STAR Kids Screening and Assessment – Core

SECTION A. IDENTIFICATION INFORMATION

1. Name

(First) (Middle Initial) (Last)

2. Gender

1. Male 2. Female 9. Unknown ☐

3. Birthdate ☐☐ – ☐☐ – ☐☐☐☐

Month Day Year

4. Ethnicity And Race

0. No 1. Yes

Ethnicity

a. **Hispanic or Latino** ☐

Race

b. **American Indian or Alaska Native** ☐
c. **Asian** ☐
d. **Black or African American** ☐
e. **Native Hawaiian or other Pacific Islander** ☐
f. **White** ☐

5. Participants In Assessment

6. Individual's Profile

a. **A little about myself:**
b. **What people like about me:**
c. **What's important to me:**
d. **What others need to know and do to support me:**
e. **What the people are like that support me best:**
f. **How I like to spend my day:**
g. **The services I am currently receiving are:**

7. Language

0. No 1. Yes

a. **English** ☐
b. **Spanish** ☐
c. **American Sign Language** ☐
d. **Other (specify):** ☐

8. Interpreter Needed

0. No 1. Yes

a. **Individual** ☐
b. **Either parent/guardian** ☐

9. Interpreter Information

a. **Signature of interpreter**
b. **Name of interpreter**
c. **Date** ☐☐ – ☐☐ – ☐☐☐☐

Month Day Year

10. Numeric Identifiers

a. Social Security Number

☐☐☐ – ☐☐ – ☐☐☐☐

b. **Medicare Number** (if applicable)

☐☐☐ – ☐☐ – ☐☐☐☐ – ☐☐

c. Medicaid Number

☐☐☐☐☐☐☐☐☐

11. Does Individual Have Healthcare Needs Not Covered By Current Funding Sources? ☐

0. No 1. Yes

If yes, please specify in space provided.

_____

_____

12. Reason For Assessment ☐

0. Initial
1. Re-assessment
2. Significant change in status re-assessment
3. Minor correction to recent assessment
4. Major correction to recent assessment

13. Assessment Reference Date

☐☐ – ☐☐ – ☐☐☐☐

Month Day Year

14. Phone Number

a. Primary

☐☐☐ – ☐☐☐ – ☐☐☐☐

b. Alternate

☐☐☐ – ☐☐☐ – ☐☐☐☐

15. Address Of Current Residence

_____

_____

street

_____

city

16. Postal/Zip Code Of Current Residence

☐☐☐☐☐ – ☐☐☐☐

17. As Compared To 90 DAYS AGO (or since last assessment), Individual Now Lives With Someone New (e.g., moved in with another person(s), other(s) moved in) 0. No 1. Yes ☐

18. Current Residence 0. No 1. Yes

Own home or apartment

a. Alone (includes person living alone who receives in-home services) ☐
b. With family ☐
c. With spouse/partner ☐
d. With non-relative/roommates ☐

Someone else's home or apartment

e. Family ☐
f. Foster family ☐
g. Non-relative/roommate ☐
h. Certified or licensed group home ☐

Group residential living

i. Assisted living facility (ALF) ☐
j. Residential treatment center (RTC) ☐

Institution

k. Nursing home ☐
l. Intermediate care facility for individuals with intellectual disability or related conditions (ICF/IID) ☐

Other living arrangements

m. No permanent residence (for example, homeless shelter, emergency shelter, assessment center) ☐
n. Other – specify: ☐

19. Prefers To Live 0. No 1. Yes

Own home or apartment

a. Alone (includes person living alone who receives in-home services) ☐
b. With family ☐
c. With spouse/partner ☐
d. With non-relative/roommates ☐

Someone else's home or apartment

e. Family ☐
f. Foster family ☐
g. Non-relative/roommate ☐
h. Certified or licensed group home ☐

Group residential living

i. Assisted living facility (ALF) ☐
j. Residential treatment center (RTC) ☐

Institution

k. Nursing home ☐
l. Intermediate care facility for individuals with intellectual disability or related conditions (ICF/IID) ☐

Other living arrangements

m. No permanent residence (for example, homeless shelter, emergency shelter, assessment center) ☐
n. Unable to determine individual's preference for living arrangement. ☐
o. Other – specify: ☐

20. Does Individual Want More Information About Community Living? ☐

0. No 1. Yes 8. N/A

21. What Is The Guardian's/LAR's Preference For Living Arrangements For This Individual?

0. No 1. Yes

- **a. Not applicable** ☐
- b. **Move to own home/apartment** (includes living with spouse/family) ☐
- **c. Move to an ALF** ☐
- **d. Move to a foster/host home** ☐
- **e. No consensus among multiple parties** ☐
- **f. Stay at current residence** ☐
- **g. Move to a certified or licensed group home** ☐
- h. **Move to a nursing home or other institutional setting** (ICF/IID, SSLC, RTC) ☐
- **i. Move to someone else's home** ☐

22. Does The Guardian/LAR Want More Information About Community Living? ☐

0. No 1. Yes 8. N/A

23. Assessor Information

a. Name of assessor

_____ _____ _____

(First) (Middle initial) (Last)

b. Date of assessment

☐☐ – ☐☐ – ☐☐☐☐

Month Day Year

24. Medical Provider Information

a. Does the individual have a regular provider that meets their medical needs? ☐

0. No
1. Yes

b. If yes, does provider accept Medicaid? ☐

0. No
1. Yes
8. No provider
9. Unknown

c. Name of provider

_____

(First) (Middle Initial) (Last)

d. Length of time individual has been in care of this provider ☐

0. 12 months or less
1. Greater than 12 months

e. Date of last visit with provider

☐☐ – ☐☐☐☐

Month Year

f. NPI/API

☐☐☐☐☐☐☐☐☐☐

g. Provider telephone

☐☐☐ – ☐☐☐ – ☐☐☐☐

h. Provider fax

☐☐☐ – ☐☐☐ – ☐☐☐☐

i. Address of provider

_____

street

_____

city

j. Zip code of provider

☐☐☐☐☐ – ☐☐☐☐

25. Guardian/LAR

a. Name of guardian/LAR

_____ _____ _____

(First) (Middle initial) (Last)

26. Legal Responsibilities/Guardianship ☐

0. Both parents are legal guardians
1. Mother is legal guardian, but not father
2. Father is legal guardian, but not mother
3. Neither parent but relative(s) or non-relative(s) is legal guardian
4. Child protection agency is legal guardian (e.g., CPS)
5. Individual is responsible for self

27. Current Dispute Over Custody/Access 0. No 1. Yes

a. This individual ☐ **b. Other individual(s) in household/family** ☐

SECTION B. SCHOOL AND WORK

1. Type Of Current School Or Day Program

0. No 1. Yes

a. Day care	☐	**f. Home school**	☐
b. ECI	☐	**g. Alternative school**	☐
c. Head Start or Pre-Kindergarten	☐	**h. Vocational or Technical/Day program**	☐
d. Kindergarten, Elementary, Middle or High School	☐	**i. College or Junior College**	☐
		j. Other (specify): _____	☐
e. Home-based (through school system)	☐	**k. Not applicable**	☐

THE INFORMATION IN ITEM B.2- B.5 IS CONFIDENTIAL. THE CAREGIVER OR THE CLIENT IS NOT REQUIRED TO RESPOND TO THESE IN ORDER TO QUALIFY FOR SERVICES.

2. Name And Address Of Current School Or Day Program

_____

3. Current Special Education

0. No 1. Yes ☐

If Yes, indicate each environment where special education services are provided (more than one may apply).

0. No 1. Yes

a. General education	☐
b. Resource room	☐
c. Self-contained room	☐
d. Special school	☐
e. Home-based	☐
f. Other (specify): _____	☐

4. Individual Has Individualized Education Plan (IEP)

0. No 1. Yes ☐

5. Individual Or Caregiver Consents To Share IEP With Assessor And Those Involved With Individual's Care ☐

0. No 1. Yes

6. Services Currently Provided At School Or Day Program (including ECI, if applicable) In Last 30 Days (or since last assessment if individual has not been in school or day program in last 30 days)

0. No 1. Yes 8. N/A

- **a. Personal care aide**
- **b. Occupational therapy**
- **c. Physical therapy**
- **d. Speech therapy**
- **e. Orientation and Mobility specialist**
- **f. Behavioral Intervention Program (BIP) or Intensive Behavioral Intervention (IBI)**
- **g. Skilled nursing visit**
- **h. Private duty nursing**
- **i. Audiology services**
- **j. Other (specify):** _____

7. Any Additional Services Received At School Not Previously Mentioned

0. No 1. Yes 8. N/A

If yes, please specify in space provided.

_____

_____

_____

8. Individual Has Preferred Learning Style

0. No 1. Yes 8. N/A

If yes, please specify in space provided.

_____

_____

_____

9. Are There Any Concerns About How Individual's Health Condition Or Behavior Affects Their Education?

0. No 1. Yes

If yes, please specify in space provided.

_____

_____

_____

10. Transition Planning Needed

From one program to other (educational or vocational or age-specific).

0. No 1. Yes

If yes, please specify in space provided.

_____

_____

_____

11. Current Employment Status

1. Employed full-time
2. Employed part-time
3. Interested in seeking employment
4. Not employed
8. Not applicable

12. Employment Interest

1. Interested in new job
2. Not interested in new job
8. Not applicable

13. Type Of Employment Or Volunteer Work

Code each item (more than one may apply).

0. No 1. Yes

- **a. Attends pre-vocational day/work activity program**
- **b. Attends sheltered workshop**
- **c. Has paid job in the community**
- **d. Works at home**
- **e. Does volunteer work**

14. Need For Assistance To Work

0. Independent (with assistive devices if uses them)
1. Needs help weekly or less
2. Needs help every day but does not need the continuous presence of another person
3. Needs the continuous presence of another person
8. Not applicable

SECTION C. GOALS FOR CARE

1. Individual's Expressed Goals Of Care

Record goals in box and primary goal in space beneath box.

2. Primary Caregiver's Expressed Goals Of Care For Individual

Record goals in box and primary goal in space beneath box.

