# Community Support Services
# Rehabilitation Needs Assessment (RNA) – Part 1

**Directions:** Part 1 focuses on background data and historical information that should be gathered from the referral source(s), available hospital/treatment records and from a face-to face evaluation and discussion with the consumer. Family members, significant others, and collateral service providers, at the request of the consumer, may participate and/or otherwise provide information, providing that their involvement is within the bounds of relevant confidentiality provisions. ***Part 1 must be completed during the Preliminary Rehabilitation Needs Assessment.***

| ☐Preliminary Rehabilitation Needs Assessment | ☐Comprehensive Rehabilitation Needs Assessment |
|---|---|
| Referral Source: | Date of Admission: |
| Diagnoses (List all): | Date of Assessment: |

## SECTION 1: DEMOGRAPHICS

| | |
|---|---|
| Individual's Name: | DOB: |
| Email: | Phone: |
| Gender: | Race / Ethnicity: |
| Religion: | Primary Language Spoken: |
| Medicaid # (If applicable): | SSN or Unique ID: |

Emergency Contact (name, relationship and contact information):

## SECTION 2: CONTINUITY OF CARE

**If applicable, indicate which of the following was obtained from the state hospital and incorporate relevant information into the CRNA.**

☐ Individual Needs Discharge Assessment (INDA): ☐Yes ☐No ☐N/A

☐ Physical Health Assessment ☐Yes ☐No ☐N/A

☐ Documented Completion of Illness Management and Recovery Modules (if yes, please identify modules completed and IMR goals) ☐Yes ☐No ☐N/A

☐ Psychiatric Rehabilitation Readiness Determination Profile (PRRDP) ☐Yes ☐No ☐N/A

☐ Documented Completion of Tools for Tenancy Module(s) ☐Yes ☐No ☐N/A

## SECTION 3: HISTORY

### EMOTIONAL/MENTAL HEALTH

Tell me about your psychiatric history (i.e., onset of illness, symptoms, previous hospitalization(s), and aftercare/other treatment providers):

What has been past diagnoses? (from referral source):

Have you had any past suicidal/homicidal ideation or attempts? ☐Yes ☐No ☐N/A
If yes, briefly describe:

How has your mental health condition impacted your life?

| |
|---|
| What coping strategies have you used? |
| **PHYSICAL HEALTH** |
| Physical health history (significant past medical conditions and any hospitalizations): |
| Allergies: ☐Yes ☐No<br>If yes, briefly describe: |
| **MEDICATIONS** |
| Medication allergies: ☐Yes ☐No<br>If yes, briefly describe: |
| Medications that have worked well in the past: |
| Have you taken your medications regularly? |
| Have you been able to self-manage your medication in the past? |
| **SUBSTANCE USE/ADDICTIVE BEHAVIOR** |
| **Check off any that apply regarding past use:** |
| ☐ Illegal drugs. If so, type and frequency? |
| ☐ Prescription medications(s). If so, type and frequency? |
| ☐ Non-prescription (OTC) medications. If so, type and frequency? |
| ☐ Alcohol. If so, type and frequency? |
| ☐ Tobacco. If so, type and frequency? |
| ☐ Gambling. If so, type and frequency? |
| ☐ Other (list): |
| **If past substance use problems are reported, gather the following information:** |
| Identify triggers and warning signs: |

How has using impacted your life?

If substance use was a past problem, how long have you been clean/sober?

Briefly describe any past utilization of treatment or support groups related to substance use:

Briefly describe any past efforts you have made to use other community resources to stop or reduce substance use:

**CRIMINAL JUSTICE INVOLVEMENT**

Have you had any involvement with the criminal justice system? ☐Yes ☐No
If yes, briefly describe (e.g., KROL status, Megan's Law status, probation, warrants, court ordered child support):

**TRAUMA**

Have you experienced any traumatic events or physical/emotional/sexual abuse? ☐Yes ☐No
If yes, briefly describe:

Have you received treatment/support to help you cope with trauma?

**OCCUPATION/EMPLOYMENT**

When was the last time you held a paid or volunteer job?

What type(s) of work did you do?

Describe some of your positive past experiences with employment? (e.g., What went well in past jobs? What did you enjoy about the work you did? Describe positive experiences with co-workers and supervisors; describe types of work tasks that you performed well, etc.)

