



National Ability Supports System (NASS)

Data collection form (v1.8)



Guidance

Please see **NASS system user manual** for information on all fields and service definitions. Only complete sections of the form relevant to the service user – *asterisked fields are required. Complete grids for service types currently availed of and those required in the next 5 years. Contact the NASS team: nass@hrb.ie

Administration

1. Main service provider* (Name of service)		2. Person responsible		3. Area of service Auto-populates in NASS	
3a. Health region of service		Area A – HSE Dublin and North East Area B – HSE Dublin and Midlands	Area C – HSE Dublin and South East Area D – HSE South West	Area E – HSE Mid West Area F – HSE West and North West	99 - Unknown
4. Area providing funding*		Areas (insert appropriate CHO number) CHO 1 - Donegal, Sligo/Leitrim, West Cavan and Cavan/Monaghan CHO 2 - Galway, Roscommon, Mayo CHO 3 - Clare, Limerick, North Tipperary/East Limerick CHO 4 - Kerry, North Cork, Cork North Lee, Cork South Lee, West Cork CHO 5 - South Tipperary, Carlow/Kilkenny, Waterford, Wexford CHO 6 - Wicklow, Dublin South including Dun Laoghaire, Dublin South East CHO 7 - Kildare/West Wicklow, Dublin West, Dublin South City, Dublin South West CHO 8 - Laois/Offaly, Longford/Westmeath, Louth/Meath CHO 9 - Dublin North, Dublin North Central, Dublin North West 99 - Unknown			
5. Service user (client) number		6. IHI		7. Referral date* (DD/MM/YY) __/__/__	
8. NIDD/NPSDD PIN		NASS ID		9. Date of death (DD/MM/YY) __/__/__	

Service user details

10. Forename* _____		22. Email address _____		25. Sex at birth* (circle code below) 1. Male 2. Female	
11. Surname* _____		23. Phone no. 1 _____		25a. Gender (Optional to identify if different to sex assigned at birth) 1. Man/boy 2. Woman/girl 3. Non-binary 4. Identifies in another way 5. Do not wish to disclose	
12. - 21. Address* _____ _____ _____		24. Phone no. 2 _____			
		26. Date of birth* (DD/MM/YY) __/__/__			
		27. Year of birth (YYYY) ____			

28. Employment status* (circle code below) 1. In paid employment (including part-time) 9. Supported employment 2. Unemployed 3. Training/day programme 4. Student/pupil 5. Housewife/husband 6. Retired 7. Unable to work due to disability 8. Other 99. Not known 29. If other, specify _____		30. Ethnic/cultural background* [self-identified] (circle code below) 9. White - Irish 10. White - Irish Traveller 11. White - Roma 12. White - Any other white background 13. Black or Black Irish - Black African 14. Black or Black Irish - Any other Black background 15. Asian or Asian Irish - Chinese 16. Asian or Asian Irish - Indian/Pakistani/Bangladeshi 17. Asian or Asian Irish - Any other Asian background 18. Other, including mixed group/background - Arabic 19. Other, including mixed group/background - Mixed, write in description 20. Other, including mixed group/background - Other, write in description 8. Do not wish to answer this question 99. Not known 30a. If other, specify _____		31. Living with* (circle code below) 1. Alone 2. Wife/husband/partner, no children 3. Wife/husband/partner and children 4. One parent 5. Both parents 13. One parent and sibling(s) 14. Both parents and sibling(s) 7. Daughter(s)/son(s) 8. Sibling(s) 9. Other relative(s) 10. Non-relative(s) 11. In a residential setting 12. Foster family 15. Home sharing – shared living family 99. Not known	
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Primary carer

33. Have you a primary carer? * (circle code below) 1. Yes 0. No 88. Not applicable		34. Do they live with you? (circle code below) 1. Yes 0. No 88. Not applicable		35. Relationship of primary carer (circle code below) 1. Wife/husband/partner 2. Parent 3. Foster parent 4. Daughter/son 5. Sibling 6. Other relative 7. Non-relative 88. Not applicable		36. Age group of primary carer (circle code below) 1. 17 years of age or under 2. 18 - 49 3. 50 - 59 4. 60 - 69 5. 70 - 79 6. 80 years of age or over 88. Not applicable 99. Not known	
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Nominated person

Complete nominated person section for all service users aged less than 16 years. *Asterisked fields are only required where 'Nominated person' details are provided.

