SPECIAL COMPENSATION FOR ASSISTANCE WITH ACTIVITIES OF DAILY LIVING (SCAADL) ELIGIBILITY

(Read DoD Instruction (DoDI) 1341.12,"Special Compensation for Assistance with Activities of Daily Living Program," DoD Manual (DoDM) 1341.12, "Special Compensation for Assistance with Activities of Daily Living Process," and the attached Instructions before completing this form.)

PRIVACY ACT STATEMENT

AUTHORITY: 37 U.S.C. Section 439; DoDD 5154.02; DoDI 1341.12, and E.O. 9397 (SSN), as amended.

PRINCIPAL PURPOSE(S): To allow a Service member to request SCAADL. To allow a DoD or VA licensed physician to certify or recertify that the applicant has a permanent catastrophic injury or illness that was incurred or aggravated in the line of duty and needs assistance from another person to perform personal functions required in everyday living or requires constant supervision and in the absence of the provision of such care would require hospitalization, nursing home, or other residential institutional care. To allow the Services to provide detailed monthly listings of individuals with such determinations to the Defense Finance and Accounting Service of the effective start and stop date of payments for special compensation for assistance with activities of daily living. To allow Commander or Service Designated Representative and DoD or VA licensed physician to determine the eligibility of the Service member to receive SCAADL.

ROUTINE USE(S): The DoD "Blanket Routine Uses" found at http://dpcld.defense.gov/Privacy/SORNsIndex/BlanketRoutineUses.aspx apply to this collection.

DISCLOSURE: Voluntary. However, failure to provide requested information may result in a denial or delay in processing your request for special compensation for assistance with activities of daily living.

DEFINITIONS

Designated Representative: A person designated to make SCAADL decisions for the Service member. This could be a person designated by the Service member, a court-appointed guardian, or a personal representative in accordance with DoD 6025.18-R.

DoD or VA Licensed Physician: A physician (excludes contractor physicians) with medical expertise in the determination of medical disability by nature of their medical specialty training, or completion of training specifically with the intent and requirements of SCAADL evaluation and certification.

Health Care Professional: Military (Active Duty/Reserve/National Guard) and civilian (GS and those working under contractual or similar arrangement) personnel who have received advanced education or training beyond the technical level in a recognized health care discipline and who are licensed, certified, or registered by a State, Government agency, or professional organization to provide specific health services in that field. This includes those involved in the provision of diagnostic, therapeutic, or preventive care, ancillary services, and administration.

Service Designated Representative: An individual authorized to certify a Service member's SCAADL eligibility on the DD Form 2948 on behalf of the respective Military Service.

ELIGIBILITY

For the Service member to be eligible for SCAADL, DoD policy requires that the person meet all four of the following conditions:

(1) has a permanent catastrophic injury or illness that was incurred or aggravated in the line of duty;
(2) has been certified by a DoD or VA licensed physician to be in need of assistance from another person to perform personal functions required in everyday living;
(3) in the absence of the provision of such assistance, would require hospitalization, nursing home care, or other residential institutional care; and
(4) meets such other criteria, if any, as the Secretary of Defense prescribes for purposes of this section.

PRESCRIBING DOCUMENTS

In accordance with DoDI 1341.12 and DoDM 1341.12, the following information is required to determine the qualification, compensation, and to recertify eligibility for the referenced Service member.

1. TYPE OF REQUEST:

☐ INITIAL APPLICATION ☐ RECERTIFICATION ☐ APPELLATE REVIEW

PART I - ELIGIBILITY CRITERIA *(The Service member is not eligible for SCAADL if any question in Section 6 is answered "No".)*

2. SERVICE MEMBER NAME *(Last, First, MI)*	3. CURRENT PAY GRADE *(e.g., O1 - O9; E1 - E9)*	4. SSN *(Last 4 digits)*	5. DATE OF BIRTH *(MM/DD/YYYY)*

6. DoD OR VA LICENSED PHYSICIAN - CERTIFYING PART I *(Select Yes or No to each question.)*
By signing this form, I certify that (1) the Service member would require hospitalization, nursing home care, or residential institutional care in the absence of assistance with any activities of daily living (ADLs), (2) I understand the intent of SCAADL, and (3) I have read the DoDI 1341.12 and DoDM 1341.12.

