



TEXAS A&M

HEALTH SCIENCE CENTER
SCHOOL OF RURAL PUBLIC HEALTH

PERSONAL CARE ASSESSMENT FORM (PCAF) USER'S MANUAL[©]

PREPARED FOR:
THE TEXAS HEALTH AND HUMAN
SERVICES COMMISSION

PREPARED BY:

TEXAS A&M HEALTH SCIENCE CENTER
SCHOOL OF RURAL PUBLIC HEALTH

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Revised Version, October, 2009

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PERSONAL CARE ASSESSMENT FORM (PCAF) AGES 4-20 and 0-3 USER'S MANUAL[©]:

ITEM-BY-ITEM INSTRUCTIONS FOR COMPLETING PCAF ASSESSMENTS

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Texas Health & Human Services Commission**

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WHO SHOULD YOU CONTACT: The only questions the development team can address relate to the proper completion of the PCAFs (e.g., how to code something; clarification of definitions; questions about data transmission). For these types of questions, you should contact Emily Naiser, who will be responsible for getting the answer you need and responding to you. In addition to answering questions, she will send out any needed clarifications to the DSHS in Austin for distribution.

All questions about the provision of services, Medicaid rules, or departmental policy must be addressed by your immediate supervisor.

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CHAPTER 1

PERSONAL CARE ASSESSMENT FORM[©]

ASSESSMENT PROCESS OVERVIEW

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1.1 Use of the PCAF: Some Guidelines

The PCAF is a standardized assessment tool developed for use in the Medicaid program of Texas to assess the needs of children seeking certain Medicaid services. For purposes of this User's Manual, we refer to those who complete the PCAF as "case managers."

Key points relative to completing PCAF assessment follow:

- The instrument is designed for use by case managers. **It is *not* a questionnaire.** The PCAF consists of items, definitions, and response codes. These should be used as a guide in helping the case manager complete the assessment in the client's home. Case managers are accustomed to engaging clients and caregivers/responsible adults in a conversation about their needs and their child's needs. The PCAF is simply a form that allows the case manager to assure that all appropriate areas of need are included in the discussion and provides a place to record the results of that discussion in a more structured manner.
- Sources of information may vary by item. However, in general the client/child (through observation and discussion) and the caregiver (or responsible adult for the older children) are the main sources of information. The case manager may need to gather information from both in order to decide which response is most accurate. The items require discussion with the client/child and caregiver (e.g., what is the child's date of birth; what type of assistance does the child receive with dressing). They do not require the case manager to perform "hands-on" tests (e.g., weighing the client/child or measuring height). Occasionally, the case manager may wish to access other information to ensure accurate responses (e.g., view the Medicaid card to record accurately the beneficiary number; view and count the number of medications, or review documents from a school, DSHS, or another agency).
- If information sources conflict on the proper response to an item, the case manager will need to use her or his professional skills to probe during additional discussion in an attempt to resolve any discrepancies. In the end, he or she will be required to make a reasoned, professional judgment about the "correct" response for a particular PCAF item.
- The items on the PCAF flow in a reasonable sequence, and this order could be followed in an assessment. However, case managers are not bound by the order of the items. The instrument should be seen as a framework for a discussion of the child's abilities and need for assistance – not a questionnaire with a fixed order and specified questions. Items may be reviewed in any sequence that works for the case manager and the person being assessed.
- Case managers must follow any protocols established by DSHS in terms of how they conduct assessments with children and family members/responsible adults.

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- Case managers must use a pen to fill out the PCAF forms.

1.2 Using the Manual

This manual provides information to facilitate an accurate and uniform assessment of clients covered by the Alberto N Settlement Agreement. These are children under the age of 21 who are eligible for EPSDT. As noted earlier, under the settlement agreement, this includes children with functional limitations or needs as a result of medical diagnoses or behavioral health diagnoses (even if they do not necessarily have an accompanying medical diagnosis). In Chapter 2, the manual provides item-by-item instructions for the PCAF for Clients aged 4 – 20. Chapter 3 provides comparable information for children aged 0 – 3. Chapter 4 provides guidance on how to move from the information on the PCAF instrument to a decision concerning services. As you will see, the item-by-item instructions usually focus on the following:

- **Intent.** The intent of items included on the PCAF (where needed).
- **Definition.** Supplemental definitions and instructions for completing PCAF items.
 - This includes reminders of the time frame that are relevant for the particular PCAF item. Note that the timeframe for all items – unless otherwise noted – is performance over the **last 7 days**.
- **Process.** Where necessary, the manual specifies the source of the information for specific items. Usually, this is done only if the source differs from the general instruction to view the caregiver or responsible adult as the primary source of information (e.g., you might ask to see the client's Medicaid card in order to record it correctly rather than simply having the caregiver or responsible adult recite it to you).
- **When you start using the PCAF, use this manual alongside the PCAF form.** Keep the manual handy. The PCAF form itself contains a wealth of information. Learn to rely on it for many of the definitions and procedural instructions necessary for a good assessment. At some point, you will no longer need the manual, except to refresh yourself on rare specific issues. However, **particularly as you start using the PCAF**, you will need to turn to the manual for clarifying information. The information in this manual should facilitate successful use of the PCAF forms.

1.3 Becoming Familiar with the PCAF

The bullet points that follow summarize the recommended approach for becoming familiar with the PCAFs. Your time investment in this multi-step review process will make you familiar with the PCAF assessment process, the items, and the response categories. This will lead to more accurate assessments and will reduce the time it takes to complete an assessment.

First, review the PCAF form itself.

- Notice how sections are organized and where information is to be recorded.
- Work through each PCAF one section at a time.
- Examine item definitions and response categories.
- Note that the relevant time frame for all items – unless otherwise designated – is performance during the **last 7 days**.
- Review procedural instructions, time frames, and general coding conventions.

Second, complete an initial review of Chapters 2 & 3 — the Item-by-Item Definitions for ages 4-20 and 0-3.

- It will take time to go through all this material. Do it slowly. Do not rush. Work through the PCAFs one section at a time.
- Are you surprised by any PCAF definitions, instructions, or case examples? For example, do you understand how to code Activities of Daily Living (ADLs) or the Communication items? The manual can assist you.
- Are there definitions or instructions for PCAF items that differ from current practice patterns in your agency?
- Make notations next to any section(s) you have questions about. Be prepared to discuss these issues during the training program you attend.

Third, review Chapter 4, which emphasizes how to move from the information on the PCAFs to service and referral decisions.

1.4 Future Use of Information in this Manual

- Keep this manual at hand during the assessment process.
- Where necessary, review the intent of each item and any responses, definitions or process instructions that would clarify an item.
- This manual is a source of information and support for you. Use it to increase the accuracy of your assessments.

1.5 Process for Initiating the PCAF Assessment

The PCAF is not a questionnaire. The process of assessment always involves talking with and observing the client/child or potential client/child and talking with the client's/child's caregiver. Like all encounters, the PCAF can open with any of a series of optional introductory or "ice-breaking" questions that can begin a dialogue with the person and his or her family. Indeed, such questions may in themselves elicit information you need to complete the assessment. It is helpful to explain what you are doing (e.g., "Today I am going to ask you a series of questions in order to see where your child is at today"). Other recommendations include referring to the child by name, keeping the child's strengths on the table, and providing an opportunity for caregivers to add additional information (e.g., at the conclusion of the interview, ask "Is there anything else you can tell me that would be helpful?").