3. One Or More Expressed Care Goals Met Since Last Assessment

0. No 1. Yes 8. N/A

4. Individual Or Individual's Family Has Been Contacted By An MCO Service Coordinator

The service coordinator would assist the individual and his/her family in connecting, with appropriate, least-restrictive, community based resources

0. No 1. Yes

5. Individual Has A STAR Kids ISP In Place Tailored To Specific Needs

1. ISP is in place and tailored to specific needs
2. ISP is in place but not tailored to specific needs
3. No ISP in place

6. Individual Receive Services Through The Following Programs

0. Receives
1. On interest list
2. Does not receive
8. Not applicable

a. Intermediate Care Facility for Individuals with an Intellectual or Developmental Disability or Related Condition (ICF/IID)

b. Nursing facility

c. Community Living and Assistance Support Services (CLASS)

d. Home and Community-based Services (HCS)

e. Deaf Blind with Multiple Disabilities (DBMD)

f. Texas Home Living (TxHmL)

g. Youth Empowerment Services (YES)

h. Medically Dependent Children Program (MDCP)

SECTION D. DIAGNOSES AND HEALTH CARE UTILIZATION

1. Diseases (Record diagnoses and ICD codes)

1. Primary Diagnosis stable; no change past 30 days
2. Primary Diagnosis; acute or acute exacerbation past 30 days
3. Other Diagnosis present, active treatment, no change past 30 days
4. Other Diagnosis present, active treatment, exacerbation past 30 days
5. Other Diagnosis present, monitored, no change past 30 days

a. _____ ☐
ICD Diagnosis Code: ☐☐☐ • ☐☐☐☐ Month/Year of Diagnosis ☐☐ — ☐☐☐☐

b. _____ ☐
ICD Diagnosis Code: ☐☐☐ • ☐☐☐☐ Month/Year of Diagnosis ☐☐ — ☐☐☐☐

c. _____ ☐
ICD Diagnosis Code: ☐☐☐ • ☐☐☐☐ Month/Year of Diagnosis ☐☐ — ☐☐☐☐

d. _____ ☐
ICD Diagnosis Code: ☐☐☐ • ☐☐☐☐ Month/Year of Diagnosis ☐☐ — ☐☐☐☐

e. _____ ☐
ICD Diagnosis Code: ☐☐☐ • ☐☐☐☐ Month/Year of Diagnosis ☐☐ — ☐☐☐☐

f. _____ ☐
ICD Diagnosis Code: ☐☐☐ • ☐☐☐☐ Month/Year of Diagnosis ☐☐ — ☐☐☐☐

g. _____ ☐
ICD Diagnosis Code: ☐☐☐ • ☐☐☐☐ Month/Year of Diagnosis ☐☐ — ☐☐☐☐

h. _____ ☐
ICD Diagnosis Code: ☐☐☐ • ☐☐☐☐ Month/Year of Diagnosis ☐☐ — ☐☐☐☐

i. _____ ☐
ICD Diagnosis Code: ☐☐☐ • ☐☐☐☐ Month/Year of Diagnosis ☐☐ — ☐☐☐☐

j. _____ ☐
ICD Diagnosis Code: ☐☐☐ • ☐☐☐☐ Month/Year of Diagnosis ☐☐ — ☐☐☐☐

k. _____ ☐
ICD Diagnosis Code: ☐☐☐ • ☐☐☐☐ Month/Year of Diagnosis ☐☐ — ☐☐☐☐

l. _____ ☐
ICD Diagnosis Code: ☐☐☐ • ☐☐☐☐ Month/Year of Diagnosis ☐☐ — ☐☐☐☐

m. _____ ☐
ICD Diagnosis Code: ☐☐☐ • ☐☐☐☐ Month/Year of Diagnosis ☐☐ — ☐☐☐☐

n. _____ ☐
ICD Diagnosis Code: ☐☐☐ • ☐☐☐☐ Month/Year of Diagnosis ☐☐ — ☐☐☐☐

o. _____ ☐
ICD Diagnosis Code: ☐☐☐ • ☐☐☐☐ Month/Year of Diagnosis ☐☐ — ☐☐☐☐

2. Individual Has No Discernable Consciousness, Is In A Persistent Vegetative State Or Is In A Coma ☐

0. No 1. Yes

3. Caregiver, Individual Or Others Are Concerned About Individual's Developmental Status Or Decline From Baseline

0. No 1. Yes

a. Related to motor skills (sitting, walking, range of motion, balance, running, jumping) ☐

b. Related to communication (talking, understanding) ☐

c. Related to learning or academic skills (coloring, reading, writing, math) ☐

d. Related to self-care (dressing, bathing, using toilet self-care) ☐

e. Related to social/emotional skill ☐

4. Further Assessment Is Needed To Determine If Individual Is Eligible/Should Be Referred For ECI Services

If individual is under 36 months old and there are any developmental concerns, they may need further assessment for ECI services. ☐

0. Client currently receives ECI services.
1. No further assessment is needed.
2. Yes, further assessment is needed.

5. Documented Severity Of Intellectual Disability ☐

0. No intellectual disabilities suspected
1. Borderline
2. Mild
3. Moderate
4. Severe
5. Profound
6. Suspected but severity not documented

6. Surgeries

List all major or critical surgeries and year performed in space provided.

0. No (go to D.7) 1. Yes ☐

Surgery	Year
a.	
b.	
c.	
d.	
e.	
f.	
g.	
h.	
i.	
j.	

7. Allergies

1. No 1. Yes ☐

a. Individual has environmental allergies
If yes, specify allergy and any reactions in space provided.

_____

_____

b. Individual has food allergies ☐
If yes, specify allergy and any reactions in space provided.

_____

_____

c. Individual has allergies to medication ☐
If yes, specify allergy and any reactions in space provided.

_____

_____

8. Prenatal History/Prematurity

0. No 1. Yes 9. Unknown

a. Premature birth ☐
b. Birth weight ‹1500 g (3lbs. 5 oz.) ☐
c. Maternal health problems during pregnancy (e.g., preeclampsia, toxemia, substance abuse, gestational diabetes) ☐

9. Prevention

0. No 1. Yes 9. Unknown

a. Complete physical examination up-to-date ☐
b. Dental exam up-to-date ☐
c. Eye screening up-to-date ☐
d. Hearing screening up-to-date ☐
e. Influenza vaccine up-to-date ☐
f. Immunizations up-to-date ☐
g. Autism screening performed (if applicable) ☐

Additional information, if necessary:

_____

10. Hospital Use, Emergency Room Use, Physician Visit, Nursing Home Stay

Code for number of times during the LAST YEAR (or since last assessment if LESS THAN A YEAR AGO). Record all 9's if unknown.

a. Inpatient acute hospital admission planned (non-psychiatric) ☐☐

b. Inpatient acute hospital admission unplanned (non-psychiatric) ☐☐

c. Emergency room visit (with no inpatient admission) ☐☐

d. Physician visit planned (or authorized assistant or practitioner) ☐☐

e. Physician visit unplanned (or authorized assistant or practitioner) ☐☐

f. Nursing home stay ☐☐

11. Time Since Last Hospital Admission

Code for most recent instance in LAST YEAR ☐

0. No hospitalization within last year
1. 6 to 12 months ago
2. 1 to 5 months ago
3. 8 to 30 days ago
4. In the last 7 days
5. Now in hospital
9. Unknown

12. Any Planned Hospitalization Or Surgeries (In-Patient Or Out-Patient) Scheduled In The <u>NEXT 90 DAYS?</u>

If yes, specify type and date in the space provided. ☐

0. No (go to D.13) 1. Yes

Hospitalization/Surgery	Date
a.	
b.	
c.	
d.	
e.	
f.	

13. Results Of Discussion Of Assistive Device/DME Needs With Individual Or Caregiver ☐

0. No concerns expressed about current DME needs
1. Yes, individual or caregiver believes new or additional DME needed
8. Individual does not use DME/assistive devices (go to D.15)

14. Individual Currently Uses Or Has A Need For Assistive Devices/DME

1. Assistive device/DME is available and adequate
2. Referral in place for assistive device/DME
3. Referral needed to assess for unmet assistive device/DME need
4. Reassessment needed to assess for device/DME need due to change in age or condition

If individual uses or has a need for DME/assistive device, specify the type(s) in space provided.

a. _____ ☐
b. _____ ☐
c. _____ ☐
d. _____ ☐
e. _____ ☐
f. _____ ☐
g. _____ ☐
h. _____ ☐
i. _____ ☐
j. _____ ☐

15. Individual Needs Care Supplies (e.g., formula, wipes, qtips, dressings, etc.) ☐

0. No 1. Yes

If yes, please specify in space provided.

_____

_____

16. Medical Emergency Plan ☐

0. The individual does not have a condition or diagnosis that requires an emergency plan.
1. Individual has a condition or diagnosis that requires an emergency plan and a plan is in place.
2. Individual has a condition or diagnosis that requires an emergency plan and a plan is NOT in place.

17. Care Transition Planning

For individuals 12 and older.

a. Have the individual's doctor or health care provider discussed having the individual see doctors or other health care providers who treat adults? 0. No 1. Yes ☐

i. If no, would discussions about transitions care to adult providers have been helpful? ☐
0. No 1. Yes

b. Have the individual's doctor or other health care provider discussed the individual's health care needs as he or she becomes an adult? 0. No 1. Yes ☐

i. If no, would discussions about the individual's health care needs have been useful? ☐
0. No 1. Yes

c. Has anyone discussed how to obtain or maintain some form of health insurance coverage as the individual becomes an adult? 0. No 1. Yes ☐

i. If no, would discussions about the individual's health insurance have been helpful? ☐
0. No 1. Yes

d. How often do the individual's doctors or health care providers encourage him or her to take responsibility for his or her health care needs (i.e., taking medications, understanding his or her health, following medical advice)? ☐

0. Never
1. Rarely
2. Occasionally
3. Frequently
4. Very frequently

18. Is There Anything Else That Would Be Helpful To Know About Individual's General Medical History?

0. No 1. Yes ☐
If yes, please specify in space provided.

_____

_____

SECTION E. CAREGIVERS AND SOCIAL SUPPORTS

1. Important People In The Individual's Life

	a.	b.	c.	d.
Name:				
Relationship:				
Phone No.:				
Address:				
City, State, Zip:				
Email:				
Important because:				

	e.	f.	g.	h.
Name:				
Relationship:				
Phone No.:				
Address:				
City, State, Zip:				
Email:				
Important because:				

2. Key Informal Caregiver(S)

a. Relationship of caregiver(s) to individual

Caregiver 1 2

0. Parent
1. Grandparent
2. Sibling
3. Spouse/significant other
4. Other relative
5. Foster parent
6. Friend or neighbor
7. Other _____
8. No informal caregiver

b. Gender of caregiver(s)

1. Male 2. Female
8. No informal caregiver

Caregiver 1 2

c. Age of caregiver(s)

