INSTRUCTIONS

FOR COMPLETING THE

MEDICAL ELIGIBILITY DETERMINATION TOOL FOR CHILDREN

(MED KIDS - PDN)

January, 2011

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INTRODUCTION: PHILOSOPHY AND INTENT OF MED KIDS

The Medical Eligibility Determination Tool for Children (MED Kids tool) was designed to be an objective tool that focuses on the immediate medical and psychiatric symptoms of children ages 18 and under. The MED Kids tool is set up in 14 basic sections with supplemental screens for behavior and cognition. Its organization is similar to the Medical Eligibility Determination (MED) tool for Adults and Maine's family of Minimum Data Set (MDS) resident assessment instruments, which are used in Nursing Facility (NF) and Residential Care Facility (RCF) settings. This similarity makes data collection easier across long-term care programs and settings.

The MED Kids tool was created by modifying the current MED tool and drawing on existing child assessment tools and items. A comprehensive list of child assessment items found on other child assessment forms was assembled. This list was then compared with assessment items already included on the MED tool. Child assessment items not already on the MED tool were reviewed to determine what value, if any, they might add to a MED Kids tool. Other items of interest included those with a MED tool equivalent that used more child-appropriate wording or examples than those used on the MED tool.

Nurse assessors helped to pinpoint areas of the MED tool that were difficult to score for children and reviewed the list of compiled child assessment items for more appropriate alternatives to problematic MED tool items. In general, assessors felt that codes and items on the MED tool could be adapted to children when the assessor is knowledgeable about children and familiar with their normal stages of development. However, there were several sections of the tool that they described as consistently difficult to score. These sections were:

- **Activities of Daily Living (ADLs)**: Items are not appropriate measures of the functioning of children under age two.
- **Independent Activities of Daily Living (IADLs)**: Most IADLs do not apply to children.
- **Diagnoses**: The diagnoses options on the MED tool are geared towards the elderly.

Some sections of the MED tool were not seen as relevant for the purpose of determining eligibility. These sections included Mood, Balance, Oral/Dental Status, and IADLs. Additionally, there was a general consensus among individuals involved in MED Kids tool design that the qualifying psychiatric behaviors and symptoms listed in policy needed to be clarified so that they described the high level of care needed to qualify for eligibility under the Katie Beckett option. These issues were taken into account when designing the new MED Kids tool.

Some original MED tool items, such as those in the Professional Nursing Services, Special Treatments, Vision and Nutritional sections, were already appropriate for children and were not changed at all. Other items, such as self-performance in ADLs and walking, required minor modifications in coding to make them more applicable to children. Whenever possible, the original format and wording of the MED tool was retained. When new items were added, they were done in a way to remain consistent with the language, definitions, and format of the MED tool. The MED Kids tool is an objective tool designed to be easily coded.

After feedback from the different assessors who would be using the tool, there was a decision to modify the MED Kids form into two versions to accommodate the different needs. Certain sections were taken out if they were not considered necessary by the assessor. The MED Kids – KB is to be used for Katie Beckett eligibility and the MED Kids – PDN is to be used for Private Duty Nursing.

These instructions provide detailed information on how to complete each section and item on the MED Kids tool. Other resources available as part of this manual include:

- A list of **clinical definitions** clarifying terms frequently used throughout the MED Kids tool (p. 9);
- **Examples of age appropriate performance** on Activities of Daily Living (p. 17);
- Child ADL support and self-performance **scoring examples** (p. 44);
- **General guidelines for age appropriate cognition** (p. 26), **behavior** (p. 29), and **communication/hearing** (p. 32);
- **General guidelines for age appropriate vision for infants** (p. 35)

MED KIDS – PDN TOOL INSTRUCTIONS

ASSESSOR RESPONSIBILITIES

Your general responsibilities as an assessor include:

- **Reading all training materials.**
- **Attending training sessions.**
- **Completing the assessments** in a thorough, efficient, and timely manner according to the requirements specified in various policies.
- **Supporting assessment scoring** with supplemental information and documentation when appropriate, and
- **Maintaining confidentiality.** It is crucial that all information gathered from all sources is treated as confidential: NO INFORMATION CAN BE DIVULGED BY AN ASSESSOR IN ANY WAY THAT WOULD SERVE TO IDENTIFY AN INDIVIDUAL CHILD. Try to conduct interviews with people in private. Keep all completed forms with you.

SECTION HEADER

The information in the header connects each section of the tool and **must be completed on each page.** Providers may choose to type in their provider number and agency name and reproduce their own supply of forms.

The Medical Eligibility Determination Tool for Children (MED Kids) Header includes the following items:

- Assessment Start Date;
- Name/Title of person coordinating assessment;
- Name/Phone number of Agency/Organization; and
- Provider number.

ASSESSMENT START DATE: This date establishes a common reference point to reflect the child's status and expected care needs. For the month and day of the assessment, enter two digits each, using zero (0) in the first box for a 1-digit month or day; use four digits for the year.

NAME/TITLE OF PERSON COORDINATING ASSESSMENT: This should be the name of the person responsible for the completion of the assessment tool. To the right of the name, enter this person's title.

AGENCY/ORGANIZATION: Enter the name of the agency or organization that is performing this assessment. To the right of the name, enter the phone number of the agency and extension of the coordinator, if applicable.

NPI #: If applicable, enter the ten-digit National Provider Number of the agency/organization.

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

This section contains the child's demographic information as well as parent/guardian contact information. This section may follow the child to prevent repetitive questioning and verification of demographic information by every provider. The child's parent or legal guardian needs to give release of information authorization for this section to be shared with other providers.

A.1 **Child's Name:** Print applicant's legal name clearly, using capital letters for first name, middle initial and last name.

A.2 **Child's Address:** Give applicant's residential address and ten-digit phone number at time of assessment.

A.3 **Social Security No. and MaineCare No.:** Enter the applicant's Social Security number and MaineCare number. Check the numbers to make sure you entered the digits correctly.

A.4 **Assessment Trigger:** Select the option that matches this referral request.

1. Service Need: Referent requests an assessment based on the consumer's need for service.

2. Reassessment due: Only applies to children with currently complete and valid assessments due to expire, and reassessment is required to determine continued medical eligibility.

3. Significant Medical Change: Only applies to children with a currently complete assessment. Indicators of significant change must be met. **A significant change in status** is defined as a major change in the child's status that: is not self-limiting; impacts on more than one area of the child's health status; and requires interdisciplinary review and/or revision of the care plan. A significant change assessment may be requested if a change is consistently noted in two or more areas of decline or two or more areas of improvement and results in a change in eligibility outcome.

4. Financial Change: Only applies to children with a currently complete assessment for whom financial eligibility has changed because of income, assets, or funding.

5. Other

A.5 **Gender:** Enter "1" for Male or "2" for Female.

A.6 **Race/Ethnicity:** Ask the child or parent/guardian when appropriate what best describes their race or ethnic background. This is an optional question.

A.7 **Birth date:** Use all spaces provided. For a one-digit month or day, place a zero in the first space. For example, January 2, 2001 should be entered as 01-02-2001.

A.8 **Citizenship:** Choose one answer from "1" U. S. Citizen, "2" Legal alien, or "3" Other.

A.9 **Primary Language:** Code for the language that the child primarily speaks or understands. Enter "0" for English, "1" for French, "2" for Spanish, or "3" Other for any language other than English, French, or Spanish. If the primary language is none of the three listed languages, specify the language in the space provided.

A.10 **Child's current qualifying condition:** Ask the child or parent/guardian when appropriate what they perceive as the child's primary condition which would qualify them for Katie Beckett eligibility or Private Duty Nursing (PDN) services. Code this condition as either "1" Medical or "2" Psychiatric/Behavioral.

ITEMS A.11-A.15 Collect the names and telephone numbers of people who can be contacted in the event of an emergency involving the child. When no contact information is available for a person (e.g. mother or father is not in the child's life or no legal guardian), draw a line across the section of the form where the contact information would have been reported.

A.11 **Mother's identifying information:** Please print the mother's first and last name clearly. Give mother's residential address and enter the mother's complete ten-digit home telephone number and work number if applicable.

A.12 **Father's identifying information:** Please print the father's first and last name clearly. Record the father's residential address and enter the father's complete ten-digit home telephone number and work number if applicable. If the information is the same as the mother's, write in "SAME."

A.13 **Legal guardian's identifying information:** If different from A.11 and/or A. 12, please print the legal guardian's first and last name clearly. Record the legal guardian's residential address and enter the legal guardian's complete ten-digit home telephone number and work number if applicable.

A.14 **Parent Contact:** Please specify who can be contacted with questions regarding the child. If the contact is someone "Other" than the child's mother, father, or legal guardian, make sure to include the contact's first and last name and telephone number, including area code.

A.15 **Physician Contact:** List the name, address, and phone number of the child's primary care physician.

A.16 **Private Insurance:** Please specify whether child is currently covered under a private health insurance policy or plan. Code "0" for No and "1" for Yes. If the child is currently covered under a private health insurance policy, please specify the health insurer as well as the child's policy number.

CLINICAL DETAIL

Clinical Detail is the portion of the MED Kids tool used to determine the child's level of care (Sections B-N). Upon completion of **Clinical Detail**, the assessor will be able to determine whether or not the child is eligible for Katie Beckett or PDN based on their level of care. Note that the clinical detail assessment is only one part of eligibility determination. In order for a child to be eligible for Katie Beckett, he/she must also meet financial eligibility requirements (determined by the Office of Integrated Access and Support) and receive a medical eligibility classification from the Medical Review Team (also part of the Office of Integrated Access and Support). In order for a child to be eligible for PDN, he/she must also meet financial eligibility requirements.

Completion of **Clinical Detail** may require review of documentation, such as IEPs, therapy notes, and documentation from a physician or mental health clinician indicating the child's diagnosis, plan of care, length of treatment and how long the condition is expected to last. Assessors are responsible for informing parents prior to the assessment about the documents that will need to be brought in at the time of the assessment. In addition to observing the child, the assessor will need to gather information from parents and/or formal caregivers to ascertain patterns of behavior and determine whether varying levels of assistance have been provided within the past 7 days.

CLINICAL DETAIL HEADER

The Clinical Detail Header includes the following items:

- Agency Name;
- Provider #;
- NPI #
- Applicant Name;
- Social Security #; and
- Assessment Date.

The information in the header connects each section of the tool and **must be completed on each page**.

AGENCY NAME/NPI #: Enter the agency/organization name responsible for completing the MED Kids assessment tool and the agency/organization's National Provider Identifier (NPI) number.

APPLICANT NAME/SOCIAL SECURITY #: Enter the child's name and his/her 9-digit social security number. Use all spaces provided for the social security number.

ASSESSMENT DATE: Enter the date the MED Kids assessment was started. This date is identical to the date entered as **Assessment Start Date** on Background Information page. Use all boxes. For a 1-digit month or day, place a zero in the first box; e.g. September 2, 2008 should be entered as 09-02-2008.

