Assessment Date:		NPI #:	
Name of Person Completing Assessment:		Assessor's Title:	
Agency Name:		Telephone #:	

Section A – Identification and Background Information

1.	**Child's Name:**						
2.	**Child's Address:**	Street:					
		City/Town:		State:		Zip Code:	
		County :		Telephone:			
3.	**Social Security #**			**MaineCare #**			
4.	**Reason for Assessment:**	1 = Initial 2 = Reassessment	3 = Significant Change in Health Status 4 = Other				
5.	**Has the member been admitted to a hospital since the beginning of the previous authorization?**	1 = no hospitalizations 2 = yes, one time 3 = yes, two or three times	4 = four or more times 5 = new admission (item 4 = 1)				
6.	**Gender**	1 = Male 2 = Female					
7.	**Race/Ethnicity (Optional)**	1 = American Indian/Alaskan 2 = Asian/Pacific 3 = Black	4 = Hispanic 5 = White 6 = Other				
8.	**Birth Date**						
9.	**Citizenship**	1 = U.S. Citizen 2 = Legal Alien	3 = Other				
10.	**Primary Language**	0 = English 1 = French	2 = Spanish 3 = Other				
11.	**Parent #1 Identifying Information**	Name:					
		Address/Street:					
		City/Town:		State:		Zip Code:	
		County:					
		Home Telephone:		Work Telephone:			
12.	**Parent #2 Identifying Information**	Name:					
		Address/Street:					
		City/Town:		State:		Zip Code:	
		County:					
		Home Telephone:		Work Telephone:			
13.	**Legal Guardian's Identifying Information (If different from above.)**	Name:					
		Address/Street:					
		City/Town:		State:		Zip Code:	
		County:					
		Home Telephone:		Work Telephone:			

Agency Name:		Applicant Name:	
Assessment Date:		MaineCare #:	
NPI # :			

Section A – Identification and Background – Cont'd

14.	**No. in Household** (Include Applicant)	Other than in institution or residential care facilities							
15.	**Parent Contact (Check all that apply.)**	Who can be contacted with questions?							
			Parent #1		Parent #2		Legal Guardian		Other
16.	**Physician Contact (Primary Care)**	Name:							
		Address/Street:							
		City/Town:		State:		Zip Code:			
		Telephone Number:							
17.	**Private Insurance**	Is child covered by private insurance? 0 = No, 1 = Yes							
		***** If yes, specify insurer:							
		If yes, provider policy #:							

*** Note: A copy of the Denied Explanation of Benefits from the primary insurance company must be included.**

Agency Name:		Applicant Name:	
Assessment Date:		MaineCare #:	
NPI # :			

Section B – Diagnosis

1.	**PSYCHIATRIC/BEHAVIORAL** Diagnosed by a certified professional. (Check all that apply) **Birth to Attainment of 6** Developmental and Emotional Disorders of Younger Infants + Preschool **Mental Retardation** – regardless of age **Ages 6 to 18** - Anxiety Disorders - Attention Deficit Hyperactivity Disorder - Autistic Disorder and Other Pervasive Development Disorders - Mood Disorders - Organic Mental Disorders - Schizophrenic Delusional (Paranoid), Schizoaffective, and other Psychotic Disorders - Somatoform, Eating, and Tic Disorders	**a.** Developmental and Emotional Disorders of Younger Infants & Preschool (Birth to attainment of 6)	
		b. Mental Retardation	
		c. Anxiety	
		d. Attention Deficit Hyperactivity Disorder	
		e. Autistic Disorder and Other Pervasive Developmental Disorders	
		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 1 Diagnoses and ICD Codes:	
		i.	
		ii.	
		iii.	
		iv.	
		v.	
		vi.	
		k. NONE OF THE ABOVE	

Agency Name:		Applicant Name:	
Assessment Date:		MaineCare #:	
NPI # :			

Section B – Diagnosis (cont'd)