1.6 Ordering the Sequence of the Assessment

When conducting a PCAF assessment, you need to consider the order in which the items in the PCAF assessment will be addressed. The response codes for many of the items may emerge at any point in your discussion with the client or caregiver. Thus, you may decide on the order in which specific topics or items are discussed. There is *not* one, specified order in which the sections of the PCAF should be completed. Being familiar with the PCAF is helpful, as information that may be provided by the caregiver while talking about one section may also provide needed information for another section. For example, in talking with a caregiver about medical diagnosis, he or she may also give information about continence. When you become familiar with the PCAF assessment tool, you will be able to move smoothly between sections as the information is presented.

At the same time, you may wish to consider issues related to achieving accurate assessments. For example, the client's or responsible person's cognitive function and communication skills may affect both the reliability of the information you can get and the need to speak to one or more other informants, such as another family member or caregiver.

Thus, you may reasonably decide to address cognition and communication at the outset -- which is why these items appear "early" in the assessment. You also need to be sensitive to the person's reaction to the "ice-breaker" questions. He or she may start to discuss issues of importance to him/her in response to one of your introductory questions, and the direction and content of that response may determine the order in which you cover PCAF items. While you will want to be sensitive to the informant and her or his way of presenting information, care should be taken to cover all the sections. When first learning the instrument, it may be most helpful to gather the information in sequential order.

CHAPTER 2

ITEM-BY-ITEM DEFINITIONS FOR THE PCAF 4-20[©]

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Item-By-Item Definitions for the PCAF 4-20

GENERAL FORMAT FOR ITEMS

To facilitate completion of the PCAF assessment and to ensure consistent interpretation of items, this chapter presents the following types of information for many (**but not all**) items:

Intent:	Purpose of the item, and sometimes, reason(s) for including the item (or set of items) in the PCAF
Definition:	Explanation of key terms
Process:	Sources of information and methods for determining the correct response for an item. The <i>usual</i> sources include: <ul style="list-style-type: none">▪ Interview with and observation of the client/applicant▪ Discussion with the client's family
Code:	Proper method of recording each response, with explanations of individual response categories

CODE ACCORDING TO THE DEFINITIONS: Please be sure to follow the item and response definitions when completing this assessment. Code all responses accurately without regard to any concerns about whether or how this item and response might affect PCS eligibility, services, or referrals. In general, no one functional assessment item determines eligibility or the number of hours that might be authorized.

What Should the Case Manager Do If Needed Information to Code a Response Is Unavailable and Will Remain Unavailable: If, despite your best efforts, the information you need to code an item is unavailable and will remain unavailable, you should record a "9" in the response box. Please use this code **sparingly, if at all**. If you do use it, you should write a rationale/explanation about why the information was unavailable on the blank part of the PCAF (e.g., by the item or in the notes section at the end), indicating the PCAF Item Number.

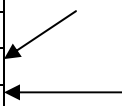
For example, if the client is aphasiac or has significant communication deficits as a result of autism and cannot respond and is living with a new foster family, you may be unable to get information on the client's "urgent health service use in the last 30 days." In such a case, record a "9" in the response box for those items.

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Coding Example:

Code: 0 = No 1 = Yes, condition active and diagnosed

C.1	MEDICAL DIAGNOSES	
a.	Anemia	0
b.	Apnea	0
c.	Asthma/respiratory disorder	0
d.	Cancer	0
e.	Cerebral Palsy	0
f.	Cleft lip or palate	0
g.	Congenital heart disorder	0
h.	Cystic Fibrosis	1
i.	Diabetes	1



- Throughout the instrument there are many items consisting of large three column tables containing numerous diagnoses, conditions, behaviors, treatments, programs, and so on. In the example table above, “C.1 Medical Diagnoses” is the general item, and in this example the rows labeled a-i contain the diagnoses.
- In the example table above, it has been determined that the client being assessed has two conditions that are current and actively affect his or her functional or health needs and have been diagnosed by a medical professional, Cystic fibrosis and Diabetes. For these two diagnoses, the assessor should code “1” (Yes) in the corresponding right hand column space for the two diagnosed conditions as shown. For all the other diagnoses listed, the assessor should code “0” (No), indicating that the client has not been diagnosed with the condition.
- Each item on the PCAF form should have a code for the appropriate response recorded on the form. A blank item that has not been considered and a blank item that is not a problem can’t be distinguished from one another. **Thus, no item should be left blank. Before placing the assessment in the file, review it to make sure there are no blanks.**
- In any instance that the response - “Other (specify)” - is used, use the available space in the instrument to record the detail. Simply begin the text of the detailed information with the item number (e.g., on PCAF 4-20 instrument, for the item M.8.O concerning other durable medical equipment, you could write in an item of DME that is not listed but is needed by the child).

NOTE:

The relevant time frame for all items is the last 7 days, unless otherwise specified in the form or the manual.

SECTION AA

CLIENT/CASE MANAGER INFORMATION

The information in Section AA is descriptive, factual information required by the Department of State Health Services. No instruction on the completion of these items is included in this manual.

SECTION A

OTHER PROGRAM/AGENCY INVOLVEMENT

A.1 Other Program/Agency Involvement

Intent: To identify any other agencies/programs (e.g., DARS, DADS, WIC, ECI, MRA, MHA, CPS, IHFS, Waiver program, etc.) with which the client or his/her family is involved.

Code: Record the agency or program providing services to the client or family in the “Agency/Program” column. In the “Client/Family Member” column, record the name of the client or other family member/responsible adult involved with the agency or program identified in the previous column. In the “Receiving/Referred /Applied/Waiting” column, record the individual’s (client or family member) status with the agency/program by recording one of the four words (receiving, referred, applied, or waiting) that best describes his or her status. In the “Contact Person” column, record the name of an individual associated with the agency/program that is involved with the client or family, if relevant. Provide the phone number for the contact person in the column labeled “Phone Number.”

Note: For any information that is not applicable or is not available (and will remain unavailable), record a “9” in the corresponding space. If only two other agencies are involved, then only rows ‘a’ and ‘b’ will be completed. For rows ‘c’ through ‘f,’ Put a “9” in column 1 and draw a line through columns 2 through 5.

SECTION B

REASON FOR ASSESSMENT AND SCHOOL SERVICES

B.1 Reason for Assessment

Intent: To record the reason for the assessment

Definition: Record the current reason for the assessment with the number in the box. If the reason is “other” please specify the reason in the space provided. This information does not come from the client or caregiver.

Code: 0 = Intake assessment

1 = Scheduled reassessment

2 = Change in status assessment

3 = Other (specify)

NOTE:

The information in Items B.2 is Confidential under Federal law related to the confidentiality of educational information (i.e., the Family Educational Rights and Privacy Act, known as “FERPA”). The caregiver or the client is NOT required to respond to these in order to qualify for PCS services or referral for DME or nursing.

B.2 Services Provided at School/Day Program

Intent: To record the type of services provided in school or a day program

- Definition:**
- a. Personal care attendant
 - b. Nursing services
 - c. Durable medical equipment
 - d. Other (specify)

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Code: **0 = Not needed at school/day program**

1 = Provided at school/day program

2 = Needed but not provided at school/day program

Record whether the child needs or is receiving services at school/day program. If the child does not need a service or needs it and is receiving a specific service, code “0”. If a child needs a service at school/day program and is receiving it there, the code is “1”. If a child needs a service at his or her school/day program, but is not receiving it, the code is “2”. If a relevant service is not listed, then use B.2.d “Other (specify)” to indicate the nature of the service.

