

FOR OFFICE USE ONLY		
<input type="checkbox"/> Approved	<input type="checkbox"/> Denied	<input type="checkbox"/> Approved w/Conditions
SIGNATURE – ALRD		Date

SELF SUPERVISION EVALUATION AND WAIVER REQUEST

The purpose of this evaluation is to determine if a resident is functioning sufficiently independent of supervision and assistance by staff and can benefit from having opportunities to remain in a Community Based Residential Facility (CBRF), unsupervised for specified and limited periods of time. This evaluation is designed to provide a structured means of planning for a resident's movement toward greater independent functioning.

Submission of this completed evaluation constitutes a request for a waiver of the staff coverage requirements specified in DHS 83.36(1)(b)2, Wisconsin Administrative Code, which states, "At least one qualified resident care staff member shall be present in the facility when one or more residents are in the facility." This waiver request must be in the best interest of the resident's development of skills for more independent functioning and not to accommodate staffing schedules.

This evaluation is to be completed by the staff person(s) most familiar with the resident's functioning. It must be completed with the direct participation of the resident. Completion of this form is voluntary.

Name- Resident	Resident Classification	Date Submitted
Name – Facility	Facility Classification	
Address - Facility		
City	Zip Code	Telephone Number

- At the time of application for this waiver, how many other current residents in this facility have been granted a waiver for self-supervision?
- Has a request for this resident been made previously? Yes No If "Yes," explain.
- How many residents do you currently have in your facility?

Except for the questions which ask for a "YES" or "NO" response or a written response, all of the questions in Sections I, II, and III must be answered using one of the following three responses which most accurately describe the resident's ability for each question. Please write the corresponding number for the appropriate response in the space to the left of each question.

1 = Does NOT do

2 = Does with assistance or prompting

3 = Does independently

I. HOME SAFETY AND PERSONAL CARE

a.	Knows his/her name, address, and phone number
b.	Uses the telephone
c.	Carries and uses identification appropriately
d.	Independently structures leisure time activities
e.	Adheres to house rules
f.	Maintains a secure home: -locks doors -keeps strangers out -carries own door key
g.	Communicates his/her needs
h.	Controls own emotions and behavior
i.	Follows directions

j. Has appropriate mobility skills and safety measures in traveling about the neighborhood or community

k. Has ability to provide self-care for minor injuries such as cuts, scrapes, sprains, etc.

II. FIRE SAFETY

a. Recognizes the potential for hazards such as careless use of smoking materials, loose fitting clothes catching on fire when cooking, improper use of combustible liquids.

b. Properly evacuates building without assistance when a fire alarm is sounded. Indicate the amount of time it takes this person to evacuate the building during a fire drill.

c. Can call fire department. NOTE: The fire department number must be attached to a fixed object near the phone.

d. Knows **how** and **where** to contact the facility manager, staff, or other designee when all staff are away from the facility. **Explain** what you have done to ensure that this resident is able to contact someone for help in an emergency.

III. MEDICATIONS

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	a. Is this person currently receiving prescribed medications? If "Yes," respond to questions "b" through "j". If "No," respond to questions "i" and "j"
		b. List current medications, including dosages and times of administration.
<input type="checkbox"/>	<input type="checkbox"/>	c. Would medication during self-supervision periods be necessary? If "No," go to questions "i" and "j."
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	d. Does the person: <ul style="list-style-type: none"> ▪ Control his/her medication container(s)? ▪ Have the facility control the medication container(s)?
<input type="checkbox"/>	<input type="checkbox"/>	e. Recognizes his or her medication containers
<input type="checkbox"/>	<input type="checkbox"/>	f. Knows proper amount of medication
<input type="checkbox"/>	<input type="checkbox"/>	g. Knows proper time(s) to take medication
<input type="checkbox"/>	<input type="checkbox"/>	h. Takes own medication without supervision
<input type="checkbox"/>	<input type="checkbox"/>	i. Is the person subject to seizure activity?
		If "Yes," explain frequency, duration, effect of current control, potential dangers, etc.

j. List any special recommendations or restrictions made by the individual's physician.

Name - Physician

IV. GENERAL INFORMATION REGARDING SELF-SUPERVISION

a. What areas of specific functioning will be improved for this person through self supervision. **Explain.**

b. Are these goals consistent with resident's individualized service plan as required in DHS 83.35(3)a? Yes No

c. Does the person want or need to be left unsupervised? Yes No **Explain.**

d. What activities (entertainment, house responsibilities, leisure time activities in the community, etc.) would the person engage in while unsupervised?

e. What evidence has the person given, in the past, of being responsible enough to be in the house unsupervised? Include examples of unsupervised times at work or travel.

f. Are this resident's behavior characteristics compatible with those of other residents being considered for, or already on, self supervision? **Explain.**

V. RESTRICTIONS

a. Identify the times during each day that the person would be on self supervision.

Day of the Week	Times Requested (e.g., 2PM – 4PM on Tuesdays, 10AM – 11AM Sundays)
Sunday	
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	

- b. What is the maximum continuous period of time that this resident would be left unsupervised?
- c. List any limits to this person’s activities when on self supervision. (e.g., no smoking, no cooking, no alcoholic beverages)

VI. SIGNATURES

Attestation - Resident

I (the resident) am aware of my responsibilities and the privileges extended to me by this evaluation. I understand and agree to all of the listed restrictions placed upon me during the period of unsupervised time in the home as well as all other current house rules. I also understand and agree that any violation of these restrictions, prior to a re-evaluation, automatically terminates my ability to remain in the home unsupervised until such time as a new evaluation is initiated.

SIGNATURE - Resident	Date Signed
SIGNATURE – County Case Worker Completing This Form	Date Signed
SIGNATURE - Person(s) Completing This Form	Date Signed

Attestation - Legal Guardian

I acknowledge that this evaluation in no way relieves me of my responsibilities or rights as a guardian for _____ . I do agree that the evaluation, as presented, is in keeping with his or her right to training for greater independence and self-responsibility.

SIGNATURE – Guardian	Date Signed
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Attestation - Licensee

I (the licensee) agree with the evaluation as being a true and accurate description of the resident's functioning, and with the restrictions placed upon the resident during his/her unsupervised time in the home. I understand that the approval of this waiver request by the Division of Quality Assurance does not relieve me of my responsibility for the health, safety, and welfare of the resident identified in this evaluation while he/she is on self-supervision.

SIGNATURE – Licensee	Date Signed
SIGNATURE – Administrator (if different from licensee)	Date Signed