2. **Medical** (Check all that apply)

	a. Allergies **specify**:		**o.** Osteoporosis	
			p. Paraplegia	
			q. Pathological bone fracture	
			r. Quadriplegia	
	b. Amputation		**s.** Renal failure	
	c. Anemia		**t.** Scoliosis	
	d. Arthritis		**u.** Seizure Disorder	
	e. Asthma/Respiratory disorder		**v.** Spina Bifida	
	f. Cancer		**w.** Traumatic brain injury	
	g. Cardiovascular disease		**x.** Tuberculosis	
	h. Cerebral Palsy		**y. Other** Current Medical Diagnoses and ICD Codes	
	i. Cleft Lip and/or Palate		i.	
	j. Cystic Fibrosis		ii.	
	k. Diabetes		iii.	
	l. Explicit terminal prognosis		iv.	
	m. Hemophilia		v.	
	n. HIV/AIDS		**z. NONE OF THE ABOVE**	

Agency Name:		Applicant Name:	
Assessment Date:		MaineCare #:	
NPI # :			

SECTION C – Physical Functioning

1. ADL SELF-PERFORMANCE - *Column 1 at right*

Column 1 Code *for performance during the last 30 days*

0 = Independent

1 = Supervision – Oversight, encouragement or cueing provided 3 + times during last 30 days – OR – Supervision plus nonweight- bearing physical assistance provided only 1 or 2 times during last 30 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 30 days.

3 = Extensive assistance – While child performed part of activity, over last 30-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 30 days.

4 = Total dependence – Full caregiver performance of activity during the **ENTIRE** 30 days.

5 = Cueing – Spoken instructions or physical guidance which serves as a signal to do an activity are required **EVERY DAY**.

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

8 = Activity did not occur during entire 30 days.

AA = Age Appropriate

2. ADL SUPPORT PROVIDED – *Column 2 at far right*

Column 2 Code for MOST SUPPORT PROVIDED OVER EACH 24 HOUR PERIOD during the last 30 days; code regardless of child's self-performance classification.

0 = No setup or physical help
1 = Setup help only
2 = One person physical assist
3 = Two + persons physical assist
5 = Cueing – Cueing support required **EVERY DAY**
6 = Needs guidance/supervision due to inability to perform without potential harm to self
8 = Activity did not occur during entire 30 days
AA = Age Appropriate

	SELF-PERFORMANCE	SUPPORT
	1	2
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. EATING/DRINKING (how child eats and drinks regardless of skill)		
e. 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)		
f. DRESSING (how child puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis)		
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)		

Agency Name:		Applicant Name:	
Assessment Date:		MaineCare #:	
NPI # :			

SECTION C – Physical Functioning (cont'd)

	1	2
h. BATHING How child takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing back and hair). [Code for most dependent in self-performance and support. Bath self-performance codes appear below.]		
0 = Independent – No help provided **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 **EVERY DAY** **6 =** Needs Guidance/Supervision Due to Inability to Perform Without Potential Harm to Self **7 =** Activity Did Not Occur During Entire 30 days. **AA = Age Appropriate**		
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 **1 =** Wheelchair **2 =** Walker **3 =** Splints or braces **4 =** Prosthetics **5 =** Orthopedic shoes **6 =** Cane/crutch **7 =** Scooting board **8 =** Other: **9 =** NONE OF THE ABOVE		

Agency Name:		Applicant Name:	
Assessment Date:		MaineCare #:	
NPI # :			

SECTION D – Professional Nurses Services and Treatments

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 registered professional nurse:

0 = Condition/treatment not present in the last 30 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/7days a week
7 = Twice a month
8 = More than once per day
9 = As needed (PRN)

		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. Gastrosomy tube	
	c. Jejunostomy tube	
3. SUCTIONING/TRACHCARE *	**a.** Nasopharyngeal suctioning	
	b. Tracheostomy care for a new/recent (within 30 days) or an unstable condition. **Insertion 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. 2nd or 3rd 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 or for a new/recent (within 30 days) condition. **Start date:**		
6. ASSESSMENT/MANAGEMENT * RN assessment, observation and management required for unstable medical conditions. Specify condition and code for child's need. **Please specify:**		

Agency Name:		Applicant Name:	
Assessment Date:		MaineCare #:	
NPI # :			

SECTION D – Professional Nurses Services and Treatments (Cont'd)

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. (i.e., grand mal)	