	YES	NO
a. Service member has a permanent catastrophic injury or illness (per DoDI 1341.12 and DoDM 1341.12).		
b. Service member needs assistance from another person to perform the personal functions required in everyday living or requires constant supervision.		
c. Service member, in the absence of assistance from another person, would require hospitalization, nursing home care, or other residential institutional care.		
d. Service member is an outpatient and has a designated primary caregiver.		

e. Service member ☐ **is eligible for SCAADL - OR -** ☐ **is not eligible for SCAADL.** *(Certifying blocks 6.a., b., c., and d.)*

f. PRINTED NAME *(Last, First, MI)*	g. CONTACT INFORMATION *(Email and/or telephone)*

h. SIGNATURE	i. DATE SIGNED *(MM/DD/YYYY)*

The Service member is not eligible for SCAADL if any question in Section 6 is answered "No". IF THE SERVICE MEMBER IS NOT ELIGIBLE FOR SCAADL BASED ON THE REQUIREMENTS IN SECTION 6, PROCEED TO SECTIONS 16 AND 17.

PART II - ASSESSMENT AND EVALUATION

(To be completed by DoD or VA Health Care Professional)

7. SOURCES USED TO COMPLETE THIS APPLICATION *(Select all that apply)*

☐ DIRECT OBSERVATION ☐ CHART REVIEW ☐ DESIGNATED PRIMARY CAREGIVER

8. SERVICE MEMBER MEDICAL FACILITY *(Facility Name, City, State, and ZIP Code)*	**9. PHYSICAL ADDRESS WHERE SERVICE MEMBER IS REHABILITATING** *(City, State, and ZIP Code)*

SCORING GUIDE

Refer to scoring guidance in Sections 10 and 11 of the DD Form 2948 Instructions.

COMBINED TOTAL SCORE:

Tier 1 (Low Dependence): 1 - 12 Tier 2 (Moderate Dependence): 13 - 20 Tier 3 (High Dependence): 21 or greater

10. ASSISTANCE WITH ACTIVITIES OF DAILY LIVING (ADL) REQUIREMENTS RESULTING FROM PERMANENT CATASTROPHIC INJURY OR ILLNESS *(Use Scoring Guide in the attached Instructions.)*

(1) AREA	**(2) SCORE** *(Enter 0 - 4)*	**(3) DID HEALTH CARE PROFESSIONAL OBSERVE?**		**(4) REASONS FOR SCORE** *(Include any pertinent information, as necessary, that explains the assessment score, i.e., in addition to what is defined under 10.(1)a. - 10.(1)g.)*
		YES	**NO**	
a. EATING *(Ability to feed self meals and snacks. This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten.)*				
b. GROOMING *(Ability to tend safely to personal hygiene needs; i.e., washing face and hands, hair care, shaving, teeth or denture care, fingernail care.)*				
c. BATHING *(Ability to wash entire body safely.)*				
d. DRESSING *(Ability to dress upper and lower body with or without dressing aids.)*				
e. TOILETING *(Ability to get to and from the toilet safely and to maintain perineal hygiene. If managing an ostomy, includes cleaning around stoma but not managing equipment.)*				
f. NEEDS ASSISTANCE WITH PROSTHETIC OR OTHER DEVICE *(Need of adjustment of any special prosthetic or orthopedic appliance which by reason of the particular disability cannot be done without aid; this will not include adjustments of appliances that non-disabled persons would be unable to adjust without aid, such as supports, belts, lacing at the back, etc.)*				
g. DIFFICULTY WITH MOBILITY *(Ability to transfer safely from bed to chair, ability to turn and position self in bed, ability to walk safely on a variety of surfaces)*				
h. TOTAL SCORE FOR ADL REQUIREMENTS				

