ICAP QUICK REFERENCE SHEET

The ICAP is completed as required for Level of Care and eligibility and updated every 3 years or when significant changes occur and/or as directed by the ISP team. All people who receive services from a Community Support Provider (CSP), a Service Provider (SP), the Family Support waiver or an Intermediate Care Facility for Intellectual Disability (ICF/ID) require an ICAP be completed.

Cover Page - Fill out cover page information completely assuring the name and number of the case manager and/or respondent is complete in the event follow up questions are required. Evaluation Date – Start with the year, then month, then day of evaluation. Update any time changes are made to the ICAP. Important to write the date of birth as the ICAP is an age-related tool

SECTIONS

A. Descriptive Information
Complete all areas.

7. Primary Means of Expression - cross reference with Section D Adaptive Behavior; Social and Communication.

9. Legal Status – Parent is Guardian for a person under 18 unless parental rights have been restricted. Persons over 18 are Legally Competent Adults unless the Courts have ordered someone to be Guardian. Keep all Guardianship documents in central file.

B. Diagnostic Status
Primary and Additional Diagnosis – Choose one of the following: Autism; Brain or neurological problem including TBI, FASD, dementia IF IT OCCURRED PRIOR TO AGE 22; CP; Seizures; MR and BIF written in Other if diagnosis and FSIQ between 71 and 85. Validated with psychological evaluations including the diagnosis/level of IQ; Neuropsychological evaluations for brain injuries, FASD, Dementia; comprehensive multidisciplinary reports for Autism Spectrum Disorders and FASD; psychiatric evaluations including the diagnosis for mental illness or situational mental health problems, or a physician's statement saying why medications are prescribed; chemical dependency evaluation for CD; ophthalmology records for blindness; audiological evaluations for deafness; medical and/or neurological reports for seizures along with prescribed anti-seizure medication, Vagus Nerve Stimulator or justification for not taking medication (such as religious beliefs, cons of side effects, etc) CP indicated somewhere in medical record as a definitive diagnosis, preferably around the time of birth or carried over in history from birth records; and for any chronic medical physical health problem, either a statement from the physician, diagnosis written on a prescription or something the physician has noted should remain in the file regardless how long ago it was recorded as long as it is still accurate for today.

Do not write anything in 13. **Other** unless the person has a diagnosis of BIF or the need for nursing in Section C, category 6 is more than Less than Monthly. All other diagnostic and

valuable information can be written in the comment box. When there is more than one primary diagnosis, choose the diagnosis that is the prevalent reflecting the need for DD services. Record all additional diagnosis in appropriate categories. Assure this list is complete and documentation is available for each category selected. Seizure diagnosis must also have a medication recorded in Section C. Current Medications in category 4 for Epilepsy, seizures unless seizures are controlled by a Vagus Nerve Stimulator or justification for not taking medication (such as religious beliefs, cons of side effects, etc.) is noted. Cross reference Health problems and Mental and Situational Mental Health problems with Section C. Current medications in category 2 for health and 3 for mental health. Cross reference additional diagnosis of Blindness and Deafness in Section C. Vision and Hearing. Must be recorded little or none if in additional diagnostic category.

C. Functional Limitations and Needed Assistance

1. Level of MR – indicate through most recent psychological evaluation with diagnosis and/or FSIQ score.
2. Vision – Opthamological records.
3. Hearing – Audiologist report

4. Frequency of seizures - Validated through averaging seizure logs from last 30 days, then 90 days, then 12 months prior to the ICAP evaluation date.

5. Health – if the person has health problems aside from and above and beyond stable disabling conditions that involve body organs, indicate the level of limitations in daily activities.

6. Required care - Review all the physician/nurse involvement the person has had in the last 30 days, then 90 days, then last 12 months and count the items that are not routine and are for chronic conditions. Anything non-routine for chronic conditions that are not delegateable are counted as required care.

7. Current Medications - Look at the MAR sheets from the month before the ICAP was completed. Make sure medication that requires a prescription for any one to obtain are categorized in 2, 3 or 4. Medications anyone can buy over the counter without a prescription are recorded in 5 other. Refer to medication manuals if unsure. Listing the name of the medications is optional.

8. Arm/Hand - Validated through review of care plan, OT/PT evals and reports and observation to determine level of assistance required due to limitations in one or both arms. Cross reference Motor Skills Adaptive Behavior.

9. Mobility – On a typical day how does the person move from point A to point B? Cross reference Motor Skills Adaptive Behavior.

10. Mobility Assistance Needed - On a typical day does the person need assistive devices to move from point A to point B? If so, does the person need help from another person sometimes? Would the person never be able to move without someone assisting? Cross reference Personal Living Skills.