37. Name _____
(forename and surname)

38. Address* – please tick if same as service user otherwise record below:

Eircode _____

45. Email _____

46. Phone no. 1* _____

47. Phone no. 2 _____

48. Relationship to service user* (circle code below)

1. Wife/husband/partner
2. Parent
3. Foster parent
4. Daughter/son
5. Sibling
6. Other relative
7. Non-relative

49. Best time to contact _____

37.1. Name _____
(forename and surname)

38.1. Address* – please tick if same as service user otherwise record below:

Eircode _____

45.1. Email _____

46.1. Phone no. 1* _____

47.1. Phone no. 2 _____

48.1. Relationship to service user* (circle code below)

1. Wife/husband/partner
2. Parent
3. Foster parent
4. Daughter/son
5. Sibling
6. Other relative
7. Non-relative

49.1. Best time to contact _____

Detail of Disability

50. Disability type*

- | | Primary
(Select one) | Secondary
(Select all that
apply) |
|---|--------------------------|---|
| 1. Intellectual | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Autism | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Deafblind – dual sensory | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Developmental delay (under 10 years only) | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Hard of hearing and/or Deafness | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Neurological | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Physical | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Specific learning difficulty (other than intellectual) | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Speech and/or language | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Visual | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Mental health | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Not verified | <input type="checkbox"/> | <input type="checkbox"/> |

51. Degree of intellectual disability*

(If 1. Intellectual selected at Q50, please record degree of intellectual disability - circle code below)

1. Borderline
2. Mild
3. Moderate
4. Severe
5. Profound
6. Not verified

Record diagnosis or diagnoses *Diagnosis is not mandatory but if diagnosis information is recorded, asterisked fields are required.

52. Diagnosis 1 (see diagnosis list)

54. Source of diagnosis*

- (circle code below)
1. Hospital specialist
 2. GP
 3. Multidisciplinary team
 4. Psychiatrist
 5. Other healthcare professional
 6. CDNT information

52.1 Diagnosis 2

54.1 Source of diagnosis*

- (circle code below)
1. Hospital specialist
 2. GP
 3. Multidisciplinary team
 4. Psychiatrist
 5. Other healthcare professional
 6. CDNT information

52.2 Diagnosis 3

54.2 Source of diagnosis*

- (circle code below)
1. Hospital specialist
 2. GP
 3. Multidisciplinary team
 4. Psychiatrist
 5. Other healthcare professional
 6. CDNT information

Services Use the relevant sections below to record service types currently availed of and required within 5 years.

Residential

Residential setting

- | | |
|--|--|
| 14. Accommodation in the community | 9. Specialist facility – mental health comorbidity |
| 15. Accommodation on campus [c] | 10. Psychiatric hospital |
| 4. Nursing home | 11. Other hospital |
| 5. Specialist facility – dementia | 12. Hospice |
| 6. Specialist facility – challenging behaviour | 13. Home sharing - shared living family |
| 7. Specialist facility – neurological | |
| 8. Specialist facility – physical | |

Note: Residential code marked [c] should only be current and ideally, should not be selected as a future service need.

Current 57.1-71.1 Please complete the grid below using a row for each residential service the service user avails of currently. Insert the appropriate number (code) to record the type of residential service, level of support provided, number of nights per week and if enhancement is required.

Service provider* (Name of service)	Location (Address or other location details of service)	Residential setting* (Enter code from list above)	Referral reason (see list - page 6)	Level of support* (Code)	Start date* (DD/MM/YY)	Date service ended (DD/MM/YY) <i>Required if a service is no longer being received or if an intervention has ended.</i>	Nights per week* (Code)	Enhancement required in next 12 months?* (Code)
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Unmet need 72.1-76.1 Please complete grid below using a row for each unmet need for residential service. Insert the appropriate number (code) to record the type of residential service, level of support, year required and if formally assessed.