11. SUPERVISION OR PROTECTION REQUIREMENTS *(Use Scoring Guide in the attached Instructions.)*				
(1) AREA	(2) SCORE *(Enter 0 - 4)*	(3) DID HEALTH CARE PROFESSIONAL OBSERVE?		(4) REASONS FOR SCORE *(Include any pertinent information, as necessary, that explains the assessment score, i.e., in addition to what is defined under 11.(1)a. - 11.(1)g.)*
		YES	NO	
a. REQUIRES SUPERVISION OR ASSISTANCE AS A RESULT OF SEIZURES *(Cannot be controlled with medication or require a complex medication regimen to control.)*				
b. DIFFICULTY WITH PLANNING AND ORGANIZING *(Requires supervision or assistance due to inability to plan or organize.)*				
c. SAFETY RISKS *(Requires supervision or assistance due to a risk to self or others and/or personal safety risks such as falls, wandering, inability to cross street safely, unsafe use of electrical/gas appliances, stove top or oven.)*				
d. DIFFICULTY WITH SLEEP REGULATION *(Requires supervision due to sleep dysregulation.)*				
e. REQUIRES ASSISTANCE OR SUPERVISION AS A RESULT OF DELUSIONS OR HALLUCINATIONS *(Requires supervision or assistance due to behavioral risks associated with delusions (irrational beliefs) and/or hallucinations (serious disturbances in perception).)*				
f. DIFFICULTY WITH RECENT MEMORY *(Requires supervision or assistance due to difficulty remembering recent events or learning new information.)*				
g. SELF REGULATION *(Requires supervision or assistance due to any of the following behaviors: aggressive or combative to self or others, verbally disruptive to include yelling ,threatening, excessive profanity, impaired decision making, inability to appropriately stop activities, disruptive, infantile or socially inappropriate behavior.)*				
h. TOTAL SCORE FOR SUPERVISION OR PROTECTION REQUIREMENTS				

12. TOTAL SCORES			
a. ADL SCORE *(from Block 10.(2)h.)*	b. SUPERVISION OR PROTECTION SCORE *(from block 11.(2)h.)*	c. COMBINED TOTAL SCORES	d. DEPENDENCE LEVEL

13. APPLICABLE ICD-09/10 CODES FOR SCORING SECTION 10 AND SECTION 11 *(Include ICD-09/10 code and clear text for each injury or illness.)*

14. HEALTH CARE PROFESSIONAL

By signing this form, I certify that I completed the assessment of the Service member's requirements for assistance with ADL and for supervision or protection.

a. SIGNATURE	b. DATE SIGNED *(MM/DD/YYYY)*

c. PRINTED NAME *(Last, First, MI)*	d. RANK AND/OR TITLE

e. TELEPHONE *(Include area code)*	f. EMAIL ADDRESS

15. DoD OR VA LICENSED PHYSICIAN *(Certifying Part II)*

By signing this form, I certify the assessment of the health care professional in Sections 10 through Section 13 and associated dependence level.

a. SIGNATURE	b. DATE SIGNED *(MM/DD/YYYY)*

c. PRINTED NAME *(Last, First, MI)*	d. RANK AND/OR TITLE

e. TELEPHONE *(Include area code)*	f. EMAIL ADDRESS

16. COMMANDER OR SERVICE DESIGNATED REPRESENTATIVE	**YES**	**NO**
a. Service member's permanent catastrophic injury(ies) or illness(es) were incurred or aggravated in the line of duty.		
b. Service member has designated a primary caregiver who will be at least 18 years of age, with the exception of the Service member's spouse, and is also not a military member.		
c. Service member is not receiving outpatient or in-home services (other than respite care) from another Federal agency for assistance with activities of daily living or supervision to avoid harm to self or others, to include TRICARE.		
d. Service member's caregiver is not receiving aid and attendance compensation from another Federal agency.		

e. Service member ☐ **is eligible for SCAADL - OR -** ☐ **is not eligible for SCAADL.** *(Certifying Sections 16.a., b., c., and d.)*

f. SIGNATURE	g. DATE SIGNED *(MM/DD/YYYY)*

h. PRINTED NAME *(Last, First, MI)*	i. RANK AND/OR TITLE

j. TELEPHONE *(Include area code)*	k. EMAIL ADDRESS

17. SERVICE MEMBER OR DESIGNATED REPRESENTATIVE ACKNOWLEDGEMENT AND SIGNATURE

a. I acknowledge both my Physician's certification of my SCAADL eligibility (Section 6) **AND** my Commander's or Service Designated Representative's certification of my SCAADL eligibility (Section 16).