Caregiver 1 2

d. Caregiver(s) live(s) with individual

0. No
1. Yes, 6 months or less
2. Yes, more than 6 months
8. No informal caregiver

Caregiver 1 2

3. Informal Caregiver(S) Status/Challenges

0. No 1. Yes 8. No informal caregiver

	Caregiver 1	Caregiver 2
a. Caregiver in school full-time		
b. Caregiver in school part-time		
c. Caregiver working full-time		
d. Caregiver working part-time		
e. Caregiver's sleep interrupted frequently throughout the night because of caregiving related to individual's condition		
f. Because of physical limitations or disabilities (strength/stamina), caregiver unable to assist individual with some ADLS or IADLS		
g. Caregiver has intellectual limitation – limited ability to learn or consistently and adequately perform key caregiving tasks		
h. Caregiver has mental/emotional limitations (includes substance abuse) – limited ability to learn or consistently and adequately perform key caregiving tasks because of emotional or mental state		
i. Caregiver expresses feelings of distress, anger or depression		
j. Caregiver indicates being overwhelmed by caregiving responsibilities		
k. Caregiver has very limited access to social support system (e.g., family, friends, church)		
l. Caregiver reports hurtful criticism of his/her caregiving from friends or relatives		
m. Other caregiver challenge/situation (specify):		

4. Household Composition

Record number of children OTHER THAN INDIVIDUAL as two-digit number (e.g., 03), if none record "00"

- **a. Number of other children in household**
- **b. Number of other children with special needs (other than individual being assessed)**
- **c. Number of other children receiving Medicaid home care services (other than individual assessed)**
  - i. Skilled Nursing Visits
  - ii. Private Duty Nursing
  - iii. Therapy Services
  - iv. Personal Care Services

5. Level Of Informal Care Is Expected To Decrease Within Next 90 Days

0. No 1. Yes

6. Alternate Plan For Caregiving

Individual or informal caregiver(s) has plans for alternative future support or living arrangements, if required (e.g., if current informal caregiver may no longer able to provide support)

0. Alternative plans not considered OR not required
1. Alternative plans not made, but under consideration
2. Alternative plans made

7. Individual's Social Relationships/Strengths In LAST 30 DAYS

0. Never/Rarely
1. Sometimes
2. Usually
3. Almost Always
4. Always
9. Unable to determine

- **a. Participates in activities/hobbies that he/she enjoys**
- **b. Is flexible about changes in daily routine**
- **c. Is cooperative in living situation**
- **d. Positive towards household members**
- **e. Positive towards peers**

8. Is There Anything Else That Would Be Helpful To Know About Individual's Social Support?

0. No 1. Yes

If yes, please specify in space provided.

SECTION F. STRENGTHS AND CHALLENGES IN PERFORMING DAILY TASKS

1. Decline In Functional Status As Compared To 90 Days Ago, Or Since Last Assessment If Less Than 90 Days Ago.

0. No 1. Yes ☐

2. IADL Self-Performance ☐

Code for whether or not condition affects the performance of any of these tasks

Meal preparation – How meals are prepared; **Ordinary housework** – How ordinary work around the house is performed; **Managing money** – How money or allowance is spent or saved, plans for small purchases; **Laundry** – sorting, washing, folding, putting away personal laundry; **Managing medications** – How medications are managed; **Phone use** –How telephone calls are made or received; **Shopping** – How shopping is performed for food and household items; **Transportation** – How travels by public transportation (navigating system, paying fare) or driving self (including getting out of house, into and out of vehicles)

0. Individual's condition does not affect the performance of any of these tasks (i.e., condition does not increase assistance needed to complete task, does not increase time it takes to perform task, does not require that the task be done more often, or does not require the assistance of additional persons to help with task)

1. Individual's condition affects the performance of at least one of these tasks (i.e., greater assistance is needed to complete task, task takes longer to perform, is performed more frequently or additional persons are needed to help with task)

3. ADL Self-Performance ☐

Code for whether or not condition affects the performance of any of these tasks:

Bathing, Personal hygiene, Dressing, Walking or moving around, Using the toilet, Bed mobility, Positioning in chair or other furniture or assistive devices, Transfers between surfaces (e.g., to/from bed, chair), **Eating** (i.e., How eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)

0. Individual's condition does not affect the performance of any of these tasks (i.e., condition does not increase assistance needed to complete task, does not increase time it takes to perform the task, does not require that the task be done more often, or does not require the assistance of additional persons to help with task)

1. Individual's condition affects the performance of at least one of these tasks (i.e., greater assistance is needed to complete task, task takes longer to perform, is performed more frequently or additional persons are needed to help with task)

4. Cognitive Skills For Daily Decision Making

Making decisions regarding tasks of daily life-e.g., when to get up or have meals, which clothes to wear or activities to do ☐

0. Independent – Decisions consistent, reasonable and safe
1. Modified independence – Some difficulty in new situations only
2. Moderately impaired – Decisions consistently poor or unsafe; cues/supervision required
3. Severely impaired – Never or rarely makes decisions
9. Unable to assess

5. Making Self Understood (Expression)

Expressing information content – both verbal and non-verbal (however able; with communication device, if normally used) ☐

0. Understood – Expresses self without difficulty
1. Usually understood – Difficulty finding words or finishing thoughts AND prompting usually required
2. Sometimes understood – Ability is limited to making concrete requests
3. Rarely or never understood
9. Unable to assess

6. Ability To Understand Others (Comprehension)

Understanding verbal information content (however able; with hearing appliance, if normally used)

- **0. Understands** – Clear comprehension
- **1. Usually understands** – Misses some part/intent of message BUT comprehends most of the conversation
- **2. Sometimes understands** – Responds adequately to simple, direct communication only
- **3. Rarely or never understands**
- **9. Unable to assess**

7. Is There Anything Else That Would Be Helpful To Know About Individual's Performance Of Daily Tasks?

0. No 1. Yes

If yes, please specify in space provided.

SECTION G. NUTRITIONAL STATUS/CONCERNS

1. Height And Weight

Record (a.) height in inches or centimeters and (b.) weight in pounds or kilograms. Base weight on most recent measure known. If height or weight is unknown, enter "9" in the boxes provided.

a. HT (in.) ☐☐.☐☐

b. WT (lbs.) ☐☐☐.☐☐

HT (cm.) ☐☐☐.☐☐

WT (kg.) ☐☐☐.☐☐

c. Date of height/weight measurements

1. Within last 30 days
2. Within last 90 days but not last 30 days
3. Within last year but not last 90 days
4. Greater than last year
9. Unknown

2. Are There Any Concerns About Individual's Weight Gain/Loss In <u>LAST 6 MONTHS</u>?

0. No 1. Yes

If yes, please specify in space provided.

3. Mode Of Nutritional Intake

0. No 1. Yes

- **a. Normal** – Swallow all types of typical foods
- **b. Modified independent** – e.g., liquid is sipped, takes limited solid food, need for modification may be unknown
- **c. Requires diet modification to swallow solid food** – mechanical diet (e.g., pureed, minced) or only able to digest specific foods
- **d. Requires modifications to swallow liquids** – e.g., thickened liquids
- **e. Feeding tube** – nasogastric or abdominal (PEG)
- **f. Parenteral feeding** – includes all types of parenteral feeding, such as total parenteral nutrition (TPN)

4. Dietary Requirements

0. No 1. Yes

- **a. Individual requires special diet (e.g., gluten-free)**

  If yes, please specify in space provided.
- **b. Special ordered diet is new or has been changed since last assessment**
- **c. Additional electrolyte drink/formula/protein shake/juice given between meals**

5. Is There Anything Else That Would Be Helpful To Know About The Individual's Nutrition?

0. No 1. Yes

If yes, please specify in space provided.

SECTION H. CURRENT TREATMENT AND PROCEDURES

1. List Of All Medications *Document medications on page 19.*

2. Resists Medications ☐

0. No 1. Yes

If yes, please specify in space provided.

_____

3. Does The Individual Receive Medications Via An Enteral (feeding) Tube? ☐

0. No 1. Yes

4. Does The Individual Receive Medications Via Injections (shots)? ☐

0. No 1. Yes

5. Formal Treatments In LAST 30 DAYS

Types of services and supports provided in the last 30 days. These occurred once or more in this time frame.

0. No 1. Yes

- **a. Chemotherapy** ☐
- **b. Dialysis** ☐
- **c. IV medication** ☐
- **d. Oxygen therapy** ☐
- **e. Radiation** ☐
- **f. Suctioning** ☐
- **g. Tracheostomy care** ☐
- **h. Transfusion** ☐
- **i. Ventilator** ☐
- **j. Wound care** ☐
- **k. Nebulizer** ☐
- **l. Urinary catheter care – insertion or maintenance** ☐
- **m. Comatose or persistent vegetative state – manage care** ☐
- **n. Continuous positive airway pressure (CPAP) or Bilevel Positive Airway Pressure (BiPAP)** ☐
- **o. Chest percussive therapy** ☐
- **p. Active medication adjustment** ☐
- **q. IPPB** ☐
- **r. Seizure Management** ☐
- **s. Other (specify):** ☐

_____

6. Formal Care In LAST 30 DAYS

Types of services and supports provided in the last 30 days. These occurred once or more in this time frame.

0. No 1. Yes

- **a. Personal care services/attendant care/home health aide** ☐
- **b. Nursing services** ☐
- **c. Medical transportation program** ☐
- **d. Homemaking services** ☐
- **e. Meals** ☐
- **f. Respiratory therapy** ☐
- **g. Physical therapy** ☐
- **h. Occupational therapy** ☐
- **i. Speech-language pathology or audiology services** ☐
- **j. Palliative care program** ☐
- **k. Hospice** ☐
- **l. PPECC** ☐
- **m. Other (specify):** ☐

_____

7. Pain Control – Adequacy Of Current Therapeutic Regimen To Control Pain ☐

0. No issue of pain
1. Pain intensity acceptable to individual; no treatment regimen or change in regimen required
2. Controlled adequately by therapeutic regimen
3. Controlled when the therapeutic regimen followed, but not always followed
4. Therapeutic regimen followed, but pain control not adequate
5. No therapeutic regimen being followed for pain; pain not adequately controlled

8. Physical Function Improvement Potential

0. No 1. Yes 8. N/A

a. Individual believes he/she is capable of improved performance in physical function ☐

b. Primary caregiver believes individual is capable of improved performance in physical function ☐

9. Is There Anything Else That Would Helpful To Know About Individual's Treatment Regimen?

0. No 1. Yes ☐

If yes, please specify in space provided.

_____

_____

SECTION I. MENTAL HEALTH AND BEHAVIORAL HEALTH CONCERNS

1. Any Medications To Assist With Behavioral Health Issues (e.g., anti-anxietal, anti-depressant, sedative, hypnotic, anti-psychotic or anti-convulsive)? ☐

0. No 1. Yes

2. Urgent Mental/Behavioral Health Service Use In The <u>LAST 6 MONTHS</u> ☐

Because of mental or behavioral problem, admission to inpatient treatment facility, trip to ER or unscheduled visit to health professional.

