

Assessment Start Date — —
 Month Day Year

NPI #

Name of Person Coordinating Assessment _____ TITLE _____

Agency/Organization _____ PHONE # _____

SECTION A - Identification and Background Information

1.	CHILD'S NAME	First: _____ Last: _____
2.	CHILD'S ADDRESS	_____ Street _____ City/Town State Zip Code _____ County Telephone: <input type="text"/> <input type="text"/> <input type="text"/> — <input type="text"/> <input type="text"/> <input type="text"/> — <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
3.	SOCIAL SECURITY # MAINECARE #	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> — <input type="text"/> <input type="text"/> — <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
4.	ASSESSMENT TRIGGER	1 = Service need 4 = Financial change 2 = Reassessment due 5 = Other 3 = Significant medical change
5.	GENDER	1 = Male 2 = Female
6.	RACE/ ETHNICITY (OPTIONAL)	1 = American Indian/Alaskan 4 = Hispanic 2 = Asian/Pacific 5 = White 3 = Black 6 = Other
7.	BIRTHDATE	<input type="text"/> <input type="text"/> — <input type="text"/> <input type="text"/> — <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
8.	CITIZENSHIP	1 = U.S. Citizen 3 = Other 2 = Legal alien
9.	PRIMARY LANGUAGE	0 = English 2 = Spanish 1 = French 3 = Other: _____
10.	CHILD'S CURRENT QUALIFYING CONDITION	1 = Medical 2 = Psychiatric/Behavioral
11.	MOTHER'S IDENTIFYING INFO.	First: _____ Last: _____ _____ ADDRESS/Street _____ City/Town State Zip Code _____ County Home Telephone: <input type="text"/> <input type="text"/> <input type="text"/> — <input type="text"/> <input type="text"/> <input type="text"/> — <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Work Telephone: <input type="text"/> <input type="text"/> <input type="text"/> — <input type="text"/> <input type="text"/> <input type="text"/> — <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

SECTION A - Identification and Background - Cont'd

12.	FATHER'S IDENTIFYING INFO.	First: _____ Last: _____ _____ ADDRESS/Street _____ City/Town State Zip Code _____ County Home Telephone: <input type="text"/> <input type="text"/> <input type="text"/> — <input type="text"/> <input type="text"/> <input type="text"/> — <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Work Telephone: <input type="text"/> <input type="text"/> <input type="text"/> — <input type="text"/> <input type="text"/> <input type="text"/> — <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
13.	LEGAL GUARDIAN'S IDENTIFYING INFO. (If different from above.)	First: _____ Last: _____ _____ ADDRESS/Street _____ City/Town State Zip Code _____ County Home Telephone: <input type="text"/> <input type="text"/> <input type="text"/> — <input type="text"/> <input type="text"/> <input type="text"/> — <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Work Telephone: <input type="text"/> <input type="text"/> <input type="text"/> — <input type="text"/> <input type="text"/> <input type="text"/> — <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
14.	PARENT CONTACT (Check all that apply.)	Who can be contacted with questions? <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other: _____
15.	PHYSICIAN CONTACT (Primary Care)	First: _____ Last: _____ _____ ADDRESS/Street _____ City/Town State Zip Code _____ Telephone: <input type="text"/> <input type="text"/> <input type="text"/> — <input type="text"/> <input type="text"/> <input type="text"/> — <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
16.	PRIVATE INSURANCE	Is child covered by private insurance? 0 = No, 1 = Yes If yes, specify insurer: _____ If yes, provider policy # _____

Agency Name: _____

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SECTION B - Diagnosis

1.	PSYCHIATRIC/BEHAVIORAL Diagnosed by a certified professional. (Check all that apply) Mental Retardation - Birth to Attainment of 6 Developmental and Emotional Disorders of Younger Infants + Preschool - 6 to 18 - 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 - Somatoform, Eating, and Tic Disorders	a. Anxiety Disorders			
		b. Attention Deficit Hyperactivity Disorder			
		c. Autistic Disorder and Other Pervasive Developmental Disorders			
		d. Developmental and Emotional Disorders of Younger Infants + Preschool (Birth to attainment of 6)			
		e. Mental Retardation			
		f. Mood Disorders			
		g. Organic Mental Disorders			
		h. Schizophrenic, Delusional (Paranoid), Schizoaffective, and other Psychotic Disorders			
		i. Somatoform, Eating, and Tic Disorders			
		j. Other DSM IV Axis I Diagnoses and ICD-9 Codes			
		i. _____ / _____			
		ii. _____ / _____			
		iii. _____ / _____			
		iv. _____ / _____			
		v. _____ / _____			
		vi. _____ / _____			
		k. NONE OF THE ABOVE			
2.	PERSISTENCE Code 0 = No 1 = Yes 2 = Not Applicable (if child does not have psych/behavioral condition)	a. Have any of the psychiatric/behavioral conditions identified in B1 persisted for <u>at least six months</u> ?			
		b. Are any of the psychiatric/behavioral conditions identified in B1 expected to persist for <u>a year or longer</u> ?			
3.	MEDICAL (Check all that apply) a. Allergies specify: _____ _____ b. Amputation c. Anemia d. Arthritis e. Asthma/Respiratory disorder f. Cancer g. Cardiovascular disease h. Cerebral Palsy i. Cleft Lip and/or Palate j. Cystic Fibrosis k. Diabetes l. Explicit terminal prognosis m. Hemophilia n. HIV/AIDS o. Osteoporosis	p. Paraplegia			
		q. Pathological bone fracture			
		r. Quadriplegia			
		s. Renal failure			
		t. Seizure Disorder			
		u. Spina Bifida			
		v. Traumatic brain injury			
		w. Tuberculosis			
		x. Other Current Medical Diagnoses and ICD-9 Codes			
		i. _____ / _____			
		ii. _____ / _____			
		iii. _____ / _____			
		iv. _____ / _____			
		v. _____ / _____			
		y. NONE OF THE ABOVE			
		4.	FUNCTIONAL ASSESSMENT SCORE a. Does child have documented functional assessment test score? 0 = No, 1 = Yes b. If yes, please check name of functional assessment test: ___ ABAS - II ___ CAFAS ___ PECFAS ___ Vineland - II ___ Other - please specify: _____ c. Child's functional assessment test score(s):		