CLINICAL DETAIL: DEFINITIONS

The definitions below clarify terms that are frequently used throughout the MED Kids tool. This is not an exhaustive list.

New/recent: where "new/recent" is used to describe the onset of a symptom or medical condition it means presenting ***within 30 days of the assessment date***.

Often: where "often" is used to describe the frequency of a symptom it means occurring on most days, or ***at least 3 days a week***.

Persistent: where "persistent" is used to describe the intensity of a symptom it means happening on a daily or near daily basis, ***at least 5 days per week***.

Continuous: where "continuous" is used to describe the intensity of a symptom it means occurring throughout every day, or ***7 days a week***.

Unstable: a medical condition is "unstable" when it is fluctuating in an irregular way and/or is deteriorating and affects the child's ability to function independently. The fluctuations are to such a degree that medical treatment and professional nursing observation, assessment and management is required at least once every 8 hours. An unstable medical condition requires increased physician involvement and should result in communication with the physician for adjustments in treatment and medication. Evidence of fluctuating vital signs, lab values, and physical symptoms and plan of care adjustments must be documented in the medical record. **Not** included is the loss of function resulting from a temporary disability from which full recovery is expected. This definition does not cover unstable behavioral health conditions.

SECTION B. DIAGNOSES

B.1 Psychiatric/Behavioral Diagnoses:

Check only if diagnosed by a qualified mental health clinician (as defined in Section 46.01), such as a Physician, Psychiatrist, Clinical Psychologist, Licensed Clinical Social Worker (LCSW), Licensed Master Social Worker, Licensed Master Social Worker Conditional Clinical (LMSW-CC), Licensed Clinical Professional Counselor (LCPC), Licensed Professional Counselor (LPC), Licensed Marriage Family Therapist (LMFT), Advanced Practice Registered Nurse Psychiatric and Mental Health Practitioner (APRN-PMH-NP), or an Advanced Practice Registered Nurse Psychiatric and Mental Health Clinical Nurse Specialist (APRN-PMH-CNS) when practicing within their scope of licensure to make a diagnosis.

The listings for biologically based mental disorders are arranged into diagnostic categories taken directly from the Social Security Administration's listing of mental disorders in children. These categories are: anxiety disorders; attention deficit hyperactivity disorder; autistic disorder and other pervasive developmental disorders; developmental and emotional disorders of younger infants and preschool; mental retardation; mood disorders; organic mental disorders; schizophrenic, delusional (paranoid), schizoaffective, and other psychotic disorders; and somatoform, eating, and tic disorders.

These categories are separated into two age groups: Birth to attainment of age six (6) and six (6) to age eighteen (18). While the category: **Mental Retardation** should be checked for all children with a diagnosis of mental retardation regardless of age, all other categories are age specific.

The category: **Developmental and Emotional Disorders of Younger Infants + Preschool** is designed to encompass all psychiatric/behavioral disorders (other than mental retardation) affecting children under the age of 6. The reason for having only one diagnostic category for this age group is that it is often difficult to diagnosis specific psychiatric/behavioral disorders in young children. Developmental factors can confound the presentation of symptoms; where symptoms are exhibited, their presentation is often quite diverse and varied. Since **Developmental and Emotional Disorders of Younger Infants + Preschool** is designed to be a "catch all" category, it should be checked for young children (birth to attainment of 6) who have been diagnosed with any type of psychiatric/behavioral disorder. When children reach the age of six, they will be placed in the appropriate diagnostic category for school age children (age 6 to 18) at the time of their annual reassessment.

Categories for: **Anxiety Disorders; Attention Deficit Hyperactivity Disorder; Autistic Disorder and Other Pervasive Developmental Disorders; Mood Disorders; Organic Mental Disorders; Schizophrenic, Delusional (Paranoid), Schizoaffective, and Other Psychotic Disorders; and Somatoform, Eating, and Tic Disorders** are designed to apply ONLY to children age 6 to 18. For children falling within this age range, check the appropriate diagnosis category or categories.

Table 1. Psychiatric/Behavioral Diagnostic Categories by Age

Birth to attainment of age 6	6 to 18
Mental Retardation	Mental Retardation
Developmental and Emotional Disorders of Younger Infants + Preschool	N/A
N/A	Anxiety Disorders
N/A	Attention Deficit Hyperactivity Disorder
N/A	Autistic Disorder and Other Pervasive Developmental Disorders
N/A	Mood Disorders
N/A	Organic Mental Disorders
N/A	Schizophrenic, Delusional (Paranoid), Schizoaffective, and other Psychotic Disorders
N/A	Somatoform, Eating, and Tic Disorders

If the child has a DSM IV Axis 1 psychiatric/behavioral diagnosis that is not captured by any of the nine diagnostic categories listed on the form, check "Other DSM IV Axis 1 Diagnoses" and write in the diagnosis and corresponding ICD-9 code in the space provided. If the child does not have any psychiatric/behavioral diagnoses, check ***NONE OF THE ABOVE***.

The choices for psychiatric/behavioral diagnoses are:

a. ***Anxiety disorders***: In these disorders, anxiety is either the predominant disturbance or is experienced if the individual attempts to master symptoms; e.g. confronting the dreaded object or situation in a phobic disorder, attempting to go to school in a separation anxiety disorder, resisting the obsessions or compulsions in an obsessive compulsive disorder, or confronting strangers or peers in avoidant disorders.

b. ***Attention deficit hyperactivity disorder***: Manifested by developmentally inappropriate degrees of inattention, impulsiveness, and hyperactivity.

c. ***Autistic disorder and other pervasive developmental disorders***: Also, includes Asperger's Disorder. Characterized by qualitative deficits in the development of reciprocal social interaction, in the development of verbal and nonverbal communication skills, and in imaginative activity. Often, there is markedly restricted repertoire of activities and interests, which frequently are stereotyped and repetitive.

d. ***Developmental and emotional disorders of younger infants + preschool (birth to attainment of 6)***: Developmental or emotional disorders of younger infants and preschoolers are evidenced by a deficit or lag in the areas of motor, cognitive/communicative, or social functioning. These disorders may be related either to organic or to functional factors or to a combination of these factors.

e. ***Mental retardation***: Characterized by significantly subaverage general intellectual functioning with deficits in adaptive functioning.

f. ***Mood disorder***: Characterized by a disturbance of mood (referring to a prolonged emotion that colors the whole psyche, generally involving either depression or elation), accompanied by a full or partial manic or depressive syndrome.

g. ***Organic mental disorders***: Abnormalities in perception, cognition, affect, or behavior associated with dysfunction of the brain. The history and physical examination or laboratory tests, including psychological or neuropsychological tests, demonstrate or support the presence of an organic factor judged to be etiologically related to the abnormal mental state and associated deficit or loss of specific cognitive abilities, or affective changes, or loss of previously acquired functional abilities.

h. ***Schizophrenic, delusional (paranoid), schizoaffective, and other psychotic disorders***: Onset of psychotic features, characterized by a marked disturbance of thinking, feeling, and behavior, with deterioration from a previous level of functioning or failure to achieve the expected level of social functioning.

i. ***Somatoform, eating, and tic disorders***: Manifested by physical symptoms for which there are no demonstrable organic findings or known physiologic mechanisms; or eating or tic disorders with physical manifestations.

j. ***Other DSM IV Axis 1 Diagnoses***: May include diagnoses such as psychoactive substance dependence disorder, conduct disorder, developmental delays, or any other DSM IV Axis 1 diagnosis that does not fall under the 9 diagnostic categories listed on the form. **Check if appropriate and fill in the diagnosis name and corresponding ICD-9 code in the space provided.**

k. ***NONE OF THE ABOVE.***

B.2 Persistence:

a. Code "0" No, or "1" Yes, if any of the psychiatric/behavioral conditions identified in B.1 have persisted for at least six months. If the child does not have a psychiatric/behavioral condition, code "2" Not Applicable.

b. Code "0" No, or "1" Yes, if the any of the psychiatric/behavioral conditions identified in B.1 are expected to persist for a year or longer. If the child does not have a psychiatric/behavioral condition, code "2" Not Applicable.

B.3 Medical diagnoses: Do NOT list inactive diagnoses. **Check only those** medical diagnoses that relate to the child's current ADL status, cognitive status, mood or behavior status, medical treatments, monitoring, or risk of death. Do not include conditions that have been resolved or no longer affect the child's functioning. If the child does not have any medical diagnoses, check NONE OF THE ABOVE.

Check if applicable:

a. Allergies - 995.3 (and specify allergies if checked)
b. Amputation – 736.89
c. Anemia – 285.9
d. Arthritis – (unspecified site) 716.90

e. Asthma/Respiratory disorder – (unspecified) 494.90
f. Cancer – (unspecified as to site or stage) 199.1
g. Cardiovascular disease – (unspecified) 429.2
h. Cerebral palsy – (unspecified) 343.90
i. Cleft lip and/or palate – lip: 749.10; palate: 749.00
j. Cystic fibrosis – 277.0
k. Diabetes – 250.0
l. Explicit terminal prognosis - A physician has put in the record that the resident is terminally ill with no more than 6 months to live. This should be substantiated with a documented disease diagnosis and deteriorating clinical course.
m. Hemophilia –286.0
n. HIV/AIDS – 042
o. Osteoporosis – (unspecified) 733.00
p. Paraplegia – 344.1
q. Pathological bone fracture – (unspecified sites) 733.10
r. Quadriplegia – 344.00 through 344.09
s. Renal failure – (unspecified) 586
t. Seizure disorder
u. Spina bifida – (unspecified region) 741.90
v. Traumatic brain injury – (unspecified) 854.00
w. Tuberculosis – (unspecified) 011.90
x. Other Current Medical Diagnoses and ICD-9 Codes: Complete if appropriate
y. **NONE OF THE ABOVE.**

B.4 **Functional Assessment Score:** Functional assessment tests are designed to objectively determine a child's level of functioning across important life and behavioral domains, such as daily living skills and socialization. There are several functional assessment tests for children, including the Adaptive Behavior Assessment System (ABAS-II), Child and Adolescent Functional Assessment Scale (CAFAS), Preschool and Early Childhood Functional Assessment Scale (PECFAS), and Vineland Adaptive Behavior Scales (Vineland-II).

a. Code "0" No, or "1" Yes, if the child has a documented functional assessment test score.
b. If the answer to B.4.a. is Yes, please indicate which functional assessment test the child was scored on.
c. If the answer to B.4.a is Yes, please record the child's functional assessment test score(s).

SECTION C. PHYSICAL FUNCTIONING

C.1 **Activities of Daily Living (ADL) Self-Performance**- Activities of Daily Living (ADL) Self-Performance describes the child's self-care performance in activities of daily living (i.e. what the child actually did alone, without assistance, and/or how much help was provided, not what he or she might be capable of doing). A child's ADL self-performance may vary from day to day and within the day (e.g. from morning to night). There are many possible reasons for these variations, including mood, stamina, relationship issues (e.g. willing to perform for a caregiver he or she likes), and medications. The responsibility of the assessor, therefore, is to

capture the total picture of the child's ADL self-performance over the 7-day period, 24 hours a day, not only how the child is at one point in time during one day.