11. TREATMENTS – CHRONIC CONDITIONS * Administration or treatments, procedures, or dressing changes which involve prescription medications, for post-operative or chronic conditions according to physician orders.	**a.** Medications via tube	
	b. Feedings via tube	
	c. Tracheostomy care-chronic	
	d. Inhalation medications	
	e. Chest PT	
	f. Oxygen therapy for chronic condition	
	g. Venipuncture	
	h. Monthly injections	
	i. Urinary catheter insertion	
	j. Urinary catheter irrigation	
	k. Barrier dressing for Stage 1 or 2 ulcers	
	l. Observation and assessment for a chronic condition	
	m. Other Physician(s) ordered Tx:	
	n. Teach/train – Specify	

*** Supporting Documentation Required for 1-6, 9, 10, & 11, or any other item required more than once per day.**

Agency Name:		Applicant Name:	
Assessment Date:		MaineCare #:	
NPI # :			

SECTION E – Medication List

List all medications given during the last 60 days. Include all PRN, prescription and over-the-counter medications. **DO NOT** include nutritional supplements.

1. **List the medication name, dosage, and frequency.**
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 (SC) **7 =** topical **9 =** enteral tube
   2 = sublingual (SL) **4 =** intravenous (IV) **6 =** rectally **8 =** inhalation **10 =** other
5. **TIMES OF ADMINISTRATION: The exact times** the medication is given, include an "A" for A.M. or a "P" for P.M.
6. **PRN-n** (number of doses):
   If the frequency is "PRN", 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, Dosage, and Frequency	2. N/C/D	3. Date of N/C/D	4. Route of Administration	5. Times of Administration	6. PRN-Number of Times

Agency Name:		Applicant Name:	
Assessment Date:		MaineCare #:	
NPI # :			

SECTION E – Medication List – Addendum

CHECK THIS BOX IF YOU DO NOT USE THIS PAGE

List all medications given during the last 60 days. Include all PRN, prescription and over-the-counter medications. **DO NOT** include nutritional supplements.

1. **List the medication name, dosage, and frequency.**
2. **New (N), changed (C), or discontinued (D) medications with 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 (SC) **7 =** topical **9 =** enteral tube
   2 = sublingual (SL) **4 =** intravenous (IV) **6 =** rectally **8 =** inhalation **10 =** other
5. **TIME OF ADMINISTRATION: The exact times** the medication is given, include an "A" for A.M. or a "P" for P.M.
6. **PRN-n** (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, Dosage, and Frequency	2. N/C/D	3. Date of N/C/D	4. Route of Administration	5. Times of Administration	6. PRN Number of Times

Agency Name:		Applicant Name:	
Assessment Date:		MaineCare #:	
NPI # :			

SECTION E – Medication List – Addendum

CHECK THIS BOX IF YOU DO NOT USE THIS PAGE

List all medications given during the last 60 days. Include all PRN, prescription and over-the-counter medications. **DO NOT** include nutritional supplements.

1. **List the medication name, dosage, and frequency.**
2. **New (N), changed (C), or discontinued (D) medications with 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 (SC) **7 =** topical **9 =** enteral tube
   2 = sublingual (SL) **4 =** intravenous (IV) **6 =** rectally **8 =** inhalation **10 =** other
5. **TIME OF ADMINISTRATION: The exact times** the medication is given, include an "A" for A.M. or a "P" for P.M.
6. **PRN-n** (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, Dosage, and Frequency	2. N/C/D	3. Date of N/C/D	4. Route of Administration	5. Times of Administration	6. PRN Number of Times

Agency Name:		Applicant Name:	
Assessment Date:		MaineCare #:	
NPI # :			

SECTION F - Medication Preparation and Administration

1. PREPARATION/ADMINISTRATION (Choose only one)

Did child prepare and administer his/her medication in last the 30 (thirty) days?

0 = Child prepared and administered ALL of his/her own medications

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 30 days.

4 = Child did not prepare, but administered SOME of his/her own medications

5 = Child requires administration of medications due to severe and disabling mental illness.

AA = Age Appropriate – It would not be age-appropriate for the child to do this.

2. COMPLIANCE (Choose only one) *

Child's level of compliance with medication prescribed by a physician/psychiatrist in the last 30 (thirty) days:

0 = 100% of prescribed medications were administered.

1 = 75% of prescribed medications were administered.

2 = 50% of prescribed medications were administered.

3 = 25% of prescribed medications were administered.

4 = 0% of prescribed medications were administered.

