DDRC
Developmental Disabilities Resource Center
Quality • Dignity • Choice

Family Support
Most In Need (MIN) Assessment

Name of Individual: _____ DOB:_____
Form Completed By: _____
Relationship to Individual: _____ Delay/Diagnosis: _____

Instructions: In each section below, please check the option that you feel best describes your family member's intellectual/developmental disability (I/DD) or developmental delay. There should be one check mark in the "Needs" area and one in the "Resources" area for each section. The number to the left is the score for each option. Your Resources score subtracted from your Needs score equals your score for that section.

Please check which resources family members in the home receive, and consider those resources when completing this form:

Home and Community Based Services Medicaid Waiver CES ☐ SLS ☐ EBD ☐ CWA ☐ CHCBS ☐ CLLI ☐ BI ☐ SCI ☐					
☐	Private health insurance	☐	Early Intervention (0 thru 2)	☐	Family Income
☐	Medicaid	☐	WIC	☐	LEAP
☐	Medicaid Buy-In Program	☐	Home Care Allowance (HCA)	☐	TANF
☐	Child Health Plan Plus (CHP+)	☐	Quest Card	☐	Section 8 Housing
☐	SSI	☐	Commodities	☐	Special Needs Trust

Mobility

Needs

Consider balance, coordination, amount of assistance needed for mobility/transfers; compare to typical development, consistent with age

0☐	Person can walk independently; mobility is not limited, person has full use of hands and feet.
1☐	Person can walk with some assistance, has use of hands and feet.
2☐	Limited use of hands and feet; person is unable to walk; person can partially assist with transfers; weight/size is not a problem.
3☐	Person is unable to walk or move around alone; unable to assist with transfers or weight/size makes transfers difficult.
Comments:	

Resources

Consider access to adaptive equipment, therapies, support from others/agencies, funding sources

4☐	No needs in this area. This is not an area of need for our family member.
3☐	Needs are completely met. We are easily able to meet this need with the resources checked above and/or natural supports.
2☐	Needs are adequately met. We have services or resources in place to address the need. No or low need for FSSP funds.
1☐	Needs are met/partially met. Cost of services causes some financial stress. We need FSSP funds to help pay for services.
0☐	Needs are not met. We are unable to meet the need without significant emotional, physical or financial stress. High need for funds.
Comments:	

Medical/Nursing Care (Including hearing and vision)

Needs

Compare to typical development

0☐	Person does not require any more medical care than routine medical appointments.
2☐	Person requires more medical care than routine medical visits.
4☐	Person requires medical care for a frequent and acute illness or medical condition.
6☐	Person has medical needs that significantly impact their ability to participate in home, school, and community activities.
Comments:	

Resources

Consider adequate medical coverage, access to healthcare, etc.

4☐	No needs in this area. This is not an area of need for our family member.
3☐	Needs are completely met. We are easily able to meet this need with the resources checked above and/or natural supports.
2☐	Needs are adequately met. We have services or resources in place to address the need. No or low need for FSSP funds.
1☐	Needs are met/partially met. Cost of services causes some financial stress. We need FSSP funds to help pay for services.
0☐	Needs are not met. We are unable to meet the need without significant emotional, physical or financial stress. High need for funds.
Comments:	

Transportation

Needs

Consider: Is the vehicle adequately equipped for the person with the I/DD? Is transportation difficult? Do you spend excessive amounts of time transporting for medical appointments?

0☐	Person/family has a typical transportation situation.
1☐	Person/family's participation in home, school, or community activities is interrupted by access to transportation at least once a week.

2☐	Person/family's participation in home, school, or community activities is interrupted by access to transportation more than once a week.
3☐	Person/family has no reliable access to transportation.
Comments:	

Resources

Consider ramps, vehicle adaptations, and other persons/agency support

4☐	No needs in this area. This is not an area of need for our family member.
3☐	Needs are completely met. We are easily able to meet this need with the resources checked above and/or natural supports.
2☐	Needs are adequately met. We have services or resources in place to address the need. No or low need for FSSP funds.
1☐	Needs are met/partially met. Cost of services causes some financial stress. We need FSSP funds to help pay for services.
0☐	Needs are not met. We are unable to meet the need without significant emotional, physical or financial stress. High need for funds.
Comments:	

Self-Care (feeding, bathing, dressing, toileting)