In order to accomplish this, it is necessary to gather information from multiple sources (i.e. discussion/observation of the child and interviews with parents and caregivers). Ask questions pertaining to all aspects of the ADL activity definitions. For example, when discussing Toileting with a caregiver, be sure to inquire specifically how the child moves onto and off of the toilet, how the child cleans him/herself, and how the child arranges his/her clothing after using the toilet. A child can be independent in one aspect of Toileting yet require extensive assistance in another aspect. Since accurate coding is important as a basis for making decisions on the type and amount of care to be provided, be sure to consider each activity definition fully.

The responses in the ADL items are used to record the child's **actual** level of involvement in self-care and the type and amount of support actually received during the last 7 days. In **Column 1, Self-Performance**, enter the code that best describes the child's self-performance for bed mobility, transfer, locomotion, dressing, eating, toilet use, personal hygiene, not including set-up*, and walking, over a 24-hour period during the last 7 days (or 24-48 hour period if the child is in a hospital). ***Exclude "Set-up" Help**: In evaluating the child's ADL Self-Performance, consider the type of assistance known as "set-up help" (e.g. comb, brush, toothbrush, toothpaste have been laid out at the bathroom sink by the aide) within the context of the "0" (Independent) code. For example: If a child grooms independently once grooming items are set up for him, code "0" (Independent) for self-performance in Personal Hygiene.

For each ADL category, code the appropriate response for the child's actual performance during the past seven days. Enter the code in the box following the ADL and its definition, under Column 1 Self-Performance. Consider the child's performance during a 24-hour period, as functionality may vary. View each activity separately: do not blend activities together. "Weight-bearing" pertains to the caregiver.

Self-performance codes are:

0. Independent.
- Child performed the task independently, receiving no help or oversight in self-performance or receiving infrequent help/oversight defined as occurring only 1 or 2 times during the last 7 days.

AA. Age Appropriate.
- Child performs the activity in a manner that is consistent with clinical expectations for a normally developing child at a given age or developmental stage and is age appropriate as defined in the Denver-II Developmental Screening Test or Vineland Adaptive Behavior Scales. See **Table 2** on page 17 for select examples of age appropriate performance on ADLs, or the Denver-II for complete standards.

1. Supervision.
- Oversight, encouragement or cueing was provided 3+ times during the last 7 days. Or
- Supervision plus nonweight-bearing physical assistance was provided only 1 or 2 times during last 7 days.

2. Limited Assistance.

- Child was highly involved in activity; received physical help in guided maneuvering of limbs, or other nonweight-bearing assistance 3 or more times. Or
- Limited assistance (3 or more times) plus weight-bearing support provided only 1 or 2 times during the last 7 days.

3. Extensive Assistance. While child performed part of activity over last 7-day period, help of the following type(s) was provided 3 or more times:
   - Weight-bearing support
   - Full caregiver performance during part (but not all) of last 7 days.

4. Total dependence. Full caregiver performance of activity during entire 7 days. Complete non-participation by child in all aspects of the ADL. For example, for Self-Performance, Eating/Drinking to be coded "4", the child must be incapable of taking any food by him/herself. Do not code "4" if the child can take finger foods or drink from a cup.

5. Cueing. Spoken instructions or physical guidance which serves as a signal to do an activity are required 7 days a week.

6. Needs guidance/supervision due to inability to perform without potential harm to self.

8. Activity did not occur at all during entire period. The child or the caregiver did not perform the ADL.

Code "8" is limited to situations where the ADL activity was not performed and is primarily applicable to full bed-bound children who were neither transferred nor moved between locations. When an "8" code is entered for self-performance, also enter an "8" code for support.

**Note: The self-performance definitions are mutually exclusive. They do not overlap. Moving from one level of self-performance to the next step requires a change in the number of times that help is provided. To move a child's scoring from Independent to Supervision, for example, oversight or help must increase from 1 or 2 times up to 3 or more times. To move from Supervision to Limited Assistance, non-weight bearing supervision or physical assistance must increase from 1 or 2 times up to 3 or more times.

For a list of Child ADL Self-Performance scoring examples, refer to Appendix A.

C.2 Activities of Daily Living (ADL) Support Provided: determines the intensity of ADL support, focusing on the time or episode when the highest level of support was provided during the last 7 days.

For each ADL category, code the highest amount of support given in Column 2, Support, irrespective of the frequency over the specific period of time. Code regardless of the child's self-performance classification (e.g. if child was independent but received a 1-person physical assist one or two times during the period). Code at the level of assistance needed to do the activity.

Support codes are:

0. No setup or physical help.

AA. Age Appropriate. Child requires support in a manner that is consistent with clinical expectations for a normally developing child at a given age or developmental stage.

1. Setup help only. Child is provided with materials or devices necessary to perform the activity of daily living independently. Examples of 'setup help only' include:

Locomotion: handing child a walker or locking wheels on wheelchair;

Dressing: retrieving clothes from closet and laying out on child's bed;
Eating: cutting food and opening containers at meals;
personal hygiene: providing wash basin or grooming articles;
bathing: placing bathing articles at tub side within child's reach.

2. **One-person physical assist.**
3. **Two + persons physical assist.**
5. **Cueing** support required 7 days a week.
6. **Needs guidance/supervision** due to inability to perform without potential harm to self.
8. **Activity did not occur** during the entire period- when an "8" code is entered for support, also enter an "8" code for self-performance.

These codes are mutually exclusive. They do not overlap. Moving from one level of support to the next requires a change in the amount of assistance provided.

For a list of Child ADL Support scoring examples, refer to Appendix A.

Table 2. Age-Appropriate Activities of Daily Living – Self-Performance

ADL'S	CHILD'S AGE							
	0 to 4 mo.	> 4 mo. to 8 mo.	> 8 mo to 1 year	> 1 to 2	> 2 to 3	> 3 to 4	> 4 to 5	> 5 and up
Bed Mobility	Dependent on caregiver	Rolls front to back; supports head	Stomach to sitting position	→	→	→	→	→
Transfer	Dependent on caregiver	Supports weight w/legs	Pulls up to stand; stands momentarily	→	→	→	→	→
Locomotion	Moves arms; stretches and kicks legs	Creeps or crawls (7-9 mo); sits with or w/o support	Crawls; walks holding furniture; two or three steps w/support	Walks alone (12 to 15 mo); Running (18 mo)	Runs well, walks up + down stairs one step at a time	→	→	→
Dressing	Dependent on caregivers	Dependent on caregivers	Dependent on caregivers	Helps to undress and put on some clothing (18 mo)	Helps to undress and put on some clothing	Helps in dressing; unbuttons clothing; puts on shoes	Dresses without supervision	Dresses and undresses
Eating/ Drinking	Nurses or feeds from bottle; spoon fed solids (4-6 mo); moves hand to mouth	Holds bottle (6 mo); reaches w/one hand	Picks up bottle	Weaning from bottle; holds and drinks from cup; picks up food with fingers	Handles spoon well; feeds self	Feeds self; diet is similar to that of the family	→	→
Toilet use	Dependent on caregivers	Dependent on caregivers	Dependent on caregivers	Dependent on caregivers	Beginning to toilet train, Day time bowel + bladder control (ave. 30 mo)	Goes to toilet alone	→	→
Personal Hygiene	Dependent on caregivers	Dependent on caregivers	Dependent on caregivers	Dependent on caregivers	Brushes teeth	Washes hands	→	→

C.h **Bathing:** **Note: Bathing is coded independently of the other ADLs because it can be done less frequently; bathing is not necessarily a daily activity for many children. The frequencies used to define the other ADLs are not appropriate for an activity that might occur only once or twice a week.

In **Column 1, Self-Performance**, enter the **special bathing self-performance code** that best describes the child's most dependent level of self-performance. When coding, apply the bathing self-performance code that reflects the highest amount of assistance that the child

received during any bathing episode. Enter "8" if bathing did not occur. Bathing self-performance codes are:

0. Independent. No help provided
AA. Age Appropriate.
1. Supervision. Oversight help only
2. Physical help limited to transfer only.
3. Physical help in part of bathing activity.
4. Total dependence.
5. Cueing. Cueing support required 7 days a week.
6. Needs guidance/supervision due to inability to perform without potential harm to self.
8. Activity did not occur during entire 7 days.

In **Column 2, Support,** enter the ADL support codes defined in **Section C.2.**

**Note: See APPENDIX A for examples of scoring ADLs.

C.3 Walking: Code the child's self-performance in walking, as well as the intensity of support needed. In **Column 1, Self-Performance**, enter the ADL self-performance codes defined in **Section C.1**. In **Column 2, Support,** enter the ADL support codes defined in **Section C.2.**

C.4 Mode of locomotion: Code the primary means by which the child moves from place to place. The choices are:

0. Walking.
1. Wheelchair.
2. Walker.
3. Splints or braces.
4. Prosthetics.
5. Orthopedic shoes.
6. Cane/crutch.
7. Scooting board.
8. Other. Please specify.
9. NONE OF ABOVE**.**

SECTION D. PROFESSIONAL NURSING SERVICES

Code for each condition/treatment for which the child will need care that is or otherwise would be provided by or under the supervision of a licensed nurse. Use the following codes for Section D.1 - D.10. Every block must be coded with a response. If a treatment or procedure is administered by the child, do not score as a nursing need to be done by another person. Score with a '0' for independent when professional nursing monitoring is not required. If the treatment or procedure is administered by the parent/guardian, then assume that the child would need licensed nursing care in the parent/guardian's absence and score according to the frequency of treatment required.

0. Conditions/treatment not present in the last 7 days.
1. 1-2 days a week.

2. 3-4 days a week.
3. 5-6 days a week.
4. 7 days a week.
5. Once a month
6. Used for Extended PDN only: At least once every 8 hours/7 days a week
7. Twice a month.

D.1 **Injections/IV feeding**. Child will need care that is or otherwise would be performed by or under the supervision of a licensed nurse for injections (intraarterial, intravenous, intramuscular or subcutaneous) or IV feeding for the treatment of an unstable condition requiring medical or licensed nursing intervention, excluding daily insulin injections for a child whose diabetes is under control. A diabetic's condition is considered to be controlled when his/her blood sugar is maintained at a level that is considered within normal limits for that individual and requires no adjustment of the maintenance dose of insulin. **Every box must be coded with a response**.

D.2 **Feeding tube**. Child will need care that is or otherwise would be performed by or under the supervision of a licensed nurse for a feeding tube (nasogastric, gastrostomy or jejunostomy tube) for a new/recent (within 30 days) or an unstable condition. **Every box must be coded with a response**.

D.3 **Suctioning/Trach care**. Child will need care that is or otherwise would be performed by or under the supervision of a licensed nurse for deep nasopharyngeal suctioning or tracheostomy care for a new/recent (within 30 days) or an unstable condition. **Every box must be coded with a response**.