Residential setting* (Enter code from list above)	Level of support* (Code)	Year service required* (Enter year YYYY) <i>Must be within next 5 years (current year +5).</i>	Has this requirement been formally assessed?*
	1. Minimum 2. Low 3. Medium 4. High 5. Intensive 1 to 1 6. Intensive > 1 to 1 88. Not applicable		1. Yes 2. Yes, and on local authority housing list (residential only) 0. No 99. Not known

Day

Day service

- | | |
|---|--|
| 24. New Directions day programme | 19. Mainstream primary/secondary school |
| 25. Other day programme (non-New Directions) | 20. Special primary/secondary school |
| 9. Rehabilitative training | 21. Special class or unit in mainstream primary/secondary school |
| 12. Mainstream early childhood education and care | 22. Third level education |
| 13. Special early childhood education and care | 23. Home tutor |

Current 57.2-71.2 Please complete the grid below using a row for each day service the service user avails of currently. Insert the appropriate number (code) to record the type of day service, level of support provided, number of days per week, number of weeks per year and if enhancement is required.

Service provider* (Name of service)	Location (Address or other location details of service)	Day service* (Enter code from list above)	Level of support* (Code)	Start date* (DD/MM/YY)	Date service ended (DD/MM/YY) <i>Required if a service is no longer being received or if an intervention has ended.</i>	Days/Week* (No. 0.5-7)	Enhancement required in next 12 months?* (Code)
			1. Staff to service user ratio is 1 to 10+ 2. Between 1 to 6 and 1 to 9 3. Between 1 to 4 and 1 to 5 4. 1 to 3 5. 1 to 2 6. 1 to 1 7. Greater than 1 to 1 88. Not applicable	--/--	--/--	---	1. Yes 2. Yes – increased staff to service user ratio 3. Yes – additional support hours/days/nights 4. Yes – increased staff to service user ratio and additional support hours/days/nights 5. Yes – child to adult services 7. Yes – incompatible placement 8. Yes – level of support beyond funding allocation (day only) 0. No 99. Not known
				--/--	--/--	---	

Unmet need 72.2-76.2 Please complete grid below using a row for each unmet need for day service. Insert the appropriate number (code) to record the type of day service, level of support, year required and if formally assessed.

Day service* (Enter code from list above)	Level of support* (Enter code from list above)	Year service required* (Enter year YYYY) <i>Must be within next 5 years (current year +5).</i>	Has this requirement been formally assessed?* (Code)
			1. Yes 0. No 99. Not known

Day respite

Day respite service

- | | |
|--|-------------------------------------|
| 1. Centre based respite (includes clubs and camps) | 3. Home sharing short breaks family |
| 2. Own home respite (includes evenings) | 4. Home sharing contract family |

Current 57.3-71.3 Please complete the grid below using a row for each **day respite service** the service user avails of currently. Insert the appropriate number (code) to record the type of day respite service, level of support provided, number of day sessions and if enhancement is required.

Service provider* (Name of service)	Location (Address or other location details of service)	Day respite service* (Code)	Level of support* (Code) 1. Staff to service user ratio is 1 to 10+ 2. Between 1 to 6 and 1 to 9 3. Between 1 to 4 and 1 to 5 4. 1 to 3 5. 1 to 2 6. 1 to 1 7. Greater than 1 to 1 88. Not applicable	Start date* (DD/MM/YY)	Date service ended (DD/MM/YY) Required if a service is no longer being received or if an intervention has ended.	Sessions* (Number)	Enhancement required in next 12 months?* (Code) 1. Yes 2. Yes – increased staff to service user ratio 3. Yes – additional support hours/days/nights 4. Yes – increased staff to service user ratio and additional support hours/days/nights 5. Yes – child to adult services 6. Yes – incompatible placement 0. No 99. Not known
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		---	---	--/--/--	--/--/--		---
		---	---	--/--/--	--/--/--		---

Unmet need 72.3-76.3 Please complete grid below using a row for each **unmet need** for day respite service. Insert the appropriate number (code) to record the type of day respite service, level of support, year required and if formally assessed.