Needs

Compare to typical development, consistent with age

0☐	Person is able to consistently perform self-care tasks.
1☐	Person requires verbal reminders to start/complete some tasks.
2☐	Person requires hands-on assistance to complete most tasks.
3☐	Person requires total care not consistent with others their age.
Comments:	

Resources

Consider availability of support from family members, neighbors, friends, agencies

4☐	No needs in this area. This is not an area of need for our family member.
3☐	Needs are completely met. We are easily able to meet the need with the resources checked above and/or natural supports.
2☐	Needs are adequately met. We have services or resources in place to address the need. No or low need for FSSP funds.
1☐	Needs are met/partially met. Cost of services causes some financial stress. We need FSSP funds to help pay for services.
0☐	Needs are not met. We are unable to meet the need without significant emotional, physical or financial stress. High need for funds.
Comments:	

Supervision

Needs

Compare to typical development, consistent with age

0☐	Supervision typical for that age.
2☐	Person needs occasional supervision.
4☐	Person requires frequent supervision.
6☐	Person requires constant supervision (can never be unsupervised)
Comments:	

Resources

Consider shared care giving in the home, support by extended family, friends, neighbors, agencies

4☐	No needs in this area. This is not an area of need for our family member.
3☐	Needs are completely met. We are easily able to meet this need with the resources checked above and/or natural supports.
2☐	Needs are adequately met. We have services or resources in place to address the need. No or low need for FSSP funds.
1☐	Needs are met/partially met. Cost of services causes some financial stress. We need FSSP funds to help pay for services.
0☐	Needs are not met. We are unable to meet the need without significant emotional, physical or financial stress. High need for funds.
Comments:	

Behavior

Needs

Consider inappropriate behaviors against self, others and/or property, running, wandering, spontaneous crying/screaming; compare to typical development consistent with age

0☐	There are no behavioral concerns.
2☐	There are mild behavioral concerns. May require verbal reminders, redirection or supervision but usually do not result in injury to self, others or property.
4☐	There are moderate behavioral concerns. Exhibits inappropriate behaviors that put self or others at risk; requires frequent interventions at least weekly.
6☐	There are extreme behavioral concerns. Exhibits inappropriate behaviors that put self or others at risk; requires frequent interventions at least daily.
Comments:	

Resources

Consider breaks from care giving, therapies, support from others/agencies

4☐	No needs in this area. This is not an area of need for our family member.
3☐	Needs are completely met. We are easily able to meet this need with the resources checked above and/or natural supports.
2☐	Needs are adequately met. We have services or resources in place to address the need. No or low need for FSSP funds.
1☐	Needs are met/partially met. Cost of services causes some financial stress. We need FSSP funds to help pay for services.
0☐	Needs are not met. We are unable to meet the need without significant emotional, physical or financial stress. High need for funds.
Comments:	

Sleep

Needs

Compare to age-appropriate sleep patterns

0☐	There are no sleep problems.
1☐	There are mild disturbances in sleep patterns that occur approximately once a week.
2☐	There are moderate disturbances in sleep patterns that occur approximately two to five times a week.
3☐	There are high disturbances in sleep patterns that require many interventions throughout the night.
Comments:	

Resources

Consider shared care giving, breaks from constant supervision, sleep aids/medications, modified sleeping environment

4☐	No needs in this area. This is not an area of need for our family member.
3☐	Needs are completely met. We are easily able to meet this need with the resources checked above and/or natural supports.
2☐	Needs are adequately met. We have services or resources in place to address the need. No or low need for FSSP funds.
1☐	Needs are met/partially met. Cost of services causes some financial stress. We need FSSP funds to help pay for services.
0☐	Needs are not met. We are unable to meet the need without significant emotional, physical or financial stress. High need for funds.
Comments:	

Communication

Needs

Compare to typical development, consistent with age

0☐	There are no communication concerns.
1☐	There are mild communication concerns. Can consistently meet needs & wants through limited verbal skills with familiar and unfamiliar people.
2☐	There are moderate communication concerns. Uses alternative means to communicate such as pointing, PECS, or device; understood only by familiar people.
3☐	There are extreme communication concerns. Limited or inconsistent ways of communicating with others.
Comments:	

Resources

Consider availability of communication devices, sign language, caregivers understanding of personal language/gestures/ expressions