D.4 **Treatment/Dressing**. Child will need care that is or otherwise would be performed by or under the supervision of a licensed nurse for the treatment and/or application of dressings when the physician has prescribed irrigation, application of prescribed medication, or sterile dressings of stage 3 or 4 decubitus ulcers, other widespread skin disorders (except psoriasis or eczema), or care of wounds, when the skills of a registered nurse are needed to provide safe and effective services (including but not limited to ulcers, 2nd or 3rd degree burns, open surgical sites, fistulas, tube sites and tumor erosions). Physician ordered daily chest physical therapy, by the licensed nurse, to support respiratory status for an acute episode of disease process. If the chest physical therapy is provided by a respiratory therapist, code in E.3a The following examples are EXCLUDED: peri rash, reddened coccyx, non-barrier dressings for Stage 1 and 2 ulcers, steristrips, and healed tube sites. **Every box must be coded with a response**.

D.5 **Oxygen**. Child will need care that is or otherwise would be performed by or under the supervision of a licensed nurse for administration of oxygen on a regular and continuing basis when his/her condition warrants professional observation for a new/recent (within 30 days) condition. **A response must be coded**. Please specify start date of oxygen administration.

D.6 **Assessment/management**. Child will need RN assessment, observation and management for an **unstable medical condition** (see previous definition on page 9) that because of

exacerbations or episodes warrants and requires professional nursing intervention for assessments, monitoring, and management. **Observation must be needed at least once every 8 hours throughout a 24 hour period.**

D.7 **Catheter**. Child will need care that is or otherwise would be performed by or under the supervision of a licensed nurse for the insertion and maintenance of a urethral or suprapubic catheter as an adjunct to the active treatment of a disease or medical condition. The need for the catheter must be documented and justified in the medical record. Examples include, but are not limited to, installation for the treatment of cancer of the bladder or as adjunctive treatment for wound or decubitus healing. If a child at home has a catheter, the assessor will need to check with the child, family, MD, or home health agency to determine why the catheter is being used. For example, if a bedridden child with a bedsore has a catheter to prevent further skin breakdown, the skin breakdown prevention and treatment qualifies as a medical need, but the catheter's use to manage incontinence for the convenience of the caregiver does not qualify as an adjunct to active treatment of disease or medical condition. **A response must be coded.**

[**Note: catheters as a method of managing incontinence are considered in Clinical detail, Section C Physical Functioning/Structural Problems: f. Toilet Use.** The above example **does** meet the toileting need addressed in Section D and would be coded with a "2" or "3" for self-performance and "2" for support.]

D.8 **Comatose**. Child will need care that is or otherwise would be performed by or under the supervision of a licensed nurse to manage a comatose condition. A child is considered comatose when in a state of unconsciousness from which he or she cannot be aroused; i.e. **persistent vegetative state**, or has a neurological diagnosis of **coma. A response must be coded**.

D.9 **Ventilator/Respirator**. Child will need care that is or otherwise would be performed by or under the supervision of a licensed nurse to manage the ventilator/respirator equipment. **A response must be coded**.

Ventilator or **Respirator**- assures adequate ventilation in child who is, or who may become, unable to support his/her own respiration. Include any type of electrically or pneumatically powered closed system mechanical ventilatory support device.
[**Note: CPAPS and BIPAPS are not ventilators.]**

D.10 **Uncontrolled Seizure Disorder**. Direct assistance from others is required for the safe management of an uncontrolled seizure disorder (i.e. grand mal). An "uncontrolled seizure disorder" is defined as a "diagnosed seizure disorder that cannot be managed by medications." The physician is the best person to make this judgment. **A response must be coded**.

SECTION E. TREATMENTS AND THERAPIES

The following codes are used for those post operative or chronic conditions that require licensed nursing care and monitoring for administration of treatments, procedures, or dressing changes which involve prescription medications, according to physician orders. Code for the number of days care would be performed by or under the supervision of a licensed nurse.

0. Not required
1. 1-2 days/week
2. 3 or more days/week
3. Once a month
7. Twice a month

[Note: Intermittent licensed nursing care (monthly or weekly) does NOT meet the minimum nursing facility eligibility requirements of Section 67.02-3.]

E.1 Treatments/Chronic Conditions. Licensed nursing care and monitoring for the administration of treatments, procedures, or dressing changes which involve prescription medications for post-operative or chronic conditions according to physician orders. Please specify. Physician orders for treatments, procedures, or dressing changes should be reflected on the order sheet. **Each box must be coded with a response**.

The following treatments are EXCLUDED:

- proper positioning of children in bed,
- wheelchair or other accommodations;
- bed baths;
- prevention and treatment of skin irritations and non-barrier dressings for Stage I and II decubitus ulcers;
- observation of vital signs and detailed recordings of findings in child's record;
- assistance and training in self-care as required for feeding, grooming, ambulation, toilet activities and other activities of daily living;
- assistance and training in person transfer techniques,
- administration of routine medications,
- performance of routine care for a person, (i.e. incontinence; prophylactic and palliative skin care including bathing and applications of creams and/or treatment of minor skin problems; routine care in connection with casts, braces, and other devices; instruction in basic health needs; and change of dressings for non-infected post-operative or chronic conditions.)

a. Medications via tube. Any medication ordered by a physician that can only be administered via a gastrostomy, jejunostomy or naso-gastric tube for a child who cannot do this for themselves. This must be done by a licensed nurse or a family/friend who has been taught to perform this skill that would otherwise require the skills of a licensed nurse.

b. Tracheostomy care >30 days old and stable. Includes cannula care, trach dressing changes and suctioning related to the routine daily tracheostomy care for children who cannot do this for themselves. This must be done by a licensed nurse or a family/friend who

has been taught to perform this skill that would otherwise require the skills of a licensed nurse.

c. Urinary Catheter change. Removal and reinsertion of a new urinary catheter for children who cannot do this themselves. This must be done by a licensed nurse or family/friend who has been taught to perform this skill that would otherwise require the skills of a licensed nurse. If the child or parent/guardian performs this task independently, then it cannot be counted and would be coded "0" -- professional nursing care and monitoring not required.

d. Urinary catheter irrigation. This includes the "flushing" of a urinary catheter to prevent or remove a deposit that prevents the drainage of urine. This must be done by a licensed nurse or a family/friend who has been taught to perform this skill that would otherwise require the skills of a licensed nurse. If the child or parent/guardian performs this task independently, then it cannot be counted and would be coded "0" -- professional nursing care and monitoring not required.

e. Venipuncture. This is the drawing of blood from a child to be sent to a lab for doctor-ordered lab studies to monitor the child's condition or response to treatment. PDN policy allows venipuncture by a Licensed Practical Nurse. Use this box to indicate venipuncture being done by either a LPN or RN.

f. Monthly injections. The administration of a doctor-ordered medication on a monthly basis via an intramuscular route. This must be done by a licensed nurse or a family/friend who has been taught to perform the injection that would otherwise require the skills of a licensed nurse. If the child or parent/guardian performs this task independently, it cannot be counted and would be coded "0" -- professional nursing care and monitoring not required.

g. Barrier dressings for Stage I or II ulcers. These dressings are occlusive dressings used to treat and/or debride Stage I or II decubitus ulcers. The assessment skills of a licensed nurse are required to monitor the affects of the treatment and to adjust or change the treatment plan in consultation with a physician. This must be done by a licensed nurse or a family/friend who has been taught to perform this skill that would otherwise require the skills of a licensed nurse. If the child or parent/guardian performs this task independently, then it cannot be counted and would be coded "0" -- professional nursing care and monitoring not required.

h. Chest PT. This is chest physical therapy for a chronic condition where the PT provides preventative/maintenance airway clearance such as in the case of a child afflicted with cystic fibrosis. This must be done by a licensed nurse or a family/friend who has been taught to perform the PT that would otherwise require the skills of a licensed nurse.

i. Oxygen therapy for chronic unstable condition >30 days old. This is the treatment of a process where the child has been diagnosed but continues to need the assessment and management of the licensed nurse to maintain respiratory status. This must be done by a licensed nurse, or a family/friend who has been taught to assess and monitor therapy that would otherwise require the skills of a licensed nurse.

j. Other. Please specify 'other' condition for which treatment is done by a licensed nurse or a family/friend who has been taught to perform this skill that would otherwise require the skills of a licensed nurse.

k. Teach/train. Refers to teaching and/or training done by a licensed nurse or MSW related to the child's medical condition, disease process, or treatment (e.g. diabetes management).

E.2 Treatments/Procedures: Code for the number of days licensed nursing is required for physician-ordered chemotherapy, radiation therapy, or dialysis.

0. Not required.
1. 1-2 days/week.
2. 3 or more days/week.
3. Once a month.
7. Twice a month.

Every box must be coded with a response.

a. Chemotherapy: Any type of chemotherapy (anticancer drug) given intravenously or by injection.
b. Radiation therapy: The treatment of disease by ionizing radiation.
c. Hemodialysis: A method for removing unwanted byproducts from the blood of persons with renal insufficiency or failure through the use of a machine (dialyzer).
d. Peritoneal Dialysis: Peritoneal dialysis (CAPD) is a method of removing unwanted byproducts from the body through the instillation of dialysate into the peritoneal cavity and using the abdominal wall as a filter.

E.3a Therapy/therapies provided by a qualified therapist-

Days per week: Enter the number of days per week required for physical therapy, speech/language therapy, occupational therapy or respiratory therapy provided or directed by a qualified therapist. This item pertains only to therapies prescribed and being received with goals, time frames, and a physician order. Enter "0" if none needed.

To be considered, a therapy must meet the following criteria:

- Finding of initial evaluation and reassessments must be documented in the recipient's medical record.
- Skilled therapeutic services must be ordered by a physician and designed to achieve specific goals within a given time frame.

Palliative or maintenance therapy is excluded: for example, respiratory therapy must be done by a respiratory therapist. If therapy is not ongoing or has not been ordered as part of the treatment plan, then this section probably will not be applicable. Enter "0" if none needed.

Rehab For physical therapy, speech/language therapy, and occupational therapy, please indicate if there is documentation by a physician or qualified therapist of rehab potential.

Total days PT, ST (w/rehab only), & OT: Sum the days per week required for each therapy and indicate total number of days of therapy per week in box. **A number (0-7) must be entered in the box**.

Total days all therapies (PT, ST, OT, & Resp): Sum the days per week required for all therapies and indicate total number of days of therapy per week in box. **A number (0-7) must be entered in the box**.

E.3b **Rehab potential-** Please refer back to E.3a and indicate if rehab potential was documented for physical therapy (PT), speech therapy (ST), or occupational therapy (OT). Code "0" if No, code "1" if Yes, and code "2" if the question is not applicable because the child did not receive therapies. Attach documentation.

Rehabilitation Potential is the documented expectation by a physician of measurable, "functionally significant improvement" in the member's condition in a reasonable, predictable period of time as the result of the prescribed treatment plan.

E.4 **Therapy**- Is therapy required at least once a month for any of the following: physical, speech/language, occupational, or respiratory therapy? Code "0" if No, code "1" if Yes. If E.3, Therapies-Total is greater than "0" for number of days of therapy per week, then E.4 = "1", therapy required at least once a month.