☐ **I do intend to appeal this decision - OR -** ☐ **I do not intend to appeal this decision.**

I know I cannot receive special compensation for assistance with activities of daily living if (a) I receive aid and attendance compensation AND (b) my caregiver is also receiving the VA Family Caregiver stipend.

b. SIGNATURE	c. DATE SIGNED *(MM/DD/YYYY)*

d. PRINTED NAME *(Last, First, MI)*	e. CONTACT INFORMATION *(Email and/or telephone)*

INSTRUCTIONS FOR COMPLETING DD FORM 2948

(This application must be completed within 30 days from the date entered in 6.i. on this form by all responsible parties. If not completed within 30 days, a new evaluation must be processed.)

1. TYPE OF REQUEST:

"Initial Application" – This is a new application. Complete all sections of this form.

"**Recertification"** – This is a periodic (at least 6 months) recertification of eligibility for SCAADL compensation by a DoD or VA licensed physician. Complete all sections of this form.

"Appellate Review" – The Service member was initially denied SCAADL eligibility by either a DoD or VA licensed physician or the member's Commander or Service Designated Representative, and is requesting another review and final determination on SCAADL eligibility. Complete all sections of this form.

PART I – ELIGIBILITY CRITERIA *(To be completed by DoD or VA licensed physician)*

2. SERVICE MEMBER NAME. As stated.

3. CURRENT PAY GRADE. Please use letter and number to convey current, not anticipated or projected, pay grade information; i.e., O1 - O9; E1 - E9; W1 - W5.

4. SSN. Please provide only last four digits.

5. DATE OF BIRTH. Enter date as a 2-digit month followed by 2-digit day and 4-digit year (01/01/2015).

6. DoD or VA LICENSED PHYSICIAN.

a. **Certifying Part I –** Select either Yes or No.
b. **Certifying Part I –** Select either Yes or No.
c. **Certifying Part I –** Select either Yes or No.
d. **Certifying Part I –** Select either Yes or No.
e. **Certifying blocks 6.a.- 6.d. –** Select either "Is eligible for SCAADL" or "Is not eligible for SCAADL."
f. **PRINTED NAME.** As stated.
g. **CONTACT INFORMATION.** As stated.
h. **SIGNATURE.** As stated.
i. **DATE SIGNED.** Enter date as a 2-digit month followed by 2-digit day and 4-digit year (01/01/2015).

PART II – ASSESSMENT AND EVALUATION

(To be completed by DoD or VA health care professional (Sections 10 - 14); DoD or VA licensed physician (Section 15); Commander or Service Designated Representative (Section 16); and Service member or Designated Representative (Section 17)).

7. SOURCES USED TO COMPLETE THIS APPLICATION. Select all that apply.

"Direct Observation" – DoD or VA health care professional directly observed the Service member's Activities of Daily Living (ADLs) requirements (Section 10) and Supervision or Protection requirements (Section 11).

"Chart Review" – DoD or VA health care professional used Service member's medical charts to determine the Service member's Activities of Daily Living (ADLs) requirements (Section 10) and Supervision or Protection requirements (Section 11).

"Designated Primary Caregiver" – DoD or VA health care professional used Service member's Primary Family Caregiver input to determine the Service member's Activities of Daily Living (ADLs) requirements (Section 10) and Supervision or Protection requirements (Section 11).

8. SERVICE MEMBER MEDICAL FACILITY. This is the location where the Service member receives primary medical treatment. Include medical facility name, city, state, and ZIP code.

9. PHYSICAL ADDRESS WHERE SERVICE MEMBER IS REHABILITATING. City, state, ZIP Code.

10. ASSISTANCE WITH ACTIVITIES OF DAILY LIVING (ADL) REQUIREMENTS RESULTING FROM PERMANENT CATASTROPHIC INJURY OR ILLNESS.

(1) Area – This section evaluates a Service member's requirement for assistance with ADLs in seven areas: eating, grooming, bathing, dressing, toileting, needs assistance with prosthetic or other device, and difficulty with mobility.

a. Eating. Ability to feed self meals and snacks. Note: This refers only to the process of eating, chewing and swallowing, not preparing the food to be eaten.

4 – Service member is unable to feed self and must be fed by Caregiver all meals and snacks or the Service member needs assistance to receive all nutrients through a nasogastric tube or gastrostomy.
3 – Service member is able to get food to mouth but needs assistance with using knife, fork or spoon; or needs assistance to receive supplemental nutrition through a nasogastric tube or gastrostomy.
2 – Service member is able to feed self independently but requires intermittent assistance or supervision.
1 – Service member requires no more than cueing, coaxing, verbal prompting or light touch to feed self.
0 – Service member completes task/activity without help.