EXAMPLE B.2

a.	Personal care aide	0
b.	Nursing services	2
c.	Durable medical equipment	0
d.	Other (specify):	0

In this example the child needs nursing services but is not receiving them while at school or in a day program, thus, the correct code is a ‘2.’ There is no problem present with the other services, so they are coded “0.” A code of “2” may indicate that the case manager should contact the school or program.

B.3 Name of School or Day Program

Code: In the space provided, record the full name of the school or day program in which the child participates.

SECTION C

DIAGNOSES & HEALTH CONDITIONS

NOTE:

For **C.1, C.2, C.3** and **C.4**: Code only for those active diagnoses that currently affect the client's functional, cognitive, or behavioral status or require treatment, therapy, or medication **AND** were diagnosed by a licensed or certified health care professional. For **C.5**, code only for conditions or problems that currently affect the client's functional, cognitive, or behavioral status or require treatment, therapy, or medication. You may not have access to relevant records from the physician and may therefore need to rely on the caregiver/responsible adult's recall of the information.

C.1 Medical Diagnoses

Intent: To document the presence of diseases or infections relevant to the person's current ADL status, cognitive status, mood or behavior status, medical treatments, nursing supervision, or risk of death. In general, these types of conditions are associated with the type and level of care needed by the person. Do not include conditions that have been resolved or no longer affect the person's function or care needs. **The disease conditions in section C.1 require a diagnosis made by a qualified health professional, usually a physician, (although you will be relying on the caregiver (or possibly the client) to relay this information to you.** Probe, however, to determine whether a physician told the family member of client that this was the diagnosis.

You do not need a medical background to complete this section, since you are asking the family to report a physician's diagnoses. The definitions below are provided merely for your information and, if necessary, to help you probe if a family member is describing the health diagnosis without using the precise words on the form. Be sure to ask whether a physician (or other health care professional) told the family member that the client has this condition. The presence of medications, equipment or on-going treatment for a health condition is a good indicator that the condition is present.

Definition:

- a. **Anemia:** includes anemia of any origin
- b. **Apnea:** temporary suspension of breathing, occurring in some newborns (infant apnea) and in some older children during sleep (sleep apnea)

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- c. **Arthritis:** either rheumatoid or osteoarthritis
- d. **Asthma/respiratory disorder:** includes chronic bronchitis, reactive airway disease
- e. **Cancer:** any malignant growth or tumor caused by abnormal or uncontrolled cell division; must be a **current** cancer, not a cancer for which the client was treated and has recovered
- f. **Cerebral Palsy:** paralysis believed to be caused by a prenatal brain defect or by brain injury during birth, characterized by difficulty in control of the voluntary muscles. It may be acquired after birth from brain damage in the first few months or years of life. CP often follows infections of the brain, such as bacterial meningitis or viral encephalitis, or it may be the result of a head injury.
- g. **Cleft Palate:** deformity of the palate at birth
- h. **Congenital heart disorder:** any heart abnormality at birth
- i. **Cystic Fibrosis:** hereditary disease affecting mucus glands, usually results in thick mucus in lungs
- j. **Diabetes:** includes insulin-dependent diabetes (IDDM) and diet-controlled diabetes (NIDDM)
- k. **Epilepsy or other chronic seizure disorder:** neurological disorder resulting in recurrent, unprovoked seizures
- l. **Explicit terminal prognosis:** physician indicates that child has six months or less to live
- m. **Failure to thrive:** descriptive of children whose current weight or rate of weight gain is significantly below that of other children of similar age and sex; growth failure, or failure to thrive (FTT), *is a descriptive term and not a specific diagnosis*. However, it is often how a medical professional may describe a child's status when that child is not growing at a normal rate.
- n. **Hemophilia:** refers to a group of bleeding disorders in which it takes a long time for the blood to clot. This may cause abnormal bleeding. The disorder almost always affects males.

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- o. Hydro/microcephaly:** hydrocephalus is a build-up of fluid inside the skull, which causes brain swelling. Hydrocephalus means "water on the brain." Microcephaly describes a head size significantly smaller than normal for a person's age and sex, based on standardized charts.
- p. Metabolic disorders:** hereditary disorders that affect the body's ability to metabolize specific types of substances (e.g., PKU)
- q. Muscular Dystrophy:** a group of hereditary muscular disorders involving progressive muscle weakness and loss of muscle tissue
- r. Paraplegia/tetraplegia/quadruplegia:** paraplegia refers to paralysis of the lower body with involvement of both legs; tetra/quadruplegia refers to paralysis of all four limbs.
- s. Pathological bone fracture:** bone fracture (often repetitive) due to problems with bone structure or strength
- t. Renal failure:** acute (sudden) kidney failure is the sudden loss of the ability of the kidneys to remove waste and concentrate urine without losing electrolytes
- u. Spina Bifida or other spinal cord dysfunction:** birth defect involving the backbone and spinal canal; includes any congenital defect involving insufficient closure of the spine
- v. Substance abuse related problems at birth:** any current problem due to substance abuse by the mother during pregnancy (e.g., fetal alcohol syndrome, cocaine dependency)
- w. Traumatic brain injury:** damage to the brain as a result of physical injury to the head

Code: **0 = No**

1 = Yes, condition active and diagnosed

For any active diagnosis from a licensed medical professional, code "1." For any listed diagnosis not active/current or not diagnosed by a medical professional, code "0."

C.2 Other Medical Diagnoses

Definition: a-c. Specify

Process: Consult the caregiver/responsible adult to determine the presence of any current/active medical diagnosis not listed in the previous item (C.1). This condition must be an active diagnosis made by a licensed health professional and must meet the same criteria as those diagnoses listed in C.1.

Code: Use the three lines labeled “Specify” to record any presently active medical diagnosis not listed in the previous item.

C.3 Infections

Definition: a. **Antibiotic resistant infection** (e.g., including but not limited to Methicillin Resistant Staphylococcus Aureus (**MRSA**)): an infection in which bacteria have developed a resistance to the effective actions of an antibiotic.

b. **Other (specify):** e.g., cellulitis, urinary tract infection.

Code: 0 = No

1 = Yes, condition active and diagnosed

Code “Yes, condition active and diagnosed” only if the infection has a relationship to current ADL status, cognitive status, mood and behavior status, medical treatment, nursing supervision, or risk of death. Do not record any conditions that have been resolved and no longer affect the client’s functional status or care plan.

For example, do not code “1” in the right hand corresponding column space for “other” because of tuberculosis if the client had TB several years ago, unless the TB is either currently being controlled with medication or is being regularly monitored to detect reoccurrence. For infections not defined above, like TB, record the name of the diagnosed infection in the space provided next to “Other (specify).”