AA = Age Appropriate – It would not be age-appropriate for the child to do this.

*** Documentation required if you coded Compliance with a 1, 2, 3, or 4**

Agency Name:		Applicant Name:	
Assessment Date:		MaineCare #:	
NPI # :			

SECTION G – Cognition

1.	**MEMORY** (Recall of what has learned or known) **0 =** Memory OK **1 =** Memory problems **2 =** Nurse unable to determine **AA =** Age Appropriate	**a.** Short-term memory – seems/appears to be 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 30 days.) **AA =** Age Appropriate	**a.** Current season	
		b. Location of own room	
		c. Names/faces	
		d. Where he/she is	
		e. Nurse unable to determine	
		f. None of the above	
3.	**COGNITIVE SKILLS FOR DAILY DECISION MAKING** (Choose only one.) **Made decisions regarding tasks of daily life.** **0 =** INDEPENDENT – decisions consistent/reasonable **1 =** MODIFIED INDEPENDENCE – some difficulty in new situations only **2 =** MODERATELY IMPAIRED – decisions poor; cues/supervision required **3 =** SEVERLY IMPAIRED – never/rarely makes decisions or nurse unable to determine **AA =** Age Appropriate		
4.	**MEMORY AND USE OF INFORMATION:** **0 =** Does not have difficulty remembering and using information. Does not require directions **1 =** Has minimal difficulty remembering and using information. Requires direction and reminding from others one (1) to three (3) times per day. Can follow simple written instructions **3 =** Has difficulty remembering and using information. Requires direction and reminding from others four 4 or more times per day. Cannot follow written instructions. **4 =** Cannot remember or use information. Requires continual verbal reminding. **AA =** Age Appropriate		
5.	**COMMUNICATION** **0 =** Speaks normally. **1 =** Minor difficulty with speech or word-finding difficulties **2 =** Able to carry out only simple conversations **3 =** Non verbal **4 =** Able to make needs known **5 =** Sign language/gesture **6 =** Communication device **AA =** Age Appropriate		
	TOTAL COGNITIVE SCORE →		0

Agency Name:		Applicant Name:	
Assessment Date:		MaineCare #:	
NPI # :			

SECTION H - Behavior

1.	**PROBLEM BEHAVIOR** **Code:** Frequency of the behavior in <u>the last 30 days.</u> **0 =** Behavior not exhibited in last 30 days. **1 =** Behavior of this type occurred 1 to 3 days per week during the last 30 days. **2 =** Behavior of this type occurred 4-6 days per week, but not daily, during the last 30 days**.** **3 =** Behavior of this type occurred daily or more than once per day. **4 =** Nurse unable to determine **AA =** Age Appropriate	**a. WANDERING** (moved with no rational purpose, seemingly oblivious to needs or safety.)	
		b. VERBALLY ABUSIVE (others were threatened, screamed at, cursed at.)	
		c. PHYSICALLY ABUSIVE (others were hit, shoved, scratched, sexually abused.)	
		d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIOR (made disruptive sounds, noisy, screams, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings.)	
		e. RESISTS CARE (resisted taking medications/injections, ADL assistance or eating.)	
2.	**SLEEP PATTERNS:** **0 =** Unchanged from "normal" for the child. **1 =** Sleeps noticeably more or less than "normal". **2 =** Restless, nightmares, disturbed. **3 =** Up wandering for all or most of the night, inability to sleep. **4 =** Nurse unable to determine **AA =** Age Appropriate		
3.	**WANDERING:** **0 =** Does not wander, or is chair / bed bound **1 =** Wanders within residence and may wander outside, but does not jeopardize health and safety. **2 =** Wanders within residence. May wander outside, health and safety may be jeopardized. Does not have history of getting lost and is not combative about returning. **3 =** Wanders outside and leaves grounds. Has a consistent history of leaving grounds, getting lost or being combative about returning. **4 =** Exit Seeking **AA =** Age Appropriate		

Agency Name:		Applicant Name:	
Assessment Date:		MaineCare #:	
NPI # :			

SECTION H - Behavior (cont'd)