0. No occurrence 1. Occurred

3. Formal Care Or Treatment Received In <u>LAST 30 DAYS</u>

0. Not needed 1. Needed and received 2. Needed and not received

a. Psychiatric facility admission (or psychiatric unit of acute care hospital) ☐

b. Visit to Psychiatrist, Psychologist, licensed mental health professional or developmental specialist ☐

c. Substance abuse program ☐

d. Targeted case management ☐

If individual needed but did not receive a service, specify the reason in space provided.

_____

4. Specific Mental State Indicators

Code for indicators observed, irrespective of assumed cause (Note: whenever possible, ask individual)

0. Not present
1. Present but not exhibited in the last month
2. Exhibited in last 8-30 days
3. Exhibited in last 7 days but not daily
4. Exhibited daily in last 7 days

a. **Persistent anger with self or others** – easily annoyed; anger at care received ☐

b. **Pattern of irritability** – marked increase in being short-tempered or upset more than expected ☐

c. **Pattern of defiance** –active, persistent refusal to comply with reasonable requests (e.g. active refusal to complete chores, actively disobeys rules) ☐

d. **Pressured speech or racing thoughts** – rapid speech, rapid transition from topic to topic ☐

e. **Compulsive behavior** – e.g., hand washing, repetitive checking of room, counting, hoarding ☐

f. **Impulsive** – e.g., running into traffic, takes risky actions without thinking, difficulty taking turns, interrupts ☐

g. **Easily distracted** – e.g., episodes of difficulty paying attention, gets sidetracked ☐

h. **Flat or blunted affect** – indifference, non-responsiveness, hard to get to smile, etc. ☐

i. **Episodes of panic** – cascade of symptoms of fear, anxiety, or loss of control ☐

j. **Hallucinations (auditory or visual)** – false sensory perceptions in the absence of external stimuli ☐

k. **Delusions** – fixed false beliefs (e.g., grandiose, paranoid, somatic, excluding beliefs specific to individual's culture or religion) ☐

5. Behavior Symptoms

Code for indicators observed, irrespective of assumed cause

0. Not present
1. Present but not exhibited in the last month
2. Exhibited in last 8-30 days
3. Exhibited in last 7 days but not daily
4. Exhibited daily in last 7 days

a. **Wandering/elopement** – attempts to or exits/leaves home/school, etc. at inappropriate times, without notice/permission, seemingly oblivious to needs for safety when moving ☐

b. **Resists care** – e.g., taking medications /injections ADL assistance, eating ☐

c. **Verbally abusive/argumentative** – e.g., others were threatened, cursed at ☐

d. **Physically abusive** – shoves, scratches, pinches, bites others ☐

e. **Bullying others** – pattern of repeated oppression or victimization of others ☐

f. **Repetitive behavior that interferes with normal activities** – finger flicking, rocking, spinning objects ☐

g. **Destructive behavior toward properties** – e.g., throwing or breaking objects, turning over beds or tables, vandalism ☐

h. **Fire-setting or preoccupation with fire** – e.g., playing with matches or lighters unsupervised, deliberate fire setting ☐

i. **Problematic sexual behavior –** sexual behavior that has an impact on social relationships or interferes with everyday functioning (e.g., excessive masturbation, inappropriate or excessive touching or physical contact) ☐

j. **Cruelty to animals** – deliberate physical injury to or torture of animals (excludes behaviors that are consistent with cultural norms) ☐

6. Lifestyle

Code for LAST 30 DAYS, unless otherwise specified.

a. Uses any tobacco daily ☐

0. No 1. Yes

b. Alcohol – highest number of drinks in any "single setting" in <u>LAST 14 DAYS</u> ☐

0. None
1. 1
2. 2-4
3. 5 or more

c. Uses illegal drugs or misuses prescription medication ☐

0. No 1. Yes

d. Engages in risky sexual behavior ☐

0. No 1. Yes

7. Is There Anything Else That Would Be Helpful To Know About The Individual's Mental State Or Behavior? ☐

0. No 1. Yes

If yes, please specify in space provided.

_____

LIST OF ALL MEDICATIONS

List all active prescriptions, and any non-prescribed (over the counter) medications taken **in the LAST 30 DAYS.**
[NOTE: Use computerized records if possible, hand enter only when absolutely necessary]

For each drug, record:

a. **Name**

b. **Dose**—*A number such as 0.5, 5, 150, 300. [Note: Never write a zero by itself after a decimal point (X mg). Always use a zero before a decimal point (0.X mg)]*

c. **Unit**—*Code using the following list:*

gtts	(Drops)	**mcg**	(Microgram)	**ml**	(Milliliter)	**%**	(Percent)
gm	(Gram)	**mEq**	(Milli-equivalent)	**oz**	(Ounce)	**Units**	
L	(Liters)	**mg**	(Milligram)	**Puffs**		**OTH**	

d. **Route of administration**—*Code using the following list:*

PO	(By mouth/oral)	**Sub-Q**	(Subcutaneous)	**NAS**	(Nasal)	**EYE**	(Eye)
SL	(Sublingual)	**REC**	(Rectal)	**ET**	(Enteral tube)	**OTH**	
IM	(Intramuscular)	**TOP**	(Topical)	**TD**	(Transdermal)		
IV	(Intravenous)	**IH**	(Inhalation)				

e. **Frequency**—*Code the number of times per day, week, or month the medication is administered using the following list:*

Q1H	(Every hour)	**Daily**		**5D**	(5 times daily)	**4W**	(4 times weekly)
Q2H	(Every 2 hours)	**BED**	(At bedtime)	**Q2D**	(Every other day)	**5W**	(5 times weekly)
Q3H	(Every 3 hours)	**BID**	(2 times daily)	**Q3D**	(Every 3 days)	**6W**	(6 times weekly)
Q4H	(Every 4 hours)		(includes every 12 hrs)	**Weekly**		**1M**	(Monthly)
Q6H	(Every 6 hours)	**TID**	(3 times daily)	**2W**	(2 times weekly)	**2M**	(Twice every month)
Q8H	(Every 8 hours)	**QID**	(4 times daily)	**3W**	(3 times weekly)	**OTH**	

f. **Stability** - Indicate whether the medication is Stable (**S**), New (**N**) or being adjusted (last 14 days) (**A**)

g. **PRN –** Code for the frequency of any medication described as PRN

0. No or not given in over a month	**2.** Yes, less than three times per week	**4.** Yes, once per day
1. Yes, less than weekly	**3.** Yes, three or more times per week	**5.** Yes, two or more times per day

h. **Administrator** – Indicate who administers the medication.

LP Licensed Professional **CG** Caregiver **I** Individual

a. **Name**	b. **Dose**	c. **Unit**	d. **Route**	e. **Freq.**	f. **Stability**	g. **PRN**	h. **Administrator**
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							
16.							
17.							

SECTION J. COGNITION AND EXECUTIVE FUNCTIONING

1. Memory/Recall Ability

Code for recall of what was learned or known

0. Yes, memory OK 1. Memory problem
9. Unable to assess

a. Short-term memory OK – Seems/appears to recall after 5 minutes ☐

b. Long-term memory OK – Seems/appears able to recall more distant past (e.g., remembers activities last week or special events) ☐

c. Procedural memory OK – Can perform all or almost all steps in a multitask sequence without cues. ☐

d. Situational memory OK – Both: recognizes caregivers' names/faces frequently encountered AND knows location of places regularly visited (bedroom, bathroom, classroom) ☐

2. Periodic Disordered Thinking Or Awareness

(Note: Accurate assessment requires conversations with family or others who have direct knowledge of the individual's behavior over this time)

0. Behavior not present
1. Behavior present, consistent with usual functioning
2. Behavior present, appears different from usual functioning (e.g., new onset or worsening; different from a few weeks ago)

a. Easily distracted – e.g., episodes of difficulty paying attention; gets sidetracked ☐

b. Episodes of disorganized speech – e.g., speech is nonsensical, irrelevant, or rambling from subject to subject; loses train of thought ☐

c. Mental function varies over the course of the day – e.g., sometimes better, sometimes worse ☐

3. Acute Change In Mental Status From Individual's Usual Functioning (e.g., restlessness, lethargy, difficult to arouse, altered environmental perception)

0. No 1. Yes ☐

4. Change In Decision-Making As Compared To 90 Days Ago (or since last assessment if less than 90 days ago)

0. Improved 2. Declined
1. No change 8. Uncertain ☐

SECTION K. COMMUNICATION AND VISION

1. Hearing

Ability to hear (with hearing appliance, if normally used) ☐

0. Adequate – No difficulty in normal conversation, social interaction, listening to TV

1. Minimal/Moderate difficulty – Problem hearing normal conversation, requires quiet setting to hear well OR difficulty in some environments

2. Severe difficulty – Difficulty in all situations (e.g., speaker has to talk loudly or speak very slowly; or individual reports that all speech is mumbled)

3. No hearing

2. Proximity Vision

Ability to see in adequate light (with glasses or with other visual appliance, if normally used) ☐

0. Adequate – Saw fine detail, including fine detail in pictures, regular print in books

1. Minimal difficulty – Needs large print

2. Moderate difficulty – Not able to see large print BUT can identify objects

3. Severe difficulty – Object identification in question, BUT eyes appear to follow objects; see only light, colors, shapes

4. No vision

3. Distance Vision

Ability to see in adequate light (with glasses or with other visual appliance, if normally used) ☐

0. Adequate – Sees and can identify faces across the room

1. Minimal difficulty – Sees and can identify faces at conversation distance, but not across the room

2. Moderate difficulty – Limited vision; can see but not identify faces at conversation distance

3. Severe difficulty – Object identification in question, BUT eyes appear to follow objects; sees only light, colors, shapes

4. No vision

SECTION L. ADDITIONAL BEHAVIORAL CONSIDERATIONS

1. Individual Has Behavior Problems That Respond To Caregiver Intervention ☐

0. No 1. Yes

*If No, skip to **M.1**. If Yes, code each item.*

0. No 1. Yes

a. Individual can be redirected ☐

b. Individual responds to verbal reinforcement ☐

c. Individual responds to rewards ☐

d. Other (specify): _____ ☐

SECTION M. FUNCTIONAL STATUS

1. Instrumental Activities Of Daily Living (IADLS) Self-Performance

Code for INDIVIDUAL'S PERFORMANCE in routine activities around the home or in the community.

0. Independent – Set-up help, cueing/redirection, or hands-on assistance never provided OR provided no more than 1 or 2 times

1. Set-up help only – Set-up help provided ≥ 3 times

2. Cueing/Redirection – Standby assistance, encouragement, cueing, redirection provided ≥ 3 times

3. Limited assistance – Individual highly involved in activity; received help on some occasions (at least ≥ 3 times) but not all the time

4. Extensive assistance – Individual received help throughout task most of the time, or full performance by others some, but not all, of the time

5. Total dependence – Full performance by others during entire period

8. Activity did not occur – During entire period

Code for EFFECT based on whether or not illness or condition affects the performance of task.

0. Individual's condition does <u>not</u> affect the performance of the task by the individual or caregiver (i.e., time it takes to do task or the number of persons needed to do task)

1. Individual's condition affects the performance of the task by the individual or caregiver (regularly takes longer to perform OR two-person assistance regularly provided/needed)

P-Performance (0-8) E-Effect (0-1)

	P	E
a. Meal preparation – Preparing meals and snacks; cooking; assembling ingredients; cutting, chopping, grinding or pureeing food; setting out food and utensils; serving food; preparing and pouring a predetermined amount of liquid nutrition; cleaning the feeding tube; cleaning area after meal; washing dishes.	☐	☐
b. Medication assistance or administration – Assisting with oral medications that are normally self-administered	☐	☐
c. Telephone use or other communication – making or receiving telephone calls; managing and setting up communication devices.	☐	☐
d. Escort or Assistance with transportation services - making transportation arrangements for medical and other appointments; accompanying the individual to a health care appointment to assist with needed ADLs.	☐	☐
e. Laundry – doing laundry; gathering, sorting, washing, drying, folding, and putting away personal laundry, bedding, and towels; removing bedding to be washed and remaking the bed; using a laundry facility.	☐	☐
f. Light Housework – Performing light housework such as cleaning and putting away dishes; wiping counter tops; dusting; sweeping, vacuuming or mopping; changing linens and making bed; cleaning bathroom; taking out trash.	☐	☐
g. Grocery or household shopping – Shopping for grocery and household items; preparing a shopping list; putting food and household items away; picking up medication and supplies.	☐	☐
h. Money management – Managing day-to-day finances; paying bills/ balancing checkbook; making deposits or withdrawals; assisting in preparing and adhering to a budget.	☐	☐

2. Activities Of Daily Living (ADLS) Self-Performance

Consider all episodes of care

0. No help/Independent – No set-up help, redirection/cueing, hands-on assistance OR some type of help provided only 1 or 2 times
1. Set-up help only – Set-up help provided ≥ 3 times
2. Cueing/Redirection – Standby assistance, encouragement, cueing, redirection provided ≥ 3 times
3. Limited assistance – Individual highly involved in activity; received physical/hands-on help (e.g., guided maneuvering of limbs) that is non-weight bearing ≥ 3 times
4. Extensive assistance – While client performed part of activity, over last 7-day period, help of the following type(s) provided 3 or more times:
- Weight-bearing support
- Full caregiver performance during part (not all) of last 7 days

5. Total dependence – Full caregiver performance of activity during entire 7 days (e.g., each time activity occurred)
8. **Activity did not occur during entire period**

Code for EFFECT based on whether or not illness or condition affects the performance of task
0. Individual's condition does <u>not</u> affect the performance of the task (i.e., time it takes to do task or the number of persons needed to do task)
1. Individual's condition affects the performance of the task (because of child's condition, task regularly takes longer to perform OR two-person assistance regularly provided/needed)

P-Performance (0-8) E-Effect (0-1)

	P	E
a. Locomotion or Mobility – Moving between locations; walking or using wheelchair, walker, or other mobility equipment.		
b. Positioning – Positioning body while in a chair, bed or other piece of furniture or equipment; changing and adjusting positions; moving to or from a sitting position; turning side-to-side; assisting the client to sit upright.		
c. Eating – Using utensils or special or adaptive eating devices; clean up after task is completed.		
d. Transferring – Moving from one surface to another with or without a sliding board; moving from bed, chair, wheelchair, or vehicle to a new position; moving the client with lift devices.		
e. Toileting – Some or all parts of toileting; using commode, bedpan, urinal, toilet chair; transferring on and off, cleansing, changing diapers, pad, incontinence supplies; adjusting clothing; clean up after task is completed.		
f. Dressing –Any or all parts of getting dressed; putting on, fastening, and taking off all items of clothing; donning and removing shoes or prostheses; choosing and laying out weather appropriate clothing.		
g. Personal hygiene –Some or all parts of personal hygiene; routine hair care; oral care; ear care; shaving; applying makeup; managing feminine hygiene; washing and drying face, hands, perineum; basic nail care; applying deodorant; routine skin care; clean up after task is completed.		
h. Bathing – Any or all parts of bathing; selecting appropriate water temperature and flow speed, turning water on and off; laying out and putting away supplies; transferring in and out of bathtub or shower; washing and drying hair and body; clean up after task is completed.		

3. Individual Needs Cueing/Redirection During ADLS Or IADLS Due To A Mental, Behavioral Or Developmental Problem/Condition ☐

0. No 1. Yes

4. Primary Mode Of Locomotion ☐

0. Walking, no assistive device
1. Walking, uses assistive device – e.g., cane, walker, crutch, pushing wheelchair
2. Wheelchair, scooter
3. Bedbound

5. Change In ADL Status As Compared To 90 Days Ago, Or Since Last Assessment If Less Than 90 Days Ago ☐

0. Improved
1. No change
2. Declined
8. Uncertain

SECTION N. CONTINENCE

1. Bladder Continence

Code for individual's control of urinary bladder function with appliances or programs, if used.

0. Continent – Complete control; DOES NOT USE any type of catheter or other urinary collection device
1. Complete control with appliance or program – over last 7 days
2. Infrequently incontinent – Not incontinent over last 7 days, but does have incontinent episodes
3. Occasionally incontinent – Less than daily
4. Frequently incontinent – Daily, but some control present
5. Incontinent – No control present
8. Did not occur – No urine output from bladder in last 7 days (referral needed)

2. Bowel Continence

Code for individual's control of bowel movement with appliances or programs, if used.

0. Continent – Complete control; DOES NOT USE any type of appliance of program
1. Control with appliance or program – over last 7 days
2. Infrequently incontinent – Not incontinent over last 7 days, but does have incontinent episodes
3. Occasionally incontinent – Less than daily
4. Frequently incontinent – Daily, but some control present
5. Incontinent – No control present
8. Did not occur – No bowel movement in last 7 days (further assessment needed)

3. Pads/Briefs/Diapers/Pull-Ups Worn
0. No 1. Yes

4. Nighttime Incontinence (Bowel/Bladder) In LAST 7 DAYS
0. No 1. Yes

SECTION O. SLEEP

1. Sleep Patterns

a. Based on the table below, individual typically receives the recommended amount of sleep daily (including naps)
0. No problem
1. Too little sleep
2. Too much sleep

Age	Hours
0-2 months old	12-18 hours
3-11 months old	14-15 hours
12-35 months old	12-14 hours
3-4 years old	11-13 hours
5-10 years old	10-11 hours
11-17 years old	8.5-9.5 hours
18-21 years old	7-9 hours

b. Average number of times individual wakes up during the night

c. Average number of days in week individual wakes up during the night without returning to sleep

d. Barriers to individual sleeping
Code each item (more than one may apply)
0. No 1. Yes

i. Individual needs care (e.g., medication, repositioning) during night
ii. Individual wakes for toileting or incontinence needs
iii. Individual has difficulty sleeping through night because of disease/condition or pain
iv. Other (specify): _____

SECTION P. HABILITATION NEEDS

1. Goals/Desired Outcomes For Habilitation

Record goals in box and primary goal in space beneath box.

2. Skill Acquisition And Training Activities Related To Attendant Care Needs

Individual requires training to acquire, enhance, or maintain the skills need to perform the following ADLs or IADLs. If yes, note individual's preferences for learning to do tasks. Refer to IADL and ADL definitions in items M.1 and M.2 if needed.

0. No 1. Yes

a. Meal preparation	☐	**i. Locomotion or Mobility**	☐
b. Medication assistance or administration	☐	**j. Positioning**	☐
c. Telephone use or other communication	☐	**k. Eating**	☐
d. Escort or assistance with transportation	☐	**l. Transferring**	☐
e. Laundry	☐	**m. Toileting**	☐
f. Light housework	☐	**n. Dressing**	☐
g. Grocery or household shopping	☐	**o. Personal hygiene**	☐
h. Money management	☐	**p. Bathing**	☐

3. Additional Habilitation Needs

Individual requires training to acquire, enhance or maintain the following skills. If yes, note individual's preferences for learning to do tasks.

0. No 1. Yes

a. Community integration ☐

b. Use of DME/assistive devices ☐

c. Personal decision-making ☐

d. Communication ☐

e. Increase positive social encounters and engagement in preferred activities ☐

f. Socialization/relationship development ☐

g. Accessing leisure and recreational activities ☐

h. Other (specify): ☐

i. Other (specify): ☐

j. Other (specify): ☐

SECTION Q. COMPLEX CONDITIONS AND NURSING CARE

Neurological

1. Individual Has Seizure Disorder ☐
0. No *(If no, skip to Q.2)* 1. Yes

a. Presence of seizures new since last assessment ☐
0. No 1. Yes

b. Seizure is ☐
1. Controlled
2. Uncontrolled

c. Typical level of seizure intervention ☐
1. Mild – minimal management
2. Moderate – medication administration
3. Severe – need medication, maintenance of airway, and prevention of injury

d. Type of seizures
Code all that apply
0. No 1. Yes
i. General ☐
ii. Focal ☐
iii. Other (specify): ☐
_____

e. Date of last seizure
☐☐ – ☐☐☐☐
Month Year

f. Frequency of interventions
0. Never used
1. Less than 4 times a month
2. 1-6 times a week
3. Daily
4. More than 2 times per day

i. Ambu-bag ☐
ii. Rescue breaths ☐
iii. Suctioning ☐
iv. Oxygen ☐
v. Medication ☐
vi. Vegal Nerve Simulator (VNS) ☐
vii. Deep Brain Simulation (DBS) ☐

g. Additional information on seizures, if necessary:
_____
_____

2. New Or Revised Shunts Within <u>LAST 30 DAYS</u> ☐
0. No 1. Yes

3. Nursing Services Related To Neurological Care
In-home treatments and programs received or scheduled in the **<u>LAST 7 DAYS</u>**
Use these codes unless otherwise specified: 0. No 1. Yes

a. Neurological assessment frequency greater than once per shift (reflexes, Glascow Coma Scale, pupillary reaction, etc.) ☐
b. Other (specify): _____ ☐
c. Other (specify): _____ ☐

Airway Management

4. Individual uses apnea monitor/pulse oximeter ☐
0. No *(If no, skip to Q.5)* 1. Yes

a. Needed: ☐
1. Intermittently
2. Continuously
3. PRN

If PRN, date of last use and reason why:
_____
_____

b. Used over night ☐
0. No 1. Yes

5. Individual Uses BI-PAP Or CPAP ☐
0. No (If no, skip to Q.6) 1. Yes

a. Needed: ☐
1. Intermittently
2. Continuously
3. PRN

If PRN, date of last use and reason why:
_____
_____

b. Used over night ☐
0. No 1. Yes

6. Individual Has Tracheostomy

0. No (If no, skip to Q.7) 1. Yes ☐

a. New or revised within last 30 days ☐
0. No 1. Yes

b. Gauge size needed ☐☐

c. Tracheostomy is ☐
1. Cuffed
2. Uncuffed

d. Appearance of site
1. Not present
2. Yes, presented in past 30 days
3. Yes, present for greater than 30 days

i. Site is red ☐
ii. Site has signs of drainage ☐
iii. Site shows excoriation ☐
iv. Site shows other problems ☐

If Yes, please specify:

_____

e. Suctioning needed ☐
1. Once a day or less frequently than daily
2. 2-5 times a day
3. 6-11 times a day
4. 12 or more times a day

f. Additional information on tracheostomy, if necessary:

_____

7. Individual Uses Supplemental Oxygen

0. No (If no, skip to Q.8) 1. Yes ☐

a. Needed ☐
1. Intermittently
2. Continuously
3. PRN

If PRN, date of last use and reason why:

_____

_____

b. Oxygen has to be titrated ☐
0. No 1. Yes

c. Oxygen administered via: ☐
1. NC
2. Mask
3. Tracheostomy

d. Oxygen amount (in L/min) ☐☐•☐☐

e. Oxygen saturation percentage ☐☐

8. Individual Uses Ventilator

0. No (If no, skip to Q.9) 1. Yes ☐

a. IPV ☐
0. No 1. Yes

b. IMV ☐
0. No 1. Yes

c. SIMV ☐
0. No 1. Yes

d. Negative Pressure Ventilator ☐
0. No 1. Yes

e. Pressure control ☐
0. No 1. Yes

f. Needed ☐
1. Intermittently
2. Continuously
3. PRN

If PRN, date of last use and reason why:

_____

g. Used over night ☐
0. No 1. Yes

h. Ventilator is on standby ☐
0. No 1. Yes

i. Additional information on ventilators, if necessary:

_____

_____

9. Nursing Services Related To Airway Management Care

*In-home treatments and programs received or scheduled in the **LAST 7 DAYS***

Use these codes unless otherwise specified:

0. No 1. Yes

a. Apnea monitor/Pulse oximeter ☐

b. Naso-pharyngeal suctioning ☐

c. Tracheal suctioning ☐

d. Oral suctioning ☐

e. Bi-Pap or C-pap ☐

f. Chest vest ☐

g. Percussor ☐

h. Manual CPT ☐

i Tracheostomy care ☐

j. Nebulizer care ☐

k. Aspiration precaution ☐

l. Cough assist (manual or use/care of cough assist machine) ☐

m. Oxygen ☐

n. IPPB ☐

o. Ventilator ☐

p. Other (specify): _____ ☐

q. Other (specify): _____ ☐

Nutritional

10. Enteral Feeding (e.g., NG/G tube) ☐

0. No *(If no, skip to Q.11)* 1. Yes

If yes, answer the following questions:

a. Frequency of Enteral Feedings

Code all

0. Not used
1. Less frequently than or equal to every 4 hours
2. More frequently than every 4 hours
3. Continuously

i. Via bolus ☐
ii. Via drip ☐
iii. Via pump ☐

b. Tube specifications

i. Diameter (FR) ☐☐

ii. Length (cm) ☐☐ • ☐☐

c. Tube site care ☐

1. Needed daily
2. Needed bid
3. Needed every 8 hours

d. Appearance of tube site

0. No 1. Yes

i. Tube site is red ☐
ii. Tube site has signs of drainage ☐
iii. Tube site shows other problems ☐

If yes, please specify:

_____

e. Concerns with feeding

0. Never
1. Rarely
2. Often
3. After each feeding

i. Because of feeding, client experiences irritability ☐
ii. Because of feeding, client experiences distension ☐
iii. Because of feeding, client experiences vomiting ☐

f. Feeding over night ☐

0. No 1. Yes

g. Additional information on tube feedings, if necessary:

_____

_____

11. Individual Has A Swallowing Problem
0. Never
1. Rarely
2. Often
3. After each feeding

12. Individual Chokes With Food
0. Never
1. Rarely
2. Often
3. After each feeding

13. Nutrition Nursing Services Care

*In-home treatments and programs received or scheduled in the **LAST 7 DAYS***

Use these codes unless otherwise specified:
0. No 1. Yes

a. Parenteral/IV feeding
b. Feeding tube (e.g., NG/G tube)
c. Reflux precautions
d. Other (specify): _____
e. Other (specify): _____

Medication

14. Individual Receives Medication Via IV
0. No (If no, skip to Q.15) 1. Yes

a. Method of IV access
1. Peripheral
2. PICC
3. Broviac/Hickman central line
4. Groshong central line
5. Port central line
6. Other (specify): _____

b. Appearance of IV site
0. No 1. Yes
i. IV site is red
ii. IV site has signs of drainage
iii. Signs of swelling
iv. Signs of infiltration
v. Signs of extravasation
vi. Signs of infection
vii. Other problem(s) (specify): _____

c. Frequency of IV site care
1. Weekly
2. Twice a week
3. Three times a week
4. Other (specify): _____

15. Nursing Services Related To Medication Care/Administration

*In-home treatments and programs received or scheduled in the **LAST 7 DAYS***

0. No 1. Yes

a. IV medication
b. Injectable medication
c. Enteral (tube feed) medication
d. Lab draw
e. Finger stick
f. Complex medication administration and/or RX>q2hr intervals
g. Medication requiring post-administration monitoring (e.g., vital signs, notating effects on condition, etc.)
h. Other (specify): _____
i. Other (specify): _____

Elimination

16. Individual has constipation
0. No 1. Yes
(if no, skip to item Q.17.)

a. Average bowel movement frequency
1. 1-3 days
2. 4-7 days
3. >7 days

b. Individual is on high fiber diet (may include fiber supplement).
0. No 1. Yes

c. Number of medications taken for constipation (oral stool softener, laxative, suppositories, etc.)
0. None
1. One
2. Two or More

d. Enemas used
0. None
1. 1-2 times per month
2. Weekly or more often

e. History of dis-impaction
0. None
1. 1-2 times per month
2. Weekly or more often

17. Individual Has Urinary Catheter

0. No 1. Yes ☐

(if no, skip to Item Q.18.)

a. Type of catheter ☐

1. Indwelling (Foley)
2. Intermittent
3. External (condom)

18. Nursing Services Related To Elimination Care

*In-home treatments and programs received or scheduled in the **LAST 7 DAYS***

0. No 1. Yes

- **a. Scheduled toileting program** ☐
- **b. Cystotomy/nephrostomy/ureterostomy care** ☐
- **c. Ileostomy/Colostomy care** ☐
- **d. Home dialysis** ☐
- **e. Other (specify):** _____ ☐
- **f. Other (specify):** _____ ☐

Integumentary

19. Individual's Skin Status

a. Current skin color ☐

0. Pink/WNL
1. Pale
2. Jaundice
3. Cyanotic

b. Current skin condition

0. No 1. Yes

- i. Warm ☐
- ii. Hot ☐
- iii. Cool ☐
- iv. Cold ☐
- v. Dry ☐
- vi. Diaphoretic ☐

c. Current number of pressure ulcers at each stage

- i. Stage I: any area of persistent skin redness ☐
- ii. Stage II: partial loss of skin layers ☐
- iii. Stage III: deep craters in the skin ☐
- iv. Stage IV: breaks in skin exposing muscle or bone ☐
- v. Not stageable (e.g., slough and/or eschar predominant) ☐

d. Pressure ulcer site or additional information (specify):

_____

_____

e. Prior pressure ulcer(s) in last 30 days ☐

0. No 1. Yes

f. Total number of venous and arterial ulcers currently present ☐

g. Other skin problems currently present

0. No 1. Yes

- i. Open lesions other than ulcers, rashes, cuts (e.g., cancer lesion) ☐
- ii. Surgical wound(s) ☐
- iii. Burn(s) (second or third degree) ☐

If yes, specify:

_____

20. Nursing Services Related To Integumentary Care

*In-home treatments and programs received or scheduled in the **LAST 7 DAYS***

0. No 1. Yes

- **a. Pressure reducing device for chair** ☐
- **b. Pressure reducing device for bed** ☐
- **c. Turning/repositioning program** ☐
- **d. Nutrition or hydration intervention to manage skin problems** ☐
- **e. Pressure ulcer care** ☐
- **f. Surgical wound care** ☐
- **g. Application of nonsurgical dressings (with or without topical medications) other than to feet** ☐
- **h. Application of ointments/medications other than to feet** ☐
- **i. Skin treatment every four hours or more often** ☐
- **j. Other (specify):** _____ ☐
- **k. Other (specify):** _____ ☐

Other Nursing Services

21. Other Nursing Services

*In-home treatments and programs received or scheduled in the **LAST 7 DAYS***

0. No 1. Yes ☐

- **a. Other (specify):** _____
- **b. Other (specify):** _____
- **c. Other (specify):** _____
- **d. Other (specify):** _____
- **e. Other (specify):** _____
- **f. Other (specify):** _____
- **g. Other (specify):** _____
- **h. Other (specify):** _____
- **I. Other (specify):** _____
- **j. Other (specify):** _____

TEXAS STAR Kids Screening and Assessment – MDCP Module

(Use last 7 days as time reference unless otherwise specified)

SECTION R. MDCP RELATED ITEMS

1. Reason For Assessment ☐

0. Initial **1.** Re-assessment **2**. Significant change **3**. Minor correction **4**. Major correction

Cognitive Patterns

2. Individual Has No Discernable Consciousness, Is In A Persistent Vegetative State, Or Is In A Coma ☐

0. No 1. Yes (If yes, skip to R.15.)

3. Making Self Understood (Expression) ☐

Expressing information content – both verbal and non-verbal (however able; with communication device, if normally used) Enter "-" dash if unable to assess.

0. Understood – Expresses self without difficulty

1. Usually understood – Difficulty finding words or finishing thoughts AND prompting usually required

2. Sometimes understood – Ability is limited to making concrete requests

3. Rarely or never understood

4. Individual Is Under 7 Yrs, At Least 7 But Rarely/Never Understood, Or Unable To Be Assessed (Expression)

0. No 1. Yes (If yes, skip to R.9.) ☐

5. Repetition Of Three Words By Individual (BIMS)

Ask individual: "I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are sock, blue and bed. Now tell me the three words. Enter "-" dash if unable to assess. Enter number of words repeated after first attempt.

0. None **1. One** **2. Two** **3. Three** ☐

After the individual's first attempt, repeat the words using cues, ("sock, something to wear; blue, a color; bed, a piece of furniture"). You may repeat the words up to two more times.

6. Temporal Orientation (orientation to year, month, and day) by Individual (BIMS)

Enter "-" dash if unable to assess.

a. Able to report correct year

Ask individual: "Please tell me what year it is right now." ☐

0. Missed > 5 years or no answer
1. Missed by 2-5 years
2. Missed by 1 year
3. Correct

b. Able to report correct month

Ask individual: "What month are we in right now?"

0. Missed by > 1 month or no answer ☐
1. Missed by 6 days to 1 month
2. Accurate within 5 days

c. Able to report correct day of the week

Ask individual: "What day of the week is today?" ☐

0. Incorrect or no answer
1. Correct

7. Recall By Individual (BIMS)

Ask individual: "Let's go back to an earlier question. What were those three words that I asked you to repeat?"

If unable to remember a word, give cue (something to wear, a color, a piece of furniture) for that word.

Enter "-" dash if unable to assess.

a. Able to recall "sock" ☐

0. No – could not recall
1. Yes, after cueing ("something to wear")
2. Yes, no cue required

b. Able to recall "blue" ☐

0. No – could not recall
1. Yes, after cueing ("a color")
2. Yes, no cue required

c. Able to recall "bed" ☐

0. No – could not recall
1. Yes, after cueing (a piece of furniture")
2. Yes, no cue required

8. Summary Score (BIMS) ☐☐

The sum of the scores for R.5-R.7. If the individual was unable to complete R.5-R.7 (i.e., 3 or more responses contain a "-" dash), record a score of 99, and proceed to R.9-R.10. Otherwise, record the sum as a number 00-15, and skip to R.11.

9. Short Term Memory (Caregiver Assessment)

Ok –seems or appears to recall after five minutes. Enter "-" dash if unable to assess.

0. Yes, memory OK **1.** Memory problem

10. Cognitive Skills For Daily Decision Making (Caregiver Assessment)

Making decisions regarding tasks of daily life-e.g., when to get up or have meals, which clothes to wear or activities to do. Enter "-" dash if unable to assess.

0. Independent – Decisions consistent, reasonable and safe

1. Modified independence – Some difficulty in new situations only

2. Moderately impaired – Decisions consistently poor or unsafe; cues/supervision required

3. Severely impaired – Never or rarely makes decisions

Skip to R.12 Caregiver Assessment of Individual Mood (PHQ 9-OV).

Mood

11. Individual Mood Interview (PHQ-9©)

Say to individual: "Over the last 2 weeks, have you been bothered by any of the following problems?" If symptom is present, enter "1" (yes) in column 1.
Then ask the individual: "About how often have you been bothered by this?" Read the individual the frequency choices. Indicate response in column 2.

1. Symptom presence
0. No (enter 0 in column 2)
1. Yes (enter 0-3 in column 2)
9. No response (enter dash "-" in column 2)

2. Symptom frequency
0. Never or 1 day
1. 2-6 days (several days)
2. 7-11 days (half or more of the days)
3. 12-14 days (nearly every day)

Mood	1. Pres	2. Freq
a. Little interest or pleasure in doing things (including non-verbal) – does not exhibit pleasure at events that would normally be pleasurable (e.g., birthdays, parties, holidays)		
b. Feeling down, depressed, or hopeless – e.g., furrowed brow, constant frowning		
c. Trouble falling or staying asleep, or sleeping too much		
d. Feeling tired or having little energy – lethargy; low energy; unusual fatigue; seems unusually worn out/tired		
e. Poor appetite or overeating		
f. Feeling bad about yourself – or that you are a failure or have let yourself or your family down		
g. Trouble concentrating on things – problems thinking/concentrating; distractibility		
h. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual		
i. Thoughts that you would be better off dead or of hurting yourself in some way		
Total severity score – the sum of all frequency responses in column 2. If the individual was unable to complete R.11 (i.e., 3 or more responses in column 2 contain a "-" dash), record a score of 99, and proceed to R.12. Otherwise, record the sum (00-27), and skip to R.13.		

12. Caregiver Assessment of Individual Mood (PHQ-9-OV©)

Over the last 2 weeks, has individual been bothered by any of the following problems. If symptom is present, enter "1" (yes) in column 1. Then move to column 2 and indicate symptom frequency in ***last 14 days. Do not complete if individual mood interview was completed.***

1. Symptom presence
0. No (enter 0 in column 2)
1. Yes (enter 0-3 in column 2)

2. Symptom frequency
0. Never or 1 day
1. 2-6 days (several days)
2. 7-11 days (half or more days)
3. 12-14 days (nearly every day)

Mood	1. Pres	2. Freq
a. Little interest or pleasure in doing things (including non-verbal) – does not exhibit pleasure at events that would normally be pleasurable (e.g., birthdays, parties, holidays)		
b. Feeling down, depressed, or hopeless – e.g., furrowed brow, constant frowning		
c. Trouble falling or staying asleep, or sleeping too much		
d. Feeling tired or having little energy – lethargy; low energy; unusual fatigue; seems unusually worn out/tired		
e. Poor appetite or overeating		
f. Feeling bad about themselves – or that they are a failure or have let themselves or their family down		
g. Trouble concentrating on things – problems thinking/concentrating; distractibility		
h. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that they have been moving around a lot more than usual		
i. Thoughts that they would be better off dead or of hurting themselves in some way		
j. Being short-tempered, easily annoyed		
Total severity score – the sum of all frequency responses in column 2. The sum should be a number (00-30).		

Behavior

13. Potential Indicators Of Psychosis

0. No 1. Yes

a. Hallucinations (auditory or visual) – False sensory perceptions in the absence of external stimuli ☐

b. Delusions – Fixed false beliefs (e.g., grandiose, paranoid, somatic, excluding beliefs specific to individual's culture or religion) ☐

14. Behavior Patterns In LAST 7 DAYS

Code for indicators observed, irrespective of the assumed cause

0. Not present
1. Behavior present 1 to 3 days
2. Behavior present 4 to 6 days, but less than daily
3. Behavior presents daily

a. Physical abuse – shoves, scratches, pinches, bites others ☐

b. Verbal abuse – threatens, screams/curses at others ☐

c. Other behavioral symptoms not directed toward others (e.g., pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) ☐

d. Rejection of care – reject evaluation or care (e.g., bloodwork, taking medications, ADL assistance) that is necessary to achieve the individual's goals for health and well-being. Do not include behaviors that have already been addressed (e.g., by discussion or care planning with the individual or family) and determined to be consistent with individual values, preferences, or goals. ☐

e. Wandering/elopement – attempts to or exits/leaves home/school, etc., at inappropriate times, without notice/permission ☐

Functional Status

Activities Of Daily Living (ADLS)

Instructions for rule of 3

· When an activity occurs three times at any one given level, code that level

· When an activity occurs three times at multiple levels, code the most dependent, exceptions are total dependence (4), activity must require full assist every time and did not occur (8), activity must not have occurred at all. Example, three times extensive assistance (3) and three times limited assistance (2), code extensive assistance (3).

· When an activity occurs at various levels, but not three times at any given level, apply the following:

  ◦ When there is a combination of full caregiver performance and extensive assistance, code extensive assistance

  ◦ When there is a combination of full caregiver performance, weight bearing assistance and/or non-weight bearing assistance, code limited assistance (2).

If none of the above are met, code supervision (1).

15. ADL Self-Performance

Code for individual's performance not including setup. If the ADL activity occurred 3 or more times at various levels of assistance, code the most dependent – except for total dependence, which requires full caregiver performance every time.

Activity Occurred 3 or More Times

0. Independent – no help or caregiver oversight at any time
1. Supervision – oversight, encouragement or cueing
2. Limited assistance – individual highly involved in activity; caregiver provided guided maneuvering of limbs or other non-weight bearing assistance
3. Extensive assistance – individual involved in activity, caregiver provided weight bearing support
4. Total dependence – full caregiver performance every time during entire 7 day period

Activity Occurred 2 or Fewer Times

7. Activity occurred only once or twice – activity did occur but only once or twice
8. Activity did not occur – activity (or any part of the ADL) was not performed by individual or caregiver at all over the entire 7 day period

16. ADL Support Provided

Code for most support provided; code regardless of individual's self-performance classification

0. No setup or physical help from caregiver
1. Setup help only
2. One person physical assist
3. Two+ persons physical assist
8. ADL activity did not occur during entire period

ADL	15. Perf	16. Supp
a. Bed mobility – How individual moves to and from lying positions, turns from side to side, and positions while in bed		
b. Transfers – How individual moves between surfaces, to/from bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)		
c. Eating – How individual eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parental nutrition)		
d. Toilet use – How individual uses the toilet room (or commode, bedpan, urinal), transfers on/off toilet, cleanses self after toilet use or incontinent episode(s), changes bed pad, manages ostomy or catheter, adjusts clothes		

Bladder and Bowel

17. Urinary Toileting Program

Current continence promotion program or trial – is an individualized continence promotion program (e.g., scheduled toileting, prompted voiding, or bladder training) currently being used to manage the individual's urinary continence? 0. No 1. Yes ☐

18. Bowel Continence Program

Is an individualized continence promotion program currently being used to manage the individual's bowel continence? 0. No 1. Yes ☐

Diagnoses and Conditions

19. Problem Conditions

0. No 1. Yes

a. Fever ☐
b. Vomiting ☐
c. Dehydrated ☐
d. Internal bleeding ☐

20. Active Diseases/Conditions

0. No 1. Yes

a. Aphasia ☐
b. Cerebral palsy ☐
c. Diabetes Mellitus (e.g., diabetic retinopathy, nephropathy, and neuropathy) ☐
d. Hemiplegia or Hemiparesis ☐
e. Multiple Sclerosis ☐
f. Pneumonia/lower respiratory infection ☐
g. Quadriplegia ☐
h. Septicemia ☐

Skin Conditions

21. Current Number Of Pressure Ulcers At Each Stage

- **a. Stage I: any area of persistent skin redness**
- **b. Stage II: partial loss of skin layers**
- **c. Stage III: deep craters in the skin**
- **d. Stage IV: breaks in skin exposing muscle or bone**
- **e. Not stageable (e.g., slough and/or eschar predominant)**