SECTION F. MEDICATION LIST

F. **Medication name and dosage:** List all medications given during the last 60 days including both prescription and over the counter medications. Include medications used regularly less than weekly as part of the child's treatment regimen. If the child does not receive any medications, specify "N/A" for Not Applicable in Column 1.

For each medication listed provide the following information in the columns provided:

1. List the **medication name** and the **dosage**.
2. **N/C/D**: New (N), changed (C), or discontinued (D) medications within the past 60 days. Include all medications prescribed in the last 60 days including any antibiotics.
3. **Date of new, changed, or discontinued medication**.
4. **Route of Administration**: list the appropriate code, 1 through 10.
5. **Frequency**: use the appropriate frequency code as listed.
6. **PRN-n**: If the frequency code is "PR," record the number of times during the past 7 days that each PRN medication was given. Do not use this column for scheduled medications.

SECTION G. MEDICATION

G.1 a. Preparation/Administration: Record whether the child prepared and administered any of her/her own medications in the last 7 days. Code a response from the following list that describes preparation and administration of medications for child.

0. Child prepared and administered **All** of his/her own medications **OR** it would not be age-appropriate for child to do this.
1. Child prepared and administered **Some** of his/her own medications.
2. Child prepared **None** of his/her own medications.
3. Child had no medications in the last 7 days.
4. Child did not prepare but administered **Some** of his/her own medications.
6. Child requires administration of medications due to severe and disabling mental illness.

G.1 b. Compliance: Determine if there are specific or potential problems with the child's medications or the way the child takes medications. Review the child's medication, question the child and his or her family or caregivers to assess how well the child complies with the medication ordered by a physician/psychiatrist. Code a response from the following list that represents the child's level of compliance during the last 7 days.

0. Child always compliant.
1. Child compliant some of the time (80% of time or more often) or compliant with some medications.
2. Child rarely or never compliant.
3. Child had no medications in the last 7 days.
4. Child requires monitoring of medications due to severe and disabling mental illness.

SECTION H. COGNITION

Children will have varying cognitive abilities depending on their ages and stages of development. When scoring items in the Cognitive Section, it is important to assess the child in relation to normal cognitive expectations for that age or developmental level. Although children develop at their own pace (and it's impossible to tell exactly when a child will learn a given skill), the examples of cognitive milestones listed below in Table 3. are meant to give a general idea of changes one may expect at different points in a child's development. Assessors are expected to apply their clinical expertise and knowledge of normal stages of child development when scoring infants and pre-verbal or nonverbal children on this section.

Table 3. General Guidelines for Age-Appropriate Cognition

CHILD'S AGE	EXAMPLES OF SOME SIGNIFICANT COGNITIVE MILESTONES
By the End of 7 mos.	▪ Finds partially hidden objects ▪ Explores with hands and mouth ▪ Struggles to get objects that are out of reach
By the End of 2 years (24 months)	▪ Finds objects even when hidden under covers ▪ Begins to sort by shapes and colors ▪ Begins make-believe play
By the End of 3 yrs. (36 months)	▪ Makes mechanical toys work ▪ Matches an object in his/her hand or room to a picture in a book ▪ Plays make-believe with dolls, animals, and people ▪ Sorts objects by shape and color ▪ Completes simple puzzles
By the End of 4 yrs. (48 months)	▪ Correctly names some colors ▪ Understands the concept of counting and may know a few numbers ▪ Tries to solve problems from a single point of view ▪ Begins to have a clearer sense of time ▪ May follow three-part commands ▪ Recalls parts of a story ▪ Understands the concepts of "same" and "different" ▪ Engages in fantasy play
By the End of 5 yrs. (60 months)	▪ Can count a handful of objects ▪ Correctly names some colors ▪ Better understands the concept of time ▪ Knows about things used every day in the home (money, food, appliances)

Source: Adapted from *CARING FOR YOUR BABY AND YOUNG CHILD: BIRTH TO AGE 5 by Steven Shelov, Robert E. Hammermann © 1991, 1993, 1998, 2004 by the American Academy of Pediatrics*

H.1 Memory- determines the child's capacity to remember both recent and past events.
Use the following codes for section H.1a. and H.1.b. Each box must be coded with a response.

0. Memory OK
1. Memory problems

H.1.a. Short-term memory- Ask the child to describe a recent event that you both had the opportunity to remember or use a more structured short- term memory test.

Examples for H.1.a
Ask child to describe the meal or activity just completed. Or - Name 3 items (e.g. book, watch, table). Immediately after you state the items, have child repeat them to verify understanding. Continue other conversation. After 5 minutes, ask child to repeat the names of the items again. If s/he cannot, code "1."

H.1.b. Long-term memory- Engage the child in a conversation that is meaningful to him or her. Ask questions for which you already know the answers (e.g. from your review of record, general knowledge, family).

Examples for H.1.b

You may use questions such as the following. What country do you live in? What is your address? Do you have any brothers or sisters? How many? When is your birthday? If child cannot answer these types of question, code "1."

H.2 **Memory/Recall Ability**- Ask the child about items a through d. For example, "What is the current season? "What is the name of this place?" "What kind of place is this?" If the child is not in his or her room, ask "Will you show me to your room?" Observe the child's ability to find his/her way.

- **Current season**- able to name the current season (e.g. correctly refers to weather for the time of year, legal holidays, religious celebrations).
- **Location of own room**- able to locate and recognize own room. He or she should be able to find the way to the room.
- **Names/faces**-able to distinguish family members, friends, caregivers, and strangers.
- **Where he/she is**- able to distinguish where child is (e.g. home, hospital, nursing home).
- NONE OF THE ABOVE **were recalled.**

For each item that the child can recall during **the last 7 days**, check the corresponding answer box.

H.3 **Cognitive Skills for Daily Decision Making**- determines the child's ability to make everyday decisions about the tasks or activities of daily living. Consult family and formal and informal caregivers. Observe the child during the assessment interview. *The inquiry should focus on whether the child is actively making these decisions, and not whether a family member or caregiver believes the child might be capable of doing so.* Remember, the intent of this item is to record what the child is doing (performance). Where a family member or formal caregiver takes decision-making responsibility away from the child regarding tasks of everyday living, or the child does not participate in decision-making, whatever his or her level of capability may be, the child should be considered to have impaired performance in decision-making. This item is especially important for further assessment and care planning in that it can alert providers of care to a mismatch between a child's abilities and his or her current level of performance, or that family and/or caregiver may be inadvertently fostering the child's dependence.

Examples:

Choosing items of clothing; knowing when to go to scheduled meals; using environmental cues to organize and plan (e.g. clocks, calendars, posted listings of upcoming events); in the absence of environmental cues, seeking information appropriately (i.e. not repetitively) from others in order to plan the day; using awareness of one's own strengths and limitations in regulating the day's events (e.g. asks for help when necessary); making the correct decision concerning how to get to the lunchroom; acknowledging need to use a walker, and using it faithfully.

Enter one number that corresponds to the most correct response. **Use the following codes**:

0. Independent- decisions consistent, reasonable and safe (reflecting lifestyle, culture, values); child organizes daily routine and makes decisions in a consistent, reasonable and organized fashion.

AA. **Age Appropriate-** child makes decisions in a manner that is consistent with clinical expectations for a normally developing child at a given age or developmental stage.

1. **Modified Independence**- child organizes daily routine and makes safe decisions in familiar situations, but experiences some difficulty in making decisions when faced with new tasks or situations.
2. **Moderately Impaired**- child's decisions are poor; child requires reminders, cues, and supervision in planning, organizing and conducting daily routines.
3. **Severely Impaired**- child's ability to make decisions is severely impaired; child never (or rarely) makes decisions.

H.4A Is professional nursing assessment, observation and management required at least 3 days/week to manage all the above cognitive patterns? Code "0" if No, code "1" if Yes.

If H.4A = "yes," proceed to Section I. Do NOT complete the Supplemental Screen for Cognition.
If H.4A = "no," **and child meets the cognitive impairment threshold** as defined below, then complete Section H.4B Cognition.

A "threshold" score for "cognition" is equal to a score of "1" for loss of short-term memory and "2" of items A-D OR E "none" for memory / recall ability and a score of "2" or "3" for cognitive skills for decision-making per Chapter II, Section 67 of the Maine Medical Assistance Manual.

If the cognitive impairment threshold is met and the child does not need nursing assessment at least 3 days a week, the Supplemental Screen for Cognition must be completed.

H.5 Is professional nursing assessment, observation and management required less frequently than 3 times per week but at least once per month? Code "0" if No, code "1" if Yes. **Enter the one number that corresponds to the correct response to this question.**

SUPPLEMENTAL SCREENING TOOL Section H.4.B COGNITION.

Complete this cognitive screen only if the response to H.4A. is 0 "no" AND the child meets the cognitive impairment threshold. A "threshold" score for "cognition" is equal to a score of "1" for loss of short-term memory and "2" of items A-D or E "none" for memory / recall ability and a score of "2" or "3" for cognitive skills for decision making per Chapter II, Section 67 of the Maine Medical Assistance Manual.

Section H.4B. COGNITION. Enter the code that most accurately describes the child's age appropriate cognition for the last 7 days.

1. Memory for Events: Enter the number that best describes child's recall of events/names within the last 7 days: 0, 1, 2, or 3.
2. Memory and Use of Information: Enter the number that best describes child's ability to remember and use information appropriately within the last 7 days: 0, 1, 3, or 4.
3. Global Confusion: Enter the number that best describes child's degree of confusion within the last 7 days: 0, 1, 2, or 3.

4. Spatial Orientation: Enter the number that best describes child's orientation to environment within the last 7 days: 0, 1, 2, or 3.
5. Verbal Communication: Enter the number that best describes child's ability to convey information within the last 7 days: 0, 1, 2, 3, or 4.

H.4B. Total Cognitive Score: Add the answers to questions 1-5 and enter this number in the box provided. **Proceed to Section I.**

SECTION I. BEHAVIOR

Children develop at their own pace, and it's impossible to tell exactly when a child will learn a given skill. The examples of social and emotional milestones listed below in Table 4. are meant to give a general idea of behavioral changes one may expect at different points in a child's development.