4. **BEHAVIORAL DEMANDS ON OTHERS:**

0 = Attitudes, habits, and emotional states **are not** creating stressors in the individual's living arrangement and companions.
1 = Attitudes, habits, and emotional states **are** creating stressors in the individual's living arrangement and companions.
2 = Attitudes, disturbances, and emotional statutes create consistent difficulties that are modifiable to manageable levels. The child's behavior can be changed to reach the desired outcome through respite, in-home services, or existing facility staffing.
3 = Attitudes, disturbances, and emotional states create consistent difficulties that are not modifiable to manageable levels. The child's behavior cannot be changed to reach the desired outcome through respite, in-home services, or existing facility staffing.
AA = Age Appropriate

5. **DANGER TO SELF AND OTHERS:**

0 = Is not disruptive or aggressive, and is not dangerous.
1 = Is not capable of harming self or others because of mobility limitations (is bed or chair bound).
2 = Is sometimes (1 to 3 times per week) disruptive or aggressive, either physically or verbally, or is sometimes extremely agitated or anxious, even after proper evaluation and treatment.
3= Is frequently (4 or more times per week) disruptive or aggressive, or is frequently extremely agitated or anxious; and professional judgment is required to determine when to administer prescribed medication.
4 = Is dangerous or physically abusive, and even with proper evaluation and treatment may require physician's orders for appropriate intervention.
AA = Age Appropriate

6. **AWARENESS OF NEEDS AND USE OFJUDGMENT:**

0 = Understands those needs that must be met to maintain self care.
1 = Sometimes (1 to 3 times per week) has difficulty understanding those needs that must be met but will cooperate when given direction or explanation.
2 = Frequently (4 or more times per week) has difficulty understanding those needs that must be met but will cooperate when given direction or explanation.
3 = Does not understand those needs that must be met for self care.
4 = Will not cooperate even though given direction or Explanation.
5 = Nurse unable to determine
AA = Age Appropriate

TOTAL BEHAVIOR SCORE → **0**

Agency Name:		Applicant Name:	
Assessment Date:		MaineCare #:	
NPI # :			

SECTION I – Communication, Hearing, and Vision 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 **3 =** HIGHLY IMPAIRED – absence of useful hearing **4 =** No response to auditory stimuli		
2.	**COMMUNICATION** (Check all that apply during the last 30 days.) **AA =** Age Appropriate	**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. None of the above	
3.	**COMMUNICATION DEVICES TECHNIQUES** Check all that apply during the last 30 days. **AA =** Age Appropriate	**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	
4.	**SPEECH CLARITY** **0 =** CLEAR SPEECH – distinct, intelligible words. **2 =** NO SPEECH – absence of spoken words. **1 =** UNCLEAR SPEECH – slurred, mumbled words. **AA =** Age Appropriate		
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 understands **AA =** Age Appropriate		
6.	**ABILITY TO UNDERSTAND OTHERS** (Choose only one.) **0 =** UNDERSTANDS (understands speaker's message). **1 =** USUALLY UNDERSTANDS (may miss some of part/intent of message) **2 =** SOMETIMES UNDERSTANDS (responds adequately to simple, direct communication) **3 =** RARELY/NEVER UNDERSTOOD **4 =** NONE OF THE ABOVE **AA =** Age Appropriate		

Agency Name:		Applicant Name:	
Assessment Date:		MaineCare #:	
NPI # :			

SECTION I – Communication, Hearing, and Vision Patterns (cont'd)

7.	**VISION** (Choose only one) **0 =** ADEQUATE - No documented visual abnormality. **1 =** ADEQUATE - WITH CORRECTIVE DEVICE. **2 =** IMPAIRED - Documented visual abnormality. **3 =** Eyes do not appear to follow objects.		
8.	**VISUAL APPLIANCES**	**0 =** No **1 =** Yes	
		a. Glasses and/or contact lenses	
		b. Artificial eye	
		c. Other:	

Agency Name:		Applicant Name:	
Assessment Date:		MaineCare #:	
NPI # :			

SECTION J – Height & Weight

1.	**HEIGHT** Record Height in inches **WEIGHT** Record weight in pounds Base weight on most recent measure in last 30 days Measure weight consistently in accordance with standard practice (e.g. in a.m. after voiding, before meal, with shoes off, and in nightclothes). BMI (Optional)	**Specify measurement date:** **Specify measurement date:**
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 = Intended** weight-**gain** – 5% or more in last 30 days; or 10% in last 180 days. **3 = Unintended** weight **loss**-5% or more in last 30 days; or 10% or more in last 180 days. **4 = Intended** weight **loss** – 5% or more in last 30 days; or 10% or more in last 180 days.	**Specify previous weight:** **Date measured:**

Agency Name:		Applicant Name:	
Assessment Date:		MaineCare #:	
NPI # :			

SECTION K – Nutrition

1.	**NUTRITIONAL APPROACH – Oral**		
	a = Oral diet (Specify regular or therapeutic)		
	b = Oral supplement (Specify)		
	c = Thickened liquids (Specify consistency)		
	d = NPO		
2.	**NUTRITIONAL APPROACH – Enteral**		
	a = Enteral diet - Specify Formula, Frequency, Amount, Schedule, Pump, or Gravity:		
	b = Enteral supplement (Specify)		
	c = Hydration Bolus (Specify times and/or frequency)		
	d = Enteral diet provides less than 50% of daily calories		
	e = Enteral diet provides 50% or more of daily calories		
	f = TPN (Total Parental Nutrition)		
	g = Not applicable		
3.	**NUTRITIONAL PROBLEMS – Oral**	**a.** Complains about the taste and texture of many foods	
		b. Chewing, swallowing problem	
		c. gagging and/or vomiting	
		d. Regular or repetitive complaints of hunger	
		e. Noncompliance with diet	
		f. aspiration risk	
		g. Food Allergies (**specify)**	
		h. Restrictions (**specify)**	
		i. none of the above	
4.	**NUTRITIONAL PROBLEMS – Enteral**	**a.** No complications	
		b. Aspiration risk	
		c. Gagging	
		d. Vomiting	
		e. Diarrhea	
		f. Venting of tube (Specify frequency)	

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SECTION L – Continence in Last 30 Days

1.	**URINARY CONTINENCE in the last 30 days**	**a. Continent** – complete control	
		b. Usually continent – incontinent episodes once a week or less	
		c. Occasionally incontinent – incontinent episodes 2 or more times per week but not daily	
		d. Frequently incontinent – tends to be incontinent daily, but some control present.	
		e. Incontinent – incontinent all or almost all of the time.	
		f. Age appropriate urinary incontinence	
2.	**Bowel Continence in the past 30 days**	**a. Continent** – complete control	
		b. Usually continent – incontinent episodes less than weekly	
		c. Occasionally incontinent – incontinent episodes once a week	
		d. Frequently incontinent – tends to be incontinent 2-3 times per week	
		e. Incontinent – incontinent all or almost all of the time.	
		f. Age appropriate bowel incontinence	
3.	**Appliances and Programs for Urinary Management** (Check all that apply.)	**a.** External (condom) catheter	
		b. Catheter-frequency:	
		c. Pads/briefs used	
		d. Ostomy present	
		e. Scheduled toileting	
		f. Age appropriate toilet training	
		g. Age Appropriate Incontinence	
		h. none of the above is applicable	
4.	**Appliances and Programs for Bowel Management** (Check all that apply.)	**a.** Pads/briefs used	
		b. Ostomy present	
		c. Scheduled toileting	
		d. Age appropriate toilet training	
		e. Age appropriate incontinence	
		g. none of the above is applicable	

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SECTION M – Skin Condition

1.	**ULCERS -** due to any pressure or circulation. Record the number of ulcers at each ulcer stage - regardless of cause. If none present at a stage, record **"0" (zero).**	**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.		
	e. UNSTAGEABLE – due to non removable dressing, slough, eschar, or suspected deep tissue injury.		

2.	**SKIN PROBLEM** (Check all that apply.) Any troubling skin conditions or changes <u>in the last 30 days?</u>	**a.** Abrasions (scrapes) or cuts	
		b. Burns	
		c. Bruises	
		d. Rash	
		e. Body lice or scabies	
		f. Itchiness	
		g. Irritation related to yeast, skin fold issues, or incontinence	
		h. Surgical wound	
		i. Surgical drain	
		j. Cast (Specify location)	
		k. Infection (Specify)	
		l. Other:	
3.	**FOOT PROBLEMS AND CARE** **0 =** No **1 =** Yes	**a.** Foot problems or infections such as corns, calluses, bunions, hammer toes, overlapping toes, pain, structural problems, gangrene toe, foot fungus, onychomycosis?	