Day respite service* (Enter code from list above)	Level of support* (Enter code from list above)	Year service required* (Enter year YYYY) Must be within next 5 years (current year +5).	Has this requirement been formally assessed?* (Code) 1. Yes 0. No 99. Not known
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Overnight respite

Overnight respite service

- | | |
|---|---------------------------------------|
| 1. House in the community/centre-based respite | 4. Holiday respite (hotel/B&B/hostel) |
| 2. Own home respite | 5. Home sharing short breaks family |
| 3. Holiday respite (residential/centre-based/summer camp) | 6. Home sharing contract family |
| | 7. Nursing home respite |

Current 57.4-71.4 Please complete the grid below using a row for each **overnight respite service** the service user avails of currently. Insert the appropriate number (code) to record the type of overnight respite service, level of support provided, number of nights and if enhancement is required.

Service provider* (Name of service)	Location (Address or other location details of service)	Overnight respite service* (Code)	Level of support* (Code) 1. Minimum 2. Low 3. Medium 4. High 5. Intensive 1 to 1 6. Intensive > 1 to 1 88. Not applicable	Start date* (DD/MM/YY)	Date service ended (DD/MM/YY) Required if a service is no longer being received or if an intervention has ended.	Respite nights received* (Number)	Enhancement required in next 12 months?* (Code) 1. Yes 2. Yes – increased staff to service user ratio 3. Yes – additional support hours/days/nights 4. Yes – increased staff to service user ratio and additional support hours/days/nights 5. Yes – child to adult services 7. Yes – incompatible placement 0. No 99. Not known
		---	---	--/--/--	--/--/--		---
		---	---	--/--/--	--/--/--		---
		---	---	--/--/--	--/--/--		---
		---	---	--/--/--	--/--/--		---

Unmet need 72.4-76.4 Please complete grid below using a row for each **unmet need** for overnight respite service. Insert the appropriate number (code) to record the type of overnight respite service, level of support, year required and if formally assessed.

Overnight respite service* (Enter code from list above)	Level of support* (Enter code from list above)	Year service required* (Enter year YYYY) Must be within next 5 years (current year +5).	Has this requirement been formally assessed?* (Code) 1. Yes 0. No 99. Not known
---	---	---	---
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Supports for daily living

Supports for daily living services

- | | | |
|---|---|--|
| <ol style="list-style-type: none"> 1. Personal assistant 2. Home support (including Supported Self-Directed Living support) | <ol style="list-style-type: none"> 9. Supported Self-Directed Living support – sleepover cover at night 10. Supported Self-Directed Living support – awake cover at night | <ol style="list-style-type: none"> 3. Community support 4. Participation in voluntary work |
|---|---|--|

Current 57.5-71.5 Please complete the grid below using a row for each **support for daily living** the service user avails of currently. Insert the appropriate number (code) to record the type of support for daily living, level of support provided, number of hours per week and if enhancement is required.

Service provider* (Name of service)	Location (Address or other location details of service)	Support for daily living* (Code)	Level of support* (Code) 1. Staff to service user ratio is 1 to 10+ 2. Between 1 to 6 and 1 to 9 3. Between 1 to 4 and 1 to 5 4. 1 to 3 5. 1 to 2 6. 1 to 1 7. Greater than 1 to 1 88. Not applicable	Start date* (DD/MM/YY)	Date service ended Required if a service is no longer being received or if an intervention has ended. (DD/MM/YY)	Hours/Week* (Number)	Enhancement required in next 12 months?* (Code) 1. Yes 2. Yes – increased staff to service user ratio 3. Yes – additional support hours/days/nights 4. Yes – increased staff to service user ratio and additional support hours/days/nights 5. Yes – child to adult services 0. No 99. Not known
		___	___	___/___/___	___/___/___		___
		___	___	___/___/___	___/___/___		___
		___	___	___/___/___	___/___/___		___

Unmet need 72.5-76.5 Please complete grid below using a row for each **unmet need** for supports for daily living. Insert the appropriate number (code) to record the type of support, level of support, year required and if formally assessed.