Table 4. General Guidelines for Age-Appropriate Behavior

CHILD'S AGE	EXAMPLES OF SOME SIGNIFICANT SOCIAL AND EMOTIONAL MILESTONES
0 to 3 mo.	▪ Begins to develop a social smile ▪ Enjoys playing with other people and may cry when playing stops ▪ Becomes more expressive and communicates more with face and body ▪ May imitate some movements and facial expressions
By the End of 7 mos.	▪ Enjoys social play ▪ Interested in mirror images ▪ May respond to other people's expressions of emotion and appears joyful often
By the End of 2 years (24 months)	▪ May imitate behavior of others, especially adults and older children ▪ More aware of herself/himself as separate from others ▪ More excited about company of other children ▪ Often demonstrates increasing independence ▪ May begin to show defiant behavior ▪ Separation anxiety may increase toward midyear than fade
By the End of 3 yrs. (36 months)	▪ Imitates adults and playmates ▪ May spontaneously show affection for familiar playmates, may express affection openly ▪ Can take turns in games ▪ Understands concepts of "mine" and "his/hers" ▪ May express a wide range of emotions ▪ By 3, begins to separate more easily from parents ▪ May object to major change in routine
By the End of 4 yrs. (48 months)	▪ Interested in new experiences ▪ Cooperates with other children ▪ May play "Mom" or "Dad" ▪ Increasingly inventive in fantasy play ▪ Dresses and undress ▪ Begins to negotiate solutions to conflicts ▪ More independent ▪ May imagine that many unfamiliar images may be "monsters" ▪ Views self as a whole person involving body, mind, and feelings ▪ Often cannot tell the difference between fantasy and reality
By the End of 5 yrs. (60 months)	▪ Wants to please friends; may want to be like his/her friends ▪ More likely to agree to rules ▪ Often likes to sing, dance, and act ▪ Shows more independence and may even visit a next-door neighbor by himself/herself ▪ Aware of gender ▪ Able to distinguish fantasy from reality ▪ Sometimes demanding, sometimes eagerly cooperative

Source: Adapted from *CARING FOR YOUR BABY AND YOUNG CHILD: BIRTH TO AGE 5 by Steven Shelov, Robert E. Hammermann © 1991, 1993, 1998, 2004 by the American Academy of Pediatrics*

When assessing children for **extreme and problem behavior**, assessors should consider not only the presence of a behavior or symptom but the degree to which it is present and may interfere with normal day-to-day functioning.

I.1 Problem Behavior - Identifies the presence of problem behaviors in the last 7 days that cause disruption and includes behaviors that are potentially harmful to the child or disruptive in the environment, even though friends, family members, or care givers appear to have adjusted to the behaviors.

a. **Wandering:** moved with no rational purpose, seemingly oblivious to needs or safety. A wandering child may be oblivious to his or her physical or safety needs. Wandering behavior should be differentiated from purposeful movement (e.g. a hungry child moving about in search of food). Wandering may be by walking or by wheelchair. Note: Do not include pacing as wandering behavior.
b. **Verbally abusive:** others were threatened, screamed at, cursed at
c. **Physically abusive**: others were hit, shoved, scratched, sexually abused
d. **Socially inappropriate/disruptive behavior:** made disruptive sounds, noisy, screams, self-abusive acts, sexual behavior or disrobing in public, smeared, threw food/ feces, hoarding, rummaged through others' belongings
e. **Resists care:** resisted taking medications, injections, ADL assistance or eating. Signs of resistance may be verbal and/or physical (e.g. verbally refusing care, pushing caregiver away, scratching caregiver). This category does **not** include instances where child has made an informed choice not to follow a course of care (e.g. child has exercised his or her right to refuse treatment, and reacts negatively as caregivers try to reinstitute treatment.)

For each disruptive behavior use one of the following codes. Report on the most disruptive behavior across a 24-hour period. **Every box must be coded 0, 1, 2, or 3 for frequency.**

Frequency codes: code for the frequency of behavior in the last 7 days.

0. Behavior not exhibited in last 7 days.
1. Behavior of this type occurred 1 to 3 days in last 7 days
2. Behavior of this type occurred on 4 to 6 days, but not every day.
3. Behavior of this type occurred daily or more frequently.

I.2A Nursing Needs - Is professional nursing assessment, observation, and management required at least 3 days per week to manage the behavior problems in I.1A-E? Code "0" if No, code "1" if Yes.

- If I.2A = "yes," proceed to Section J. Do NOT complete the Supplemental Screen for Behavior.
- If I.2A = "no," **and child meets the behavioral impairment threshold** as defined below, then complete Section I.2B Behavior.

A "threshold" score for problem behavior is equal to a score of "2" or "3" (occurs at least 4 times per week) in one of these four criteria: wandering, verbally abusive, physically

abusive, socially inappropriate/disruptive behavior (1a-1d), per Chapter II, Section 67 of the Maine Medical Assistance Manual.

If the behavioral impairment threshold is met and the child does not need nursing assessment at least 3 days a week then the Supplemental Screen for Behavior must be completed.

I.3 Is professional nursing assessment, observation and management required less frequently than 3 days per week but at least once per month? Code "0" if No, code "1" if Yes.

SUPPLEMENTAL SCREENING TOOL Section I.2.B BEHAVIOR.

Section I.2B. BEHAVIOR. Complete this behavioral screen only if the response to I.2A. is 0 "no" and the child meets the behavioral impairment threshold. A "threshold" score for problem behavior on the eligibility assessment form is equal to a score of "2" or "3" in one of these four criteria (1a-1d) and occurs at least 4 times per week.

Section I.2B. BEHAVIOR. Enter the code that most accurately describes the child's behavior for the last 7 days.

1. Sleep patterns: Enter the number that best describes child's sleep patterns within the last 7 days: 0, 1, 3, or 4.
2. Wandering: Enter the number that best describes child's wandering behavior within the last 7 days: 0, 1, 2, 3, or 4.
3. Behavioral Demands on Others: Enter the number that best describes the effect of child's behavior on their living arrangement within the last 7 days: 0, 1, 3, or 4.
4. Danger to Self and Others: Enter the number that best describes the extent to which the individual has been dangerous to self or others within the last 7 days: 0, 1, 2, 3, or 5.
5. Awareness of Needs/Judgment: Enter the number that best describes child's awareness of their needs and level of cooperation in meeting those needs within the last 7 days: 0, 1, 2, or 3.

I.2B. Total Behavior Score: Add the answers to questions 1-5 and enter this number in the box provided. **Proceed to Section J.**

SECTION J. COMMUNICATION/HEARING PATTERNS

There are many possible causes for communication problems. Usually a communication problem is caused by more than one factor. For example, a child might have aphasia as well as a long-standing hearing loss. The child's physical, emotional, and social situation may also complicate communication problems. Additionally, a noisy or isolating environment can inhibit opportunities for effective communication.

Deficits in the child's ability to understand (receptive communication deficits) can involve impairments in hearing, comprehension (spoken or written), or recognition of facial expressions. Deficits in ability to make oneself understood (expressive communication deficits) can include reduced voice volume and difficulty in producing sounds, or difficulty in finding the right word, making sentences, writing, and gesturing.

The assessor should interact with the child. Observe and listen to the child's efforts to communicate with you. Observe the child's interactions with others. Consult with caregivers and family members. Be alert to what you have to do to communicate with the child. For example, if you have to speak more clearly, use a louder tone, speak more slowly, or use gestures, or if the child needs to see your face to know what you are saying, or if you have to take the child to a more quiet area to conduct the interview, these may be indications that there is a hearing problem.

Although children develop at their own pace (and it's impossible to tell exactly when a child will learn a given skill), the examples of communication/hearing milestones listed below in Table 5. are meant to give a general idea of changes one may expect at different points in a child's development.

Table 5. General Guidelines for Age-Appropriate Communication/Hearing

CHILD'S AGE	EXAMPLES OF SOME SIGNIFICANT MILESTONES - COMMUNICATION/HEARING
0 to 3 mos.	▪ Smiles at sound of voice ▪ Begins to babble ▪ Begins to imitate some sounds ▪ Turns head towards direction of sound
By the End of 7 mos.	▪ Responds to own name ▪ Begins to respond to "no" ▪ Can tell emotions by tone of voice ▪ May respond to sound by making sounds ▪ Uses voice to express joy and displeasure ▪ Babbles chains of sounds
By the End of 2 years (24 months)	▪ Points to object or picture when it's named for him/her ▪ Recognizes names of familiar people, objects, and body parts ▪ Says several single words (by 15 to 18 months) ▪ Uses simple phrases (by 18 to 24 months) ▪ Uses 2 to 4 word sentences ▪ Follows simple instructions ▪ May repeat words overhead in conversation
By the End of 3 yrs. (36 months)	▪ Follows a two and three part command ▪ Recognizes and identifies almost all common objects and pictures ▪ Understands most sentences ▪ Understands placement in space ("on," "in," "under") ▪ Uses 4 to 5 word sentences ▪ Can say name, age, and sex ▪ Uses pronouns (I, you, me, we, they) and some plurals (cars, dogs, cats) ▪ Strangers may be able to understand most of child's words
By the End of 4 yrs. (48 months)	▪ Has mastered some basic rules of grammar ▪ Speaks in sentences of 5 to 6 words ▪ Speaks clearly enough for most strangers to understand ▪ Tells stories
By the End of 5 yrs. (60 months)	▪ Recalls part of a story ▪ Speaks sentences of more than 5 words ▪ Uses future tense ▪ Tells longer stories ▪ Says name and address

Source: Adapted from *CARING FOR YOUR BABY AND YOUNG CHILD: BIRTH TO AGE 5 by Steven Shelov, Robert E. Hammermann © 1991, 1993, 1998, 2004 by the American Academy of Pediatrics*

J.1 Hearing: Code for the child's ability to hear. Enter 0, 1, 2, or 3, depending on the appropriate response. If hearing appliance is used, code child's ability to hear with hearing appliance.

0. Hears adequately. The child hears all normal conversational speech, including when using the telephone, watching television, and engaged in group activities.
1. Minimal difficulty. The child hears speech at conversational levels but has difficulty hearing when not in quiet listening conditions or when not in one-to-one situations.
2. Hears in special situations only. Although hearing-deficient, the child compensates when the speaker adjusts tonal quality and speaks distinctly, or the child can hear only when the speaker's face is clearly visible.
3. Highly impaired - absence of useful hearing. There is no comprehension of conversational speech, even when the speaker makes maximum adjustments.

J.2 Communication Devices/Techniques: Check all that apply during last 7 days:

a. Hearing aid, present and used. A hearing aid or other assistive device is available to the child and is used regularly.
b. Hearing aid, present and not used regularly. The hearing aid is used only occasionally or is broken.
c. Other receptive communication techniques used. (e.g. lip reading) A mechanism or process is used by the child to enhance interaction with others, e.g. touching to compensate for hearing deficit, writing is done by another child, use of a communication board.
d. NONE OF ABOVE.

J.3 Speech clarity: Code the child's ability to speak clearly. Enter 0, 1, or 2 depending on the appropriate response.

0. Clear speech. Child's speech is distinct and intelligible enough to be understood by most people most of the time.
1. Unclear speech. There are enough errors in speech so that child's speech is unintelligible to people who are not familiar with the child or when no context is provided.
2. No speech. Absence of spoken words

J.4 Communication: Check the methods by which the child communicated during the last 7 days. Remember to check all that apply. Choices include:

a. Speech.
b. Writing message to express or clarify needs.
c. American or other sign language, Braille.
d. Communication device. For example, picture exchange, special computers, augmentative and alternative communication devices (AAC).
e. Eye gaze.
f. Gestures. Includes pointing, leading, head nods, hand squeezes, etc.
g. Other. Please specify.
h. NONE OF ABOVE.