4☐	No needs in this area. This is not an area of need for our family member.
3☐	Needs are completely met. We are easily able to meet this need with the resources checked above and/or natural supports.
2☐	Needs are adequately met. We have services or resources in place to address the need. No or low need for FSSP funds.
1☐	Needs are met/partially met. Cost of services causes some financial stress. We need FSSP funds to help pay for services.
0☐	Needs are not met. We are unable to meet the need without significant emotional, physical or financial stress. High need for funds.
Comments:	

Access To Support Networks

Needs

Consider level of isolation or lack of support networks for the family

0☐	These are not affected by having a person with an I/DD in the home.
1☐	These are mildly affected by having a person with an I/DD in the home.
2☐	These are moderately affected by having a person with an I/DD in the home.
3☐	These are extremely affected by having a person with an I/DD in the home.
Comments:	

Resources

Consider shared care giving, support from extended family/friends, church, community organizations, and agencies

4☐	No needs in this area. This is not an area of need for our family.
3☐	Needs are completely met. We are easily able to meet this need with the resources checked above and/or natural supports.
2☐	Needs are adequately met. We have services or resources in place to address the need. No or low need for FSSP funds.
1☐	Needs are met/partially met. Cost of services causes some financial stress. We need FSSP funds to help pay for services.
0☐	Needs are not met. We are unable to meet the need without significant emotional, physical or financial stress. High need for funds.
Comments:	

Family Support
Most In Need (MIN) Assessment

Family Composition & Stability

Please mark the box that best represents your family/living situation.	N/A 0	Mild 1	Moderate 2	High 3
Relationships are strained within the family.	☐	☐	☐	☐
There are other children or adults with disabilities/delays/illnesses in the home.	☐	☐	☐	☐
Siblings show signs of stress due to a family member with an I/DD living in the home.	☐	☐	☐	☐
Our family has responsibility for other extended family members.	☐	☐	☐	☐
Within the last year there has been a divorce, separation, death, or addition to the family.	☐	☐	☐	☐
Our family's activities center on the needs of the family member with an I/DD. Caregiver(s) spends excessive time coordinating various needs for family member with I/DD.	☐	☐	☐	☐
Caregiver(s) spends excessive time away from job to meet the needs of family member with an I/DD. Caregiver(s) has had to quit their job or is unable to work due to the needs of the family member with an I/DD.	☐	☐	☐	☐
There are additional difficulties due to the aging/health of caregiver(s).	☐	☐	☐	☐
Caregiver(s) experiences additional difficulties due to family member with an I/DD being home all day (no school/respite).	☐	☐	☐	☐
Other areas of stress on Caregiver(s) not addressed in assessment:				

I verify that the information stated above is true to the best of my knowledge.

Completed by Date

Contact Information:

Parent Name	
Parent Address	
County	
Parent Phone Number Daytime phone	

Return this form by mail, email or fax to: DDRC/CFS 11177 W. 8th Ave. Lakewood, CO 80215
Email: FSSPMIN@ddrcco.com Subject line: FSSP MIN or Fax: 303.462.6697

Families are *eligible* for the Family Support Services Program (FSSP) if they have a family member with a developmental delay or disability living in the family home. The Most In Need (MIN) assessment process determines your family's *level of need* for FSSP per State guidelines. Families are enrolled in FSSP and prioritized for funds based on their total MIN Score, unless their family member is enrolled in a Medicaid Waiver or Early Intervention services. DDRC considers an individual enrolled in CES, SLS, or the EBD Medicaid Waiver as "least in need" regardless of his/her MIN score. Persons enrolled in other programs will have their level of need determined on an individual basis. The amount of funds approved is based on the services requested, supporting documentation, and available funds. If you have questions or need help to complete the form please contact your Resource Coordinator, or the CFS Administrative Assistant at 303.462.6576.

Admin Use Only Below this line

Date Received MIN: MIN Score: MIN Level:

Low (0-19) Moderate (20-39) High (40+)

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Children and Family Services
11177 W 8th Ave., Lakewood, CO 80215 Voice/
*TDD 303.233.3363 * T Fax 303.462.6697*

FAMILY SUPPORT REQUEST
JULY 2019 thru JUNE 2020

RC Name _____

Section A. Identifying Information
Eligible Individual:

First Name:	Middle:	Last:
County: Jefferson_ ☐ Gilpin_☐ Clear Creek☐ Summit☐	DOB:	Gender: Male ☐ Female ☐
Address:	City:	Zip code:
Delay/Diagnosis or Medical Condition(s)		
Enrolled in ☐EI ☐CWA ☐CES ☐CHCBS	☐CLLI ☐SLS ☐EBD	☐SCI ☐BI ☐CMHS

Parent/Family:

Individual lives with:	Both parents	Mother	Father	Other
Primary Language:	English	Spanish/Espanol ☐	Other: ☐	

Primary contact is typically the mother and/or father of the eligible individual, or whomever they live with.