SECTION C - Physical Functioning

1.	ADL SELF-PERFORMANCE - Column 1 at right → Column 1 Code for performance during the last 7 days 0 = Independent AA = Age Appropriate 1 = Supervision - Oversight, encouragement or cueing provided 3+ times during last 7 days - OR - Supervision plus nonweight-bearing physical assistance provided only 1 or 2 times during last 7 days. 2 = Limited assistance - Child 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) 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. 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 during entire 7 days.		
2.	ADL SUPPORT PROVIDED - Column 2 at far right → Column 2 Code for MOST SUPPORT PROVIDED OVER EACH 24 HOUR PERIOD during the last 7 days; code regardless of child's self-performance classification. 0 = No setup or physical help AA = Age Appropriate 1 = Setup help only 2 = One-person physical assist 3 = Two+ persons physical assist 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		
		a. BED MOBILITY (how child moves to and from lying position, turns side to side, and positions body while in bed)	
		b. TRANSFER (how child moves between surfaces - to/from: bed, chair, wheelchair, standing position (Exclude to/from bath/toilet/dressing))	
		c. LOCOMOTION (how child moves between locations in his/her room and areas on same floor. If in wheelchair, self-sufficiency in chair)	
		d. DRESSING (how child puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis)	
		e. EATING/DRINKING (how child eats and drinks regardless of skill)	
		f. TOILET USE (how child uses the toilet room or commode, bedpan, urinal; transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjust clothes)	
		g. PERSONAL HYGIENE (how child maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum; excludes bath and shower)	
		h. BATHING How child takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair). [Code for most dependent in self-performance and support. Bath self-performance codes appear below.] 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 7 = Activity Did Not Occur During Entire 7 Days	
3.	WALKING	a. How child walks for exercise only	
		b. How child walks around own room	
		c. How child walks within home	
		d. How child walks outside	
4.	MODE OF LOCOMOTION (Code primary mode) 0 = Walking 4 = Prosthetics 8 = Other: 1 = Wheelchair 5 = Orthopedic shoes 2 = Walker 6 = Cane/crutch 3 = Splints or braces 7 = Scooting board 9 = NONE OF ABOVE		

Agency Name: _____

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SECTION D - Professional Nursing Services

Use the following codes for section D1 to D10 (every block should be coded with a response)
 Child will need care that is or otherwise would be performed by or under the supervision of a licensed nurse:

- 0 = Condition/treatment not present in the last 7 days
- 1 = 1-2 days/week
- 2 = 3-4 days/week
- 3 = 5-6 days/week
- 4 = 7 days/week
- 5 = Once a month
- 6 = At least once every 8 hours/7 days a week (used for Extended PDN only)
- 7 = Twice a month

		CODE
1. INJECTIONS/IV FEEDING Injections/IV feeding for an unstable condition (excluding daily insulin for a child whose diabetes is under control):	a. Intraarterial injection b. Intramuscular injection c. Subcutaneous injection d. Intravenous injection e. Intravenous feeding	
2. FEEDING TUBE Feeding tube for a new/recent (within 30 days) or an unstable condition: Insertion date: _____	a. Nasogastric tube b. Gastrostomy tube c. Jejunostomy tube	
3. SUCTIONING/TRACH CARE	a. Nasopharyngeal suctioning b. Tracheostomy care for a new/recent (within 30 days) or an unstable condition. Start date: _____	
4. TREATMENT/DRESSING Treatment and/or application of dressings when the physician has prescribed irrigation, the application of prescribed medication, or sterile dressings when the skills of a registered nurse are needed to provide safe and effective services.	a. Stage 3 or 4 decubitus ulcers b. Open surgical site c. 2 nd or 3 rd degree burns d. Stasis ulcer e. Open lesions other than stasis/pressure ulcers or cuts (including but not limited to fistulas, tube sites and tumor erosions) f. Other: _____	
5. OXYGEN Administration of oxygen on a regular and continuing basis when recipient's condition warrants professional observation for a new/recent (within 30 days) condition. Start date: _____		
6. ASSESSMENT/MANAGEMENT RN assessment, observation and management required for unstable medical conditions. Observation must be needed at least once every 8 hours. Specify condition and code for applicant's need. Please specify: _____		
7. CATHETER Insertion and maintenance of a urethral or suprapubic catheter as an adjunct to the active treatment of a disease or medical condition.		
8. COMATOSE Professional care is needed to manage a comatose condition.		
9. VENTILATOR/RESPIRATOR Care is needed to manage ventilator/respirator equipment.		
10. UNCONTROLLED SEIZURE DISORDER Direct assistance from others is needed for safe management of an uncontrolled seizure disorder.		

SECTION E - Treatments and Therapies

1. TREATMENTS - CHRONIC CONDITIONS Licensed nursing care and monitoring for administration or treatments, procedures, or dressing changes which involve prescription medications, for post-operative or chronic conditions according to physician orders. CODE for 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	a. Medications via tube	
	b. Tracheostomy care-chronic stable	
	c. Urinary catheter change	
	d. Urinary catheter irrigation	
	e. Veni puncture	
	f. Monthly injections	
	g. Barrier dressing for Stage 1 or 2 ulcers	
	h. Chest PT	
	i. Oxygen therapy for chronic unstable condition	
	j. Other: _____	
	k. Teach/train	
2. TREATMENTS/PROCEDURES CODE for number of days licensed nursing is required: 0 = Not required 1 = 1-2 days/week 2 = 3 or more days/week 3 = Once a month 7 = Twice a month	a. Chemotherapy	
	b. Radiation Therapy	
	c. Hemodialysis	
	d. Peritoneal Dialysis	
3a. THERAPY - THERAPIES PROVIDED BY A QUALIFIED THERAPIST	Indicate the number of days per week for each therapy required. ENTER 0 if none.	Days Per Week
	a. Physical therapy	
	b. Speech/language therapy	
	c. Occupational therapy	
	1. Total days PT, ST (w/rehab only), & OT:	
	d. Respiratory therapy	
	2. Total days all therapies (PT,ST,OT, & Resp):	
3b. REHAB POTENTIAL	Indicate if rehab potential has been documented for PT, ST, or OT. 0=No 1=Yes 2=N/A	
4. THERAPY	Is therapy required at least once a month for any of the following: physical, speech/language, occupational or respiratory therapy? 0 = No 1 = Yes	

Agency Name: _____

Applicant Name: _____

Assessment Date: — —
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SECTION F - Medication List

List all medications given during the last 60 days (over-the-counter and prescription drugs).
 Include medications used regularly less than weekly as part of the person's treatment regimen.
 If child receives no medications, specify "N/A" for not applicable in Medication Name and Dosage column.

- 1. List the medication name and the dosage**
- 2. New (N), changed (C), or discontinued (D) medications within the past 60 days**
 (This will include all medications prescribed in the last 60 days including any antibiotics taken in the last 60 days)
- 3. Date of new, changed, or discontinued medication**
- 4. RA (Route of Administration).** Use the appropriate code from the following list:

1 = by mouth (PO)	3 = intramuscular (IM)	5 = subcutaneous (SubQ)	7 = topical	9 = enteral tube	11 = intrathecal
2 = sublingual (SL)	4 = intravenous (IV)	6 = rectally	8 = inhalation	10 = other	
- 5. FREQ (Frequency):** Use the appropriate frequency dose to show the number of times per day that the medication was given.

PR = (PRN) as necessary	1D = (qd or hs) once daily	1W = (QWeek) once every week	1M = (QMonth) once every month
1H = (qh) every hour	2D = (BID) two times daily (includes every 12 hours)	2W = twice every week	2M = twice every month
2H = (q2h) every two hours	3D = (TID) three times daily	3W = three times every week	C = continuous
3H = (q3h) every three hours	4D = (QID) four times daily	4W = four times every week	O = other
4H = (q4h) every four hours	5D = five times daily	5W = five times every week	
6H = (q6h) every six hours		6W = six times every week	
8H = (q8h) every eight hours			
- 6. PRN-n** (prn – number of doses):
 If the frequency code is "PR", record the number of times during the past 30 days that each PRN medication was given. Do not use this column for scheduled medications.

1. Medication Name and Dosage	2. N / C / D	3. Date of N / C / D	4. RA	5. Freq	6. PRN-n

SECTION G - Medication

1a. PREPARATION/ADMINISTRATION (Choose only one)
 Did child prepare and administer his/her medications in the last 7 days?

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 and administered NONE of his/her own medications.
3 = Child had no medication 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.

1B. COMPLIANCE (Choose only one)
 Child's level of compliance with medication prescribed by a physician/psychiatrist in 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 during last 7 days
4 = Child requires monitoring of medications due to severe and disabling mental illness.

Agency Name: _____

Applicant Name: _____

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SECTION H - Cognition	
1. MEMORY (Recall of what was learned or known) 0 = Memory OK 1 = Memory problems	a. Short-term memory – seems/appears to recall after 5 minutes b. Long-term memory – seems/appears to recall long past
2. MEMORY/RECALL ABILITY (Check all that child normally is able to recall during last 7 days, age-appropriate.)	a. Current season b. Location of own room c. Names/faces d. Where he/she is e. NONE OF THE ABOVE were
3. COGNITIVE SKILLS FOR DAILY DECISION MAKING (Choose only one.) Made decisions regarding tasks of daily life. 0 = INDEPENDENT-decisions consistent/reasonable AA = Age Appropriate 1 = MODIFIED INDEPENDENCE-some difficulty in new situations only 2 = MODERATELY IMPAIRED-decisions poor; cues/supervision required 3 = SEVERLY IMPAIRED-never/rarely made decisions	
4a. NURSING NEEDS Is professional nursing assessment, observation and management required at <u>least 3 days/week</u> to manage all the above cognitive patterns? 0 = NO 1 = YES If 4a = 1 (YES), proceed to next Section I. If 4a = 0 (NO), and person meets the cognitive impairment threshold as defined in Chapter II, Section 67 of the MaineCare Benefits Manual, then go to next column and complete Section H.4b of the Cognitive Supplemental Screening tool.	
5. Is professional nursing assessment, observation and management required once a month to manage all the above cognitive patterns? 0 = NO 1 = YES	

SECTION H.4B - Supplemental Screen for Cognition	
H.4B	Enter the code that most accurately describes the child's cognition for the last 7 days, age-appropriate.
1. MEMORY FOR EVENTS:	0 = Can recall details and sequences of recent experiences and remember names of meaningful acquaintances. 1 = Cannot recall details or sequences or recent events or remember names of meaningful acquaintances. 2 = Cannot recall entire events (e.g. recent outings, visits of relatives or friends) or names of close friends or relatives without prompting. 3 = Cannot recall entire events or family members even without prompting.
2. MEMORY AND USE OF INFORMATION:	0 = Does not have difficulty remembering and using information. Does not require directions or reminding from others. 1 = Has minimal difficulty remembering and using information. Requires direction and reminding from others one to three times per day. Can follow simple written instructions. 3 = Has difficulty remembering and using information. Requires direction and reminding from others four or more times per day. Cannot follow written instructions. 4 = Cannot remember or use information. Requires continual verbal reminding.
3. GLOBAL CONFUSION:	0 = Appropriately responsive to environment. 1 = Nocturnal confusion and awakening. 2 = Periodic confusion during daytime. 3 = Nearly always confused.
4. SPACIAL ORIENTATION:	0 = Oriented, able to find and keep his/her bearings. 1 = Spatial confusion when driving or riding in local community. 2 = Gets lost when walking neighborhood. 3 = Gets lost in own home or present environment.
5. VERBAL COMMUNICATION	0 = Speaks normally. 1 = Minor difficulty with speech or word-finding difficulties. 2 = Able to carry out only simple conversations. 3 = Unable to speak coherently or make needs known. 4 = Non-verbal
H.4b. →	TOTAL COGNITIVE SCORE

Proceed to Section I

Agency Name: _____

Applicant Name: _____

Assessment Date: - -
Month Day Year

Social Security #: - -

NPI #:

SECTION J - Communication/Hearing Patterns

1. HEARING (Choose only one.) (With hearing appliance, if used) 0 = HEARS ADEQUATELY-normal talk, TV, phone 1 = MINIMAL DIFFICULTY when not in quiet setting 2 = HEARS IN SPECIAL SITUATIONS ONLY-speaker has to adjust tonal quality and speak distinctly 3 = HIGHLY IMPAIRED-absence of useful hearing																	
2. COMMUNICATON DEVICES/ TECHNIQUES Check all that apply <u>during</u> last 7 days.	<table border="1"> <tr><td>a. Hearing aid, present and used</td><td></td></tr> <tr><td>b. Hearing aid, present and not used regularly</td><td></td></tr> <tr><td>c. Other receptive communication techniques used (e.g. lip reading)</td><td></td></tr> <tr><td>d. NONE OF THE ABOVE</td><td></td></tr> </table>	a. Hearing aid, present and used		b. Hearing aid, present and not used regularly		c. Other receptive communication techniques used (e.g. lip reading)		d. NONE OF THE ABOVE									
a. Hearing aid, present and used																	
b. Hearing aid, present and not used regularly																	
c. Other receptive communication techniques used (e.g. lip reading)																	
d. NONE OF THE ABOVE																	
3. SPEECH CLARITY 0 = CLEAR SPEECH-distinct, intelligible words 1 = UNCLEAR SPEECH-slurred, mumbled words 2 = NO SPEECH-absence of spoken word																	
4. COMMUNICATION Check all that apply <u>during</u> last 7 days.	<table border="1"> <tr><td>a. Speech</td><td></td></tr> <tr><td>b. Writing message to express or clarify needs</td><td></td></tr> <tr><td>c. American or other sign language, Braille</td><td></td></tr> <tr><td>d. Communication device</td><td></td></tr> <tr><td>e. Eye gaze</td><td></td></tr> <tr><td>f. Gestures</td><td></td></tr> <tr><td>g. Other: _____</td><td></td></tr> <tr><td>h. NONE OF THE ABOVE</td><td></td></tr> </table>	a. Speech		b. Writing message to express or clarify needs		c. American or other sign language, Braille		d. Communication device		e. Eye gaze		f. Gestures		g. Other: _____		h. NONE OF THE ABOVE	
a. Speech																	
b. Writing message to express or clarify needs																	
c. American or other sign language, Braille																	
d. Communication device																	
e. Eye gaze																	
f. Gestures																	
g. Other: _____																	
h. NONE OF THE ABOVE																	
5. MAKING SELF UNDERSTOOD (Choose only one.) Expressing information however able: 0 = UNDERSTOOD - uses nouns, names objects, can give first and last names 1 = USUALLY UNDERSTOOD - difficulty finding words or finishing thoughts 2 = SOMETIMES UNDERSTOOD - ability is limited to making concrete requests 3 = RARELY/NEVER UNDERSTOOD																	
6. ABILITY TO UNDERSTAND OTHERS (Choose only one.) 0 = UNDERSTANDS (understands speaker's message) 1 = USUALLY UNDERSTANDS (may miss some part/intent of message) 2 = SOMETIMES UNDERSTANDS (responds adequately to simple, direct communication) 3 = RARELY/NEVER understands																	

SECTION K - Vision

1. VISION (Choose only) Ability to see in adequate light and with glasses if used. 0 = ADEQUATE-sees fine detail, including regular print in newspapers/books 1 = IMPAIRED-sees large print, but not regular print in newspapers/books 2 = MODERATELY IMPAIRED-limited vision; not able to see newspaper headlines, but can identify objects 3 = HIGHLY IMPAIRED-object identification in question, but eyes appear to follow objects 4 = SEVERLY IMPAIRED-no vision or sees only light, colors, or shapes; eyes do not appear to follow objects													
2. VISUAL APPLIANCES	<table border="1"> <tr><td>0 = No 1 = Yes</td><td></td></tr> <tr><td>a. Glasses, contact lenses</td><td></td></tr> <tr><td>b. Artificial eye</td><td></td></tr> <tr><td>c. Other: _____</td><td></td></tr> <tr><td>_____</td><td></td></tr> <tr><td>_____</td><td></td></tr> </table>	0 = No 1 = Yes		a. Glasses, contact lenses		b. Artificial eye		c. Other: _____		_____		_____	
0 = No 1 = Yes													
a. Glasses, contact lenses													
b. Artificial eye													
c. Other: _____													

SECTION L - Nutritional Status

1. WEIGHT Record weight in pounds. Base weight on most recent measure in last 30 days. Specify measurement date: _____ Measure weight consistently in accordance with standard practice (e.g. in a.m. after voiding, before meal, with shoes off, and in nightclothes).	<input type="text"/> <input type="text"/> <input type="text"/> WT (lb.)																								
2. WEIGHT CHANGE 0 = No weight change 1 = Unintended weight gain-5% or more in last 30 days; or 10% or more in last 180 days 2 = Unintended weight loss-5% or more in last 30 days; or 10% or more in last 180 days Specify previous weight: _____ Date measured: _____																									
3. NUTRITIONAL PROBLEMS OR APPROACHES (Check all that apply)	<table border="1"> <tr><td>a. Chewing or swallowing problem</td><td></td></tr> <tr><td>b. Complains about the taste of many foods</td><td></td></tr> <tr><td>c. Regular or repetitive complaints of hunger</td><td></td></tr> <tr><td>d. Leaves 25% or more of food uneaten at most meals</td><td></td></tr> <tr><td>e. Therapeutic diet (specify) _____</td><td></td></tr> <tr><td>f. Mechanically altered (or pureed) diet</td><td></td></tr> <tr><td>g. Gastric Tube provides 50% or more of daily calories</td><td></td></tr> <tr><td>h. Gastric Tube provides less than 50% of calories</td><td></td></tr> <tr><td>i. Noncompliance with diet</td><td></td></tr> <tr><td>j. Food Allergies (specify) _____</td><td></td></tr> <tr><td>k. Restrictions (specify) _____</td><td></td></tr> <tr><td>l. NONE OF ABOVE</td><td></td></tr> </table>	a. Chewing or swallowing problem		b. Complains about the taste of many foods		c. Regular or repetitive complaints of hunger		d. Leaves 25% or more of food uneaten at most meals		e. Therapeutic diet (specify) _____		f. Mechanically altered (or pureed) diet		g. Gastric Tube provides 50% or more of daily calories		h. Gastric Tube provides less than 50% of calories		i. Noncompliance with diet		j. Food Allergies (specify) _____		k. Restrictions (specify) _____		l. NONE OF ABOVE	
a. Chewing or swallowing problem																									
b. Complains about the taste of many foods																									
c. Regular or repetitive complaints of hunger																									
d. Leaves 25% or more of food uneaten at most meals																									
e. Therapeutic diet (specify) _____																									
f. Mechanically altered (or pureed) diet																									
g. Gastric Tube provides 50% or more of daily calories																									
h. Gastric Tube provides less than 50% of calories																									
i. Noncompliance with diet																									
j. Food Allergies (specify) _____																									
k. Restrictions (specify) _____																									
l. NONE OF ABOVE																									

SECTION M - Continance in Last 14 Days

1. APPLIANCES AND PROGRAMS (Check all that apply)	<table border="1"> <tr><td>a. External (condom) catheter</td><td></td></tr> <tr><td>b. Indwelling catheter</td><td></td></tr> <tr><td>c. Pads/briefs used</td><td></td></tr> <tr><td>d. Ostomy present</td><td></td></tr> <tr><td>e. Scheduled toileting/other program</td><td></td></tr> <tr><td>f. Age Appropriate</td><td></td></tr> <tr><td>g. NONE OF ABOVE</td><td></td></tr> </table>	a. External (condom) catheter		b. Indwelling catheter		c. Pads/briefs used		d. Ostomy present		e. Scheduled toileting/other program		f. Age Appropriate		g. NONE OF ABOVE	
a. External (condom) catheter															
b. Indwelling catheter															
c. Pads/briefs used															
d. Ostomy present															
e. Scheduled toileting/other program															
f. Age Appropriate															
g. NONE OF ABOVE															

Agency Name: _____

Applicant Name: _____

Assessment Date: — —
Month Day Year

Social Security #: — —

NPI #:

SECTION N - Skin Condition

1. ULCERS (Due to any cause) Record the number of ulcers at each ulcer stage - regardless of cause. If none present at a stage, record "0" (zero). CODE all that apply <u>during last 7 days</u> . Code 9=9 or more.		Number of Pressure Ulcers any lesion caused by pressure resulting in damage of underlying tissue	Number of Stasis Ulcers open lesion caused by poor circulation in the lower extremities
	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.		
2. SKIN PROBLEMS (Check all that apply.) Any troubling skin conditions or changes in the last 180 days?	a. Abrasions (scrapes) or cuts		
	b. Burns		
	c. Bruises		
	d. Rashes, itchiness, body lice, scabies		
	e. Open sores or lesions		
	f. NONE OF ABOVE		
3. FOOT PROBLEMS AND CARE 0 = No 1 = Yes	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, bunions, hammer toes, overlapping toes, pain, structural problems, gangrene toe, foot fungus, onychomycosis?		

Agency Name: _____

Applicant Name: _____

Assessment Date: — —
Month Day Year

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NPI #:

NF LEVEL OF CARE

		Yes	No
NF1	a. In Section D, Professional Nursing Services, items 1-8, did you code any of the responses with a 4 (i.e., services needed 7 days/week)?		
	b. In Section D, item 9 (Ventilator/Respirator) did you code this response with a 2, 3, or 4 (care needed at least 3 days/week)?		
	c. In Section D, item 10 (Uncontrolled Seizure), did you code this response with a 1, 2, 3, or 4 (care needed at least once a week)?		
	d. In Section E, item 3a.2 (PT, ST, OT, Resp Therapies), was the total number of days of therapy 5 or more days/week?		
	e. In Section C (Physical Functioning/Structural Problems), were 3 or more shaded ADLs coded with a 3 (extensive assistance) or 4 (dependent) in self-performance?		
	If the answer to any of these questions is "YES", then the child appears medically eligible for NF level care. Otherwise continue.		
NF2	PROFESSIONAL NURSING SERVICES: Enter 0-No; 1-Yes, unless otherwise specified		
	a. In Section D, Nursing Services, items 1-8, how many were coded with a 2 or 3 (service needed 3-6 days/week - Enter number.		
	b. In Section E, item 3.a.1 (PT,ST (w/rehab), OT Therapies), was the total number of days of therapy 3 or 4 days/week?		
	c. In Section E, items 1a-1e and 1g-1j (excluding 1f, monthly injections), did you code any of the responses with a 2?		
	d. In Section E, items 2a-d, did you code any of the responses with a 2?		
Total			
NF3	Impaired Cognition	Yes	No
	a. Is Section H1a (short term memory) coded with a 1?		
	b. In Section H2 (memory recall) are 1 or 2 boxes checked in H2a-H2d OR is H2e (None of the above) checked (person is able to recall no more than 2 items)?		
	c. Is Section H3 coded with a 2 or 3?		
	d. [Is Section H4A 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 H4B (from page 5 Supplemental Screening Tool) is 13 or more]?		
If all the answers to the above questions are "yes", then score this section with a "1."			
NF4	Behavior Problems	Yes	No
	a. In Section I1, are 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 I2a 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 I2b (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."			
NF5	Compute the total nursing score from questions 2, 3 and 4. If the total nursing score is 1 or more, proceed. Otherwise child appears not to be medically eligible for NF level of care. Please proceed to the next page.		
Total Nursing			
NF6	In Section C (Physical Functioning/Structural Problems), how many "shaded" ADLs were coded with a 2, 3 or 4 in self-performance AND required one or more physical assists in support (support coded as 2 or 3)?		
Total ADL Needs			
NF7	Total Professional Nursing and ADL Needs Score (NF.5+NF.6) If the Total Nursing and ADL Needs score is 3 or more, the child appears to be medically eligible for NF level of care. Otherwise, child appears not to be medically eligible.		
NF8	Does the child meet the criteria for NF level of care?	Yes	No

NEXT:
If the child did not qualify for NF level of care, proceed to PDN Eligibility Determination (next page).

RN Signature:

Date: _____

Agency Name: _____

Applicant Name: _____

Assessment Date: - -
Month Day Year

Social Security #: - -

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PDN/PCS Nursing Score		Yes	No
Private Duty Nursing			
RN.A.	a. In Section D, Nursing Services, were any items 1-8 coded with a 1, 2, 3, 5, or 7? b. In Section D, item 9 (ventilator/respirator), did you code this response with a 1, 5, or 7? c. In Section D, item 10 (uncontrolled seizures) did you code this with a 5 or 7 (care needed once or twice a month)? d. In Section D, was item 11 (assessment/management) coded with a 1 or 7 (assessment needed once or twice a month)? <i>If the answer to any of these questions is "YES," then score this section with a "1."</i>		
Professional Nursing Services			
RN.B.	In Section E.1-E.2, Treatments and Therapies, were any boxes (excluding E.1.e. venipuncture) coded with a 1, 2, 3, or 7? <i>If the answer is "YES," then score this section with a "1."</i>		
Impaired Cognition			
RN.C.	a. Is Section H.1.a (short term memory) coded with a 1? b. In Section H.2 (memory recall) are 1 or 2 boxes checked in H.2.a-H.2.d or is H.2.e, none of the above, checked? c. Is Section H.3 coded with a 2 or 3? d. Is Section H.5 coded with a 1 (i.e. is professional nursing assessment, observations and management required once a month to manage all the above cognitive patterns)? <i>If all the answers to the above questions are "YES," then score this section with a "1."</i>		
Behavior Problems			
RN.D.	a. In Section I.1, Problem Behavior, are one or more of the behaviors I.1.a-I.1.d coded with a 2 or 3? b. Is Section I.3 coded with a 1 (i.e. is professional nursing assessment, observations and management required once a month to manage the above behavior problems)? <i>If the answer to both of these questions is "YES," then score this section with a "1."</i>		
RN.E.	Compute the total PDN nursing score from questions RN.A., RN.B., RN.C. and RN.D. <i>If the Total nursing score is 1 or more, proceed. Otherwise, the child appears NOT to be medically eligible for PDN Level II or Level III.</i>		
PDN/PCS LEVEL 1			
R.1.A.	In Clinical Detail, Section C, Physical Functioning, were d, e, f and h (dressing, eating, toilet use, and bathing) all coded with a '5' (cueing) in Self-Performance AND Support?		
R.1.B.	In Clinical Detail, Section C, Physical Functioning, were 2 of the following 7 ADLs (bed mobility, transfer, locomotion, eating, toilet use, bathing, or dressing) coded with a 2, 3, or 4 in Self-Performance AND a 2 or 3 in Support?		
R.1.C.	In Clinical Detail, Section C, Physical Functioning, was at least 1 ADL from the following 7 ADLs (bed mobility, transfer, locomotion, eating, toilet use, bathing, or dressing) coded with a 2, 3, or 4 in Self-Performance AND a 2 or 3 in Support?		
R.1.D.	In RN.E, is the PDN Nursing Score '1' or more? <i>If the answer to ANY of these questions is 'yes,' then score this section with a '1.' Child appears to be eligible for PDN Level 1.</i>		

PDN/PCS LEVEL 2		Yes	No
R.2.A.	In Clinical Detail, Section C, Physical Functioning, were d, e, f, and h (dressing, eating, toilet use, and bathing) all coded with a '5' (cueing) in Self-Performance AND Support?		
R.2.B.	In Clinical Detail, Section C, Physical Functioning, were 2 of the following 7 ADLs (bed mobility, transfer, locomotion, eating, toilet use, bathing, or dressing) coded with a 2, 3, or 4 in Self-Performance AND a 2 or 3 in Support?		
R.2.C.	ADL Needs Score: If the answer to either R.2.A or R.2.B is 'yes' then score this section with a '1'.		
R.2.D.	PDN Level 2 Eligibility Determination (RN.E + R.2.C) a. In RN.E, is the PDN Nursing Score '1' or more OR is Clinical Detail, Section E.1.e., venipuncture, coded with a 1, 2, 3, or 7? b. In R.2.C, is the ADL Needs Score '1'?		
<i>If the answer to both of these questions is YES, score '1' in the box. The child appears to be eligible for PDN Level 2. Otherwise, the child appears NOT to be eligible for PDN Level 2.</i>			

PDN/PCS LEVEL 3		Yes	No
R.3.A.	In Clinical Detail, Section C, Physical Functioning, were 2 of the following 5 Shaded ADLs (bed mobility, transfer, locomotion, eating, toilet use) coded with a 2, 3, or 4 in Self-Performance AND a 2 or 3 in Support?		
R.3.B.	ADL Needs Score: If the answer to R.3.A is 'yes' then score this section with a '1'.		
R.3.C.	PDN Level 3 Eligibility Determination (RN.E + R.3.B) a. In RN.E, is the PDN Nursing Score '1' or more OR is Clinical Detail, Section E.1.e., venipuncture, coded with a 1, 2, 3, or 7? b. In R.3.B, is the ADL Needs Score '1'?		
<i>If the answer to both of these questions is YES, score '1' in the box. The child appears to be eligible for PDN Level 3. Otherwise, the child appears NOT to be eligible for PDN Level 3.</i>			

PDN LEVEL 8 - Nursing Only		Yes	No
R.8.A.	In RN.E, PDN/PCS Nursing Score, is the PDN Nursing Score '1' or more?		
R.1.B.	Is the child medically eligible for NF Level of Care (NF.8 on page 8 under Eligibility Determination)? <i>If the answer to either of these questions is YES, score '1' in the box. The child appears to be eligible for PDN Level 8. Otherwise, the child appears NOT to be eligible for PDN Level 8.</i>		

PDN / PCS LEVEL V		Yes	No
EXP.1	In Section D, was item 9 (ventilator/respirator) coded with a 4 (nursing services needed 7 days a week)? <i>If the answer is YES, then child appears to be medically eligible for Extended PDN. Score '1' in the box.</i> <i>If the answer is NO, then proceed to EXP.2.</i>		
EXP.2	a. In Section D, was one of the items from 1 (injections/IV feedings), 2 (feeding tube), 3 (suctioning/trach care), 4 (treatment/dressings), 8 (comatose), or 10 (uncontrolled seizure) coded with a 6 (service needed at least once every 8 hours, 7 days a week)? b. In Section D, were 2 additional items from 1, 2, 3, 4, 8, or 10 coded with a 4? <i>If the answer to BOTH 2a. and 2b. is YES, then child appears to be medically eligible for PDN Level 5. Score '1' in the box.</i> <i>If NO, then child appears to NOT be medically eligible for PDN Level 5.</i>		

RN Signature: _____

Date: _____

Agency Name: _____

Applicant Name: _____

Assessment Date: - -
 Month Day Year

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NPI #:

PDN LEVEL VI - Medication Services for Persons with Severe and Disabling Mental Illness

		Yes	No
R.10	a. Is there a physician certification in the child's record verifying the child's eligibility or coverage for services under Section 17?	<input type="checkbox"/>	<input type="checkbox"/>
	b. Has a physician certified that use of outpatient services is contraindicated for this child?	<input type="checkbox"/>	<input type="checkbox"/>
R.11	<i>If the answer to both of these questions is "YES", then score this section with a "1".</i>	<input type="checkbox"/>	<input type="checkbox"/>
	a. In Section G, Medication, is G1a (preparation/administration) coded with a 6?	<input type="checkbox"/>	<input type="checkbox"/>
	b. In Section G, Medication, is G1b (compliance) coded with a 4?	<input type="checkbox"/>	<input type="checkbox"/>
	<i>If the answer to either of these questions is "YES", then score this section with a "1".</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>If the answer to both R.10 and R.11 is scored with a "1" then this child appears to be eligible for Medication Services under Private Duty Nursing. Otherwise, this child appears NOT to be eligible for Medication Services.</i>		<input type="checkbox"/>	<input type="checkbox"/>

PDN LEVEL VII - Venipuncture Only Services

		Yes	No
R.12	a. Is there a physician order in the child's record for <u>only</u> venipuncture services on a regular basis?	<input type="checkbox"/>	<input type="checkbox"/>
	b. Has a physician certified that use of outpatient services is contraindicated for this child?	<input type="checkbox"/>	<input type="checkbox"/>
	c. In Section E, Treatments and Therapies, is E.1.e (venipuncture) coded with a 1, 2, or 3?	<input type="checkbox"/>	<input type="checkbox"/>
<i>If the answers to R.12 a., b., and c. are "YES", then score this section with a "1". Child appears to be eligible for Venipuncture Services under Private Duty Nursing.</i>		<input type="checkbox"/>	<input type="checkbox"/>

RN Signature: _____

Date: _____

COMMUNITY OPTIONS CODING SHEET FOR CARE PLAN SUMMARY

1. Funding Source

Enter the payment code for the funding source which will pay for the recommended service.

Program ID-Program Name

- 30 - PDN Level I
- 2 - PDN Level II
- 31 - PDN Level III
- 4 - PDN Level IV (NF Kids)
- 3 - PDN Level V (Extended)
- 9 - Katie Beckett
- 20 - Other

For the 3rd Party Payor Block, use the following codes:

Program ID-Program Name

- 22 - 3rd Party Payors (Anthem, Champus, VA, LTC Insurance)
- 23 - Community MaineCare
- 24 - Consumer's Funds
- 25 - Nursing Facility
- 38 - MaineCare Hospice

Enter the appropriate code from the following list to indicate the service category recommended to meet the need.

3. Duration

Enter the Start and End Dates for the proposed service.

4. Unit Code

Enter the unit of time which is used in calculating the cost of this service, using the following list.

- | | | |
|----------------|---------------|-------------------|
| 1 = 15 minutes | 6 = Week | 11 = Installation |
| 2 = 1/2 hour | 7 = Month | 12 = Lifetime |
| 3 = hour | 8 = Visit | 13 = PRN Hour |
| 4 = day | 9 = Mile | 14 = PRN Visit |
| 5 = night | 10 = Per trip | 15 = Annual |

5. Number of Units

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

6. Rate

Enter the current rate for this service based on the maximum allowable MaineCare rate for that specific unit of service as found in the appropriate MaineCare manual.

7. Total Cost

Calculate the total cost per month for this service.

2. Service Category

- 1- Administrative care management
- 2- Face-to-face care management
- 4- Personal care assistant (hour)
- 5- Personal care assistant (live-in)
- 6- Personal care assistant (night)
- 7- Homemaker
- 8- RN-visit
- 9- RN-hour
- 10- LPN-visit
- 11- LPN-hour
- 12- Home health aide-visit
- 13- Home health aide-hour
- 14- Certified nurse's aide-visit
- 15- Certified nurse's aide-hour
- 16- Physical therapy-visit
- 17- Physical therapy-hour
- 18- Occupational therapy-visit
- 19- Occupational therapy-hour
- 20- Speech therapy-visit
- 21- Speech therapy-hour
- 22- Emergency response
- 23- Emergency response installation
- 24- Psychiatric RN-visit
- 25- Master's social work-visit
- 26- Master's social work-hour
- 27- Social services
- 28- Transportation
- 32- Family
- 33- Friend
- 34- Residential care
- 35- Independent living assessment
- 36- Certified occupational therapy aide
- 37- Certified physical therapy aide
- 39- Comprehensive care management
- 40- Environmental mods
- 41- Licensed speech therapy assistant
- 42- Psychiatric medication services
- 43- Health assessment
- 44- Institutional respite-NF
- 45- Institutional respite-residential care
- 46- Personal care assistant (visit)
- 47- Independent RN
- 48- Family Provider
- 49- RN Multiple
- 50- LPN Multiple
- 51- Care Management-PDN
- 52- Care Management-CDAS
- 53- Independent PT
- 54- Independent OT
- 55- Independent Speech
- 56- Personal care assistant (hour)(PDW)

Agency Name: _____ Applicant Name: _____

Assessment Date: — —
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1. CHECK ALL THAT APPLY:

- A: There are adult family members, kin or close family friends who help in caring for the child.**

Who are the adults living at home with the child? Please include their relationship to the child. (i.e., John-Father, Sue-oldest sister, etc.)

Please describe how parents or other family or kin meet the child's complex health needs. What have they been trained to do to meet the child's complex care needs? (i.e., tube feedings, suctioning, seizure protocols, etc.): _____

Please describe when the adults in the family help to care for the child (i.e., activities they assist with and regular days/times during the week care is provided): _____

- B: Parents and adult family members are currently unable to provide care for the child.
(i.e., due to disability or other reason).**

Please describe the care that adult family members or kin need training to provide, are unable to provide or learn to provide and the reason:

Is this situation time-limited? (i.e., due to armed forces deployment of a parent, hospitalization of a parent, etc) Is the situation expected to resolve? No Yes, Date: _____

- C: Parents and adult family members who have provided care to the child in the past are unable to provide more care or need more help.**

Please describe the needs of the child that are unable to be met: _____

Agency Name: _____ Applicant Name: _____

Assessment Date: — —
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NPI #:

STANDARD NURSING NOTES

Information provided by: _____

Location of Assessment: _____

ADL Abilities:

Nursing Services:

Adaptive Equipment:

Description of Child:

Brief HX of Current Illness:

Behavior Problems:

Agency Name: _____

Applicant Name: _____

Assessment Date: — —
Month Day Year

Social Security #: — —

NPI #:

STANDARD NURSING NOTES

Legal Problems/Parole/School Suspension:

Current Treatment/Therapies: (IEP, OT/PT/SLT/DT/Professional Services,etc):

Documentation Provided?

Activities (school/home):

Other:

KB Eligible: **PDN Eligible** **Denial**

Level: _____

Copies of documents given (list documents):