J.5 **Making self understood:** Code the child's ability to communicate to others when articulating requests and needs, whether in speech, writing, sign language, or a combination of these (including use of word or key board). Enter 0, 1, 2, or 3 depending on the appropriate response**.**

0. Understood. When communicating with others, child uses nouns, names objects, and can give first and last names.
1. Usually understood. Child has difficulty finding words or finishing thoughts.
2. Sometimes understood. Child's ability to communicate with others is limited to making concrete requests.
3. Rarely/ never understood. Child's ability to communicate with others is limited to highly individual, child-specific sounds or body language/gestures.

J.6 **Ability to Understand Others:** Code for the child's ability to understand others. Enter 0, 1, 2, or 3 depending on the appropriate response.

0. Understands. The child understands a speaker's age-appropriate message and demonstrates comprehension by words or actions/ behaviors.
1. Usually understands. The child may miss some part or intent of the message but comprehends most of it.
2. Sometimes understands. The child demonstrates frequent difficulties integrating information, and responds adequately only to simple and direct questions or directions.
3. Rarely/ never understands. The child demonstrates very limited ability to understand communication. Or, the child can hear sounds but does not understand messages.

SECTION K. VISION

K.1 **Vision:** Code 0, 1, 2, 3, or 4 depending on the appropriate response.

0. Adequate. Child sees fine detail, including regular print in newspapers/ books.
1. Impaired. Child sees large print, but not regular print in newspapers, books.
2. Moderately impaired. Child has limited vision; not able to see newspaper headlines, but can identify objects.
3. Highly impaired. Object identification is in question, but eyes appear to follow objects.
**Note: some children with severe cognitive impairment are unable to participate in vision screening because they are unable to follow directions or are unable to tell you what they see. However, many such children appear to "track" or follow moving objects in their environment with their eyes. For children who do this, check "3."
4. Severely impaired. Child has no vision or sees only light, colors, or shapes, eyes do not appear to follow objects

When scoring infants on this item, refer to Table 6 as a general guide on what constitutes "adequate" and/or age-appropriate vision.

Table 6. General Guidelines for Age-Appropriate Vision for Infants

CHILD'S AGE	EXAMPLES OF SOME SIGNIFICANT MILESTONES - VISION
0 to 3 mo.	▪ Watches faces intently ▪ Follows moving objects ▪ Recognizes familiar objects and people at a distant ▪ Starts using hands and eyes in coordination
By the End of 7 mos.	▪ Develops full color vision ▪ Distance vision matures ▪ Ability to track moving objects improves

Source: Adapted from *CARING FOR YOUR BABY AND YOUNG CHILD: BIRTH TO AGE 5 by Steven Shelov, Robert E. Hammermann © 1991, 1993, 1998, 2004 by the American Academy of Pediatrics*

K.2 Visual Appliances: Code "0" if No, "1" if Yes.

a. Glasses, contact lenses.
b. Artificial eye.
c. Other. Please specify.

SECTION L. NUTRITIONAL STATUS

L.1 Weight: Record weight in pounds. Base weight on most recent measure in last 30 days; measure weight consistently in accord with standard practice (e.g. in a.m. after voiding, before meal, with shoes off, and in nightclothes). Specify date on which recorded weight was measured.

L.2 Weight change: Code appropriate response for weight change in last 180 days.

0. No weight change.
1. Unintended weight loss. 5% or more in last 30 days or 10% or more in last 180 days.
2. Unintended weight gain. 5% or more in last 30 days or 10% or more in last 180 days.

In the space provided, please specify previous weight as well as the date on which it was measured.

L.3 Nutritional problems or approaches: Check all items that are applicable.

a. Chewing or swallowing problem. Inability to chew food easily and without pain or difficulties, unless due to teething.
b. Complains about the taste of many foods. The sense of taste can change as a result of health conditions or medications.
c. Regular or repetitive complaints of hunger. On most days (at least 2 out of 3) child asks for more food or complains of feeling hungry (even after eating a meal)
d. Leaves 25% or more of food uneaten at most meals. Eats less than 75% of food (even when substitutes are offered) at least 2 out of 3 meals a day
e. Therapeutic diet. A diet ordered to manage problematic health conditions. Examples include calorie-specific, low-salt, low-fat, lactose, no added sugar, and supplements during meals. Specify which therapeutic diet the child is following.

f. Mechanically altered (or pureed) diet. A diet specifically prepared to alter the consistency of foods in order to facilitate oral intake. Diets for people who can only take liquids that have been thickened to prevent choking are included in this definition.
g. Gastric tube provides 50% or more of daily calories.
h. Gastric tube provides less than 50% of calories.
i. Noncompliance with diet. Child does not comply with specific diet orders.
j. Food allergies. Specify any known food allergies that the child has.
k. Restrictions. Specify any dietary restrictions, such as caffeine, chocolate, or meat that the child may have.
l. NONE OF ABOVE

SECTION M. CONTINENCE IN LAST 14 DAYS

Control of bladder and bowel function is a sensitive subject. Children with poor control may try to hide their problems out of embarrassment or fear of retribution. Validate continence patterns with family members or caregivers who know the child well. Remember to consider continence patterns over the last **14 day period, 24 hours** a day.

M.1 Appliances/Programs: For children 3 years and older, check all that apply or check f. NONE OF ABOVE. Be sure to ask about any items that are usually hidden from view because they are worn under street clothing.

- **a. External (condom) catheter.** A urinary collection appliance worn over the penis.
- **b. Indwelling catheter.** A catheter that is maintained within the bladder for the purpose of continuous drainage of urine. Includes catheters inserted through the urethra or by supra-pubic incision.
- **c. Pads, briefs used.** Any type of absorbent, disposable or reusable undergarment or item, whether worn by the child (e.g. diaper) or placed on the bed or chair for protection from incontinence. Does NOT include the routine use of pads on beds where child is never or rarely incontinent.
- **d. Ostomy present.** Any type of ostomy of the gastrointestinal or genitourinary tract.
- **e. Scheduled toileting/ other program**. Timed/ scheduled toileting of the child or any other program such as bladder retraining.
- **f. Age appropriate**. Child uses age appropriate toileting appliances and/or programs. See Table 2. on Age-Appropriate Activities of Daily Living-Self-Performance for clinical expectations for age appropriate toilet use.
- **g. NONE OF ABOVE.**

SECTION N. SKIN CONDITIONS

N.1 Ulcers: Record the number of pressure and stasis ulcers at each of the four ulcer stages-regardless of the cause. Code all occurrences during the **last 7 days**. If no ulcers are present at a stage, record "0". If one ulcer is present at a stage, record "1." Code "9", if 9 or more ulcers are present at a given stage. If an ulcer cannot be staged (i.e. covered with eschar), code as Stage 4.

The four stages are:

a. STAGE 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.
b. STAGE 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.
c. STAGE 3. A full thickness of skin is lost, exposing the subcutaneous tissues, presents as a deep crater with or without undermining adjacent tissue.
d. STAGE 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.

The type of ulcers are:

a. Pressure ulcer. any lesion caused by pressure resulting in damage of underlying tissue.
b. Stasis ulcer. open lesion caused by poor circulation in the lower extremities.

MaineCare only covers RN care for Stage 3 or 4 ulcers.

N.2 Skin problems: Document presence of skin problems and conditions (other than ulcers) that are risk factors for more serious problems. Check all that apply in the last 180 days. If none, check f. NONE OF ABOVE.

a. Abrasions. (scrapes) Includes skin that has been scraped or rubbed away, such as skin tears.
b. Burns. (second or third degree) Includes burns from any cause (e.g. heat, chemicals) in any stage of healing. This category does not include first-degree burns (changes in skin color only).
c. Bruises. Includes ecchymoses, localized areas of swelling, tenderness and discoloration.
d. Rashes, itchiness, body lice, scabies. Includes inflammation or eruption of the skin that may include change in color, spotting, blistering, etc. and symptoms such as itching, burning, or pain. Record rashes from any cause (e.g. heat and bacteria, viruses, contact with irritating substances such as urine or detergents, allergies, etc.), including rashes (dermatitis) within skin folds (Intertrigo).
e. Open sores or lesions. A wound, injury, or destructive change in body tissue (e.g. a sore or boil); includes a stasis ulcer, eczema or psoriasis.
f. NONE OF ABOVE.

N.3 Foot Problems and Care: Code "0" No or "1" Yes for Questions a. and b.

a. Child or someone else inspects child's feet on a regular basis.
b. One or more foot problems or infections such as corns, calluses, hammer toes, overlapping toes, pain, structural problems, gangrene toe, foot fungus, onychomycosis.

ELIGIBILILTY DETERMINATION

NURSING FACILITY LEVEL OF CARE

NF.1 Nursing Services

Check “yes" to any nursing services coded with responses as specified in the box. If the answer is "yes" to any of these questions, then the child appears to be medically eligible for nursing facility level of care. If the answer is "no" to all questions in **NF.1**, proceed to **NF.2, Professional Nursing Services.**

NF.2 Professional Nursing Services

- **a. Nursing Services.** Enter the number of conditions or treatments in Section D items 1-8 that required nursing services 3-6 times a week.
- **b. Therapies**. Enter 1 for “yes” if the total number of days of therapy in Section E.3.a.1 was 3 or 4 days a week.
- **c. Conditions.** Enter 1 for “yes” if you coded any of the responses in Section E with a “2” (service needed 3 or more days per week) for items 1a-1e and 1g-1j (excluding 1.f monthly injections).
- **d. Procedures.** Enter 1 for “yes” if you coded any of Section E items 2a -2d with a “2.”

Compute the nursing services score and enter the total in Total box. Proceed to **NF.3**.

If no conditions or treatments are checked, enter “0” in Total box and proceed to **NF.3**, **Impaired Cognition**.

NF.3 Impaired Cognition

- **a. Is Section H.1.a.** (short-term memory) coded with a “1”? Check ‘Yes’ or ‘No’.
- **b. In Section H.2.** (memory recall) are 1 or 2 boxes checked in H.2.a through H.2.d or is H.2.e., None of the Above, checked (Person is able to recall no more than 2 items)? Check ‘Yes’ or ‘No’.
- **c. Is Section H.3** coded with a “2” or “3”? Check ‘Yes’ or ‘No’.
- **d.** [**Is Section H.4.A** coded with a “1”] **OR** [in **Section C**, is at least one shaded ADL coded with a “2,” “3,” or “4” in self-performance and a “2” or “3” in support **AND H.4.B** (from page 5 **Supplemental Screening Tool)** is “13” or more]? Check ‘Yes’ or ‘No’.

If all the answers to the above questions are “yes”, then score this section with a “1.” Proceed to **NF.4 Behavior Problems.**

NF.4 Behavior Problems

- **a. In Section I.1**, is one or more of the behaviors from items **a-d** (wandering, verbally abusive, physically abusive, socially inappropriate behavior) coded with a “2” or “3”?

b. [**Is Section I.2.A**. coded with a "1"] **OR** [in **Section C**, is at least one shaded ADL coded with a "2", "3', or "4" in self-performance and a "2' or "3" in support **AND I.2.B** (from page 6 **Supplemental Screening Tool)** is "14" or more]?