22. Total Number Of Venous And Arterial Ulcers Present

23. Other Skin Problems

0. No 1. Yes

- **a. Open lesion(s) other than ulcers, rashes, cuts** (e.g., cancer lesion)
- **b. Surgical wound(s)**
- **c. Burn(s) (second or third degree)**

24. Foot Problems

0. No 1. Yes

- **a. Infection of the foot** (e.g., cellulitis, purulent drainage)
- **b. Diabetic foot ulcer(s)**
- **c. Other open lesion(s) on foot**

25. Skin and Ulcer Treatments

0. No 1. Yes

- **a. Pressure reducing device for chair**
- **b. Pressure reducing device for bed**
- **c. Turning/repositioning program**
- **d. Nutrition or hydration intervention to manage skin problems**
- **e. Pressure ulcer care**
- **f. Surgical wound care**
- **g. Application of nonsurgical dressings** (with or without topical medications) other than to feet
- **h. Applications of ointments/medications** other than feet
- **i. Applications of dressing to feet** (with or without topical medications)

Nutritional Status

26. Nutritional Approaches

If yes to Question 26a. or 26b., answer Question 26.c and 26.d. If no, proceed to Question R.28

a. Individual uses parenteral/IV feeding

0. No 1. Yes

b. Individual uses feeding tube-nasogastric or abdominal (PEG or G-button)

0. No 1. Yes

c. Proportion of total calories the individual received through parenteral or tube feeding during entire 7 days

0. None
1. 25% or less
2. 26-50%
3. 51% or more

d. Average fluid intake per day by IV or tube feeding during entire 7 days

1. 500 cc/day or less
2. 501 cc/day or more

27. Weight loss of 5% or more in <u>LAST 30 DAYS</u> or 10% or more in <u>LAST 180 DAYS</u>

0. No or unknown
1. Yes, on physician prescribed weight-loss program
2. Yes, not on physician prescribed weight-loss program

Physician Care

28. Number of days the physician (or authorized assistant or practitioner) examined the individual in LAST 14 DAYS ☐☐

29. Number of days the physician (or authorized assistant or practitioner) changed the individual's orders in LAST 14 DAYS ☐☐

Special Treatments, Procedures, and Programs

30. Record The Number Of Days That Injections Of Any Type Were Received During The Last 7 Days ☐☐

31. Formal Treatments In LAST 14 DAYS

Types of services and supports provided in the **last 14 days.** These occurred once or more in this time frame.

0. No 1. Yes

- **a. Chemotherapy** ☐
- **b. Radiation** ☐
- **c. Oxygen therapy** ☐
- **d. Suctioning** ☐
- **e. Tracheostomy care** ☐
- **f. Ventilator or respirator** ☐
- **g. IV medication** ☐
- **h. Transfusion** ☐
- **i. Dialysis** ☐

32. Restorative Nursing Programs

Code the number of days each of the following programs was performed (for at least 15 minutes a day) in the last 7 calendar days (enter 0 if none or less than 15 minutes daily)

- **a. Range of motion (passive)** ☐
- **b. Range of motion (active)** ☐
- **c. Splint or brace assistance** ☐
- **d. Training/skill practice in bed mobility** ☐
- **e. Training/skill practice in transfer** ☐
- **f. Training/skill practice in walking** ☐
- **g. Training/skill practice in dressing and/or grooming** ☐
- **h. Training/skill practice in eating and/or swallowing** ☐
- **i. Training/skill practice in amputation/prostheses care** ☐
- **j. Training/skill practice in communication** ☐

33. Speech-Language Pathology And Audiology Services

a. Individual minutes – record the total number of minutes this therapy was administered to the individual individually in **last 7 days** ☐☐☐☐

b. Concurrent minutes – record the total number of minutes this therapy was administered to the individual concurrently with one other individual in the **last 7 days** ☐☐☐☐

c. Group minutes – record total number of minutes this therapy was administered to the individual as part of a group of individuals in the **last 7 days** ☐☐☐☐

If sum of individual, concurrent and group minutes is zero, skip to R.34, occupational therapy.

d. Days – record the number of days this therapy was administered for at least 15 minutes a day in the **last 7 days** ☐

34. Occupational Therapy

a. Individual minutes – record the total number of minutes this therapy was administered to the individual individually in **last 7 days** ☐☐☐☐

b. Concurrent minutes – record the total number of minutes this therapy was administered to the individual concurrently with one other individual in the **last 7 days** ☐☐☐☐

c. Group minutes – record total number of minutes this therapy was administered to the individual as part of a group of individuals in the **last 7 days** ☐☐☐☐

If sum of individual, concurrent and group minutes is zero, skip to R.35, physical therapy.

d. Days – record the number of days this therapy was administered for at least 15 minutes a day in the **last 7 days** ☐

35. Physical Therapy

a. Individual minutes – record the total number of minutes this therapy was administered to the individual individually in **last 7 days** ☐☐☐☐

b. Concurrent minutes – record the total number of minutes this therapy was administered to the individual concurrently with one other individual in the **last 7 days** ☐☐☐☐

c. Group minutes – record total number of minutes this therapy was administered to the individual as part of a group of individuals in the **last 7 days** ☐☐☐☐

If sum of individual, concurrent and group minutes is zero, skip to R.36, respiratory therapy.

d. Days – record the number of days this therapy was administered for at least 15 minutes a day in the **last 7 days** ☐

36. Respiratory Therapy

a. Days – record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days ☐

SECTION Z. ASSESSMENT SUMMARY

1. Individual Or Caregiver Has Urgent Concerns ☐

0. No 1. Yes

If yes, please specify in space provided.

_____

_____

_____

2. Individual Receives Services That Are Helpful ☐

0. No 1. Yes

If yes, please specify in space provided.

_____

_____

_____

3. PCS Needs

a. PCAM triggered ☐

0. No 1. Yes

b. Recommended PCS hours

☐☐☐.☐☐

4. Nursing Needs

a. NCAM triggered ☐

0. No 1. Yes

b. Recommended nursing hours

☐☐☐.☐☐

MDCP and CFC Determinations

5. MN (CFC or MDCP) and MDCP RUG Requirements

a. MN Determination Needed? ☐

0. No 1. Yes

b. MDCP RUG Calculation Required? ☐

0. No 1. Yes

ERS*-Emergency Response Services*

6. Does The Client Require ERS? ☐

0. No 1. Yes

If yes, please describe how the individual will benefit from ERS.

_____

Support Management *includes how to select, manage and dismiss attendants*

7. Is The Individual Currently Receiving Support Management? ☐

0. No 1. Yes

8. Would The Individual Like To Receive Support Management? ☐

0. No 1. Yes

9. If Z.7 Or Z.8 Is "Yes," Identify Any Needs, Requests, Or Considerations Specific To This Service That Are Necessary For The CFC Provider To Know When Supporting The Individual In Achieving His/Her Outcomes.

_____

_____

Service Delivery Options

For Initial Assessment:

10. Is The Individual Or Guardian/LAR Interested In Self-Directing CFC Services? ☐

0. No 1. Yes

For Renewal:

11. What Service Delivery Option Is The Individual Currently Using?
1. Agency 2. CDS 3. SRO ☐

12. Does The Individual Want To Change Their Service Delivery Option?
0. No 1. Yes ☐

13. If Yes To 12, What Service Delivery Option Would The Individual or Guardian/LAR Want To Use?
1. Agency 2. CDS 3. SRO ☐

14. Summary Of Recommended CFC Services

a. CFC PCS/HAB recommended Total Hours per week:
☐☐☐.☐☐

b. Support management:
0. No 1. Yes ☐

c. ERS:
0. No 1. Yes ☐

15. Further Assessment is Needed
0. No 1. Yes

a. Behavioral Health *(Code "Yes" if B.6.f., H.2, I.1., or I.2 are "1", or any of I.3.a-d are not "0", OR any of I.4.a-k or I.5.a-j are not "0")* ☐

b. Assistive Devices/DME *(Code "Yes" if D.13 is "1" OR any of D.14.a-j are not "1")* ☐

c. Physical Therapy *(Code "Yes" if B.6.c, D.3.a, OR H.6.g are "1")* ☐

d. Occupational Therapy *(Code "Yes" if B.6.b, D.3.a, OR H.6.h are "1")* ☐

e. Speech Language Pathology *(Code "Yes" if B.6.d, D.3.b, or H.6.i are "1", OR F.5. is not "0")* ☐

f. Respiratory Therapy *(Code "Yes" if H.6.f is "1")* ☐

g. ECI *(Code "Yes" if D.3.a or D.3.b is "1", OR D.4 is "2")* ☐

h. Nutrition *(Code "Yes" if any of G.3.b-f are "1")* ☐

i. IDD *(Code "Yes" if D.5 is "6")* ☐

j. Education *(Code "Yes" if B.9 OR D.3.c. are "1")* ☐

k. Medical Provider evaluation; i.e., longer than one year since office visit *(Code "Yes" if A.24.e. is greater than 12 months ago)* ☐

l. Blind Services for Children *(Code "Yes" if B.6.e. is "1")* ☐

m. Deaf and Hard of Hearing Services *(Code "Yes" if B.6.i. is "1")* ☐

n. Employment Services; e.g., supported employment, employment assistance, vocational rehabilitation *(Code "Yes" if B.11 is "3", or B.12 is "1", OR B.14 is "1-3")* ☐

o. Medical care supplies requested *(Code "Yes" if D.15 is "1")* ☐

p. Medical Emergency Plan required *(Code "Yes" if D.16 is "2")* ☐

q. ISP required *(Code "Yes" if C.5 is "3")* ☐

r. ISP update requested *(Code "Yes" if C.5. is "2")* ☐

16. Additional Information/Referrals Recommended by Assessor

0. No 1. Yes

a. MCO Disease Management ☐
b. In-Home and Family Support Program ☐
c. Children with Special Healthcare Needs (CSHCN) ☐
d. STAR+PLUS Waiver (for members nearing age 21) ☐
e. Waiver Interest List (MDCP, YES, CLASS, HCS, TxHmL, DBMD) ☐
f. State Supported Living Center crisis diversion slot ☐
g. PASRR crisis diversion slot ☐
h. Medicaid Medical Transportation Program (MTP) ☐
i. Blind Children's Program ☐
j. Deaf and Hard of Hearing Services ☐
k. Autism Program ☐
l. Comprehensive Rehabilitation Services Program ☐
m. Independent Living Services ☐
n. Other Non-Medicaid, Non-State, Community Services (e.g., family or client housing, community transportation, respite); specify_____ ☐