10. ASSISTANCE WITH ACTIVITIES OF DAILY LIVING (ADL) REQUIREMENTS RESULTING FROM PERMANENT CATASTROPHIC INJURY OR ILLNESS *(Continued)***.**

b. Grooming. Ability to tend safely to personal hygiene needs (i.e., washing face and hands, hair care, shaving or make up, teeth or denture care, fingernail care)**.**

4 – Service member depends entirely on Caregiver for grooming needs.
3 – Service member is able to do part of some grooming activities but needs assistance throughout.
2 – Service member needs to have grooming utensils placed within reach before able to complete grooming activities.
1 – Service member requires no more than cueing, coaxing, verbal prompting or light touch to complete grooming activities.
0 – Service member completes task/activity without help.

c. Bathing. Ability to wash entire body safely.

4 – Service member is unable to participate effectively in bathing and is bathed totally by Caregiver.
3 – Service member is able to participate in bathing self in bed, at the sink, in bedside chair, or on commode with the assistance or supervision of Caregiver throughout the bath.
2 – Service member is able to participate in bathing self in shower or tub but requires presence of Caregiver throughout the bath for assistance or supervision.
1 – Service member is able to bathe in shower or tub with intermittent assistance such as intermittent supervision or encouragement or reminders or assistance with getting into or out of the shower or tub or for washing difficult to reach areas.
0 – Service member completes task/activity without help.

d. Dressing. Ability to dress upper and lower body with or without dressing aids.

4 – Service member depends entirely on Caregiver to dress upper and lower body.
3 – Service member needs assistance to put on upper body clothing or to put on undergarments, slacks, socks or nylons, and shoes.
2 – Service member is able to dress upper body or lower body if clothing and shoes are laid out or handed to the Service member.
1 – Service member requires no more help than cueing, coaxing, verbal prompting or light touch to dress.
0 – Service member completes task/activity without help.

e. Toileting. Ability to get to and from the toilet safely and to maintain perineal hygiene, if managing an ostomy, includes cleaning area around stoma but not managing equipment.

4 – Service member is totally dependent in toileting.
3 – Service member is unable to get to and from the toilet but is able to use a bedside commode, bed pan/urinal independently.
2 – Service member requires assistance from a Caregiver to maintain toileting hygiene and/or adjust clothing.
1 – Service member is able to get to and from the toilet and manage toileting hygiene with cueing, coaxing, verbal prompting or light touch.
0 – Service member completes task/activity without help.

f. Needs Assistance with Prosthetic/Other Device. Requires adjustment of any special prosthetic or orthopedic appliance which by reason of the particular disability cannot be done without aid. This will not include the adjustment of appliances that non-disabled persons would be unable to adjust without aid, such as supports, belts, lacing at the back, etc.

4 – Service member is unable to put on or adjust a prosthetic device without Caregiver assistance.
3 – Service member is able to assist in putting on or adjusting prosthetic device but still requires Caregiver assistance to complete the task.
2 – Service member is able to manage putting on or adjusting prosthetic device if Caregiver sets up equipment.
1 – Service member manages putting on or adjusting prosthetic device with Caregiver providing cueing, coaxing, verbal prompting or light touch.
0 – Service member completes task/activity without help.

g. Difficulty with Mobility. Ability to transfer safely from bed to chair, ability to turn and position self in bed, ability to walk safely on a variety of surfaces.

4 – Service member is unable transfer and to turn and position self or unable to ambulate and be up in a chair.
3 – Service member is unable to transfer and is unable to bear weight or pivot when transferred by the Caregiver. Is able to turn and position self in bed.
2 – Service member is unable to walk (with or without assistive devices) or negotiate stairs without the assistance or supervision of a Caregiver.
1 – Service member is able to transfer and walk on even and uneven surfaces with minimal assistance from the Caregiver.
0 – Service member completes task/activity without help.

h. Total Score for ADL Requirements. This section sums up the scores from 10.a.-10.g.

(2) Score – For 10.a.-10.g., each score must be linked to a task actually performed by a caregiver for a Service member. Use of adaptive equipment or risks of danger are insufficient grounds for a score. A Caregiver must actually be required to assist with the task or be present with the Service member to prevent harm to self or others.