If the answer to both questions is "yes," then score this section with a "1."

NF.5 Total Nursing

Total the scores from **NF.2, NF.3,** and **NF.4.** Place the total in the **Total Nursing** box.
If the **Total Nursing Score** is "1" or more, proceed to **NF.6**. If the **Total Nursing Score** is "0", the child appears **not** to be medically eligible for nursing facility level of care.

NF.6 Total ADL Needs

In determining the **Total ADL Needs** from **Section C (Physical Functioning/Structural Problems)**, the shaded ADLs --bed mobility, transfer, locomotion, eating and toilet use-- must be coded with a "2", "3" or "4" in Self-Performance AND ALSO require a one or more physical assist (i.e. Support must be coded with a "2" or" 3"). See example.

ADL Needs

	Self-Performance	**Support**
Bed Mobility	2	1
Transfer	3	2
Locomotion	2	2
Eating	3	3
Toilet Use	2	1

In the example above, the **Total ADL Needs** would equal "3" because three ADLs (transfer, locomotion and eating) had a **Self-Performance** code of "2" and "3" and had a corresponding **Support** code of either "2" or "3."

NF.7 Total Nursing and ADL Needs Score (NF.5 + NF.6)

Total the numbers from **NF.5** and **NF.6** and place in the appropriate box. If the **Total Nursing and ADL Needs Score** is "3" or more, the child appears to be medically eligible for nursing facility level of care. Otherwise, the child appears not to be medically eligible.

Private Duty Nursing (PDN) and Personal Care Services (PCS) ELIGIBILITY

There are several levels of PDN care. A child meets the medical eligibility requirements for a particular level of PDN care if he or she needs a combination of assistance with the required numbers of Activities of Daily Living and nursing services, as appropriate. The scoring pages for determining level of PDN can be found on pages 10 and 11 of the MED Kids – PDN tool.

**Note: Medical eligibility for PDN care and the scores for criteria, such as extensive assistance or total dependence, behavior and cognition, as well as Activities of Daily Living, must be reviewed in the context of an individual's age-appropriate development. A child or infant shall not qualify for covered PDN services by virtue of scoring high dependency requirements with the ADLs, or the aforementioned criteria, when these dependency requirements are normal for the child's age.

CARE PLAN SUMMARY

Header-Complete the following items: **Agency Name, Provider-Assessor #, Assessment Date, Applicant Name, Social Security. Refer to the coding sheet on the previous pages when completing this care plan summary.**

SUPPORT SERVICES
Informal support is care provided that is NOT reimbursed by a formal Program/funding source. When hours of care are not being reimbursed, they should be entered in this section as informal support. Enter the hours on the appropriate row for the type of care provided

- When family/friends are not being reimbursed for care they provide, those hours are listed here and also included on the care plan under Program/funding source = other.
- When family/friends are being reimbursed for care they provide under an authorized program, those hours are not entered in this Support Services section. They are included on the care plan under the authorized Program/funding source.

1. Extent of help: for instrumental and personal activities of daily living received *over the last 7 days*, indicate extent of help from family, friends, and neighbors on a. 5 weekdays and b. 2 weekend days. Round hours of care.

2. Two Key Informal Helpers: Information on two family members, friends, or neighbors most relied on for help with ADLs or IADLs (or who could be relied on, if no one now helps with these activities.)

Name of Person 1 and Person 2
Complete A. and B. For items a. and b., note the information for Person 1 is recorded in the left column, and information for Person 2 is recorded in the right column.

3. Caregiver Status: Check all that apply from a, b, c, d, and/or e. Or check f. NONE OF ABOVE.

For **Person A,** complete the current number of weekday and weekend hours of help provided. Enter the number of hours provided in each category, Advice or emotional support, ADL care, IADL care, Supervision only. Is this person willing to increase the number of weekday hours? If "yes", fill in the number of additional hours. Is this person willing to increase the number of weekend hours? If " yes", fill in the number of additional hours. If person not willing to or able to increase hours, enter "0". For each category, enter the extent of knowledge the caregiver has about that category: 0 = Full knowledge, 1 = Partial knowledge, 2 = No knowledge for that particular category.
Fill in the same information for **Person B**, if applicable.

3RD PARTY PAYORS:

Indicate routine Medicaid services in this block. For the **Third party Payor** Block, use the following codes: code 22 for 3rd party payors, such as BC/BS, Champus, VA, and LTC insurance, code 23 for Community Medicaid, code 24 for Consumer's Funds, or 25 for nursing facility. In most cases the assessor does not authorize services under these funding sources. This space is provided to record services recommended by the assessor or services being received that are reimbursed by third party payors.

1. Funding Source: Enter the payment code, 1 through 20, for the funding source that will pay for the recommended service.

2. Service Category: Enter the appropriate code to indicate the service category recommended to meet the need. Be sure that the service category selected is reimbursable under the program/funding source.

3. Reason Code/Need met: List all reasons for service. Be sure to match functional needs to level of service category.

4. Duration Enter the **4a. Start Date** and **4b. End Date** for the proposed service**.**

5. Unit Code Enter the unit of time that is used in calculating the cost of this service, using the codes 1 through 11. **NOTE: The unit code used on the care plan summary table must match the allowable unit codes for each policy and as required by the HCCA. Each Medicaid policy includes Chapter III, reimbursement codes and maximum allowances. Please refer to individual policy.**

6. Number of units per month Enter the number of units needed *per month* to meet the person's needs.

7. Rate per unit: Enter the current rate for this service based on the maximum allowable Medicaid rate for that specific unit of service in this program as found in the appropriate Medicaid manual.

8. TOTAL cost per month. Add the numbers in column 8 and place total in box labeled **3rd Party total.**

ALL OTHER FUNDING SOURCES/SERVICES PROVIDED:

1. Funding Source: Enter the payment source that will pay for the recommended service. Codes for PDN care include: 30-Level 1, 2-Level II, 31-Level III, 4-Level IV (NF Kids), and 3-Level V (Extended).

2. Service Category: Enter the appropriate code to indicate the service category recommended to meet the need and tasks identified in the assessment. **Be sure that the service category and unit of service selected is reimbursable under the program/funding source.** If you have a question, refer to the specific policy for the program.

3. Duration Enter the **4a. Start Date** (this may differ from the eligibility date because of the due process requirement to give so many days notice to the recipient) and **4b. End Date** for the proposed service**.**

4. Unit Code Enter the unit of time that is used in calculating the cost of this service, using the codes 1 through 11 from the unit code list. **NOTE: The unit code used on the care plan summary table must match the allowable unit codes for each policy and as required by the HCCA. Each Medicaid policy includes Chapter III, reimbursement codes and maximum allowances. Please refer to individual policy. NOTE: The unit code used on the care plan summary table must match the allowable unit codes for each policy and as required by the HCCA. Each Medicaid policy includes Chapter III, reimbursement codes and maximum allowances. Please refer to individual policy.**

5. Number of units per month Enter the number of units needed *per month* to meet the person's needs.

6. Rate per unit: Enter the current rate for this service based on the maximum allowable Medicaid rate for that specific unit of service in this program as found in the appropriate Medicaid manual.

7. TOTAL cost per month. Add the numbers in column 8 and place total in box labeled **Other Funding Sources Total.**

Fill in the 8 columns for each service as described above for all other funding sources. Add the numbers in column 8 and place total in box labeled **Other Funding Sources Total.**

STANDARD NURSING NOTES

The Standard Nursing Notes section makes up the final two pages of the MEDKids Tool. Assessors are expected to use the space provided to report any supplemental information that describes and supports their scoring decisions.

This section may contain additional detail on a child's specific conditions and/or treatments. For example, if an assessor indicated that a child is receiving chemotherapy in Section E – Treatments and Therapies, the assessor would want to indicate in the Nursing Notes what type of chemotherapy the child is receiving. The Nursing Notes section is also a place for assessors to record what documentation they received and who it was provided by (i.e. parent, physician, therapist).

APPENDIX A – CHILD ADL SCORING EXAMPLES

SP = Self-Performance
S = Support

Bed Mobility:

Robert is 2 months old and cannot roll over yet. His mother must reposition him in his crib.
SP = Age appropriate **S = Age appropriate**

Janice is 9 months old. Her mother notices that she never moves in the bed. Her position remains unchanged. She will look at her mother but makes no attempt to grasp her hand. Her mother must lift her out of bed.
SP = 4 **S = 2**

Jack is 9 months old. His mother enters his room to get him for breakfast and finds him standing in his crib waiting for her. She lifts him out of the crib.
SP = 0 **S = 0**

Transfer:

Alice is 3 months old. Her mother notices that Alice never moves in the bed. Her position remains unchanged. She will look at her mother but makes no attempt to grasp her hand. Her mother must lift her out of bed.
SP = Age appropriate **S = Age appropriate**

Charles is a 1 year old and he likes his new bunk bed. When he wakes up in the morning, he can get out of bed by himself.
SP = 0 **S = 0**

Sarah is a 1 year old. Her mother notices that she never moves in the bed. Her position remains unchanged. She will look at her mother but makes no attempt to grasp her hand. Her mother must lift her out of bed.
SP = 4 **S = 2**

Locomotion:

Charlene is 6 months old and cannot get to the kitchen for breakfast without her mother's assistance.
SP = Age appropriate **S = Age appropriate**

Dillon is a year old and he likes his new bunk bed. When he wakes up in the morning he can get out of bed by himself. Although still unsteady on his feet, he can walk short distances. When he tires, he will crawl to get to the kitchen.
SP = 0 **S = 0**

John is 2 years old and is unable to transfer or walk by himself. A wheelchair has been ordered. His mother or father must lift and carry him to the kitchen.

SP = 4 **S = 2**

Dressing:

One year old Christy cannot remove or put on any article of clothing.

SP = Age appropriate **S = Age appropriate**

Two year old Suzie cannot get her arms in her sweater correctly. Her mother must assist her in getting dressed.

SP = Age appropriate **S = Age appropriate**

Although four year old Sam has no problem removing his clothes, he still has difficulty putting on clothing. His mother assists him each time he is dressed.

SP = 3 **S = 2**

Eating:

Billy, who is three months old, cannot hold his bottle for feedings.

SP = Age appropriate **S = Age appropriate**

One year old Timmy has no difficulty picking up and putting sandwich wedges, apple slices and other finger foods in his mouth. His mother assists him with all food requiring a spoon or fork.

SP = Age appropriate **S = Age appropriate**

Two year old Becky cannot use a cup or fork. Her mother feeds her all of her meals.

SP = 4 **S = 2**

Toilet Use:

Eight month old James still requires diapers which are changed by his mother or father whenever needed.

SP = Age appropriate **S = Age appropriate**

Three year old Cathy can use the toilet by herself but cannot clean herself properly after. Her mother wipes her each time she uses the bathroom.

SP = 3 **S = 2**