C.4 Psychiatric, Developmental, or Behavioral Diagnoses

- Definition:**
- a. **Anxiety disorders (e.g., OCD, separation anxiety):** a non-psychotic mental disorder. There are five types, and they include: generalized anxiety disorder; obsessive-compulsive disorder (OCD); panic disorder; phobias; and post-traumatic stress disorder.
 - b. **Autistic disorder or other pervasive developmental disorders (e.g., Asperger's, Rett's):** Autistic Spectrum Disorder (ASD), Pervasive Developmental Disorder (PDD). The main signs and symptoms of autism involve problems in communication, problems in social interactions, or repetitive behaviors. Because people with autism can have very different features or symptoms, health care providers think of autism as a "spectrum" disorder. Asperger's syndrome is a form of autism. Rett's syndrome is a rare inherited disease related to autism that causes developmental and nervous system problems, mostly in females.
 - c. **Attention Deficit Disorder (ADD or ADHD):** Attention Deficit Hyperactivity Disorder (ADHD), sometimes called Attention Deficit Disorder (ADD), is a problem with inattentiveness, over-activity, impulsivity, or a combination of these behaviors. For these problems to be diagnosed as ADHD, the behaviors must be out of the normal range for the child's age and developmental level.
 - d. **Disruptive behavior disorder (e.g., conduct disorder, oppositional defiant disorder):** Conduct disorder involves chronic behavior problems, such as defiant, impulsive, or antisocial behavior; drug use; or criminal activity. Oppositional defiant disorder involves almost constant disobedient, hostile, and defiant behavior toward authority figures.
 - e. **Down Syndrome:** a genetic syndrome that is usually accompanied by specific physical characteristics and lower cognitive functioning.
 - f. **Intellectual disability/MR/DD:** Intellectual disability is also called mental retardation (MR) or mental retardation/development disability (MR/DD) or developmental delay. It is a condition diagnosed before age 18 that includes below-average general intellectual function, accompanied by impairment in the person's ability to acquire the skills necessary for daily living.

Diagnosed ID Level: As part of item C.4.f, information is requested on the severity of the child's ID. Many children, especially those involved in public education, will have a level of intellectual disability that has been diagnosed by a physician. These levels are referred to as mild (code=1),

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moderate (code=2), severe (code=3) or profound (code=4). If the severity is unknown, then use code “9.” If C.4.f equals zero or no ID, then code a zero (0) for ID severity.

- g. Mood disorders (e.g., depression, bipolar disorder):** Depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for an extended period of time. Adolescent depression occurs during the teenage years and is marked by persistent sadness, discouragement, loss of self-worth, and loss of interest in usual activities. Bipolar disorder is characterized by periods of excitability (mania) alternating with periods of depression.
- h. Schizophrenic, delusional (Paranoid), schizoaffective, and other psychotic disorders:** Schizophrenia is a disturbance characterized by delusions, hallucinations, disorganized speech, grossly disorganized behavior, disordered thinking, and flat affect.
- i. Somatoform, eating, and tic disorders (e.g., anorexia nervosa, bulimia, pica):** anorexia nervosa, bulimia or binge-purge behavior, or pica (eating non-food substances, such as paper, chalk, ashes)
- j. Other (specify):** any other behavioral problem diagnosed by a behavioral health or medical professional that is current/active.
- k. Other (specify):** any other behavioral problem diagnosed by a behavioral health or medical professional that is current/active.

Process: These are psychiatric conditions and should be based on a formal diagnosis by a qualified health professional. Ask caregiver/responsible adult about whether the client has a history of mental health issues (e.g., inpatient psychiatric hospitalization; treated by a mental health professional) or if they have been told by a physician or mental health professional that the child has a mental health/psychiatric diagnosis. Some people use the phrase “mental, emotional or nervous disorder.” A “yes” can lead you to more probing questions about whether there was a formal diagnosis by a medical or mental health professional.

Code: **0 = No**

1 = Yes, condition active and diagnosed

C.5 Health Conditions

Definition:

- a. **Bed-bound or chair-fast (because of health condition; spends at least 23 hours per day in bed or in chair – not wheelchair):** e.g., client may get out of bed or chair to use the bathroom but is otherwise chair-fast. This does not include using a wheelchair throughout the day.
- b. **Contracture(s):** a tightening of muscle, tendons, ligaments, or skin that prevents normal movement. The most common causes are scarring and lack of use (due to immobilization or inactivity).
- c. **Fall(s) related to client's condition:** fell and hit the ground or an object, such as a chair (all the euphemisms, such as tripped, slipped down and so on, count if it involved hitting the ground or an object).
- d. **Fracture(s):** broken bone.
- e. **Limitation in range of motion – limitations that interfered with daily functions or placed client at risk of injury:** functional limitation in the ability to use one's limbs that interferes with daily functioning (particularly with activities of daily living), or places the client at risk of injury.
- f. **Pain interferes with normal activities (e.g., school, work, social activities, ADLs):** Pain refers to any type of physical pain or discomfort in any part of the body. Pain may be localized to one area, or may be more generalized. It may be acute or chronic, continuous or intermittent (comes and goes), or occur at rest or with movement. Pain experience is very subjective: pain is whatever the client complains of (verbal) or indicates through behavior (e.g., moaning, wincing when touched) or the caregiver/responsible adult observes. This is pain that interferes with the client's normal day-to-day activities.
- g. **Pressure ulcer, wound, skin lesion:** any skin breakdown on any portion of the client's body (no physical examination needed).
- h. **Recurrent aspiration:** note the extended time frame. Often occurs in individuals with swallowing difficulties or who receive tube feeding (e.g., esophageal reflux of stomach contents).
- i. **Shortness of breath during normal activities:** difficulty breathing occurring at rest or in response to normal activities.

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- j. **Other (specify): e.g., pregnant; syncope** (the medical term for fainting and involves temporary loss of consciousness. Syncope occurs when there is a transient cessation of blood flow to the brain.)

Process: Gather information from client or caregiver. These conditions do not demand a diagnosis by a health professional, but they must affect the child's current function or health.

Code: 0 = No

1 = Yes, currently active

C.6 Client's Current Condition

Intent: To document the current qualifying condition under which the assessment is being performed.

Process: Consult caregiver/responsible adult or client (if appropriate) to determine the type of qualifying condition under which client falls. Review responses Sections C.1-C.5. You may also need to review documents in DSHS files. .

Code: 1 = Medical

2 = Psychiatric/Developmental/Behavioral

3 = Both

Code for the response that most accurately describes the client's condition(s) qualifying him/her for assessment concerning PCS, nursing, therapy, and DME needs.

COMPLETE ITEM O.1.a.(3) NOW

Intent: This is the first instance in which you transfer information from one part of the assessment form to another section. This is done so that when you reach the point of making a decision concerning PCS services or a referral needed by the child, you will have information you may need available in Section O without having to go back thru the form to find assessment information.

Process: Review the section just completed and transfer the relevant information to Section O.1. If one or more potential problems or conditions are noted in the section, the

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proper code for Item O.1.a column (3) is “1.” You may also complete O.1 column (4) with any specific or detailed information that you consider relevant to the child’s needs, which are not captured by the response codes used in the assessment form.

Code: **0 = No problems noted**

1 = At least one problem noted

SECTION D

COGNITIVE FUNCTION

Intent: To determine the client's ability to remember, think coherently, and organize daily self-care activities. These items are crucial factors for many service decisions. Your focus is on client's ability or performance, which may include a demonstrated ability to remember recent and long-past events and to make decisions about key daily activities/tasks or may be based on information provided by the primary caregiver.

You may talk with the client as well as the caregiver/ responsible party about these issues. Be cognizant of possible cultural differences that may affect your perception of the client's or caregiver's responses, since education level may mask or exaggerate problems in cognitive functioning. Remember that you are asking about performance over the last 7 days.

