

Options Counseling Individual Support Record

(All references to "Individual" refer to the individual who may participate or is participating in OC; * indicates can be collected in NWD system either as a field or in notes; Italics indicate reporting requirement in standards)

Determining the Need for OC

1. *Name of person making the original contact: _____
2. *Relationship of original contact to individual:
 Self Family member Surrogate decision-maker Caregiver Provider Other
3. *Reason for initial contact: _____
4. *Demographics of individual:
Name: _____
Address: _____
City: _____ County/FIPS _____ Zip: _____
 Private residence Congregate facility Other: _____
Date of Birth: _____ Age: _____
 Male Female Married Single/divorced Veteran
5. *Individual's preferred method and preferred contact information:
 Use of communication device _____ Sign language
 Foreign language _____ Other _____
 Self Home Phone: _____ Self Cell Phone: _____
 Self Email: _____
 Other (Name and Relationship): _____
 Home Phone: _____ Cell Phone: _____
 Email: _____
6. *Surrogate decision-maker legally authorized to share information with an Options Counselor:
Name: _____
Address: _____
 Home Phone: _____ Cell Phone: _____
 Email: _____
7. *Progress Notes: _____
8. *Initial referrals made: _____
9. *Date referral was made to Options Counseling: _____
10. *Referral to OC made by: _____
11. *Situation that triggered the referral to Options Counseling: _____

Delivering OC

1. *First OC contact with individual: Date: _____ *Individual wants OC:* Yes No
2. *Name of Options Counselor: _____
3. * First time participating in OC *Reengagement in OC*
4. *Preference for communication: In person (Location) _____
 Phone _____ Email _____
5. *Others involved in OC (See attached)
6. Confirmed information provided on surrogate decision-maker: (Copy of the Guardianship order or the POA and the determination of incapacity) Yes No
7. *Race Amer Ind/Alask Nat Asian Black/African Amer Native Hawaiian/Other Pac Islander
 White Hispanic White not Hispanic Other Refused to Answer Unknown
8. *Ethnicity Hispanic/Latino Not Hispanic/Latino Other Refused to Answer Unknown
9. *Current Circumstances:
Paid and informal supports: _____

Employment/financial resources and benefits: _____

Financial/legal plan for future: _____

Housing: _____

Transportation: _____

Social/recreational activities: _____

Assistive technology: _____

10. *Individual perspective:

Preferences: _____

Needs: _____

Values: _____

Definition of success: _____

Desired outcomes: _____

11. *Options:

Option 1: _____
Risks/Benefits: _____

Alternative supports: _____

Option 2: _____
Risks/Benefits: _____

Alternative supports: _____
Option 3: _____

Risks/Benefits: _____

Alternative supports: _____

Option 4: _____

Risks/Benefits: _____

Alternative supports: _____

Option 5: _____

Risks/Benefits: _____

Alternative supports: _____

Option 6: _____

Risks/Benefits: _____

Alternative supports: _____

Option 7: _____

Risks/Benefits: _____

Alternative supports: _____

12. *Units of Service (prior to Action Plan): Time Spent: _____ Number of Contacts: _____

13. Authorization to share individual information: Yes Date Signed: _____ No

14. Termination: Date: _____ No longer seeks support No longer has unmet needs

Has not responded in over 6 months OC attempted contact dates: _____

Has exhausted all appeals Is dissatisfied/OC has no further alternatives available

Others Involved in OC

5a. *Name: _____

Family member Friend/neighbor Caregiver Provider Other _____

Address: _____

Home Phone: _____ Cell Phone: _____

Email: _____

5b. *Name: _____

Family member Friend/neighbor Caregiver Provider Other _____

Address: _____

Home Phone: _____ Cell Phone: _____

Email: _____

5c. *Name: _____

Family member Friend/neighbor Caregiver Provider Other _____

Address: _____

Home Phone: _____ Cell Phone: _____

Email: _____

5d. *Name: _____

Family member Friend/neighbor Caregiver Provider Other _____

Address: _____

Home Phone: _____ Cell Phone: _____

Email: _____

5e. *Name: _____

Family member Friend/neighbor Caregiver Provider Other _____

Address: _____

Home Phone: _____ Cell Phone: _____

Email: _____

5f. *Name: _____

Family member Friend/neighbor Caregiver Provider Other _____

Address: _____

Home Phone: _____ Cell Phone: _____

Email: _____