SOUTHERNTIERCONNECT
AN I/DD CARE COLLABORATIVE

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NAME OF THE ASSESSMENT	WHO NEEDS THIS ASSESSMENT?	FREQUENCY OF ASSESSMENT*	REASON FOR ASSESSMENT	WHO COMPLETES THE ASSESSMENT?	ADDITIONAL INFORMATION
Developmental Disabilities Profile, Version 2 (DDP-2)	All STC members	• Within 30 days of enrollment • At least every 2 years • When needs change	Used to identify challenges and current service needs	Care Manager with member/family member/ advocate	This assessment is being phased out and replaced by the CAS/ CANS
Child & Adolescent Needs and Strengths (CANS)	Members 17 years and younger	Once per year	Functional needs assessment designed to give a profile of the current needs and strengths of a child/ adolescent and their caregiver(s).	OPWDD staff or staff from OPWDD contracted agency (Maximus) with member/family member/ advocate The Care Manager then reviews the results with you within a month of the assessment date	This assessment must be current if requesting additional OPWDD services or a change to any existing OPWDD services, including an SDS budget amendment
Coordinated Assessment System (CAS)	Members 18 years and older	Every 2 years	Comprehensive assessment tool used to identify strengths, needs and interests.	OPWDD staff or staff from OPWDD contracted agency (Maximus) with member/family member/ advocate The Care Manager then reviews the results with you within a month of the assessment date	This assessment must be current if requesting additional OPWDD services or a change to any existing OPWDD services, including an SDS budget amendment
Health Related Social Needs (HRSN)	All STC members	Once per year	Screening tool to help your Care Manager identify needs related to social determinants of health including housing instability, food insecurity, transportation problems, utility help needs, interpersonal safety, and more.	Care Manager with member/family member/ advocate	This assessment is often completed at the same time as the IAM assessment
It's All About Me (IAM)	All STC members	• Within 60 days of CCO enrollment and • Once per year, generally the month before the annual Life Plan meeting	Comprehensive assessment which identifies the disability, medical, mental health, behavioral health, chemical dependency, social and emotional needs of an individual.	Care Manager with member/family member/ advocate. Additional information is also sought from members of the individual's team (service providers, medical/mental health providers, residential staff, and others)	This assessment is often completed at the same time as the HRSN
Housing Checklist	All STC members living in non-certified settings	Once per calendar year (Jan-Dec)	Screening tool to help your Care Manager proactively identify areas that could lead to housing insecurity to better support you.	Care Manager with member/family member	This assessment must be completed in the person's home
Level of Care Eligibility Determination (LCED)	All STC members	Once per year	Used for initial determination and annual redetermination of an individual's eligibility to receive Home and Community Based Services (HCBS) and/or Care Coordination	Care Manager	A copy of the LCED can be found here: LCED

Any assessment may be completed more frequently if needs or circumstances change to reflect current status