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PDN Level of Care – I (Continue scoring each section until there is a "no" as a final score in any section.)		**YES**	**NO**
PDN LEVEL I	**A.** In Clinical Detail, Section C, Physical Functioning, were d, e, f, and h (eating/drinking, toilet use, dressing, and bathing) all coded with a '5' (cueing) in Self-Performance **AND** Support? **OR**		
	B. In Clinical Detail, Section C, Physical Functioning, were 2 of the following ADL's (bed mobility, transfer, locomotion, eating/drinking, toilet use, bathing, or dressing) coded with a 2, 3, or 4 in Self-Performance **AND** a 2 or 3 in Support?		
	C. In Clinical Detail, Section D, were any of the items 1-5 or 7-11 coded to indicate nursing services were needed at least one time per month?		
	*If A **or** B **or** C is checked as yes the child **appears** to be eligible for PDN Level I.*		

PDN Level of Care - II		**YES**	**NO**
PDN LEVEL II	**A.** In Clinical Detail, Section C, Physical Functioning, were d, e, f, and h (eating/drinking, toilet use, dressing, and bathing) all coded with a '5' (cueing) in Self-Performance **AND** Support? **OR**		
	B. In Clinical Detail, Section C, Physical Functioning, were 2 of the following ADL's (bed mobility, transfer, locomotion, eating/drinking, toilet use, bathing, or dressing) coded with a 2, 3, or 4 in Self-Performance **AND** a 2 or 3 in Support? **AND**		
	C. In Clinical Detail, Section D, were any of items 1 – 11 coded to indicate nursing services are needed at least one time per month?		
	*If A **or** B is checked as yes **AND** C is coded yes, the child **appears** to be eligible for PDN Level II.*		

PDN Level of Care - III		**YES**	**NO**
PDN LEVEL III	**A.** In Clinical Detail, Section C, Physical Functioning, were 2 of the following 5 Shaded ADLs (bed mobility, transfer, locomotion, eating/drinking, toilet use) coded with a 2, 3, or 4 in Self-Performance **AND** a 2 or 3 in Support? **AND**		
	B. In Section D, were any of items 1 – 11 coded to indicate nursing services are needed at least one time per month?		
	*If A **AND** B are checked as yes, the child **appears** to be eligible for PDN Level III.*		

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PDN Level of Care - IV		YES	NO
PDN LEVEL IV	**a.** In Section D, Professional Nursing Services, items 1-5, 7, or 8, did you code any of the responses with a 4 (i.e., services needed 7 days per week)? **OR**		
	b. In Section D, Professional Nursing Services, item 6, did you code a response of 6 (services needed at least every eight (8) hours)? **OR**		
	c. In Section D, item 9 (Ventilator/Respirator) did you code this response with a 2, 3, or 4 (care needed at least 3 days per week? **OR**		
	d. in Section D, item 10 (Uncontrolled Seizure), did you code this response with a 1, 2, 3, or 4 (care needed at least one time per week? **OR**		
	e. In Section C (Physical Functioning), were 3 or more shaded ADLs coded with a 3 (extensive assistance) or a 4 (totally dependent) in self performance? (This does not include the "AA" code.)		
	*If the answer to **any** of these questions is "YES", then the child **appears** medically eligible for PDN Level IV.*		

PDN Level of Care - V		YES	NO
PDN LEVEL V	**1a.** In Section D, was one of the items from 1-4, 8, or 10 coded with a **6** indicating service needed at least once every 8 hours, 7 days a week? **AND**		
	1b. In Section D, were two (2) items from 1-4, 8, or 10 coded with a **4** indicating service needed 7 days per week.		
	*If the answer to **BOTH** 1a, and 1b is YES, then the child **appears** to be medically eligible for PDN Level V.*		
	2. In Section D, was item 9 (ventilator/respirator) coded with a 4 (nursing services needed 7 days a week)?		
	*If the answer is YES, then the child **appears** to be medically eligible for PDN Level V.*		

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STANDARD NURSING NOTES

Who provided the clinical details? *(check all that apply)*: ☐ parent #1 ☐ parent #2 ☐ RN caregiver ☐ LPN direct caregiver ☐ CNA direct caregiver ☐ agency RN ☐ care manager ☐ guardian ☐ other *(specify)*: _____

Who was present for the assessment?: *(check all that apply)*: ☐ parent #1 ☐ parent #2 ☐ child ☐ RN direct caregiver ☐ LPN direct caregiver ☐ CNA direct caregiver ☐ guardian ☐ other(s) *(specify)*: _____

1. Description of Child: (age, dx, characteristics, does the child attend school, etc.)

2. Adaptive Equipment:

3. ADL Abilities:

4. Nursing Services:

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STANDARD NURSING NOTES (cont'd)

5. Brief History of Current Condition:

6. Behavior Problems:

7. Required Documentation From Section D and Section G:

8. Activities (school/home):

9. Reasons for location of services other than home:

10. PDN Level of Care:		**Level I**		**Level II**		**Level III**		**Level IV**		**Level V**

11. Copies of Documents included (list documents):

	Plan of Care		
	IEP		
	Nurses notes		
	Task Time Allowance worksheet		
	Seizure Logs		
	Physician notes		
	Medication Administration Records (MAR)		

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Family Circumstances

CHECK ALL THAT APPLY:

☐ **12a.** List all members of the household and their relationship to the child:

☐ **12b.** Describe how parents or others have been trained to meet the child's complex care needs? (i.e., tube feedings, suctioning, seizure protocols etc.):

☐ **13.** Describe the training that is needed for family members to care for the child:

☐ **14.** Indicate reason(s) family members are unable to care for the child:

☐ **15.** What are parents expressing that they need help with, specifically, to support them in providing care for their child?

☐ **16.** Are there times when family is unavailable to provide care when assistance is needed?

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Family Circumstances (cont'd)

Indicate Hours of Work (i.e., 8 A – 5 P) **Includes travel time:** ☐ **Yes** ☐ **No**

17. For adults in the home	MON	TUES	WED	THURS	FRI	SAT	SUN
Person # 1							
Person # 2							
Person # 3							

18. Services: RN, LPN, CNA, PSS	**Start Date**	**End Date**	**Indicate Hours per Day**							**Total Hours per Week**	**Total Hours per Month**	**Total Cost**
			Sun	**Mon**	**Tues**	**Wed**	**Thu**	**Fri**	**Sat**			
RN per week										0		$0.00
LPN per week										0		$0.00
CNA per week										0		$0.00
PSS per week										0		$0.00
RN per month												$0.00
											Total cost per week (total all lines)	$0.00
											Total per month (total cost per week x 4.33)	$0.00
											Grand Total per month	$0.00

19. LOCATION OF SERVICES (Check all that apply)

Home ☐ School ☐ Medical Appointments ☐ Other ☐ _____

PLAN OF CARE MUST INDICATE LOCATION OF SERVICES, HOURS PER DAY, AND DAYS PER WEEK.

When the cost of services per calendar year exceeds the annual cap for the selected PDN level, documentation to justify exceeding the cap must be submitted.

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20. Attestation Statement:

I certify that the information submitted in this assessment accurately reflects this member and that I collected or coordinated collection of this information. To the best of my knowledge, this information was collected in accordance with applicable MaineCare requirements. I understand that this information is used as a basis for ensuring the member receives medically appropriate, quality care, and as a basis for payment from state and federal funds. I further understand that payment of such funds and continued participation in this program is contingent on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information on behalf of the agency listed above.

RN Signature: _____

Date: _____

The MED assessment tool shall be submitted to MaineCare Services, Quality Improvement Division **within 72 hours of completion** of the MED form, for initial assessments or reassessments. MaineCare payment ends with the reassessment date, also known as the eligibility end date. (MaineCare Benefits Manual, Chapter II, Section 96.07-2.B

The Department reserves the right to request additional information to evaluate medical necessity. (MaineCare Benefits Manual, Chapter II, Section 96.03.D)

Agency Name:		Applicant Name:	
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Addendum	**Enter item number from pages 24-27 and add additional information as needed**		**CHECK THIS BOX IF YOU DO NOT USE THIS PAGE**

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Addendum	**Enter item number from pages 24-27 and add additional information as needed**		**CHECK THIS BOX IF YOU DO NOT USE THIS PAGE**