Support for daily living* (Enter code from list above)	Level of support* (Enter code from list above)	Year service required* (Enter year YYYY) Must be within next 5 years (current year +5).	Has this requirement been formally assessed?* (Code) 1. Yes 0. No 99. Not known
___	___	___	___
___	___	___	___

Specialist supports

Specialist supports

- | | | |
|---|---|--|
| <ol style="list-style-type: none"> 1. Assistive technology/client technical service 2. Behaviour therapy 3. Case manager 4. Key worker 5. Complementary therapy 6. Creative therapy 7. Dietetics 8. Orthotics/prosthetics 9. Chiropody 10. Dentistry/orthodontics 11. Palliative care 12. Nursing | <ol style="list-style-type: none"> 13. Occupational therapy 14. Play therapy 15. Physiotherapy 16. Psychiatry 17. Clinical psychology 18. Counselling psychology 19. Educational psychology 20. Neuro psychology 21. Resource Teacher 22. Special Needs Assistant (SNA) 23. Social work 24. Speech and language therapy | <ol style="list-style-type: none"> 25. Vision communication - IT/AT & alternative formats 26. Vision rehabilitation services 27. Neurorehabilitation services 28. Aural communication - IT/AT & alternative formats 29. Aural rehabilitation services 30. Animal-assisted therapy 31. Children’s Disability Network Team (CDNT) 32. Peer support 33. Advocacy 34. Transport services 35. Guide dog/assistance dog 36. Family and caregiver supports 37. Behavioural support |
|---|---|--|

Current 57.6-71.6 Please complete the grid below using a row for each **specialist support service** the service user avails of currently. Insert the appropriate number (code) to record the type of specialist support, frequency of support and if enhancement is required.

Service provider* (Name of service)	Location (Address or other location details of service)	Specialist support service* (Code)	Referral reason (see list - page 6)	Start date* (DD/MM/YY)	Date service ended Required if a service is no longer being received or if an intervention has ended. (DD/MM/YY)	Frequency of support* (Code) 1. Once a year 2. Once in 6 months 3. Once in 3 months 4. Once in 2 months 5. Once a month 6. Once in 2 weeks 7. Once a week 8. Twice a week 9. More than twice a week 10. As required	Enhancement required in next 12 months?* (Code) 1. Yes 2. Yes – increased staff to service user ratio 3. Yes – additional support hours/days/nights 4. Yes – increased staff to service user ratio and additional support hours/days/nights 5. Yes – child to adult services 9. Yes – additional clinical support required (specialist supports only) 0. No 99. Not known
		___	___	___/___/___	___/___/___	___	___
		___	___	___/___/___	___/___/___	___	___
		___	___	___/___/___	___/___/___	___	___

Unmet need 72.6-76.6 Please complete grid below using a row for each **unmet need** for specialist support. Insert the appropriate number (code) to record the type of specialist support, year required and if formally assessed.

Specialist support* (Enter code from list above)	Referral reason (see list - page 6)	Year service required* (Enter year YYYY) Must be within next 5 years (current year +5).	Has this requirement been formally assessed?* (Code) 1. Yes 0. No 99. Not known
___	___	___	___
___	___	___	___
___	___	___	___

Assistive products

You may record any assistive products that the service user currently uses or has been assessed as requiring - provide as much detail as possible about the item so that it can be identified using the NSAI assistive products list on NASS.

77. Current	77. Unmet need

Review

83. Review date* (DD/MM/YY) ___/___/___		84. Person responsible*	
85. Has the service user been involved in the completion of this form?*	86. Have others been involved in the completion of this form?*	87. If yes, what is their relationship to the service user?*	88. Does this person have a written person-centred plan/care plan?*
(circle code below) 1. Yes 0. No 99. Not known	(circle code below) 1. Yes 0. No 99. Not known	(circle code below) 1. Wife/husband/partner 2. Parent 3. Foster parent 4. Daughter/son 5. Sibling 6. Other relative 7. Non-relative 8. Professional/case worker 88. Not applicable	(circle code below) 1. Yes 0. No 99. Not known

Level of support definitions for residential and overnight respite services:

Minimum

The individual can live in this setting independently and can undertake activities or participate in life with minimal support/supervision. Staffing levels range from staff calling in during day to check their welfare/well-being to regular day presence/hours every day (not night). Staff may be available on-call.