Primary Contact Name(s)		Phone number _____-_____-_____ home _____-_____-_____ cell
Address: If different than above		Relationship: Email address:
Preferred method of contact during day: Phone ☐ Text ☐ Work phone ☐ Email ☐ Mail ☐		

Secondary Contact Name (optional)		Primary phone number _____-_____-_____ home _____-_____-_____ cell
Address: If different than above		Relationship: Email address:

Other family members living in the home: (Use additional page if needed)

Name	Relationship	Age (if under 18)
Name	Relationship	Age (if under 18)

Section B. Resource Coordination Services: Listed below are some examples of information or referrals your Resource Coordinator could assist you with.

☐	We want information on Special Needs Trusts & Wills and/or Home Ownership programs	☐	We need a behavioral assessment or services (describe below)
☐	We need a home modification assessment (help to make our home more accessible)	☐	We need counseling, or mental health services (describe below)
☐	We want information on how to use our family member's Medicaid insurance (what is covered?)	☐	My child has significant medical or behavioral needs- I want information about Medicaid Waiver programs & other options

Additional comments or other information that would be helpful to my family

Section C. FUNDING REQUEST: What services or supports would you purchase using Family Support funds? Check ☑ all that apply. Describe the specific services you want below, how it would be helpful and the estimated cost/reimbursement requested.

☑	FSSP Services	☑	FSSP Services
☐	**Respite Care:** temporary care of the family member with a disability that provides relief to the family.	☐	**Professional Services:** (e.g., therapy, counseling, nursing care, and items/activities recommended as part of therapy).
☐	**Medical/Dental/Vision:** services necessary to attain or maintain physical health not covered by another source. **Excluded**: OTC medications and vitamins.	☐	**Transportation** expenses to specialty medical appointments, therapies, or other disability related appointments not covered by other sources. (Travel costs, lodging, food expense).
☐	**Assistive Technology:** equipment necessary due to the person's disability to communicate, move through or manipulate their environment (e.g., hearing aids, glasses, wheelchair, communication device).	☐	**Other Services**: Consultant/Advocate assistance to access services outside the CCB (i.e.; public benefits, guardianship, and IEP meetings). Recreational needs when the cost of the recreation is above and beyond the typical cost.
☐	**Environmental Engineering:** Necessary home or vehicle modification due to person's disability (i.e.; lifts, ramps, or other adaptations to address health and safety, increase independence and accessibility).	☐	**Parent/Sibling Support:** Necessary support to assist family to manage additional stress due to providing care for the family member with a developmental disability (e.g., counseling, conferences). **Excluded:** cost of recreation for family.

Requesting funds for	**Cost for service or item**	**How is this service or item helpful to your family?** **I currently pay out of pocket for this service?** **Yes ☐ No ☐ Receipt/bid/bill attached Yes ☐ No ☐**
Requesting funds for	**Cost for service or item**	**How is this service or item helpful to your family?** **I currently pay out of pocket for this service?** **Yes ☐ No ☐ Receipt/bid/bill attached Yes ☐ No ☐**
Requesting funds for	**Cost for service or item**	**How is this service or item helpful to your family?** **I currently pay out of pocket for this service?** **Yes ☐ No ☐ Receipt/bid/bill attached Yes ☐ No ☐**
What is the total amount of funding you are requesting for FSSP services this year? 7/1/2019 thru 6/30/2020	**$_____**	**Use additional page if needed**

Section C. SIGNATURE: A follow-up visit, or call may be necessary as part of the assessment process. You will be notified in writing when a funding decision has been made. The process may take several months due to the large number of families we serve. Call your Resource Coordinator if you have an urgent need.

Print name(s) of person completing form: _____

Signature: _____ Date: _____

Enter Eligible Family Member's Name

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Children and Family Services * 11177 West 8th Avenue * Lakewood, Colorado 80215
Voice (303) 233-3363 * Toll Free (800) 649-8815 * Fax (303) 462-6697

Additional Comments: