration<br><input type="checkbox"/> >= 30 Days for DDS Only<br><input type="checkbox"/> Weekly but not daily<br><input type="checkbox"/> Monthly but not daily |
| <input type="checkbox"/> Other Skilled/Specialized Therapies |  |  |

**Please provide supporting documentation.**

### H.56 Heat Treatments

Heat treatments which have been specifically ordered by a physician as a part of active treatment and which require observation by nurses to adequately evaluate the individual's progress.

☐ Yes ☐ No

#### Performed By

☐ Caregiver/Parent  
☐ Nurse/OT/PT/Physician  
☐ Direct Care Worker/ST/Certified Nurse Aide  
☐ Self

#### Frequency

☐ Daily > 21 Day Duration for DAAS Only  
☐ Daily <= 21 Day Duration  
☐ >= 30 Days for DDS Only  
☐ Weekly but not daily  
☐ Monthly but not daily





## Arkansas Independent Assessment (ARIA)

### H.57 Rehabilitation Procedures

Rehabilitation procedures, including the related teaching and adaptive aspects of nursing/therapies, that are part of active treatment, to obtain a specific goal and NOT AS MAINTENANCE of existing function.

☐ Yes ☐ No

#### Performed By

- ☐ Caregiver/Parent  
☐ Nurse/OT/PT/Physician  
☐ Direct Care Worker/ST/Certified Nurse Aide  
☐ Self

#### Frequency

- ☐ Daily > 21 Day Duration for DAAS Only  
☐ Daily <= 21 Day Duration  
☐ >= 30 Days for DDS Only  
☐ Weekly but not daily  
☐ Monthly but not daily

Please provide supporting documentation.

#### Comments

### Assessment of Pain

### H.58 Is the person CURRENTLY experiencing pain anywhere on their body?

☐ Yes ☐ No ☐ Chose not to answer

### H.59 Please provide supporting documentation.

#### Comments

↓If H.58 YES, PLEASE COMPLETE THE REMAINDER OF THE PAIN SECTION: ↓

### H.60 How frequently do they experience pain?

#### Frequency of pain

### H.61 What is the location of the pain?

#### Location of pain

### H.62 Indicate the severity of your pain: (Rate 0= No Pain, 10 = Worst Pain Imaginable)

#### Severity of pain



## Arkansas Independent Assessment (ARIA)

H.63 How does the person manage their pain?

### I. Psychosocial

[Return to Index](#)

#### Injurious to Self

- I.1 **Person engages in, or would without an intervention, behavior that causes physical harm or has significant potential for causing physical harm to their own body. Includes putting self in dangerous situations.**

☐ Yes ☐ No

↓ **IF I.1 IS YES, PLEASE COMPLETE THE REMAINDER OF THE INJURIOUS TO SELF SECTION: ↓**

- I.2 **In what types of physical harm to self do they engage? Select all that apply.**

☐ Chemical abuse/misuse

☐ Head-banging

☐ Pulling out hair

☐ Puts self in dangerous situations that causes harm or injury

☐ Self-burning

☐ Self-biting/cutting/hitting/poking/ or stabbing

☐ Self restricts eating

☐ Other

**Other types of self-harm:**

---

*(Any other types of self harm)*

- I.3 **Intervention: Support and/or services provided by staff and/or caregiver**

☐ Requires no intervention **(if selected, frequency question (I.4) is not asked)**

☐ Needs interventions in the form of cues - responds to cues

☐ Needs redirection - responds to redirection

☐ Needs behavior management or instruction - resists redirection/intervention

☐ Needs behavior management or instruction - physically resists intervention

- I.4 **How often on a weekly basis is intervention needed?**

☐ Less than weekly

☐ One time per week

☐ Two times per week

☐ Three times per week

☐ Four or more times per week but not daily

☐ Daily



## Arkansas Independent Assessment (ARIA)

### Aggressive Toward Others, Physical

- I.5 **Person engages in, or would without an intervention, behavior that causes physical harm to other people or to animals. A person who causes physical harm due to involuntary movement is not considered to have physical aggression towards others.**  
☐ Yes ☐ No

**↓If I.5 IS YES, PLEASE COMPLETE THE REMAINDER OF THE AGGRESSIVE TOWARD OTHERS, PHYSICAL SECTION↓:**

- I.6 **What types of physical aggression toward others do they engage? Select all that apply.**

- |   |   |
|---|---|
| <input type="checkbox"/> Bites              | <input type="checkbox"/> Throws objects at others                             |
| <input type="checkbox"/> Hits/Punches/Kicks | <input type="checkbox"/> Touches others in a sexual manner against their will |
| <input type="checkbox"/> Pulls others hair  | <input type="checkbox"/> Uses objects to hurt others                          |
| <input type="checkbox"/> Pushes             | <input type="checkbox"/> Other  |
| <input type="checkbox"/> Scratches          |   |

**Other types of physical aggression:**

---

*(Any other types of physical aggression. Please provide supporting documentation.)*

- I.7 **Intervention: Support and/or services provided by staff and/or caregiver for aggression**

- ☐ Requires no intervention **(if selected, frequency question (I.8) is not asked)**  
☐ Needs interventions in the form of cues - responds to cues  
☐ Needs redirection - responds to redirection  
☐ Needs behavior management or instruction - resists redirection/intervention  
☐ Needs behavior management or instruction - physically resists intervention

- I.8 **How often on a weekly basis is intervention needed for aggression?**

- |   |  |
|---|--|
| <input type="checkbox"/> Less than weekly   | <input type="checkbox"/> Three times per week                      |
| <input type="checkbox"/> One time per week  | <input type="checkbox"/> Four or more times per week but not daily |
| <input type="checkbox"/> Two times per week | <input type="checkbox"/> Daily                                     |

### Aggressive Toward Others, Verbal Gestural

- I.9 **Person engages in, or would without an intervention, the use language verbally, through written words or symbols, or non-verbally through facial expressions, gestures or signs which threaten psychological, emotional or physical harm towards others.**  
☐ Yes ☐ No



## Arkansas Independent Assessment (ARIA)

**↓IF I.9 IS YES, PLEASE COMPLETE THE REMAINDER OF THE AGGRESSIVE TOWARD OTHERS, VERBAL/GESTURAL SECTION:↓**

**I.10 What types of verbal/gestural aggression toward others do they display? Select all that apply.**

- |  |  |
|--|--|
| <input type="checkbox"/> Attempts to intimidate through aggressive gestures with no physical contact | <input type="checkbox"/> Swears/yells/screams at others/verbal threats |
| <input type="checkbox"/> Goading/Intimidation/Staring  | <input type="checkbox"/> Taunting/Teasing                              |
| <input type="checkbox"/> Resistive to care   | <input type="checkbox"/> Writes threatening notes                      |
|  | <input type="checkbox"/> Other   |

**Other types of verbal/gestural aggression:**

---

*(Any other types of verbal/gestural aggression)*

**I.11 Intervention: Support and/or services provided by staff and/or caregiver for aggressive nature Toward Others, Verbal/Gestural**

- ☐ Requires no intervention **(if selected, frequency question (I.12) is not asked)**
- ☐ Needs interventions in the form of cues - responds to cues
- ☐ Needs redirection - responds to redirection
- ☐ Needs behavior management or instruction - resists redirection/intervention
- ☐ Needs behavior management or instruction - physically resists intervention

**I.12 How often on a weekly basis is intervention needed?**

- |   |  |
|---|--|
| <input type="checkbox"/> Less than weekly   | <input type="checkbox"/> Three times per week                      |
| <input type="checkbox"/> One time per week  | <input type="checkbox"/> Four or more times per week but not daily |
| <input type="checkbox"/> Two times per week | <input type="checkbox"/> Daily                                     |

### Socially Unacceptable Behavior

**I.13 Person expresses themselves, or would without an intervention, in an inappropriate or unacceptable manner including sexual, offensive or injurious to self with others. Includes behavior (verbal/ non-verbal) that draws negative attention to themselves.**

- ☐ Yes ☐ No



## Arkansas Independent Assessment (ARIA)

↓ If I.13 is YES PLEASE COMPLETE THE REMAINDER OF THE SOCIALLY UNACCEPTABLE BEHAVIORS SECTION. ↓

I.14 **Type of Socially Unacceptable Behavior Displayed: Select all that apply.**