For clients with limited communication skills or who are best understood by their caregiver, you will need to carefully consider clients' or caregivers' responses in this area, especially in determining short- or long-term memory.

- When appropriate, engage the client in general conversation to help establish rapport.
- Actively listen and observe for clues to help you structure your assessment. Remember: repetitiveness, inattention, rambling speech, defensiveness, or agitation may be challenging to deal with during the assessment, but they provide important information about cognitive function.
- Be open, supportive, and reassuring during your conversation with the client and caregiver, since people are often sensitive about issues related to memory and decision-making.

It is often difficult to accurately assess cognitive function, how someone is able to think, remember, and make decisions about his or her daily life, when he or she is unable to verbally communicate with you. It is particularly difficult when the areas of cognitive function you want to assess require some kind of verbal response from the client (e.g., memory recall). It is certainly easier to perform an evaluation when you can converse with a client and hear responses from them that give you clues to how the client is able to think (judgment) and if he/she understands his/her strengths and limitations (insight).

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D.1 Comatose or Persistent Vegetative State

Intent: To determine whether the client's physician has given a documented neurological diagnosis of coma or persistent vegetative state.

Definition: Comatose (coma) is a pathological state in which neither arousal (wakefulness, alertness) or awareness (cognition of self and environment) is present. The comatose person is unresponsive and cannot be aroused; he/she does not open his/her eyes, does not speak, and does not move his/her extremities on command or in response to noxious stimuli (e.g., pain).

Code: 0 = No

1 = Yes

Enter the appropriate number in the box provided. If the client has been diagnosed as comatose or in a persistent vegetative state, code "1," then **Skip to Section H.** If client is not comatose or in a persistent vegetative state, code "0" and proceed to next item (D.2).

NOTE THAT FOR ITEM D.2-D.5, IF YOU ARE UNABLE TO DETERMINE WHAT YOU BELIEVE IS THE CORRECT RESPONSE BY INTERACTION WITH THE CLIENT, ASK THE CAREGIVER ABOUT THESE ITEMS – MEMORY, TASK PERFORMANCE, AND DECISION-MAKING.

D.2 Short-Term Memory

Intent: To determine the client's short-term recall performance.

Definition: The client recalls very recent events, such as what he/she had for the most recent meal or is able to recall a recent activity.

Process: You may rely on the opinion of the caregiver, although you need to make clear that you are asking about the client's ability to recall things that are very recent, such as what he/she ate for breakfast or whether the child can remember things he/she was told a few minutes earlier. When feasible, you may want to talk with the client directly. You can talk about the same kinds of issues – as long as you know what actually occurred quite recently (e.g., asking "Did you just have lunch?" or "What did you have for lunch?"). Or you can ask the client to

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remember an activity that they did recently. If the client is unable to recall the meal or the activity, code “1.” Otherwise, code “0.” For persons with communication deficits, *non-verbal responses are acceptable* (e.g., pointing to the items).

Code: **0 = Memory/recall ok**

1 = Memory/recall problem

D.3 Long-Term Memory

Intent: To assess the client’s long-term recall.

Process: Again, you can ask the caregiver or ask questions of the client to determine whether he/she has problems with long-term memory. For children of this age range, they should be able to tell you their name, where they are, where they live, their siblings’ or pets’ names. . Additional questions might include names of their friends or relatives. If the client has difficulty remembering events or people from his/her past, code “1.” Code “0” for no problem.

Code: **0 = Memory/recall ok**

1 = Memory/recall problem

D.4 Procedural Task Performance

Definition: This item refers to the cognitive ability needed to perform sequential activities. Dressing is an example of such a task. It requires multiple steps to complete the entire task. Bathing and washing hair or managing medications are other examples of tasks that have multiple steps that should be performed in sequence (turning on water, using soap, rinsing, and drying, putting on clean clothing).

The person must be able to perform or remember to perform all or almost all of the steps independently in most multi-step tasks in order to be scored a “0.” If the person demonstrates difficulty in completing most tasks involving two or more steps, code as “1.”

NOTE: Clients in need of personal care services in the home often have physical limitations that impede their independent performance of activities. Do not

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confuse such physical limitations with the cognitive ability (or inability) to perform sequential activities.

Process: Ask the caregiver/responsible adult or, if possible, observe the client during your visit.

Code: **0 = Performs most or all multiple-step tasks without cueing, redirection or monitoring**

1 = Needs cueing, redirection or monitoring for most or all multiple-step tasks

D.5 Cognitive Skills for Daily Decision-Making

Intent: To record the client's actual performance in making everyday decisions about the tasks of daily living. This item will help determine the nature of cueing and redirection a client may need on a daily basis. For example, it's not expected that four-year-olds will consistently make weather- appropriate decisions about clothing; however, they should be able to choose a shirt, pants and shoes or other similarly complete outfits.

Examples of Daily Decision-Making Tasks

Choosing items of clothing; knowing when to fix or eat meals; being oriented within the home and using space appropriately (e.g., knowing where the toilet is); using environmental cues to organize and plan the day (e.g., clocks, calendars, the weather); in the absence of environmental cues, seeking information appropriately (e.g., asking once, not repetitively) from family in order to plan the day; using awareness of one's own strengths and limitations in regulating the day's events (e.g., asks for help when necessary); making a correct decision about how and when to go outdoors, when to get ready for school, or when to do homework; recognizing any need to use an assistive device, such as a brace and using it faithfully.

Process: Consult the caregiver/responsible party. Observations of the client can also be helpful. Review the events of each day. The inquiry should focus on whether the client is actively making these decisions, and not whether there is *belief* on the part of the client or a family member that the client might be capable of daily decision-making. Remember the intent of this item is to record what the client is doing (performance). When a family member takes decision-making responsibility away from the client regarding tasks of everyday living, or the person does not

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participate in decision-making, whatever his or her level of capability may be, the client should be considered to have impaired performance in decision-making.

Code: Enter the single number that corresponds to the most correct response

0 = Independent – Decisions consistent/reasonable

1 = Modified independent – Consistent/reasonable decisions in customary situations or environments but experienced difficulty with new/unfamiliar tasks or in specific situations (e.g., crowds)

2 = Moderately dependent – Decisions consistently poor; cues, redirection or monitoring required frequently

3 = Completely dependent – Never/rarely made decisions; cueing, redirection or monitoring required continually

Additional

Definitions: **1 = Modified independent:** The client functions well with decision-making when involved in his or her customary routines and in familiar environments. However, when she or he encounters or is involved in a new, unfamiliar situation or setting, the client has difficulty making consistent, reasonable, or safe decisions. There may also be certain specific situations in which the client does not function well and needs supervision by others or requires cueing to make decisions about daily tasks. The emphasis is on SPECIFIC, NEW or UNFAMILIAR settings or situations that alter usual decision-making.

COMPLETE ITEM O.1.b. (3) NOW

Process: Review the section just completed and transfer the relevant information to Section O.1. If one or more potential problems or conditions are noted in the section, the proper code for Item O.1.b column (3) is “1.” You may also complete O.1 column (4) with any specific information that you consider relevant to the child’s needs that are not captured by the response codes used in the assessment.