Mobility and Mobility Assistance evaluate what is required to move from point A to point B in a typical day. Some examples of movement include from the work station to the cafeteria, from the

parking lot to inside a building, from the kitchen to the bedroom, from a chair to the bed, from a chair to the toilet. Validate through observation, speaking with familiar caregivers, review of care plan and OT/PT records.

All other information related to functional limitations and statements justifying response can be written in the comments box.

D Adaptive Behavior - There are 4 domains or categories in this section rating the person's ability compared to a person without disabilities. The items begin at a developmental stage of a 6-month infant and progress to the final item as skills of mature adults. The first few items in each category are expected developmental milestones beginning at age 6 months to 2 years, the next few are 2 years to 5 years, the next few 5 years to 9 years, then 9 years to 12 years, then 12 years to 15 and the last few items 15 years to adulthood. It is typical to see higher scores at the beginning of the category with a progression of lower scores as the tasks become more involved and difficult.

Scoring options range from zero to three, zero meaning the person is not able to do the task because it is too difficult, it wouldn't be safe, and it's beyond their skill level. Do not give a score for participation in a task if the person does not have the developmental skill to understand the task. Scoring a three means the person knows when to do the task and does the task well without being reminded or the person has mastered the skill and moved on. If the person usually needs to be reminded before completing a task or does the task on their own but not that well, the score is likely a 2. If the person would only complete the task when being reminded and requires some assistance to complete the task the score is likely a 1. Some tasks have more than one item being evaluated such as washing, drying and putting away dishes and states day, month and year of birth. The person must do all parts of the task to score a 3. If the person is not able to do any one part of a task at all, the score is a zero. Stating the day and month of birth but not able to state the year is scored a zero. Washing and drying dishes but requiring a reminder to put them away, is likely scored a 2.

Validation in Adaptive Behavior occurs through observation, performance, talking with familiar caregivers and review of care plan. See ICAP Guidelines for specific considerations for almost all items in each category.

E. Maladaptive Behavior - There are eight categories for documenting problem behavior. The first three, hurtful to self, hurtful to others and destructive to property are indications of aggressive concerns and should only be recorded when harmful or destructive behavior occurs. Only record behaviors you feel compelled to address, stop, prevent or redirect that have occurred in the 90 days prior to the ICAP completion date. Behaviors that require a BSP are recorded from the past 12 months from the ICAP completion date. Behaviors that occurred more than a year ago but are so severe that supports to prevent re-occurrence are still required are recorded in the appropriate category with a frequency of less than monthly.

If a person is displaying behaviors and no one is doing anything to address it, stop it, prevent it or redirect it, don't record it as a problem behavior. Providing direction and assistance with participation due to low adaptive behavior ability should not be considered as a problem behavior.

Do not record more than one behavior in any category. If the person is displaying multiple behaviors in any one category, choose the most frequent and severe. When behaviors have history of escalation with specific components that occur in progression, record as a tantrum, grouped, escalating, cluster, outbursts or some description indicative of happening in a single episode. Write the components of the behavior in progression in parenthesis next to the description ending with the most severe component that has occurred during an episode. Select the behavior category based on the behavior that is most frequent (typically the first component of the episode) and indicate the frequency of occurrence of that component. Severity is scored from the most severe component of the behavior that has occurred in an episode regardless if it occurs during every episode.

Do not record a problem in any category with a frequency of Never and/or severity level of Not Serious, not a problem. Frequency determined by occurrence, Severity level determined by category where all criteria are met in the bulleted items outlined in the ICAP Guidelines. Refer to ICAP Guidelines for further instructions and Severity Criteria. Response to Problem Behaviors: Choose the response based on the most severe behavior recorded. All other information related to problem behaviors can be written in the comments box.

F. Residential Placement
Indicate type of residence, number of people etc, where the person is currently living. Indicate the Recommended Change within two years. If no change recommended, check no change recommended.

G. Daytime Program
Select the Daytime Program where the person spends the majority of their daytime hours. When a person spends time in more than one setting option available, select the setting where the person spends the highest number of hours during a typical week. Indicate the Recommended Change within two years. If no change recommended, check no change recommended.

H. Support Services
Check which services the person is currently receiving. In the second column, check which services not currently receiving but may need. Descriptions of each support service are in the ICAP Guidelines.

I. Social and Leisure Activities
In first column, mark all activities the person has participated in within the last month. In second column, mark factors that limit participating in social activities.

Check yes or no whether the results provide accurate representation of the person and their functioning.