

Take Me Home, West Virginia
 RISK ANALYSIS AND MITIGATION TOOL - Version 5.2

PARTICIPANT INFORMATION

Last Name	First Name	Medicaid No.	Date of Birth	Transition Date
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

SECTION A. RISK IDENTIFICATION

1. HEALTH, MEDICAL & NUTRITION

- Chronic health conditions
- Mental health
- Access to medical care
- Treatment compliance
- ER Visits and/or hospitalizations
- Nutrition and/or special diets
- Skin breakdown
- Seizures
- Elimination
- Aspiration
- Other

2. ADLs and SAFETY

- Food and liquid intake
- Meal preparation
- Ambulation
- Transfers
- Toileting
- Bathing
- Communication
- Falls
- Injuries
- Victimization
- Emergency response
- Home maintenance
- Other

3. BEHAVIORAL AND LIFESTYLE

- Endangering self (or self-neglect)
- Endangering others
- Destruction of property
- Aggression
- Substance abuse
- Victimization or exploitation
- Justice system involvement
- Isolation
- Inappropriate sexual behavior
- Finances
- Homelessness
- Other

4. MEDICATIONS

- Multiple prescriptions
- Medication complications
- Psychotropic medications
- Use of OTC or herbal medicines
- Medication compliance
- Medication administration
- Other

5. HOME AND INFORMAL SUPPORTS

- Informal support capacity
- Limited support system
- Service refusal
- Social Opportunities
- Isolation
- Home stability and situation
- Housemate compatibility
- Other

6. OTHER POSSIBLE RISKS

- Hazardous dwelling
- Sanitation
- Neighborhood
- Accessibility
- Community access
- Other

7. ARE ANY OF THE ABOVE BELIEVED TO BE RELATED TO ABUSE, NEGLECT OR EXPLOITATION? (If yes, explain in Question #8 Notes section.)

- Yes No

8. ADDITIONAL INFORMATION

Question #8 Notes

Last Name

First Name

Medicaid No.

SECTION B. RISK EVALUATION

SEVERITY OF OUTCOME: 1) Possibly harmful to health/welfare 2) Likely harmful to health/welfare 3) Immediately harmful to health/welfare 4) Debilitating or death

FREQUENCY OF RISK: 1) Rarely or Annually 2) Seasonally 3) Monthly 4) Weekly 5) Daily 6) More than daily

SIGNIFICANT RISK FACTOR(S) (from Section A)	SEVERITY OF OUTCOME	FREQUENCY OF RISK	DESCRIPTION OF CIRCUMSTANCES	COULD THIS POTENTIALLY JEOPARDIZE SERVICES?

Last Name

First Name

Medicaid No.

SECTION B. RISK EVALUATION

SEVERITY OF OUTCOME: 1) Possibly harmful to health/welfare 2) Likely harmful to health/welfare 3) Immediately harmful to health/welfare 4) Debilitating or death

FREQUENCY OF RISK: 1) Rarely or Annually 2) Seasonally 3) Monthly 4) Weekly 5) Daily 6) More than daily

SIGNIFICANT RISK FACTOR(S) (from Section A)	SEVERITY OF OUTCOME	FREQUENCY OF RISK	DESCRIPTION OF CIRCUMSTANCES	COULD THIS POTENTIALLY JEOPARDIZE SERVICES?

Last Name

First Name

Medicaid No.

SECTION B. RISK EVALUATION

SEVERITY OF OUTCOME: 1) Possibly harmful to health/welfare 2) Likely harmful to health/welfare 3) Immediately harmful to health/welfare 4) Debilitating or death

FREQUENCY OF RISK: 1) Rarely or Annually 2) Seasonally 3) Monthly 4) Weekly 5) Daily 6) More than daily

SIGNIFICANT RISK FACTOR(S) (from Section A)	SEVERITY OF OUTCOME	FREQUENCY OF RISK	DESCRIPTION OF CIRCUMSTANCES	COULD THIS POTENTIALLY JEOPARDIZE SERVICES?

Last Name

First Name

Medicaid No.

SECTION B. RISK EVALUATION

SEVERITY OF OUTCOME: 1) Possibly harmful to health/welfare 2) Likely harmful to health/welfare 3) Immediately harmful to health/welfare 4) Debilitating or death

FREQUENCY OF RISK: 1) Rarely or Annually 2) Seasonally 3) Monthly 4) Weekly 5) Daily 6) More than daily

SIGNIFICANT RISK FACTOR(S) (from Section A)	SEVERITY OF OUTCOME	FREQUENCY OF RISK	DESCRIPTION OF CIRCUMSTANCES	COULD THIS POTENTIALLY JEOPARDIZE SERVICES?

Last Name

First Name

Medicaid No.

SECTION C. RISK MITIGATION PLAN

Significant Risk Factor(s)	What can be done to prevent or mitigate risk?	What strengths or assets does the participant have to reduce the risk?	What additional supports would be helpful in reducing the risk?	Who can help with prevention or mitigation of the risk?	Is the risk addressed in HCBS plan?(Y/N)

Last Name

First Name

Medicaid No.

SECTION C. RISK MITIGATION PLAN

Significant Risk Factor(s)	What can be done to prevent or mitigate risk?	What strengths or assets does the participant have to reduce the risk?	What additional supports would be helpful in reducing the risk?	Who can help with prevention or mitigation of the risk?	Is the risk addressed in HCBS plan?(Y/N)

Last Name

First Name

Medicaid No.

SECTION C. RISK MITIGATION PLAN

Significant Risk Factor(s)	What can be done to prevent or mitigate risk?	What strengths or assets does the participant have to reduce the risk?	What additional supports would be helpful in reducing the risk?	Who can help with prevention or mitigation of the risk?	Is the risk addressed in HCBS plan?(Y/N)

Last Name

First Name

Medicaid No.

SECTION C. RISK MITIGATION PLAN

Significant Risk Factor(s)	What can be done to prevent or mitigate risk?	What strengths or assets does the participant have to reduce the risk?	What additional supports would be helpful in reducing the risk?	Who can help with prevention or mitigation of the risk?	Is the risk addressed in HCBS plan?(Y/N)

Last Name	First Name	Medicaid No.
<input type="text"/>	<input type="text"/>	<input type="text"/>

SECTION D: CONTACTS

If Take Me Home staff are unable to reach me for a regularly scheduled Monthly Contact or other purpose, please contact the following individuals, who will know how I can be reached at all times:

Last Name	First Name	Home Phone	Cell Phone	Work Phone	Relationship
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Last Name	First Name	Home Phone	Cell Phone	Work Phone	Relationship
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Last Name	First Name	Home Phone	Cell Phone	Work Phone	Relationship
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

AUTHORIZING SIGNATURES (If Participant signs with a mark, two witnesses are required).

The participant agrees to the Risk Mitigation Plan? YES NO

<input type="text"/>	<input type="text"/>
Signature of Participant or Legal Representative	Date of Signature

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Signature of Witness	Date of Signature	Signature of Witness	Date of Signature

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Signature of Transition Navigator	Date of Signature	Transition Navigator Name	Agency