

PERFORMANCE ON MAJOR LIFE ACTIVITY
Michigan Department of Health and Human Services

Name of Person Applying for HSW	Medicaid ID #	Date of Birth
*Diagnosis (Do not enter diagnosis code/s only)		

Performance on Major Life Activity completed by _____		is QIDP <input type="checkbox"/>
Tools Utilized to complete LOC		
<input type="checkbox"/> Bio-Psychosocial Assessment <input type="checkbox"/> Clinical Assessment <input type="checkbox"/> Observation <input type="checkbox"/> Direct Interview <input type="checkbox"/> Other		

PERFORMANCE ON AREAS OF MAJOR LIFE ACTIVITY

0. **INDEPENDENT** – No help or oversight – or – help/oversight provided only 1 or 2 times during the last 7 days.
1. **SUPERVISION** – Oversight, encouragement or cuing provided 3+ times during last 7 days – OR – supervision plus physical assistance provided only 1 or 2 times during last 7 days. Person is able to complete task/skill with oversight and encouragement or limited cuing.
2. **LIMITED ASSISTANCE** – Person is highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3+ times – or – more help provided only 1 or 2 times during last 7 days. Person is highly involved in activity, need for limited prompting, and guidance to complete task/skill.
3. **EXTENSIVE ASSISTANCE** – While person performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:
 - Weight Bearing Support.
 - Full staff performance during part (but not all) of last 7 days.
 - Frequent daily need for assistance/ training to direct, guide, teach for skill acquisition/ task completion.
4. **TOTAL DEPENDENCE** – Full staff performance of activity during entire 7 days. Hand over hand assistance to teach/complete task.

**** Specify any devices or equipment needed for any area of major life activity in the space below each description and indicate performance (0-4 as described above) in the box to the right of each activity.** Please reference the Technical Assistance for Completing Performance on Areas of Major Life Activity Form for additional guidance.

a. Bed Mobility	How person moves to and from lying position, turns side-to-side, and positions body while in bed.	
b. Transfer	How person moves between surfaces, to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet).	
c. Dressing	How person puts on, fastens, and takes off all items of clothing, including donning/removing prosthesis.	

d. Eating	How person eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition).	
e. Toilet Use	How person uses the toilet room (or commode, bedpan, urinal), transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes.	
f. Personal Hygiene	How person maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, and hands and perineum (EXCLUDE baths and showers).	
g. Bathing	How person takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower.	
h. Receptive & Expressive Language	How person communicates with others to express their desires and needs, including understanding verbal, pictorial, or written communication. Person's ability to express or communicate requests, needs, opinions, urgent problems, and social conversation, whether in speech, writing, sign language, or a combination of these. Specify any devices used to communicate:	
i. Learning	How person learns new information, generalizes what they have learned to new situations. If there is a diagnosis of Intellectual disability, please specify below:	
j. Mobility	How person moves between locations on even surfaces. If in wheelchair, self-sufficient once in chair. Specify any mobility devices used:	
k. Self-Direction	How person directs their own life. How person plans, initiates activities, problem solves, carries out goal-directed activities, transitions from one activity to another, management of time, safety awareness. Describe any behavioral issues or concerns. If there is a guardian, please specify the areas in which person continues to make decisions:	

<p>l. Capacity for Independent Living</p>	<p>How person manages a household and schedule, including financial affairs (e.g., bill paying, money management), domestic responsibility (e.g., housekeeping, chores, maintenance), nutritional status (e.g., menu planning, shopping, cooking), arranging transportation if applicable, medication management and managing own health status.</p> <p>If under 18 and appropriate to age: how does the individual complete household chores/tasks, manage routine, and follow schedules.</p>	
<p>m. Economic Self-Sufficiency</p>	<p>How person is employed and whether his/her income is sufficient to support him/herself. If working toward economic self-sufficiency, when does person expect to achieve this?</p> <p>If under age 18 this should not be scored.</p>	