- |   |  |
|---|--|
| <input type="checkbox"/> Disruptive of other's activities             | <input type="checkbox"/> Other – Socially offensive behavior     |
| <input type="checkbox"/> Doesn't understand personal boundaries       | <input type="checkbox"/> Exposes private body areas to others    |
| <input type="checkbox"/> Spitting                                     | <input type="checkbox"/> Inappropriate touching of others        |
| <input type="checkbox"/> Throws food                                  | <input type="checkbox"/> Masturbates in public                   |
| <input type="checkbox"/> Urinating/Defecating in inappropriate places | <input type="checkbox"/> Other - Inappropriate sexual activities |
| <input type="checkbox"/> Other  |  |

**Other types of unacceptable behavior:**

---

*(Any other types of unacceptable behavior)*

I.15 **Intervention: Support and/or services provided by staff and/or caregiver for socially unacceptable behavior.**

- ☐ Requires no intervention **(if selected, frequency question (I.16) is not asked)**
- ☐ Needs interventions in the form of cues - responds to cues
- ☐ Needs redirection - responds to redirection
- ☐ Needs behavior management or instruction - resists redirection/intervention
- ☐ Needs behavior management or instruction - physically resists intervention

I.16 **How often on a weekly basis is intervention needed for socially unacceptable behavior?**

- |   |  |
|---|--|
| <input type="checkbox"/> Less than weekly   | <input type="checkbox"/> Three times per week                      |
| <input type="checkbox"/> One time per week  | <input type="checkbox"/> Four or more times per week but not daily |
| <input type="checkbox"/> Two times per week | <input type="checkbox"/> Daily                                     |

### Property Destruction

I.17 **Person engages in behavior, or would without an intervention, to intentionally disassemble, damage or destroy public or private property or possessions.**

- ☐ Yes ☐ No



## Arkansas Independent Assessment (ARIA)

### I.18 Type of Property Destruction: Select all that apply

- ☐ Breaks windows, glasses, lamps or furniture ☐ Uses tools/objects to damage property  
☐ Sets fires ☐ Other

**Other types of property destruction:**

---

*(Any other types of property destruction)*

### I.19 Intervention: Support and/or services provided by staff and/or caregiver for property destruction.

- ☐ Requires no intervention **(if selected, frequency question (I.20) is not asked)**  
☐ Needs interventions in the form of cues - responds to cues  
☐ Needs redirection - responds to redirection  
☐ Needs behavior management or instruction - resists redirection/intervention  
☐ Needs behavior management or instruction - physically resists intervention

### I.20 How often on a weekly basis is intervention needed for property destruction behavior?

- ☐ Less than weekly ☐ Three times per week  
☐ One time per week ☐ Four or more times per week but not daily  
☐ Two times per week ☐ Daily

## Wandering/ Elopement

### I.21 Person purposefully will, or would without an intervention, leave an area or group without telling others or depart from the supervision staff unexpectedly resulting in increased vulnerability.

- ☐ Yes ☐ No

**↓If I.21 IS YES, PLEASE COMPLETE THE REMAINDER OF THE WANDERING/ELOPEMENT SECTION↓**

### I.22 Type of Wandering/Elopement Behaviors Displayed: Select all that apply.

- ☐ Intentionally wanders away from staff while in the community  
☐ Leaves living area for extended period of time without informing appropriate person  
☐ Runs away  
☐ Other

**Other types of wandering behavior:**

---

*(Any other types of wandering behavior)*



## Arkansas Independent Assessment (ARIA)

**I.23 Intervention: Support and/or services provided by staff and/or caregiver for wandering**

- ☐ Requires no intervention **(if selected, frequency question (I.24) is not asked)**
- ☐ Needs interventions in the form of cues - responds to cues
- ☐ Needs redirection - responds to redirection
- ☐ Needs behavior management or instruction - resists redirection/intervention
- ☐ Needs behavior management or instruction - physically resists intervention

**I.24 How often on a weekly basis is intervention needed for wandering?**

- ☐ Less than weekly
- ☐ One time per week
- ☐ Two times per week
- ☐ Three times per week
- ☐ Four or more times per week but not daily
- ☐ Daily

### Legal Involvement

**I.25 Person has been arrested and convicted of breaking a law or laws.**

- ☐ Yes ☐ No

**↓ IF I.25 IS YES, PLEASE COMPLETE THE REMAINDER OF THE LEGAL INVOLVEMENT SECTION: ↓**

**I.26 Types of Legal Involvement Behaviors Displayed: Select all that apply.**

- |  |  |
|--|--|
| <input type="checkbox"/> Assault                                       | <input type="checkbox"/> Public nuisance     |
| <input type="checkbox"/> Burglary                                      | <input type="checkbox"/> Sexual crimes       |
| <input type="checkbox"/> Commits arson                                 | <input type="checkbox"/> Shoplifting         |
| <input type="checkbox"/> Drug related crimes                           | <input type="checkbox"/> Terroristic threats |
| <input type="checkbox"/> Financial crimes/stealing/compulsive spending | <input type="checkbox"/> Trespassing         |
| <input type="checkbox"/> Prostitution                                  | <input type="checkbox"/> Other               |

**Other types of legal involvement:**

---

*(Any other types of legal involvement)*

**I.27 Intervention: Support and/or services provided by staff and/or caregiver in legal involvement**

- ☐ Requires no intervention **(if selected, frequency question (I.28) is not asked)**
- ☐ Needs interventions in the form of cues - responds to cues
- ☐ Needs redirection - responds to redirection
- ☐ Needs behavior management or instruction - resists redirection/intervention
- ☐ Needs behavior management or instruction - physically resists intervention



## Arkansas Independent Assessment (ARIA)

I.28 **How often on a weekly basis is intervention needed?**

- ☐ Less than weekly      ☐ Three times per week  
☐ One time per week      ☐ Four or more times per week but not daily  
☐ Two times per week      ☐ Daily

### PICA (Ingestion of Non-Nutritive Substances)

I.29 **Person will ingest or would without an intervention, inedible items such as paper, strings, dirt or toilet water that may cause physical harm to that person.**

- ☐ Yes    ☐ No

↓ **IF I.29 IS YES, PLEASE COMPLETE THE REMAINDER OF THE PICA SECTION:** ↓

I.30 **Intervention: Support and/or services provided by staff and/or caregiver**

- ☐ Requires no intervention **(if selected, frequency question (I.31) is not asked)**  
☐ Needs interventions in the form of cues - responds to cues  
☐ Needs redirection - responds to redirection  
☐ Needs behavior management or instruction - resists redirection/intervention  
☐ Needs behavior management or instruction - physically resists intervention

I.31 **How often on a weekly basis is intervention needed?**

- ☐ Less than weekly      ☐ Three times per week  
☐ One time per week      ☐ Four or more times per week but not daily  
☐ Two times per week      ☐ Daily

---

### Comments

### Susceptibility to Victimization

I.32 **Person engages in, or would without an intervention, behaviors that increase or could potentially increase a person's level of risk or harm or exploitation by others such as befriending strangers.**

- ☐ Yes    ☐ No





## Arkansas Independent Assessment (ARIA)

I.33 **How is person susceptible to victimization? Select all that apply.**

- |   |  |
|---|--|
| <input type="checkbox"/> Caregiver neglect                            | <input type="checkbox"/> Physically threatened   |
| <input type="checkbox"/> Domestic abuse                               | <input type="checkbox"/> Puts self in harm's way |
| <input type="checkbox"/> Financial exploitation                       | <input type="checkbox"/> Sexual exploitation     |
| <input type="checkbox"/> Person easily manipulated to their detriment | <input type="checkbox"/> Other                   |
| <input type="checkbox"/> Physical exploitation                        |  |

**Other types of susceptibility to victimization:**

---

*(Any other types of susceptibility to victimization)*

- I.34 **Intervention: Support and/or services provided by staff and/or caregiver**
- ☐ Requires no intervention **(if selected, frequency question (I.39) is not asked)**
- ☐ Needs interventions in the form of cues - responds to cues
- ☐ Needs redirection - responds to redirection
- ☐ Needs behavior management or instruction - resists redirection/intervention
- ☐ Needs behavior management or instruction - physically resists intervention

I.35 **How often on a weekly basis is intervention needed?**

- |   |  |
|---|--|
| <input type="checkbox"/> Less than weekly   | <input type="checkbox"/> Three times per week                      |
| <input type="checkbox"/> One time per week  | <input type="checkbox"/> Four or more times per week but not daily |
| <input type="checkbox"/> Two times per week | <input type="checkbox"/> Daily                                     |

### Withdrawal

- I.36 **Person has a tendency, or would without an intervention, to avoid, isolate or retreat from conversation, interaction or activity.**
- ☐ Yes ☐ No

**↓ IF I.36 IS YES, PLEASE COMPLETE THE REMAINDER OF THE WITHDRAWAL SECTION: ↓**

I.37 **Types of Withdrawal Behaviors Displayed:**

- |                                    |  |
|------------------------------------|--|
| <input type="checkbox"/> Avoidance | <input type="checkbox"/> Lack of interest in life's events |
| <input type="checkbox"/> Isolation | <input type="checkbox"/> Other                             |

**Other types of withdrawal behaviors:**

---

*(Any other types withdrawal behaviors)*



## Arkansas Independent Assessment (ARIA)

I.38 **Intervention: Support and/or services provided by staff and/or caregiver for withdrawal behavior.**

- ☐ Requires no intervention **(if selected, frequency question (I.39) is not asked)**
- ☐ Needs interventions in the form of cues - responds to cues
- ☐ Needs redirection - responds to redirection
- ☐ Needs behavior management or instruction - resists redirection/intervention
- ☐ Needs behavior management or instruction - physically resists intervention

I.39 **How often on a weekly basis is intervention needed?**

- ☐ Less than weekly
- ☐ Three times per week
- ☐ One time per week
- ☐ Four or more times per week but not daily
- ☐ Two times per week
- ☐ Daily

### Agitation

I.40 **Person has a tendency, or would without an intervention, to suddenly or quickly become upset or violent.**

- ☐ Yes ☐ No

**↓ IF I.40 IS YES, PLEASE COMPLETE THE REMAINDER OF THE AGITATION SECTION:↓**

I.41 **Types of Agitation Behaviors Displayed: Select all that apply.**

- ☐ Easily agitated / Easily angered
- ☐ Easily frustrated
- ☐ Other

**Other types of agitation behaviors:**

---

*(Any other types of agitation behaviors)*

I.42 **Intervention: Support and/or services provided by staff and/or caregiver**

- ☐ Requires no intervention **(if selected, frequency question (I.43) is not asked)**
- ☐ Needs interventions in the form of cues - responds to cues
- ☐ Needs redirection - responds to redirection
- ☐ Needs behavior management or instruction - resists redirection/intervention
- ☐ Needs behavior management or instruction - physically resists intervention



## Arkansas Independent Assessment (ARIA)

I.43 **How often on a weekly basis is intervention needed?**

- ☐ Less than weekly
- ☐ One time per week
- ☐ Two times per week
- ☐ Three times per week
- ☐ Four or more times per week but not daily
- ☐ Daily

### Impulsivity

I.44 **Person has a propensity, or would without an intervention, for sudden or spontaneous decisions or actions.**

- ☐ Yes ☐ No

**↓ IF I.44 IS YES, PLEASE COMPLETE THE REMAINDER OF THE IMPULSIVITY SECTION:↓**

I.45 **Types of Impulsive Behaviors Displayed: Select all that apply.**

- |  |   |
|--|---|
| <input type="checkbox"/> Disregard for personal safety | <input type="checkbox"/> High risk behaviors          |
| <input type="checkbox"/> Easily influenced by others   | <input type="checkbox"/> Thoughtless about boundaries |
| <input type="checkbox"/> Financial                     | <input type="checkbox"/> Other                        |

**Other types of impulsive behaviors:**

---

*(Any other types of impulsive behaviors)*

I.46 **Intervention: Support and/or services provided by staff and/or caregiver**

- ☐ Requires no intervention **(if selected, frequency question (I.47) is not asked)**
- ☐ Needs interventions in the form of cues - responds to cues
- ☐ Needs redirection - responds to redirection
- ☐ Needs behavior management or instruction - resists redirection/intervention
- ☐ Needs behavior management or instruction - physically resists intervention

I.47 **How often on a weekly basis is intervention needed?**

- |   |  |
|---|--|
| <input type="checkbox"/> Less than weekly   | <input type="checkbox"/> Three times per week                      |
| <input type="checkbox"/> One time per week  | <input type="checkbox"/> Four or more times per week but not daily |
| <input type="checkbox"/> Two times per week | <input type="checkbox"/> Daily                                     |

### Intrusiveness

I.48 **Person has a tendency, or would without an intervention, for entering personal or private space without regard or permission.**

- ☐ Yes ☐ No



## Arkansas Independent Assessment (ARIA)

↓ IF I.48 IS YES, PLEASE COMPLETE THE REMAINDER OF THE INTRUSIVENESS SECTION: ↓

I.49 **Types of Intrusive Behaviors Displayed: Select all that apply.**

- |   |   |
|---|---|
| <input type="checkbox"/> Inappropriate boundaries in public/private areas | <input type="checkbox"/> Unawareness of interpersonal space |
| <input type="checkbox"/> Physical   | <input type="checkbox"/> Other                              |
| <input type="checkbox"/> Verbal   |   |

**Other types of intrusive behaviors**

---

*(Any other types of intrusive behaviors)*

I.50 **Intervention: Support and/or services provided by staff and/or caregiver.**

- ☐ Requires no intervention **(if selected, frequency question (I.51) is not asked)**
- ☐ Needs interventions in the form of cues - responds to cues
- ☐ Needs redirection - responds to redirection
- ☐ Needs behavior management or instruction - resists redirection/intervention
- ☐ Needs behavior management or instruction - physically resists intervention

I.51 **How often on a weekly basis is intervention needed?**

- |   |  |
|---|--|
| <input type="checkbox"/> Less than weekly   | <input type="checkbox"/> Three times per week                      |
| <input type="checkbox"/> One time per week  | <input type="checkbox"/> Four or more times per week but not daily |
| <input type="checkbox"/> Two times per week | <input type="checkbox"/> Daily                                     |

### Injury to Others, Unintentional

I.52 **Person engages in behavior, or would without an intervention, that causes actual injury to others that is unintentional, including hitting and punching.**

- ☐ Yes ☐ No

↓ IF YES, PLEASE COMPLETE THE REMAINDER OF THE INJURY TO OTHERS-UNINTENTIONAL SECTION: ↓

I.53 **Types of Injury to Others:**

- ☐ Unintentional
- ☐ Other

**Other types of injury to others:**

---

*(Any other types of injury to others:)*



## Arkansas Independent Assessment (ARIA)

- I.54 **Intervention: Support and/or services provided by staff and/or caregiver**
- ☐ Requires no intervention **(if selected, frequency question (I.55) is not asked)**
  - ☐ Needs interventions in the form of cues - responds to cues
  - ☐ Needs redirection - responds to redirection
  - ☐ Needs behavior management or instruction - resists redirection/intervention
  - ☐ Needs behavior management or instruction - physically resists intervention
- I.55 **How often on a weekly basis is intervention needed?**
- ☐ Less than weekly      ☐ Three times per week
  - ☐ One time per week      ☐ Four or more times per week but not daily
  - ☐ Two times per week      ☐ Daily

### Anxiety

- I.56 **An overwhelming feeling of apprehension and nervousness characterized by physical symptoms such as sweating and panic attacks. Worry, over-concern or restlessness due to fear that prevents the individual from doing things they want to do.**
- ☐ Yes    ☐ No
- I.57 **Types of Anxious Behaviors Displayed: Select all that apply.**
- ☐ Avoidance of people/situations      ☐ Phobias due to fear
  - ☐ Easily triggered due to past trauma      ☐ Rocking
  - ☐ Hoarding      ☐ Other
  - ☐ Hyper-vigilance
  - ☐ Inability to concentrate
- Other types of anxious behaviors:**

---

*(Any other types of anxious behaviors)*

- I.58 **Intervention: Support and/or services provided by staff and/or caregiver**
- ☐ Requires no intervention **(if selected, frequency question (I.59) is not asked)**
  - ☐ Needs interventions in the form of cues - responds to cues
  - ☐ Needs redirection - responds to redirection
  - ☐ Needs behavior management or instruction - resists redirection/intervention
  - ☐ Needs behavior management or instruction - physically resists intervention



## Arkansas Independent Assessment (ARIA)

### I.59 How often on a weekly basis is intervention needed?

- ☐ Less than weekly      ☐ Three times per week  
☐ One time per week      ☐ Four or more times per week but not daily  
☐ Two times per week      ☐ Daily

Psychotic Behaviors: if age ≤ 17 consult with supervisor before selecting yes

### I.60 Markedly inappropriate behavior that affects a person's daily functioning and social interactions. Behavior characterized by a radical change in personality and a distorted or diminished sense of reality.

- ☐ Yes    ☐ No

**↓ IF I.60 IS YES, PLEASE COMPLETE THE REMAINDER OF THE PSYCHOTIC BEHAVIORS SECTION: ↓**

### I.61 Types of Psychotic Behaviors Displayed: Select all that apply.

- |  |   |
|--|---|
| <input type="checkbox"/> Catatonic behavior  | <input type="checkbox"/> Hallucinations   |
| <input type="checkbox"/> Delusions           | <input type="checkbox"/> Thought disorder |
| <input type="checkbox"/> Disorganized speech | <input type="checkbox"/> Other            |

**Other types of psychotic behaviors:**

---

*(Any other types of psychotic behaviors:)*

### I.62 Intervention: Support and/or services provided by staff and/or caregiver

- ☐ Requires no intervention **(if selected, frequency question (I.63) is not asked)**  
☐ Needs interventions in the form of cues - responds to cues  
☐ Needs redirection - responds to redirection  
☐ Needs behavior management or instruction - resists redirection/intervention  
☐ Needs behavior management or instruction - physically resists intervention

### I.63 How often on a weekly basis is intervention needed?

- ☐ Less than weekly      ☐ Three times per week  
☐ One time per week      ☐ Four or more times per week but not daily  
☐ Two times per week      ☐ Daily

Manic Behaviors: If age = <17 consult with supervisor before selecting yes

### I.64 Elevated changes in mood states characterized by severe fluctuations in energy and activity level, inappropriate elation and grandiose notions. Manic behavior patterns include hyperactivity, increased energy and heightened mood.

- ☐ Yes    ☐ No



## Arkansas Independent Assessment (ARIA)

**↓ IF I.64 IS YES, PLEASE COMPLETE THE REMAINDER OF THE MANIC BEHAVIORS SECTION: ↓**

**I.65 Types of Manic Behaviors Displayed: Select all that apply.**

- |   |  |
|---|--|
| <input type="checkbox"/> Decreased need for sleep | <input type="checkbox"/> Rapid/intense speech inappropriate to situation |
| <input type="checkbox"/> Distractibility          | <input type="checkbox"/> Other   |
| <input type="checkbox"/> Grandiosity              |  |
| <input type="checkbox"/> Inflated self-esteem     |  |

**Other types of manic behaviors**

---

*(Any other types of manic behaviors)*

- I.66 Intervention: Support and/or services provided by staff and/or caregiver**
- ☐ Requires no intervention **(if selected, frequency question (I.67) is not asked)**
- ☐ Needs interventions in the form of cues - responds to cues
- ☐ Needs redirection - responds to redirection
- ☐ Needs behavior management or instruction - resists redirection/intervention
- ☐ Needs behavior management or instruction - physically resists intervention

**I.67 How often on a weekly basis is intervention needed?**

- |   |  |
|---|--|
| <input type="checkbox"/> Less than weekly   | <input type="checkbox"/> Three times per week                      |
| <input type="checkbox"/> One time per week  | <input type="checkbox"/> Four or more times per week but not daily |
| <input type="checkbox"/> Two times per week | <input type="checkbox"/> Daily                                     |

### Difficulties Regulating Emotions

**I.68 Person has instances, or would without an intervention, of emotional behavior that are atypical of others in similar situations.**

- ☐ Yes ☐ No



## Arkansas Independent Assessment (ARIA)

### ↓IF I.68 IS YES, PLEASE COMPLETE THE REMAINDER OF THE DIFFICULTIES REGULATING EMOTIONS SECTION

I.69 **Check all that apply:**

- |   |   |
|---|---|
| <input type="checkbox"/> Cries                                | <input type="checkbox"/> Screams              |
| <input type="checkbox"/> Frequently argues about small things | <input type="checkbox"/> Shouts angrily       |
| <input type="checkbox"/> Impulsivity                          | <input type="checkbox"/> Tantrums             |
| <input type="checkbox"/> Isolation                            | <input type="checkbox"/> Throws self on floor |
| <input type="checkbox"/> Over excitement                      | <input type="checkbox"/> Other                |
| <input type="checkbox"/> Overzealous social exchanges         |   |

**Other difficulties in regulating emotions:**

---

*(Any other difficulties in regulating emotions)*

I.70 **Intervention: Support and/or services provided by staff and/or caregiver**

- ☐ Requires no intervention **(if selected, frequency question (I.71) is not asked)**
- ☐ Needs interventions in the form of cues - responds to cues
- ☐ Needs redirection - responds to redirection
- ☐ Needs behavior management or instruction - resists redirection/intervention
- ☐ Needs behavior management or instruction - physically resists intervention

I.71 **How often on a weekly basis is intervention needed?**

- |   |  |
|---|--|
| <input type="checkbox"/> Less than weekly   | <input type="checkbox"/> Three times per week                      |
| <input type="checkbox"/> One time per week  | <input type="checkbox"/> Four or more times per week but not daily |
| <input type="checkbox"/> Two times per week | <input type="checkbox"/> Daily                                     |

**Patient Health Questionnaire (PHQ-2) (Ages 18-64)**

**During the last two weeks, have you often been bothered**

I.72 **By having little interest or pleasure in doing things?**

- ☐ Yes ☐ No

I.73 **By feeling down, sad or hopeless?**

- ☐ Yes ☐ No





## Arkansas Independent Assessment (ARIA)

↓ IF EITHER I.72 OR I.73 IS YES, ANSWER PHQ-9 BELOW. ↓

### Patient Health Questionnaire (PHQ-9) (Ages 18-64)

**Over the last two weeks, how often have you been bothered of little interest or pleasure in things?**

Answer this if response for any of PHQ- 2 is Yes

I.74 **Little interest or pleasure in doing things.**

- ☐ Not at all      ☐ More than half the days  
☐ Several Days      ☐ Nearly every day

I.75 **Feeling down, depressed, or hopeless.**

- ☐ Not at all      ☐ More than half the days  
☐ Several Days      ☐ Nearly every day

I.76 **Trouble falling or staying asleep or sleeping too much.**

- ☐ Not at all      ☐ More than half the days  
☐ Several Days      ☐ Nearly every day

I.77 **Feeling tired or having little energy**

- ☐ Not at all      ☐ More than half the days  
☐ Several Days      ☐ Nearly every day

I.78 **Poor appetite or overeating**

- ☐ Not at all      ☐ More than half the days  
☐ Several Days      ☐ Nearly every day

I.79 **Feeling bad about yourself**

- ☐ Not at all      ☐ More than half the days  
☐ Several Days      ☐ Nearly every day

I.80 **Trouble concentrating on things**

- ☐ Not at all      ☐ More than half the days  
☐ Several Days      ☐ Nearly every day

I.81 **Moving or speaking so slowly**

- ☐ Not at all      ☐ More than half the days  
☐ Several Days      ☐ Nearly every day

I.82 **Thoughts that you would be better off dead**

- ☐ Not at all      ☐ More than half the days  
☐ Several Days      ☐ Nearly every day

**If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?**

- ☐ Not difficult at all      ☐ Very difficult  
☐ Somewhat difficult      ☐ Extremely difficult

### Geriatric Depression Scale -Preceptor (Age 65+)

**During the last two weeks, have you often been bothered?**

I.83 **By about having little interest in doing things?**

- ☐ Yes      ☐ No

I.84 **By feeling down, sad or hopelessness?**

- ☐ Yes      ☐ No



## Arkansas Independent Assessment (ARIA)

↓IF EITHER ANSWER IS YES, ANSWER THE QUESTIONS BELOW. ↓

### Geriatric Depression Scale (Age 65+)

During the last two weeks, have you often been bothered?

- I.85 Are you basically satisfied with your life?  
☐ Yes ☐ No
- I.86 Have you dropped many of your activities?  
☐ Yes ☐ No
- I.87 Do you feel that your life is empty?  
☐ Yes ☐ No
- I.88 Do you often get bored?  
☐ Yes ☐ No
- I.89 Are you in good spirits most of the time?  
☐ Yes ☐ No
- I.90 Been bothered of being afraid of something bad?  
☐ Yes ☐ No
- I.91 Do you feel happy most of the time?  
☐ Yes ☐ No
- I.92 Do you often feel helpless?  
☐ Yes ☐ No
- I.93 Prefer to stay at home, then go out?  
☐ Yes ☐ No
- I.94 Do you feel you have more problems with memory than most?  
☐ Yes ☐ No
- I.95 Do you think it is wonderful to be alive now?  
☐ Yes ☐ No
- I.96 Do you feel pretty worthless?  
☐ Yes ☐ No
- I.97 Do you feel full of energy?  
☐ Yes ☐ No
- I.98 Do you feel that your situation is hopeless?  
☐ Yes ☐ No
- I.99 Do you think that most people are better off than you are?  
☐ Yes ☐ No

### Pediatric Symptom Checklist (PSC-17) (Ages 4 - 17)

- I.100 Have you or another caregiver ever completed a Pediatric Symptom Checklist form at school or in a physician's office?  
☐ Yes ☐ No ☐ Unsure

↓IF ANSWER IS NO OR UNSURE, ASK THE QUESTIONS BELOW. ↓

- I.101 Fidgety, unable to sit still  
☐ Never ☐ Sometimes ☐ Often
- I.102 Feels sad, unhappy  
☐ Never ☐ Sometimes ☐ Often
- I.103 Daydreams too much  
☐ Never ☐ Sometimes ☐ Often



## Arkansas Independent Assessment (ARIA)

- I.104 **Refuses to share**  
☐ Never ☐ Sometimes ☐ Often
- I.105 **Does not understand other people's feelings**  
☐ Never ☐ Sometimes ☐ Often
- I.106 **Feels hopeless**  
☐ Never ☐ Sometimes ☐ Often
- I.107 **Has trouble concentrating**  
☐ Never ☐ Sometimes ☐ Often
- I.108 **Fights with other children**  
☐ Never ☐ Sometimes ☐ Often
- I.109 **Is down on him or herself**  
☐ Never ☐ Sometimes ☐ Often
- I.110 **Blames others for his/her troubles**  
☐ Never ☐ Sometimes ☐ Often
- I.111 **Seems to be having less fun**  
☐ Never ☐ Sometimes ☐ Often
- I.112 **Does not listen to rules**  
☐ Never ☐ Sometimes ☐ Often
- I.113 **Acts as if driven by a motor**  
☐ Never ☐ Sometimes ☐ Often
- I.114 **Teases others**  
☐ Never ☐ Sometimes ☐ Often
- I.115 **Worries a lot**  
☐ Never ☐ Sometimes ☐ Often
- I.116 **Takes things that do not belong to him/her**  
☐ Never ☐ Sometimes ☐ Often
- I.117 **Distracted easily**  
☐ Never ☐ Sometimes ☐ Often

### Suicide Screen

- I.118 **Have you thought about hurting yourself or taking your life?**  
☐ No ☐ Yes-within last 30 days  
☐ Person unable to respond or refuses to answer ☐ Yes - greater than 30 days  
☐ Yes-now

**IF "YES-NOW" OR "YES – WITHIN LAST 30 DAYS" ARE SELECTED FOR I.118, ASK THE REMAINDER OF THE SUICIDE SCREEN SECTION:**

- I.119 **Do you have a plan?**  
☐ No  
☐ Yes – contact a mental health professional immediately  
☐ Person unable to respond or refused to answer



## Arkansas Independent Assessment (ARIA)

I.120 **Do you have the means or some way to carry out your plan?**

- ☐ No  
☐ Yes – contact a mental health professional immediately  
☐ Person unable to respond or refused to answer

I.121 **Do you have a time planned that you will do this?**

- ☐ No  
☐ Yes – contact a mental health professional immediately  
☐ Person unable to respond or refused to answer

### Alcohol/Substance Abuse (Age >=12)

I.122 **Do you currently drink alcoholic beverages like beer, wine or liquor?**

- ☐ No  
☐ Yes  
☐ Sometimes  
☐ Choose not to answer

**IF “YES” OR “SOMETIMES” ARE SELECTED FOR I.122, ASK THE REMAINDER OF THE ALCOHOL USE SECTION:**

I.123 **How frequently do you drink alcoholic beverages?**

- ☐ Daily ☐ Once a month or less  
☐ 1-3 times per week ☐ Rarely  
☐ 4-6 times per week ☐ Chose not to answer

I.124 **Within the last year, has drinking affected your job, family life and friendships or caused legal problems?**

- ☐ Yes ☐ No ☐ Choose not to answer

**If yes, please explain** *(Please provide supporting documentation of substance, amount, and frequency.)*

**↓ If “Yes” answered for I.124 above, ask the Alcohol CAGE questions below: ↓**

### Alcohol CAGE Questionnaire

I.125 **Have you felt you should cut down on your drinking?**

- ☐ No ☐ Yes ☐ Chose not to answer

I.126 **Have people annoyed you by criticizing your drinking?**

- ☐ No ☐ Yes ☐ Chose not to answer

I.127 **Have you ever felt bad or Guilty about your drinking?**

- ☐ No ☐ Yes ☐ Chose not to answer



## Arkansas Independent Assessment (ARIA)

I.128 **Have you had a drink first thing in the morning to steady your nerves or to get rid of a hangover (eye opener)?**

☐ No ☐ Yes ☐ Chose not to answer

### Substance Abuse (Age 12+)

I.129 **Does the person currently use any street/illegal drugs (i.e. methamphetamine, speed, marijuana) or misuse/abuse prescription?**

☐ No ☐ Yes ☐ Sometimes ☐ Chose not to answer

I.130 **Within the last year, has your substance use affected your job, family life and friendships or caused legal problems?**

☐ No ☐ Yes ☐ Chose not to answer

---

**If yes, please explain** *(Please provide supporting documentation of substance, amount, and frequency)*

**IF “YES” ANSWERED FOR I.130 ABOVE, ASK THE SUBSTANCE ABUSE CAGE QUESTIONS BELOW:**

I.131 **Have you felt you should Cut down on your drug use?**

☐ No ☐ Yes ☐ Chose not to answer

I.132 **Have people annoyed you by criticizing your drug use?**

☐ No ☐ Yes ☐ Chose not to answer

I.133 **Have you ever felt bad or Guilty about your drug use?**

☐ No ☐ Yes ☐ Chose not to answer

I.134 **Have you gotten high first thing in the morning to steady your nerves or to help you feel better (eye opener)?**

☐ No ☐ Yes ☐ Chose not to answer

## J. Memory & Cognition

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### Functional Memory & Cognition

J.1 **Does the person have a problem with cognitive functioning due to developmental disabilities or related condition, which manifested itself during the developmental period (birth through age 21) by report or by review of psychological testing results?**

☐ No ☐ Undetermined ☐ Yes – Due to developmental disabilities

J.2 **If Undetermined, Referral for testing?**

☐ Need referral ☐ Referral made - waiting testing results

J.3 **Does the person have a documented diagnosis of brain injury or related neurological condition that is not congenital?**

☐ No ☐ Yes



## Arkansas Independent Assessment (ARIA)

**IF YES ANSWERED FOR J.3 ABOVE, CHOOSE ONE FROM J.4 BELOW**

J.4 **Choose one:**

- ☐ Acquired or traumatic brain injury
- ☐ Degenerative or genetic disease that became symptomatic on or after the person's 18<sup>th</sup> birthday

J.5 **What is the diagnosis?**

---

### Diagnosis

J.6 **Rancho Los Amigos Level of Cognitive Fn? Only complete if client has traumatic or acquired brain injury.**

- |  |   |
|--|---|
| <input type="checkbox"/> Person is completely unresponsive to stimuli  | <input type="checkbox"/> Person shows goal directed behavior but depends on external input for direction  |
| <input type="checkbox"/> Person reacts inconsistently and non-purposefully to stimuli  | <input type="checkbox"/> Person goes through daily routine automatically, has absent to minimal confusion, but lacks insight  |
| <input type="checkbox"/> Person responds specifically but inconsistently to stimuli and may follow simple commands   | <input type="checkbox"/> Person is alert and oriented. Independence in the home and community has returned. Social, emotional and cognitive abilities may be decreased. |
| <input type="checkbox"/> Person is in a heightened state of activity with severely decreased ability to process information. Behavior is non-purposeful relative to the immediate environment. |   |
| <input type="checkbox"/> Person appears alert and responds to simple commands fairly consistently. Agitation, which is out of proportion (But directly related to stimuli), may be evident.    |   |

---

### Notes/Comments

#### Mental Status Evaluation

J.7 **Now, I'm going to read you a list of questions. These are questions that are often asked in interviews like this, and we are asking them the same way to everyone. Some may be easy, and some may be difficult. Would this be alright?**

☐ No ☐ Yes ☐ Refused



## Arkansas Independent Assessment (ARIA)

**IF YES, FOR EACH OF THE QUESTIONS BELOW, ENTER THE NUMBER OF ERRORS THE INDIVIDUAL MAKES. PLEASE NOTE THE MAXIMUM ALLOWED FOR EACH QUESTION**

J.8 **LET'S START WITH TODAY'S DATE. What year is it now? Maximum Error = 1**

- ☐ Answered Correctly  
☐ Answered Incorrectly

J.9 **What month is it now? Maximum Error = 1**

- ☐ Answered Correctly  
☐ Answered Incorrectly

J.10 **Memory Phase: Ask beneficiary to repeat phrase after you TWICE:**

John Brown, 42 Market Street, Chicago

---

J.11 **About what time is it? (within 1 hour) Maximum errors = 1**

- ☐ Answered Correctly  
☐ Answered Incorrectly

J.12 **Count backwards 20 to 1 Maximum Errors = 2**

- ☐ Answered Correctly  
☐ Answered Incorrectly  
☐ Answered Incorrectly Twice

J.13 **Say the months in reverse order. Maximum Errors = 2**

- ☐ Answered Correctly  
☐ Answered Incorrectly Once  
☐ Answered Incorrectly Twice

J.14 **Ask beneficiary to repeat memory phrase above**

Repeat the memory phrase (once) **Maximum Errors = 5**

- ☐ Answered Correctly  
☐ Answered Incorrectly Once  
☐ Answered Incorrectly Twice  
☐ Answered Incorrectly Thrice  
☐ Answered Incorrectly 4 times  
☐ Answered Incorrectly 5 times

**Please provide supporting documentation.**

---

**Comments**



# Arkansas Independent Assessment (ARIA)

## Types of Supports Needed

- J.15 **What type of support does the person need in the home to remain safe, such as assistance with activities that require remembering, decision-making or judgment?**
- ☐ Someone else needs to be with the person always to observe or provide supervision.
- ☐ Someone else needs to be around always, but they only need to check on the person now and then.
- ☐ Sometimes the person can be left alone for an hour or two.
- ☐ Sometimes the person can be left alone for most of the day.
- ☐ The person can be left alone all day and all night, but someone needs to check in on the person every day.
- ☐ The person can be left alone without anyone checking in.
- J.16 **What type of support does the person need away from home to remain safe, such as assistance with activities that require remembering, decision-making, or judgment?**
- ☐ The person requires intense support when leaving home because of behavioral difficulties (becomes very confused or agitated during outings, engages in inappropriate behavior, becomes aggressive etc.)
- ☐ Someone always needs to be with the person to help with remembering, decision making or judgment when away from home.
- ☐ The person can go places alone as long as they are familiar places
- ☐ The person does not need help going anywhere
- Please provide supporting documentation.**

## Comments

### K. Sensory & Communication

[Return to Index](#)

#### Vision

- K.1 **Does the person have any problems with their vision?**
- ☐ No ☐ Yes ☐ Chose not to answer
- IF K.1 IS YES, PLEASE COMPLETE THE REMAINDER OF THE VISION SECTION:**
- K.2 **Describe your vision WITHOUT the use of an assistive device.**
- ☐ *Adequate:* Can read regular print in books or newspapers
- ☐ *Minimally Limited:* Can read regular print but may have decreased peripheral vision; may not read regular print but can read headlines or large print.
- ☐ *Moderately Limited:* Must have large print to read; has difficulty identifying small objects; vision has limited usefulness for navigation.
- ☐ *Severely Limited:* Sees primary lights and shadows; has significantly restricted field vision; or no useful vision.
- K.3 **Does the person use any assistive device to help with their vision?**
- ☐ No ☐ Yes ☐ Chose not to answer





## Arkansas Independent Assessment (ARIA)

---

**IF K.3 IS YES, ASK K.4 BELOW**

**K.4 Describe your vision WITH the use of an assistive device.**

☐ *Adequate*: Can read regular print in books or newspapers

☐ *Minimally Limited*: Can read regular print but may have decreased peripheral vision; may not read regular print but can read headlines or large print

☐ *Moderately Limited*: Must have large print to read; has difficulty identifying small objects; vision has limited usefulness for navigation

☐ *Severely Limited*: Sees primary lights and shadows; has significantly restricted field vision; or no useful vision

**Please provide supporting documentation.**

---

### Comments

**K.5 Does the person have any problems with their hearing?**

☐ No ☐ Yes ☐ Chose not to answer

**K.6 Describe your hearing WITHOUT use of an assistive device.**

☐ *Normal*

☐ *Minimally Impaired*: Difficulty in 1:1 conversation with some people and/or in noisy environments.

☐ *Moderately Impaired*: Some useful hearing; using own speech to make needs and wants known.

☐ *Highly Impaired*: May hear loud sounds; identifying source and allocation of sound may be difficult; relies on visual means for understanding others (sign language, written language, speech reading, captioning on television)

☐ *Severely Impaired*: No useful hearing

☐ *Unknown*

**K.7 Does the person use any assistive devices to help with their hearing?**

☐ No

☐ No-uses interpreter

☐ Yes

☐ Chose not to answer



## Arkansas Independent Assessment (ARIA)

K.8 **Describe your hearing WITH use of an assistive device.**

☐ *Normal*

☐ *Minimally Impaired* – difficulty 1:1 conversation with some people and/or in noisy environments.

☐ *Moderately Impaired* – Overall useful hearing; uses own speech to make needs and wants known.

☐ *Highly Impaired* – may not hear loud sounds; identifying source and location of sound may be difficult; relies on visual means for understanding (sign language, written language, speech reading, captioning on television)

☐ *Severely Impaired* – No useful hearing.

**Please provide supporting documentation.**

---

### Comments

#### Functional Communication

K.9 **Does the person have difficulty communicating with and | or making their wants and needs known to others?**

☐ No ☐ Yes ☐ Chose not to answer

**IF K.9 IS YES, PLEASE COMPLETE THE REMAINDER OF THE FUNCTIONAL COMMUNICATION SECTION:**

K.10 **What type of difficulty does the person have? (check all that apply):**

☐ Delayed expressive language

☐ No functional communication

☐ No functional expressive language

☐ Non-verbal

☐ Receptive language impairment (inability to comprehend spoken language)

☐ Speech impairment (articulation)

☐ Speech impairment (functional expressive language)

K.11 **What is the primary cause of the difficulties you identified?**

☐ Cognitive issues (delayed | disordered development)

☐ Deaf

☐ Motor issues (cerebral palsy, act)

☐ Neurological issues (e.g., seizures, aphasia, apraxia)

☐ Physical | medical issues (e.g., after a laryngectomy)

☐ Other

**Please provide supporting documentation.**

---

**If Other, please explain**



## Arkansas Independent Assessment (ARIA)

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- K.12 **Expressive Communication Skills** (*How does the person communicate with others? This means their functional ability to communicate with others.*)
- |  |   |
|--|---|
| <input type="checkbox"/> No impairment                                   | <input type="checkbox"/> Uses single signs or gestures to express wants and needs |
| <input type="checkbox"/> Speech intelligible to familiar listeners       | <input type="checkbox"/> Uses augmentative communication                          |
| <input type="checkbox"/> Speech difficult to understand                  | <input type="checkbox"/> Does not have functional expressive language             |
| <input type="checkbox"/> Combines signs and   or gestures to communicate |   |

- K.13 **Receptive Communication Skills** (*How does the person understand others? This means their functional ability to understand others.*)
- |  |   |
|--|---|
| <input type="checkbox"/> Comprehends conversational Speech                         | <input type="checkbox"/> Comprehends signs   gestures   modeling prompts              |
| <input type="checkbox"/> Comprehends phrases with gestural cues   modeling prompts | <input type="checkbox"/> Does not comprehend verbal, visual or gestural communication |
| <input type="checkbox"/> Limited Comprehension - one or two words                  |   |

**Please provide supporting documentation.**

---

### Comments

- K.14 **Does the person currently receive speech and language therapy?**  
☐ No ☐ Yes ☐ Chose not to answer  
**Please provide supporting documentation.**

---

### Comments

**IF K.14 IS YES, ASK K.15 BELOW:**

- K.15 **Does the person use some form of sign language to communicate?**  
☐ No ☐ Yes ☐ Chose not to answer



## Arkansas Independent Assessment (ARIA)

---

**IF K.15 IS YES, ASK K.16 BELOW:**

K.16 **What types of sign language do you use?**

- |   |  |
|---|--|
| <input type="checkbox"/> American Sign Language                               | <input type="checkbox"/> Limited or Close Vision Signing   |
| <input type="checkbox"/> Baby sign  | <input type="checkbox"/> Manual alphabet (finger spelling) |
| <input type="checkbox"/> Emoticon+Bodicon (Facial expression + body language) | <input type="checkbox"/> Signed English                    |
| <input type="checkbox"/> Home signs, gestures                                 | <input type="checkbox"/> Tactile (hand in hand) signing    |
| <input type="checkbox"/> International sign language                          | <input type="checkbox"/> Other                             |

**Please provide supporting documentation.**

---

**If Other, please explain**

K.17 **Does the person use visual language, other than sign language to communicate?**

- ☐ No ☐ Yes ☐ Chose not to answer

**IF K.17 IS YES, ASK K.18 BELOW:**

K.18 **What type?**

- ☐ Cued speech  
☐ Speech reading  
☐ Writing or typing  
☐ Other

**Please provide supporting documentation.**

---

**If Other, please explain**

K.19 **Facilitated communication (also known as supported typing) is a form of augmentative and alternative communication in which someone PHYSICALLY SUPPORTS ANOTHER PERSON and helps them to point at pictures or words.**

- ☐ No ☐ Yes ☐ Chose not to answer

K.20 **Uses augmentative communication device? This includes methods to supplement or replace speech or writing for those with impairments in speaking or comprehending spoken or written language.**

- ☐ No ☐ Yes ☐ Chose not to answer



## Arkansas Independent Assessment (ARIA)

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**IF K.20 IS YES, ASK K.21 BELOW:**

**K.21 What type of device?**

- |  |  |
|--|--|
| <input type="checkbox"/> Alpha Smart                 | <input type="checkbox"/> PECS                          |
| <input type="checkbox"/> Alpha Talker                | <input type="checkbox"/> Pocket Talker                 |
| <input type="checkbox"/> Artificial Larynx           | <input type="checkbox"/> Speak Easy                    |
| <input type="checkbox"/> Big mac Switch              | <input type="checkbox"/> TTY                           |
| <input type="checkbox"/> Braille Screen Communicator | <input type="checkbox"/> Voice Photo Album             |
| <input type="checkbox"/> Cheap talk                  | <input type="checkbox"/> Voice Recognition Software    |
| <input type="checkbox"/> Dynamite                    | <input type="checkbox"/> Other Personal Listing Device |
| <input type="checkbox"/> Dynavox                     | <input type="checkbox"/> Other picture systems         |
| <input type="checkbox"/> Electric output device      | <input type="checkbox"/> Other                         |
| <input type="checkbox"/> Link Assistive Device       |  |
| <input type="checkbox"/> Mini Message Mate           |  |

**Please provide supporting documentation.**

---

**If Other, please explain**

**K.22 Condition where multisensory integration is not adequately processed in order to provide appropriate responses to the demands of the environment, making it difficult to use the body effectively within the environment.**

☐ No ☐ Yes ☐ Chose not to answer

**Please provide supporting documentation.**

---

**If Yes, please explain**

**K.23 Does the person have a Hypersensitivity Diagnosis – are they overly sensitive to sensory stimulation (touch, taste, smell, movement, hearing, vision)?**

☐ No ☐ Yes ☐ Chose not to answer

**Please provide supporting documentation.**

---

**If Yes, please explain**

**K.24 Does the person use assistive devices or other interventions help with sensory integration?**

☐ No ☐ Yes ☐ Chose not to answer



## Arkansas Independent Assessment (ARIA)

**IF K.24 IS YES, CHECK ALL THAT APPLY FOR K.25 BELOW:**

K.25

**Check all that apply.**

- ☐ Noise cancelling headphones
- ☐ Occupational therapy
- ☐ Safety ear plugs
- ☐ Sensory diet / menu for gaining behavioral control
- ☐ Other device
- ☐ Other intervention

**Please provide supporting documentation.**

---

*If Other device, please explain*

**Please provide supporting documentation.**

---

*If Other intervention, please explain*

K.26

**Any issues related to sensory input? Does the person experience any of the following issues related to sensory input?**

- |  |   |
|--|---|
| <input type="checkbox"/> Appear to hear adequately, but have a delayed response to sounds / speech                     | <input type="checkbox"/> More clumsy or careless than peers                             |
| <input type="checkbox"/> Can't keep hands to self  | <input type="checkbox"/> Overly sensitive to touch, movement, sights, lights, or sounds |
| <input type="checkbox"/> Difficulty keeping tongue in mouth, put hands/fingers in mouth frequently                     | <input type="checkbox"/> Poor balance   |
| <input type="checkbox"/> Difficulty making transitions from one situation to another                                   | <input type="checkbox"/> Prefer activities that involve swinging, spinning, rocking     |
| <input type="checkbox"/> Difficulty screening out sights and sounds (visual/auditory stimuli)                          | <input type="checkbox"/> Reject textures of food, clothing                              |
| <input type="checkbox"/> Difficulty unwinding or calming self  | <input type="checkbox"/> Respond to loud or unexpected noise by becoming upset          |
| <input type="checkbox"/> Engage in self-injury   | <input type="checkbox"/> Rock self to sleep, in frustration, in comfort, in excitement  |
| <input type="checkbox"/> Engage in self-stimulation  | <input type="checkbox"/> Smell objects  |
| <input type="checkbox"/> Fearful of activities moving through space, such as using an escalator, climbing stairs, etc. | <input type="checkbox"/> Under-reactive to touch, movement, sights, or sounds           |
| <input type="checkbox"/> Fearful of new tasks and situations   | <input type="checkbox"/> Unusually high activity level                                  |
| <input type="checkbox"/> Grind, clench teeth   | <input type="checkbox"/> Unusually low activity level                                   |
| <input type="checkbox"/> Make repetitive vocal sounds – such as humming, throat-clearing, frequent coughing            | <input type="checkbox"/> Unusual reaction to pain – doesn't seem to notice              |
| <input type="checkbox"/> Misjudge force required to open and close doors, give hugs, etc.                              | <input type="checkbox"/> Unusual reaction to pain – particularly noticeable reaction    |
|  | <input type="checkbox"/> Walk on toes   |
|  | <input type="checkbox"/> Other  |

**Please provide supporting documentation.**

---

**If Other, please explain**



## Arkansas Independent Assessment (ARIA)

### L. Safety/Self Preservation

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Self-Preservation: Consider age appropriateness when answering all questions

- L.1 **BH Assessments ONLY- Does the person requires a 24-hour plan of care that includes a back-up plan that reasonably assures their health and safety in the community?**
- ☐ No – Person accesses supports as needed  
☐ No – Person requires some services; doesn't require a 24-hour Plan of Care  
☐ Yes  
☐ Unknown
- ↓IF L.1 IS YES, ASK L.2 BELOW AND COMPLETE. ↓**
- L.2 **BH Assessments ONLY - Which of the following items does the 24-Hour Plan require?**
- ☐ Awake supervision  
☐ Formal behavior support
- L.3 **Does the person have the judgment and physical ability to cope, make appropriate decisions and take action in a changing environment or a potentially harmful situation?**
- ☐ Independent ☐ Physically unable  
☐ Minimal supervision (verbal/physical prompts for preservation) ☐ Both mentally and physically unable  
☐ Mentally unable
- L.4 **This person is at risk of self-neglect?**  
(Consider the examples below under Check all that apply. In the absence of a guardian or other person, would this client be at risk of neglecting self?)
- ☐ No ☐ Yes
- L.5 **Check all that apply:**
- ☐ Alcohol and/or other drug use leading to health or safety concerns  
☐ Behaviors that pose a threat of harm to self or others  
☐ Dehydration or malnutrition  
☐ Hygiene that may compromise health  
☐ Impairment of orientation, memory, reasoning and/or judgment  
☐ Inability to manage funds that may result in negative consequences  
☐ Inability to manage medications or to seek medical treatment that may threaten health or safety  
☐ Unsafe/unhealthy living conditions  
☐ Other



## Arkansas Independent Assessment (ARIA)

**L.6 This person is at risk of neglect, abuse by others?**

*(This is due to the fact that the client must rely on someone else for self-care (including living in an institutional setting), thus placing them at risk of abuse, neglect, or exploitation.)*

☐ No ☐ Yes

**Other type of risk of self-neglect**

**Please provide supporting documentation.**

### M. Caregiver

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M.1

***First and Last Name***

M.2 **Relationship**

*(For DDS Population, If the value of Subdivision 5 or 6 Intermediate Care Facility is selected in the Relationship field, no need to fill rest of questions, please save record)*