Code: **0 = No problems noted**

1 = At least one problem noted

Example

Sixteen-year-old Harriet lives at home with her parents. She has a diagnosis of Down Syndrome. She functions well in their home, making reasonable decisions about clothes selection, food choices, and some of her daily activities, including when it is a good time to play outdoors with her puppy. However, she gets distracted in new or different environments, and she is not able to make safe independent decisions when she is in new settings, such as at the mall or at someone else’s house.

Code Decision-Making: 1 = Modified independent

Example

Eight-year-old Kayla has a developmental delay. She functions well in the family home. She can partially dress herself, but rarely makes reasonable decisions about clothes selection, food choices, and some of her daily activities, including when it is a good time to play outdoors with her puppy.

Code Decision-Making: 2 = Moderately impaired

Example

Ten-year-old Jimmy lives with his mother and two younger siblings. He manages fairly well at home, where he prefers to spend time alone but is able to interact with the family and make basic decisions, such as choosing among the vegetables available at dinner when asked. However, when he and his mother and siblings go out to dinner, he becomes agitated in the restaurant, particularly if they go to a buffet, where he must select his meal among many choices and where the noisy and crowded environment clearly is upsetting to him. He always needs cueing about meal selection, such as, “Jimmy, do you want fish or chicken today? What about vegetables – would you like some mashed potatoes or would you prefer creamed corn?” He needs more redirection because of his agitation whenever he is in a noisy setting or one with a crowd of people. This is even true at home if his brothers make too much noise or turn up the volume on the television so that it is very loud. He becomes agitated and makes poor decisions, such as running outside to get away from the noise even if it is raining or might be dangerous.

Code Decision-Making: 3 = Severely impaired

SECTION E

COMMUNICATION

E.1 Making Self Understood

Intent: To document the client's performance with respect to expressing or communicating requests, needs, opinions, urgent problems, and social conversation, whether in speech, writing, sign language, or a combination of these (includes use of word board or keyboard).

Process: Interact with the client. Observe and listen to the client's efforts to communicate with you. If possible, observe his or her interactions with family members. If this is not possible, then question the responsible adult.

Code: Enter the number corresponding to the most correct response.

0 = Understood: expressed desires/needs without difficulty

1 = Usually understood: some difficulty finding words or finishing thoughts but usually understood

2 = Sometimes understood: ability was limited to making concrete requests understood (e.g., hunger)

3 = Rarely/never understood: communication limited to interpretation of highly individual, person-specific sounds, behaviors, or body language understood by a limited number of people or client can't make his or her needs or desires understood.

E.2 Ability to Understand Others (Comprehension)

Intent: To describe the client's performance in terms of comprehending information whether communicated to the client orally, in writing, or in sign language or Braille. This item measures not only the client's performance in terms of hearing messages but also in terms of processing and understanding language.

Process: Interact with the client. Consult the client's caregiver/responsible adult.

Code: Enter the number corresponding to the most correct response.

0 = Understands: clear comprehension

1 = Usually understands: sometimes missed some part or intent of message

2 = Sometimes understands: responded only to simple, direct messages or communication

3 = Rarely/never understands: observer has difficulty determining whether the client comprehends messages; or the client can hear sounds but did not understand the meaning of messages

COMPLETE ITEM O.1.c.(3) NOW

Process: Review the section just completed and transfer the relevant information to Section O.1. If one or more potential problems or conditions are noted in Section E, then the proper code for Item O.1.c column (3) is "1." You may also complete O.1 column (4) with any specific information that you consider relevant to the child's needs that are not captured by the response codes used in the assessment.

Code: **0 = No problems noted**

1 = At least one problem noted

SECTION F

HEARING AND VISION

F.1 Hearing

Intent: To evaluate the client's hearing during the past 7-day period. The hearing assessment is done with any hearing appliance normally used by the client.

Process: Evaluate the client's hearing after the client has any hearing appliance in place and turned on -- if the client uses an appliance. Be sure to ask if the battery works and if the hearing aid is turned on if the client uses such a device. Interview and observe the client, and consult the client's family. Test the accuracy of your findings by observing the client during your verbal interactions.

Be alert to what you have to do to communicate with the client. For example, note if you have to speak more clearly, use a louder tone, speak more slowly, or use more gestures; or if the client needs to see your face to know what you are saying; or if you have to take the client to a more quiet area to conduct the interview — all of these are cues that there is a hearing problem, and should be so indicated in the coding.

Also, if possible, observe the client interacting with others (e.g., family member).

Code: Enter the number that corresponds to the most correct response.

0 = Hears adequately: no difficulty in normal conversation, social interaction, TV, phone

1 = Some impairment: problems with specific types of sounds (e.g., low register) or with specific situations (e.g., requires quiet setting to hear well)

2 = Highly impaired: absence of useful hearing

F.2 Vision

Intent: To evaluate the client's ability to see close objects in adequate lighting, using the client's customary visual appliances (e.g., glasses, magnifying glass).

Definition: **Adequate lighting:** Lighting that is sufficient or comfortable for a person with normal vision, excludes both lighting that is too low and light that is glaring

Process: Ask the client or responsible adult about the client's functional vision. For example, a child who cannot read can usually tell you whether he/she can see distinct leaves on a tree in the yard or identify numbers. Otherwise, ask the caregiver/responsible family member. You can use some of the probes designed for use with clients to ask more specific questions of family members as well.

Be sensitive to the fact that some clients are not literate, may not read English, or may not read at all. In such cases, see whether the client can read printed dates or page numbers or is able to name items in small pictures.

Code: Enter the number corresponding to the most correct response.

0 = Vision adequate: saw fine detail, including fine detail in pictures, regular print in books

1 = Some impairment: limited vision; was able to see large print or numbers in books; identify large objects in pictures

2 = Highly impaired: no vision or saw only light, colors, or shapes; eyes do not appear to follow objects

COMPLETE ITEM O.1.d.(3) NOW

Process: Review the section just completed and transfer the relevant information to Section O.1. If one or more potential problems or conditions are noted in the section, the proper code for Item O.1.d column (3) is "1." You may also complete O.1 column (4) with any specific information that you consider relevant to the child's needs that are not captured by the response codes used in the assessment.

Code: **0 = No problems noted**

1 = At least one problem noted

SECTION G

BEHAVIOR PATTERNS

G.1 Signs and Symptoms in Last 30 Days

Intent: To identify the frequency of behavioral symptoms during the last 30 days that cause distress to the person or are distressing or disruptive to others with whom the person lives (or interacts with in such settings as school or a sheltered workshop). Such behaviors include those that are potentially harmful to the person or disruptive to others. These items are designed to pick up problem behaviors exhibited by the person that may be considered as “combative or agitated” by some health professionals.

Be sure to probe. Family members tend to “normalize” a client’s usual behavior and thus under-report the presence, frequency and intensity of behaviors. You might try to avoid using phrases such as “difficult,” “challenging” or “maladaptive” behaviors, since loved ones often deny the behavior is a problem. Simply focus on the behavior (e.g., ask “Does _____ ever wander around the house or outside without seeming to be aware of where he/she is going or whether it is safe to do so?”).