Describe some employment challenges that you have faced (e.g., What did not go well in past jobs? What did you dislike about the work you did? Did you struggle with task concentration? Did you struggle to maintain you motivation to work? Also, describe any challenging experiences with co-workers and supervisors.

| INTELLECTUAL/EDUCATIONAL | |
|---|---|
| Highest grade completed: | |
| Describe your past educational experiences (e.g., What subjects did you enjoy in high school? What challenges did you face while in school? What was your college major? What college degrees do you have?): | |
| Were you ever diagnosed with a learning disability or assigned to special education classes? | |
| **HOUSING** | |
| Briefly describe your past housing environments/experiences (e.g., Where did you live? Who did you live with? What is your satisfaction/dissatisfaction with past living situations?): | |
| Describe benefits/challenges on any past independent living experiences you've had as a tenant or home owner (i.e., relationship with landlord, ability to pay bills, eviction, home maintenance issues): | |
| Have you ever been homeless? ☐Yes ☐No<br>If yes, briefly describe: | |
| **FAMILY** | |
| Briefly describe your family of origin. Include information on important aspects of cultural identity: | |
| Do you have a history of mental illness and/or substance abuse in your family? ☐Yes ☐No<br>If yes, provide relevant details: | |
| Have you ever been married? ☐Yes ☐No<br>Provide relevant details: | |
| Do you have any children? ☐Yes ☐No<br>If yes, provide relevant details: | |
| **Part 1 - Sources of Information** | |
| The above information was gathered from the following (check all that apply): | |
| ☐ Self-report | ☐ Family |
| ☐ Referral source (list): | ☐ Other collateral (list): |

# Community Support Services
# Rehabilitation Needs Assessment (RNA) – Part 2

**Directions:** Please identify and complete the areas that are of immediate need for the Preliminary Rehabilitation Needs Assessment. Please complete additional sections for the Comprehensive Rehabilitation Needs Assessment. Gather information to complete each section. This should be done during face-to-face discussion with the consumer. Family members, significant others, and other collateral service providers, at the request of the consumer, may participate and/or otherwise provide information, providing that their involvement is within the bounds of confidentiality.

**A numerical scale is included in each key life domain**. Ask the consumer to choose a value of 1-5 to indicate their current satisfaction, and a value of 1-5 for where they would like to be. 1 indicates a low level of satisfaction and 5 indicates a high level of satisfaction. If the person wants a goal in the domain to be added to their IRP, assist them in articulating an initial goal statement.

**Note:** Part 2 of the RNA should be done every 6 months the first year, then annually. Also update diagnosis, demographic, and historical information in Part 1 - if any changes have occurred.

| **Date of Admission:** | **Date of Assessment:** |
|---|---|

## SECTION 1: KEY LIFE DOMAINS

### Part A: WELLNESS DIMENSIONS

(Adapted from: Swarbrick, M. (2012). *Introduction to Wellness Coaching*. Freehold, NJ: Collaborative Support Programs of New Jersey Inc., Institute of Wellness and Recovery )

### HOUSING/ENVIRONMENTAL WELLNESS

Do you currently receive a housing subsidy: ☐Yes ☐ No
If yes, what type?
If no, date of eligibility:

| **How satisfied are you with your housing/environmental wellness?** **1 2 3 4 5** | **Where would you like to be?** **1 2 3 4 5** |
|---|---|

Tell me more about your rationale for your current rating (include current barriers and past achievements/strengths)?

Is the place where you currently live your desired living arrangement? ☐ Yes ☐ No

If no, what are your hopes/dreams/aspirations related to your housing status?