☐ Parent

☐ Guardian/Legal Representative

☐ Child

☐ Subdivision 5 or 6 Intermediate Care Facility

☐ Spouse/Significant Other/Partner ☐ Other

**Please provide supporting documentation.**

***If Other, please explain***

M.3 **Does client receive 24-hour 7 days a week one-on-one direct care staff under the waiver or personal care services?**

☐ Yes

☐ No

☐ Not applicable: BH

☐ Not applicable: DAAS

M.4 **Does the unpaid caregiver currently live in the same household as the INDIVIDUAL who needs care?**

☐ No ☐ Yes ☐ Chose not to answer

**Please provide supporting documentation.**

***If Yes, please explain***





## Arkansas Independent Assessment (ARIA)

---

M.5 **What kind of help does the unpaid caregiver give this individual?**

- |   |  |
|---|--|
| <input type="checkbox"/> None   | <input type="checkbox"/> Paperwork like filing insurance claims or handling legal matter |
| <input type="checkbox"/> Arranging   Coordinating care, including clinic visits, etc. | <input type="checkbox"/> Personal care (such as bathing, dressing, toileting, etc.)      |
| <input type="checkbox"/> Housekeeping (such as meal preparation, cleaning & laundry)  | <input type="checkbox"/> Shopping and errands  |
| <input type="checkbox"/> Managing medications (like helping set up)                   | <input type="checkbox"/> Supervision for safety  |
| <input type="checkbox"/> Money management   | <input type="checkbox"/> Transportation  |
| <input type="checkbox"/> Monitoring health (like blood pressure or diabetes)          | <input type="checkbox"/> Other   |

**Please provide supporting documentation.**

---

**If Other, please explain**

M.6 **Does the unpaid caregiver or other family have concerns about the individual's memory, thinking or ability to make decisions?**

☐ No ☐ Yes ☐ Chose not to answer

**Please provide supporting documentation.**

---

**If Yes, please explain**

**IF M.6 IS YES ANSWER M.7**

M.7 **Is the unpaid caregiver very concerned or somewhat concerned about the client?**

- ☐ Very concerned  
☐ Somewhat concerned

M.8 **Are there any safety concerns that the unpaid caregiver has about this client or their home environment?**

☐ No ☐ Yes ☐ Chose not to answer

**Please provide supporting documentation.**

---

**If Yes, please explain**

M.9 **Given the client's CURRENT CONDITION, has the unpaid caregiver ever considered placing client in a different type of care setting, such as a nursing home or another care facility for long-term placement?**

- ☐ Probably not  
☐ Definitely not  
☐ Probably would  
☐ Definitely would  
☐ Does not apply – individual is in care facility



## Arkansas Independent Assessment (ARIA)

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- M.10 **How would you (the unpaid caregiver) describe your own health?**  
☐ Excellent  
☐ Good  
☐ Fair  
☐ Poor  
☐ Chose not to answer
- M.11 **Does the unpaid caregiver's health problems ever get in the way of providing care?**  
☐ No ☐ Yes ☐ Chose not to answer
- M.12 **How would the unpaid caregiver rate his/her level of stress related to caring for this individual?**  
☐ None  
☐ Low  
☐ Medium  
☐ High  
☐ Unsure  
☐ Chose not to answer
- M.13 **Does the unpaid caregiver have difficulty getting a good night's sleep, 3 or more times a week as a result of caring for this client?**  
☐ No  
☐ Yes  
☐ Sometimes  
☐ Chose not to answer
- M.14 **Is the care the unpaid caregiver provides impacting his/her ability to be employed as a result of caring for this client?**  
☐ Working full time  
☐ Yes, I can only work Part Time  
☐ No I can't work at all  
☐ N/A
- M.15 **Does the unpaid caregiver have anyone to help with caregiving? This is unpaid assistance, not a provider**  
☐ No ☐ Yes ☐ Chose not to answer  
**↓IF M.15 IS YES, ASK QUESTION M.16 BELOW: ↓**
- M.16 **Can the unpaid caregiver depend on this person to help when needed?**  
☐ No  
☐ Yes  
☐ Unsure  
☐ Chose not to answer  
**Please provide supporting documentation.**

---

**If No, please explain**



## Arkansas Independent Assessment (ARIA)

- M.17 **Is the unpaid caregiver currently receiving any caregiver support (e.g., respite, training or education, caregiver coaching or counseling or support groups)?**

☐ No ☐ Yes ☐ Chose not to answer

**Please provide supporting documentation.**

---

**If Yes, please explain**

- M.18 **Are there any issues | obstacles that make it more difficult for the unpaid caregiver to provide support to the individual?**

☐ No ☐ Yes ☐ Chose not to answer

**↓ IF M.18 IS YES, CHECK ALL THAT APPLY: ↓**

- M.19 **Check all that apply:**

- ☐ Information
- ☐ Education or training (direct care skills, disease process)
- ☐ Help managing his | her memory care or behavior issues
- ☐ Help managing his | her care needs (medications, treatments)
- ☐ Help with finances
- ☐ Finding time for myself (respite, breaks from caregivers)
- ☐ One-to-one coaching or counseling
- ☐ Developing an informal network of support
- ☐ Dealing with family relationships and communications
- ☐ Home | Safety modifications
- ☐ Technology and assistive devices
- ☐ Hiring my own help
- ☐ Balancing work, family and caregiving responsibilities
- ☐ Help with chemical or mental health issues for myself
- ☐ Other

**Please provide supporting documentation.**

---

**If Other, please explain**

- M.20 **On an average day, how many hours do you provide care for this individual PER DAY (If child, ask about variances in schedule for school vs non-school schedule.)**

- ☐ 0-4 hours of care
- ☐ 4.1 – 8 hours of care
- ☐ 8.1 – 16 hours of care
- ☐ 16.1 – 23 hours of care
- ☐ 24 hours of care

- M.21 **On average, how many days per week do you provide care for this individual? Please consider times for work week vs weekend.**

- ☐ less than 2 days per week
- ☐ 3-4 days per week
- ☐ 5-6 days per week
- ☐ 7 days per week



## Arkansas Independent Assessment (ARIA)

M.22 Please provide supporting documentation.

### Comments

#### N. Employment

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Employment: (Ages  $\geq$  13-64)

N.1 Has your school team discussed plans to begin exploring your work, volunteer or post-secondary education options? (Ages 13-21)

☐ No ☐ Yes ☐ Chose not to answer

↓IF N.1 IS NO, ASK N.2 BELOW: ↓

N.2 Do you know referral to Vocational Rehabilitation is an option, even while they attend high school? (Ages 13-21)

☐ No ☐ Yes ☐ Chose not to answer

N.3 Describe planning efforts such as employment goals included on IEP, etc. (Ages 13-21)

### Comments

N.4 Is the person currently employed? (Ages 13-64)

☐ No ☐ Yes ☐ Chose not to answer ☐ N/A

↓IF N.4 IS NO, ASK N.5 BELOW↓

↓IF N.4 IS YES ASK N.6BELOW↓

N.5 Which statement best describes your status at this time?

☐ Unemployed: looking for work

☐ Unemployed: not looking for work - If unemployed and not looking for work, please explain:

☐ Retired

*If unemployed and not looking for work, please provide supporting documentation*

### Comments



## Arkansas Independent Assessment (ARIA)

### Type of Employment

N.6

#### Type of employment:

- ☐ Center-based sheltered employment | activity
- ☐ Competitive – with job support | coaching
- ☐ Competitive – without job support
- ☐ Educational Program
- ☐ Self-employed – with job support
- ☐ Self-employment – without job support
- ☐ Supported work in an enclave | group | crew setting
- ☐ Other

---

*Name of agency/contact*

---

*If Other, please provide supporting documentation*

### O. Quality of Life

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#### Routines and Preferences

O.1 What is a typical day like for you?

O.2 What are some things you enjoy doing?

O.3 How do you want to spend your time?

O.4 Do you like where you live?

☐ No ☐ Yes ☐ Chose not to answer

**If No, please explain**



## Arkansas Independent Assessment (ARIA)

### Strengths and Accomplishments

O.5 What are some of the things you feel you are good at doing?

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Notes/Comments

### SUPPORTS, FAMILY, FRIENDS, AND OTHERS

O.6 Who are some people you enjoy spending time with?  
Supports-Family, Friends and Others?

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### Future Plans

O.7 What would you like for yourself in the future?

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Notes/Comments