- Definition:**
- a. **Wandering:** moved (locomotion) with no apparent rational purpose; seemingly oblivious to needs for safety
 - b. **Elopement:** attempted to or exited/left home/school etc. at inappropriate time, without notice/permission, with impaired safety awareness
 - c. **Verbally abusive:** threatened, screamed at or cursed others
 - d. **Physically abusive or injures others:** shoved, scratched, pinched or bit others
 - e. **Bullying/Menacing Behavior:** no physical contact but others made to feel unsafe/at-risk; invaded personal space of others; or intimidated others
 - f. **Socially inappropriate or disruptive behavior:** disruptive acts or sounds; noisiness; screaming; smeared/threw food/feces; hoarding; rummaging through other’s belongings
 - g. **Repetitive behavior that interferes with normal activities:** e.g., finger flicking, rocking, spinning objects

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- h. Inappropriate sexual behavior:** e.g., sexually abused/attacked others; inappropriate sexual activity or disrobing; masturbating in public
- i. Resists ADL care:** resisted assistance with ADLs, such as bathing, dressing, toileting, eating
- j. Physically resists prescribed treatments and therapies:** e.g., range-of-motion exercises, chest percussion, or medications
- k. Injury to self:** self-abusive acts; non-accidental injuries (e.g., cutting arms, head banging) that are not suicide attempts
- l. Suicide attempt:** effort(s) by client to end his/her life
- m. Suicidal ideation:** recurrent thoughts of death or suicide; saying that they wished they were dead or that they are going to kill themselves
- n. Injury to animals:** deliberate physical injury to or torture of animals
- o. Dangerous, non-violent behavior:** e.g., , leaving candle lit or range burner turned on, playing with fire, engaging in risky behavior such as climbing or jumping or running in settings where such activity is dangerous
- p. Deliberate damage to property:** e.g., intentional fire-setting, smashing furniture, breaking household objects
- q. Other (specify):**

Process: Ask the family member caregiver if each specified behavior occurred. Take an objective view of the client's behavioral symptoms and focus on the client's actions, not intent. It is often difficult to determine the meaning behind a particular behavioral symptom. Some family members may have become accustomed to a behavior or minimize the difficulty of the client's behavior because they see it often or understand its cause (e.g., "Oh, no. He's not physically abusive. He doesn't really mean to hurt anyone- he's just frightened."). Such assumptions about the cause, while they may be factually correct, should not be considered in deciding whether the behavior was present or not and in coding items. Rather, code each item based on whether the client manifested the behavioral symptom.

If you have the opportunity during your visit, observe the client and how the client responds to attempts by family members or others to deliver care. Ask the caregiver

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if they know what occurred throughout the day and night (e.g., 24-hours a day) for the past 30 days. If possible, try to do this when the client is not in the room. Recognize that responses given with the client present may need to be validated later. For example, a client's behavior in school where there may be a lot of external stimulation may be different from what is observed at home. Similarly, behavior may differ between day and night.

Determine whether the behavior in question has occurred at all during the last 30 days. If the answer is "yes," then probe to determine whether the behavior occurred in the last week

- Code:**
- 0 = No occurrence in the last 30 days**
 - 1 = Occurred in last month but not during last 7 days**
 - 2 = Occurred once or more in the last 7 days**

G.2 Urgent Mental/Behavioral Health Service Use in Last 30 Days

Intent: To determine if mental or behavioral health services have been used in the last 30 days.

- Definition:**
- a. Admission to inpatient treatment for mental or behavioral health problem (includes hospital or free-standing psychiatric/mental health unit)**
 - b. Visit to emergency room for care or treatment of a mental or behavioral health problem**
 - c. Urgent visit to physician, psychiatrist, or mental or behavioral health specialist office (not a regularly scheduled visit or assessment) because of a mental or behavioral health issue:** note that this is not a regularly scheduled visit or assessment
 - d. Other (specify)**

- Code:**
- 0 = No occurrence in last 30 days**
 - 1 = Occurred in last 30 days**

G.3 Child May Require Referral to a Mental or Behavioral Health Specialist

Intent: To indicate whether a referral to a mental or behavioral health specialist is needed because of the child's behaviors or concerns that some identified behaviors may directly interfere with meeting the child's personal care needs.

Code: 0 = No

1 = Yes

COMPLETE ITEM O.1e.(3) AND O.3.a NOW

Process: Review the section just completed and transfer the relevant information to Section O. If one or more potential problems or conditions are noted in the section, the proper code for Item O.1.e column (3) is "1." You may also complete O.1 column (4) with any specific information that you consider relevant to the child's needs that are not captured by the response codes used in the assessment. In O.3.a, indicate whether a referral is needed.

Code: O.1.e(3)

0 = No problems noted

1 = At least one problem noted

O.3.a

0 = No

1 = Yes

SECTION H

WEIGHT AND HEIGHT

H.1 & H.2 Weight and Height (based on last 30 days)

Intent: To record a current weight and height in order to monitor nutrition and hydration status over time; also, to provide a mechanism for supervision stability of weight over time. Unintended weight loss can signify a significant health problem. Other weight changes may be expected and intended. For example, a person who has had edema can have an intended and expected weight loss as a result of taking a diuretic. Weight loss could be the result of poor intake or adequate intake accompanied by recent participation in a fitness program.

Process: For weight, record the most recent weight taken, preferably within last 30 days and preferably during a visit to a health care provider. Ask the client, if he/she is able to provide this information; otherwise, ask the caregiver. If the physician's weight was more than 30 days ago, ask for any recent weight taken by the client. For height, ask the client; if the client is unable to report, ask the caregiver.

Code: Report weight in pounds or kilos (whichever unit the measurement is provided or measured in by the client). Use "0" as a filler if the client weighs less than one hundred pounds or kilos. Record the weight in the form the client or caregiver reports.

0	6	4		0	2	9
Weight in lbs.			OR	Weight in kilos		

Report height in inches or centimeters (whichever unit the measurement is provided or measured in). Use "0" as

a filler if the client is less than one hundred centimeters tall or, for instance, 5 feet 4 inches tall. For example: a person that is 5 feet 4 inches or 163 centimeters tall will be recorded as below. A measurement recorded in one unit will suffice; do not try to convert. Be careful regarding your response on this item. Accurate information is often hard to obtain.

5		0	4		1	6	3
Feet		inches		OR	Centimeters		

COMPLETE ITEM O.1.f.(3) NOW

Process: Review the section just completed and transfer the relevant information to Section O.1. If one or more potential problems or conditions are noted in the section, the proper code for Item O.1.f column (3) is “1.” You may also complete O.1 column (4) with any specific information that you consider relevant to the child’s needs that are not captured by the response codes used in the assessment. A problem is present if there is some indication that the client’s height or weight are not within normal bounds for his or her age. Case managers should use their best judgment in making this determination.

Code: **0 = No problems noted**

1 = At least one problem noted

SECTION I MEDICATIONS

I.1 Number of Different Medications Taken

Intent: To determine the number of different medications taken by the client in the last 7 days. This includes prescription and over-the-counter medications, as well as any medications prescribed on an “as-needed” or PRN basis. Consider medications that are administered by any route (e.g., pills, injections, ointments, and inhalers).

Process: Ask the caregiver/responsible adult or the client (if he/she manages his/her own medications) to provide the count of medications actually taken in the last 7 days. Be certain that you specify that this is not just prescription medications, but any medications used, regardless of how it was obtained (by prescription or OTC) and regardless of the route of administration. Be sure to emphasize in your questioning that the response should include all medications, herbal supplements, and so on. This includes parts of a therapeutic diet (e.g., supplements).