**Do you want a goal in this area to be added to the IRP? (if yes, note this in SECTION 2)**
☐Yes ☐No
If yes, identify initial goal statement:

☐ Please check if this section will be completed during the Comprehensive Rehabilitation Needs Assessment

| FINANCIAL WELLNESS | |
|---|---|
| List all current sources of income (wages, etc.): | |
| List current benefits and amounts if applicable (Medicaid, Medicare, SSI, SSDI, VA, etc.): | |
| Do you have a representative payee? ☐Yes ☐No<br>If yes, specify contact information for payee: | |
| **How satisfied are you with your financial wellness?**<br>**1 2 3 4 5** | **Where would you like to be?**<br>**1 2 3 4 5** |
| Tell me more about your rationale for your current rating (include current barriers and past achievements/strengths)? | |
| What are your hopes/dreams/aspirations related to your financial status? | |
| **Do you want a goal in this area to be added to the IRP? (if yes, note this in SECTION 2)**<br>☐Yes ☐No<br>If yes, identify initial goal statement: | |
| ☐ Please check if this section will be completed during the Comprehensive Rehabilitation Needs Assessment | |

| OCCUPATIONAL/EMPLOYMENT WELLNESS | |
|---|---|
| Check off any current involvement in the following: | |
| ☐ Full or ☐ Part Time Competitive Employment<br>☐ Other employment setting (describe below)<br>☐ Seasonal work | ☐ Volunteer (non-paid) work<br>☐ Unemployed and looking for work<br>☐ Unemployed and not interested |
| If currently employed, what type of work do you do? | |
| Do you have any hobbies that occupy your time (e.g., knitting, scrapbooking, social media, photography)? ☐Yes ☐No<br>If yes, briefly describe: | |
| What other activities do you engage in during the day to occupy your time? | |

| How satisfied are you with your occupational/employment wellness?<br>1 2 3 4 5 | Where would you like to be?<br>1 2 3 4 5 |
|---|---|
| Tell me more about your rationale for your current rating (include current barriers and past achievements/strengths)? | |
| What are your hopes/dreams/aspirations related to your occupational/employment status? | |
| **Do you want a goal in this area to be added to the IRP? (if yes, note this in SECTION 2)**<br>☐Yes ☐No<br>If yes, identify initial goal statement: | |
| ☐ Please check if this section will be completed during the Comprehensive Rehabilitation Needs Assessment. | |
| **INTELLECTUAL/EDUCATIONAL WELLNESS** | |
| Check off any current involvement in the following educational courses/programs: | |
| ☐ GED<br>☐ Undergraduate | ☐ Graduate<br>☐ Technical/Trade<br>☐ Other (please describe): |
| If currently in school, what are you studying? | |
| Do you have any learning disabilities that may require support? ☐Yes ☐No<br>If yes, briefly describe: | |
| Describe other activities you take part in to increase your intellectual stimulation (crossword puzzles, reading, music): | |
| **How satisfied are you with your intellectual/educational wellness?**<br>**1 2 3 4 5** | **Where would you like to be?**<br>**1 2 3 4 5** |
| Tell me more about your rationale for your current rating (include current barriers and past achievements/strengths)? | |
| What are your hopes/dreams/aspirations related to your intellectual/educational status? | |

**Do you want a goal in this area to be added to the IRP? (if yes, note this in SECTION 2)**
☐Yes ☐No
If yes, identify initial goal statement:

☐ Please check if this section will be completed during the Comprehensive Rehabilitation Needs Assessment.

## SPIRITUAL WELLNESS

Do you have any spiritual or cultural beliefs or practices that are important to you? ☐Yes ☐No

If yes, please identify:

| **How satisfied are you with your spiritual wellness?** | **Where would you like to be?** |
|---|---|
| **1 2 3 4 5** | **1 2 3 4 5** |

Tell me more about your rationale for your current rating (include current barriers and past achievements/strengths)?

What are your hopes/dreams/aspirations related to your spirituality?

**Do you want a goal in this area to be added to the IRP? (if yes, note this in SECTION 2)**
☐Yes ☐No
If yes, identify initial goal statement:

☐ Please check if this section will be completed during the Comprehensive Rehabilitation Needs Assessment.

## SOCIAL WELLNESS

Who do you spend time with on a regular basis?

Who do you enjoy spending your time with?

Where do you go to meet people?

What characteristics are you looking for in the people you socialize with?

What are some social and recreational activities that you participate in during your free time?

Describe any special skills and/or talents that you have:

Have you ever utilized a wellness center? ☐Yes ☐No
If no, would you like to? ☐Yes ☐ No

| **How satisfied are you with your social wellness and how you spend your leisure time?**<br>**1 2 3 4 5** | **Where would you like to be?**<br>**1 2 3 4 5** |
|---|---|

Tell me more about your rationale for your current rating (include current barriers and past achievements/strengths)?

What are your hopes/dreams/aspirations related to your social wellness?

**Do you want a goal in this area to be added to the IRP? (if yes, note this in SECTION 2)**
☐Yes ☐No
If yes, identify initial goal statement:

☐ Please check if this section will be completed during the Comprehensive Rehabilitation Needs Assessment.

## EMOTIONAL WELLNESS / MENTAL HEALTH

Are you currently receiving services from other treatment providers? ☐Yes ☐No
If yes, identify the providers, describe the services and indicate how often do you meet with them?

How would you describe your current mental health condition?

What does it look like when you need extra support (behavior changes, physical changes, increase in symptoms)?

What helps you to cope/manage your mental health condition?

Do you have a Psychiatric Advance Directive: ☐Yes ☐No if yes, attach a copy.
If no, would you like to create one? ☐Yes ☐No

| **How satisfied are you with your emotional wellness/mental health?**<br>**1 2 3 4 5** | **Where would you like to be?**<br>**1 2 3 4 5** |
|---|---|

Tell me more about your rationale for your current rating (include current barriers and past achievements/strengths)?

What are your hopes/dreams/aspirations related to your emotional wellness/mental health?

**Do you want a goal in this area to be added to the IRP? (if yes, note this in SECTION 2)**
☐Yes ☐No
If yes, identify initial goal statement:

☐ Please check if this section will be completed during the Comprehensive Rehabilitation Needs Assessment.

## PHYSICAL HEALTH AND WELLNESS

List current medical conditions, current treatment, and names of current health care providers:

Allergies: ☐Yes ☐No
If yes, briefly describe:

If applicable, provide date of last:

| | | |
|---|---|---|
| ☐ Physical Exam: | ☐ Dental Exam: | ☐ Blood Work: |
| ☐ Eye Exam: | ☐ Podiatrist Exam: | ☐ STD Screening: |
| ☐ Colonoscopy: | ☐ Gynecological Exam: | ☐ Prostate Exam: |
| ☐ Mammogram: | ☐ Dermatological Exam: | ☐Other: _____ |

Do you have/need any adaptive devices that would better assist you with integrating into the community?
☐Yes ☐No
If yes, briefly describe:

| **How satisfied are you with your physical health/wellness?** **1 2 3 4 5** | **Where would you like to be?** **1 2 3 4 5** |
|---|---|

Tell me more about your rationale for your current rating (include current barriers and past achievements/strengths)?

What are your hopes/dreams/aspirations related to your physical health/wellness?

Do you have a Medical Advance Directive and/or Living Will: ☐Yes ☐No
If yes, attach a copy.
If no, would you like to create one? ☐Yes ☐No

**Do you want a goal in this area to be added to the IRP? (if yes, note this in SECTION 2)**
☐Yes ☐No
If yes, identify initial goal statement:

☐ Please check if this section will be completed during the Comprehensive Rehabilitation Needs Assessment.

## Part B: OTHER LIFE DOMAINS

### MEDICATIONS

| Current Medications (list all) | Dose | Frequency | Prescribing Physician |
|---|---|---|---|
| | | | |

**Medication allergies?** ☐Yes ☐No
If yes, briefly describe:

| What is your current satisfaction with your medication(s) (efficacy, side effects, and ability to self-manage)? | Where would you like to be? |
|---|---|
| **1 2 3 4 5** | **1 2 3 4 5** |

Tell me more about your rationale for your current rating (include information about efficacy, side effects, ability to self-manage medication regimen, etc.)?

**Do you want a goal in this area to be added to the IRP? (if yes, note this in SECTION 2)**
☐Yes ☐No
If yes, identify initial goal statement:

☐ Please check if this section will be completed during the Comprehensive Rehabilitation Needs Assessment.

## SUBSTANCE USE/ADDICTIVE BEHAVIOR

**Check off any that apply regarding current use:**

☐ Illegal drugs. If so, type and frequency?

☐ Prescription medications(s). If so, type and frequency?

☐ Non-prescription (OTC) medications. If so, type and frequency?

☐ Alcohol. If so, type and frequency?

☐ Tobacco. If so, type and frequency?

☐ Gambling. If so, type and frequency?

☐ Other

Briefly identify any current triggers and warning signs of substance use:

Briefly discuss how substance use is currently impacting your life:

Briefly describe current utilization of substance use treatment or support groups:

Briefly describe current use of other community resources to stop or reduce substance use:

| **What is your current satisfaction with your substance use/addictive behavior?**<br>**1 2 3 4 5** | **Where would you like to be:**<br>**1 2 3 4 5** |
|---|---|

Tell me more about your rationale for your current rating (include current barriers and past achievements/strengths)?

**Do you want a goal in this area to be added to the IRP? (if yes, note this in SECTION 2)**

☐Yes ☐No

If yes, identify initial goal statement:

☐ Please check if this section will be completed during the Comprehensive Rehabilitation Needs Assessment.

## FAMILY

How do you define family (identify the people in your life who you consider to be members of your family)?

Are you currently supported by members of your family/significant others? ☐Yes ☐No

If yes, ask the questions below:

Who provides support?

| |
|---|
| Describe the type of support you receive (emotional, financial, physical help with ADLS, etc.): |
| Describe type of contact and frequency of contacts (e.g. visits, phone, e-mail): |
| Do you want family members/significant others involved in your services? ☐Yes ☐No<br>If yes, identify who should be involved: |

| **What is your current satisfaction with your family support?**<br>**1 2 3 4 5** | **Where would you like to be:**<br>**1 2 3 4 5** |
|---|---|

| |
|---|
| Tell me more about your rationale for your current rating (include current barriers and past achievements/strengths): |
| What are your hopes/dreams/aspirations related to significant relationships in your life? |
| **Do you want a goal in this area to be added to the IRP? (if yes, note this in SECTION 2)**<br>☐Yes ☐No<br>If yes, identify initial goal statement: |
| ☐ Please check if this section will be completed during the Comprehensive Rehabilitation Needs Assessment. |

**ACTIVITY OF DAILY LIVING SKILLS (ADLS)**

Check off the appropriate level of assistance needed in the following areas:

| ADLS | No Support | Low Level of Support | High Level of Support | Unable to Assess |
|---|---|---|---|---|
| Maintaining a Safe Home Environment (e.g., self-preservation skills, evacuation skills) | | | | |
| Cooking | | | | |
| Cleaning | | | | |
| Grocery Shopping | | | | |
| Using Transportation | | | | |
| Maintaining Personal Hygiene | | | | |
| Other: _____ | | | | |

| What is your current satisfaction with your level of independence with ADLS?<br>1 2 3 4 5 | Where would you like to be:<br>1 2 3 4 5 |
|---|---|
| Tell me more about your rationale for your current rating (include current barriers and past achievements/strengths)? | |
| **Do you want a goal in this area to be added to the IRP? (if yes, note this in SECTION 2)** ☐Yes ☐No<br>If yes, identify initial goal statement: | |
| ☐ Please check if this section will be completed during the Comprehensive Rehabilitation Needs Assessment. | |
| **MANAGING CRISES** | |
| Briefly describe precursors or contributing factors to stress: | |
| Briefly describe current strategies or supports that help you manage your stress level and deescalate a crisis: | |
| Do you currently have any of the following: | |
| Crisis Plan: ☐Yes ☐No | |
| If yes, add to clinical record and incorporate relevant content into the IRP.<br>If no, would you like to create one? ☐Yes ☐No | |
| WRAP: ☐Yes ☐No | |
| If yes, add to clinical record and incorporate relevant content into the IRP.<br>If no, would you like to create one? ☐Yes ☐No | |
| **What is your current satisfaction with your ability to manage a crisis?**<br>**1 2 3 4 5** | **Where would you like to be:**<br>**1 2 3 4 5** |
| Tell me more about your rationale for your current rating (include current barriers and past achievements/strengths)? | |
| **Do you want a goal in this area to be added to the IRP? (if yes, note this in SECTION 2)**<br>☐Yes ☐No<br>If yes, identify initial goal statement: | |

☐ Please check if this section will be completed during the Comprehensive Rehabilitation Needs Assessment.