Low

Individuals who are independent in many areas of their everyday living skills but require regular daily support and minimal night-time support.

Medium/moderate

Medium support level refers to situations where individuals have moderate levels of independence but require assistance or support to live/stay in this setting. Staff are on-site every day and on duty overnight (sleep cover).

High

High level support is for individuals who require 24-hour supervision/support for a variety of reasons. Support is provided during the day and overnight awake cover.

Intensive 1 to 1

Intensive level of support is for individuals who have high needs (such as challenging behaviours) and require intensive supervision/support. Staff are on duty for 24 hours, including overnight awake cover supervision/support.

Intensive greater than 1 to 1

Individuals who require greater than 1 to 1 support/supervision are those who always need help/supervision in their living/respite setting. Staffing levels are greater than 1 to 1 24/7.

Not Applicable

Only applies to 'Home sharing family' response options.

Referral reason for residential services:

31. Delayed transfer of care (DTC)

Referral reason for specialist support services:

Social Work

- 24. Social & Environmental Factors (Housing needs, Social isolation, transport, Financial strain)
- 25. Risk & Protection Concerns (Child protection, Substance abuse, Challenging behaviour, Safeguarding)
- 26. Health & Care Needs (Diagnosis, Medical Needs, Care Needs, sleep deprivation, supporting changing needs)
- 54. Social Work Input & Service Engagement (Advocacy, PsychoEducation, Crisis Management)
- 55. Services & Supports Access & Wait lists
- 56. Substance Use

Occupational therapy

- 1. Access/Environmental adaptations
- 2. Independence in Activities of Daily Living (ADLs)
- 3. Assistive Technology
- 4. Mental Health of Intellectual Disability
- 5. Occupational/meaningful engagement
- 7. Wheeled mobility and seating
- 8. Sensory Processing
- 60. Assistive Equipment (OT)
- 61. Falls Prevention
- 62. Needs Assessment (OT)
- 63. Supporting Transitions
- 64. Transport and Independent Travel
- 65. Vocational Skills and Supported Employment

Dietetics

- 32. Risk of Malnutrition
- 33. Overweight/Obesity
- 34. Micronutrient Difficulties
- 35. Tube Feeding
- 36. Wound Management
- 37. Bowel problems

Psychiatry

- 21. Assessment & Diagnosis (Psychiatry)
- 22. Substance Use (Psychiatry)
- 23. Treatment plan

Physiotherapy

- 9. Assessment (Physiotherapy)
- 10. Individual Treatment Session (Physio)
- 11. Group Treatment Session
- 12. Hydrotherapy
- 13. Functional Movement
- 14. Respiratory Status
- 15. Orthotic Clinic
- 16. Falls Clinic
- 17. Pain Clinic
- 39. Postural Management (Physio)
- 40. Lymphoedema
- 41. Reduced Mobility/Balance
- 42. Health Promotion Advice
- 43. MSK
- 44. Equipment

Psychology

- 18. Assessment & Diagnosis
- 19. Behavioural & Emotional Challenges
- 20. Training & Support
- 45. Planning & Provision of Interventions
- 46. Autism (diagnosed or undiagnosed)
- 47. Mental Health Need
- 48. Complex Need (dual diagnosis)
- 49. Changing Need (including dementia)
- 50. Transition Planning
- 51. Personal & Sexual Identity
- 52. Capacity
- 53. Substance Use

Speech and language

- 27. Assessments/Communication Assessment (SLT)
- 28. Individual Treatment Session (SLT)
- 29. Training & support (including family) (SLT)
- 30. EDS Difficulties
- 57. Communication Supports for Decision making/social communication
- 58. Augmentative Alternative Communication (AAC)
- 59. Dementia Care (SLT)

Comments