(3) Did Health Care Professional Observe – Select either Yes or No.

(4) Reasons for Score – Include any pertinent information, as necessary, that explains the assessment score; i.e., in addition to what is defined under 10.(1).

11. SUPERVISION OR PROTECTION REQUIREMENTS.

(1) Area – This section evaluates a Service member's requirement for supervision or protection.

a. Requires Supervision or Assistance as a Result of Seizures. Service member requires supervision or assistance due to seizures which cannot be controlled with medication or require a complex medication regimen to control.

4 – Service member's seizure condition requires that a Caregiver be available to administer emergency medications at onset or immediately following a seizure.
3 – Service member has a highly complex seizure medication regimen requiring multiple medications, varying dosages, special instructions and actions and requires Caregiver to administer to assure proper management.
2 – Service member requires Caregiver direction to follow regimen in taking multiple medications for seizure, (varying time intervals, some with specific times for administration such as every 6 hours).
1 – Service member is able to follow seizure medication regimen after medications are organized by Caregiver also may need occasional reminders.
0 – Service member completes task/activity without help.

b. Difficulty with Planning and Organizing. Service member requires supervision or assistance due to inability to plan and organize.

4 – Service member is unable to initiate and complete tasks and requires Caregiver to motivate and break down each task into smaller steps and requires Caregiver assistance throughout.
3 – Service member requires the assistance of a Caregiver to plan the day, schedule all appointments and assure that appointments are kept, review tasks that must be completed.
2 – Service member is able to initiate and complete tasks with occasional direction from the Caregiver.
1 – Service member requires minimal cueing, coaxing, verbal prompting or light touch to complete tasks or make and keep appointments.
0 – Service member completes task/activity without help.

c. Safety Risks. Service member requires supervision or assistance due to a risk to self or others and/or personal safety risks such as falls, wandering, inability to cross street safely, unsafe use of electrical appliances, stove top or oven.

4 – Service member is at risk of harming self or others without constant Caregiver supervision.
3 – Service member is unable to leave the home or is unable to use electrical or cooking appliances without direct Caregiver supervision.
2 – Service member is able to leave the home and will be safe when remaining in a defined area or Service member able to safely use electrical or cooking appliances with occasional direction from the Caregiver.
1 – Service member is able to leave the home safely and is able to safely us e electrical and cooking appliances with Caregiver cueing, coaxing, verbal prompting or light touch.
0 – Service member completes task/activity without help.

d. Difficulty with Sleep Regulation. Service member requires supervision or assistance due to sleep dysregulation.

4 – Service member is awake all night, requires overnight safety precautions such as locked doors to prevent wandering and overnight supervision by Caregiver.
3 – Service member frequently awakens in middle of night with frightening nightmares and requires the assistance of Caregiver to be able to calm down.
2 – Service member is likely to sleep all day and have poor sleep hygiene without Caregiver direction.
1 – Service member stays up late into the night, physical presence of Caregiver in the home is essential but Service member is able to get sleep. Occasional direction from the Caregiver is required to regulate Service member's sleep.
0 – Service member completes task/activity without help.

e. Requires Assistance or Supervision as a Result of Delusions or Hallucinations. Service member requires supervision or assistance due to behavioral risks associated with delusions (irrational beliefs) and/or hallucinations (serious disturbances in perception).

4 – Service member expresses delusional thoughts or has hallucinations daily and requires full-time Caregiver supervision.
3 – Service member expresses delusional thoughts or has hallucinations several times a week which require Caregiver supervision.
2 – Service member expresses delusional thoughts or has hallucinations several times a month which require Caregiver supervision.
1 – Service member expressions delusional thoughts or has hallucinations once a month or less which require Caregiver supervision.
0 – Service member completes task/activity without help.

f. Difficulty with Recent Memory. Service member requires supervision or assistance due to difficulty remembering recent events or learning new information.

4 – Service member's memory problems are severe with inability to recall events of past 24 hours so that supervision by Caregiver is required.
3 – Service member's memory problems impact ability to work, help at home, drive or care for children placing responsibility for these activities on the Caregiver.
2 – Service member requires cueing, coaxing, verbal prompting or light touch by Caregiver to recall recent information.
1 – Service member occasionally needs assistance and utilizes electronic devices such as PDA or cell phone to assist with memory, Caregiver may need to prompt Service member to use the device.
0 – Service member completes task/activity without help.