**MENTAL STATUS EXAM**

| | | | |
|---|---|---|---|
| **Appearance (observed)** | ☐ Casual dress, normal grooming & hygiene<br>☐Other: | **Attitude (observed)** | ☐ Calm & Cooperative<br>☐ Hostile<br>☐ Evasive<br>☐ Other: |
| **Behavior (observed)** | ☐ No unusual movements or psychomotor changes<br>☐ Other: | **Speech (observed)** | ☐ Normal rate/tone/ volume/ without pressure<br>☐ Other: |
| **Affect (observed)** | ☐ Normal range; mood congruent<br>☐ Labile<br>☐ Tearful<br>☐ Blunted<br>☐ Depressed<br>☐ Constricted<br>☐ Flat<br>☐ Other: | **Mood (inquired)** | ☐ Euthymic<br>☐ Irritable<br>☐ Elevated<br>☐ Anxious<br>☐ Depressed<br>☐ Other: |
| **Thought Process (observed/inquired)** | ☐ Goal-directed & logical<br>☐ Tangential<br>☐ Loose associations<br>☐ Disorganized<br>☐ Other: | | |
| **Thought Content (observed/inquired)** | ☐ Suicidal ideation<br>☐ None☐Passive ☐ Active<br>If active:<br>Plan: ☐ Yes ☐ No<br>Intent: ☐ Yes ☐ No<br>Means: ☐ Yes ☐ No | ☐ Homicidal ideation<br>☐ None ☐ Passive<br>☐ Active<br><br>If active:<br>Plan: ☐ Yes ☐ No<br>Intent: ☐ Yes ☐ No<br>Means: ☐ Yes ☐ No | ☐ Delusions<br>☐ Obsessions/compulsions<br>☐ Phobias |
| **Perception (observed/inquired)** | ☐ No hallucinations or delusions evident during interview<br>☐ Other: | **Orientation (inquired)** | ☐ Oriented x3<br>☐ Other: |
| **Memory/Concentration (observed/inquired)** | ☐ Short-term intact<br>☐ Long-term intact<br>☐ Distractible/Inattentive<br>☐ Immediate memory<br>☐ Other: | **Insight/Judgment (observed/inquired)** | ☐ Good<br>☐ Fair<br>☐ Poor |

**Additional Comments on Goal Planning Process (add relevant consumer comments and/or practitioner impressions):**

## SECTION 2: Transitioning the PRNA/CRNA to the Preliminary Individualized Rehabilitation Plan (PIRP)/Individualized Rehabilitation Plan (IRP)

Review information obtained in **SECTION 1 – PARTS A AND B**. Then list **ALL** goals gathered from **KEY LIFE DOMAINS** below:

| Goal | Goal |
|---|---|
| 1. | 8. |
| 2. | 9. |
| 3. | 10. |
| 4. | 11. |
| 5. | 12. |
| 6. | 13. |
| 7. | |

Assist the consumer in prioritizing the goals listed above. Then list the **top 2-3 goals** for immediate inclusion on the IRP. Also indicate a related valued life role (e.g., employee, student, neighbor, friend, etc.) for each of the top goals.
**NOTE: Complete IRP Worksheet 1 (Knowledge, Skills, and Resources) in order to break down the goal into its critical components.**

| Goal | Valued Life Role |
|---|---|
| 1. | |
| 2. | |
| 3. | |

| |
|---|
| List any active goals that he person is currently working on with previous service providers or other current service providers (e.g., a goal the person began working on in the hospital, a goal the person is working on at his/her supported employment program, partial care program, etc.): |
| Based on the information from the RNA, provide recommendations for referral to other rehabilitation service providers of supporters (e.g., supported employment, supported education, wellness center, partial care, etc.): |

## SECTION 3: SIGNATURES AND CREDENTIALS

**The development of this Preliminary/Comprehensive Rehabilitation Needs Assessment was a consumer driven process that included face-to-face evaluation by a licensed professional and meaningful discussion with the consumer.**

| Primary Service Coordinator: | Date Assigned: |
|---|---|
| Name : | Signature: |

| | | |
|---|---|---|
| Consumer's Name | Signature | Date |
| Licensed Practitioner's Name/Credentials | Signature | Date |
| Contributing Team Member Name/Credentials | Signature | Date |
| Contributing Team Member Name/Credentials | Signature | Date |
| Optional Signatures (family members, service providers, etc.) | Signature | Date |