INSTRUCTIONS FOR COMPLETING DD FORM 2948 *(Continued)*

11. SUPERVISION OR PROTECTION REQUIREMENTS *(Continued)*.

g. Self-Regulation. Service member requires supervision or assistance due to any of the following behaviors: aggressive or combative to self or others, verbally disruptive including yelling, threatening, excessive profanity, impaired decision making, inability to appropriately stop activities, disruptive, infantile or socially inappropriate behavior.
4 Service member displays one or more of the behaviors (described above) on a daily basis and thus requires Caregiver supervision.
3 Service member displays one or more of the behaviors (described above) several times a week requiring Caregiver supervision.
2 Service member displays one or more of the behaviors (described above) several times a month requiring Caregiver supervision.
1 Service member displays one or more of the behaviors (described above) once a month or less requiring Caregiver supervision.
0 Service member completes task/activity without help.

h. Total Score for Supervision or Protection Requirements. This section sums up the scores from 11.a.-11.g.

(2) Score. For 11.a.-11.g., each score must be linked to a task actually performed by a caregiver for a Service member. Use of adaptive equipment or risks of danger are insufficient grounds for a score. A Caregiver must actually be required to assist with the task or be present with the Service member to prevent harm to self or others.

(3) Did Health Care Professional Observe – Select either Yes or No.

(4) Reasons for Score – Include any pertinent information, as necessary, that explains the assessment score; i.e., in addition to what is defined under 11.(1).

12. TOTAL SCORES.
a. ADL. This is the total score from 10.h.
b. Supervision or Protection. This is the total score from 11.h.
c. Combined Total Scores. This is the sum of the total score from 10.h. and the total score from 11.h., entered in block 12.c.
d. Dependence Level. Based on the combined total scores in 12.c., a Service member receives a dependence level (e.g., Tier 1, Tier 2, or Tier 3), as described in the Scoring Guide on page 2 of this form.

13. APPLICABLE ICD 09/10 CODES FOR SCORING SECTION 10 AND SECTION 11. List **ALL** ICD 09/10 codes that were used to score each of the subareas Section 10 and Section 11; include clear text for each injury or illness.

14. HEALTH CARE PROFESSIONAL. By signing this form, I certify that I completed the assessment of the Service member's requirements for assistance with ADL and for supervision or protection.
a. SIGNATURE.
b. DATE SIGNED. Enter date as a 2-digit month followed by 2-digit day and 4-digit year (01/01/2015).
c. PRINTED NAME. As stated.
d. RANK AND/OR TITLE. As stated.
e. TELEPHONE. As stated.
f. EMAIL ADDRESS. As stated.

15. DoD OR VA LICENSED PHYSICIAN. Certifying Part II.
a. SIGNATURE.
b. DATE SIGNED. Enter date as a 2-digit month followed by 2-digit day and 4-digit year (01/01/2015).
c. PRINTED NAME. As stated.
d. RANK AND/OR TITLE. As stated.
e. TELEPHONE. As stated.
f. EMAIL ADDRESS. As stated.

16. COMMANDER or SERVICE DESIGNATED REPRESENTATIVE. Certifying 15.a.-15.d.
a. Select either Yes or No.
b. Select either Yes or No.
c. Select either Yes or No.
d. Select either Yes or No.
e. Select either "Is eligible for SCAADL" or "Is not eligible for SCAADL."
f. SIGNATURE. As stated.
g. DATE SIGNED. Enter date as a 2-digit month followed by 2-digit day and 4-digit year (01/01/2015).
h. PRINTED NAME. As stated.
i. RANK AND/OR TITLE. As stated.
j. TELEPHONE. As stated.
k. EMAIL ADDRESS. As stated.

17. SERVICE MEMBER OR DESIGNATED REPRESENTATIVE ACKNOWLEDGEMENT AND SIGNATURE.
a. Select appropriate acknowledgement box.
b. SIGNATURE. As stated.
c. DATE SIGNED. Enter date as a 2-digit month followed by 2-digit day and 4-digit year (01/01/2015).
d. PRINTED NAME. As stated.
e. CONTACT INFORMATION. As stated.