Code: Record the number of medications the client is currently taking in the boxes provided. Use “0” as a filler if the client is currently taking fewer than 10 different medications. For example, for an individual taking 8 different medications, record:

0	8
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COMPLETE ITEM O.1.g.(3) NOW

Process: Review the section just completed and transfer the relevant information to Section O.1. If one or more potential problems or conditions are noted in the section, the proper code for Item O.1.g column (3) is “1.” You may also complete O.1 column (4) with any specific information that you consider relevant to the child’s needs that are not captured by the response codes used in the assessment.

Code: 0 = No problems noted

1 = At least one problem noted

SECTION J

LICENSED/PROFESSIONAL NURSING NEEDS

J.1 Care Activities Needed or Provided during Last 7 Days that May Require Nursing Care

Intent: To determine if the child is receiving or should possibly receive services provided by a licensed nurse or under the “supervision” of a licensed nurse if the task may be delegated to a non-nurse under Texas law/regulation or the Nurse Practice Act.

- Definition:**
- a. **Medication management:** includes injections and other nursing activities related to medication management
 - b. **Intravenous medications:** includes any drug or biological (e.g., contrast material) given by intravenous push or drip through a central or peripheral port
 - c. **Intravenous feeding (parenteral or IV):** feeding through a vein. This is also sometimes called “parenteral alimentation or parenteral nutrition.”
 - d. **Feeding tube:** called enteral or tube feeding; the presence of any type of tube that can deliver food/nutritional substances/fluids/medications directly into the gastrointestinal system. Examples include, but are not limited to, nasogastric tubes, gastrostomy tubes, jejunostomy tubes and percutaneous endoscopic gastrostomy tubes (PEG).
 - e. **Nasopharyngeal suctioning:** suctioning of secretions from the upper-most part of the throat, behind the nose (e.g., often used with pediatric bronchitis patients)
 - f. **Tracheostomy care:** includes removal of cannula and cleansing of tracheostomy site and surrounding skin with appropriate solutions
 - g. **Wound or skin lesion care:** treatment or dressing of stasis or pressure/decubitus ulcer, surgical wound, burns, open lesions
 - h. **Oxygen:** administration or supervision
 - i. **Urinary catheter care:** insertion or maintenance (e.g., change, irrigation)
 - j. **Comatose or persistent vegetative state:** care to manage the condition

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- k. Ventilator or respirator – to manage equipment:** mechanical device designed to provide adequate ventilation in persons who are, or may become, unable to support their own respiration. Include any client who was in the process of being weaned off of the ventilator or respirator in the last 7 days. This does not include nebulizers or CPAP machines (used for apnea).
- l. Uncontrolled seizure disorder:** care and supervision for safe management
- m. Unstable medical condition:** assessment, observation, and management on a daily basis
- n. Other periodic assessment, management, supervision:** once or twice a month
- o. Other (specify)**

Process: Consult client, if appropriate, or caregiver for each item. Ask if the child has received or has needed each type of care activity within the last 7 days.

Code: **0 = Not needed**

1 = Needed and provided

2 = Needed but not provided

For all services the client does not receive code “0” in the corresponding right-hand column space. Code “1” in the corresponding right-hand column space for all professional nursing services the client has received. Code “2” in the corresponding right-hand column space for any professional nursing services that may be required but are not currently provided or received. A code of “2” may be indicative of a need for a referral.

J.2 Urgent Medical Care Use in Last 30 Days

Intent: To identify the occurrence of medical care usage in the past 30 days

Definition: **a. Visit to emergency room for care or treatment of a medical problem**

b. Admission to hospital for medical care

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c. Urgent visit to physician's office for physical illness (not a regularly scheduled visit or checkup)

d. Other (specify)

Code: **0 = No occurrence in last 30 days**

1 = Occurred in last 30 days

J.3 Referral for Nursing Assessment

Intent: To identify the need for referral for an assessment to determine whether new or additional nursing services are needed. For example: an unstable medical condition; significant change in health or functional status; needs more/different care, additional services, or monitoring.

Code: **0 = No**

1 = Yes

COMPLETE ITEM O.3.b NOW

Process: In O.3.b, indicate whether a referral is needed.

Code: **0 = No**

1 = Yes

SECTION K

TREATMENTS AND THERAPIES

K.1 Treatments or Therapies Received or Needed in Last 30 Days (outside of day program/school)

- Intent:** To review prescribed treatments the client has received or needed in the last 30 days. This section includes special treatments, therapies and programs received or scheduled during the last 30 days. Includes services received in the home or on an outpatient basis, but not within a day program/school.
- Definition:**
- a. **Chemotherapy:** includes any type of chemotherapy (anticancer drug) given by any route
 - b. **Radiation therapy:** includes radiation therapy or having a radiation implant
 - c. **Hemodialysis:** removal of blood from artery and return after it has been altered to achieve some therapeutic end (e.g., cleared of waste)
 - d. **Peritoneal dialysis:** dialysis in which the peritoneum is permeable membrane used for fluid transfer
 - e. **Hospice:** comfort care for those dying that is palliative, not curative
 - f. **Physical therapy:** therapy services that are provided or directly supervised by a qualified physical therapist. A qualified physical therapy assistant may provide therapy but not supervise others giving therapy.
 - g. **Occupational therapy:** therapy services that are provided or directly supervised by a qualified occupational therapist. A qualified occupational therapy assistant may provide therapy but not supervise others giving therapy.
 - h. **Speech therapy:** services provided by a qualified speech-language pathologist. Services may involve assessment of swallowing ability or hearing ability; swallowing therapy; speech therapy; communication therapy, or providing hearing appliances and education.
 - i. **Mental health services (includes substance abuse treatment):** therapy given by a licensed mental health professional, such as a psychiatrist, psychologist, psychiatric nurse, or psychiatric social worker
 - j. **Home health aide:** traditionally provides “hands-on” assistance/support with activities of daily living (ADLs), such as bathing, dressing, using the toilet, etc.

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k. Restorative nursing care/habilitative care: services provided by a licensed nurse (or under direct supervision of an RN) to help maintain function (e.g., range of motion exercises)

l. Other (specify)

Code: **0 = Not needed**

1 = Needed and provided

2 = Needed but not provided

For all other treatments and therapies the client does not need, code “0.” Code “1” for all treatments or procedures the client has **received in the last 30 days**. Code “2” for any treatments or procedures the client may need, but are not currently provided. A code of “2” may be indicative of a need for a referral.

K.2 Referral to Consider Need for New/Different Treatment or Therapy

Intent: To determine whether referral is needed to consider prescribing a new or different treatment/therapy.

Code: **0 = No**

1 = Yes

COMPLETE ITEM O.3.c NOW

Process: In O.3.c, indicate whether a referral is needed.

Code: **0 = No**

1 = Yes

SECTION L

CONTINENCE

L.1 Bladder and Bowel Programs & Appliances in Last 7 Days

Definition: **Appliances:**

- a. **Indwelling catheter:** a catheter that is maintained within the bladder for the purpose of continuous drainage of urine; includes catheters inserted through the urethra by supra-pubic incision
- b. **Intermittent catheter:** a catheter that is used periodically for draining urine from the bladder. This type of catheter is usually removed immediately after the bladder has been emptied, includes intermittent catheterization whether performed by a licensed professional or by the client. Catheterization may occur as a onetime event (e.g., obtain a sterile specimen) or as part of a bladder-emptying program.
- c. **External catheter:** a urinary collection appliance worn over the penis
- d. **Ostomy:** any type of excretory ostomy of the gastrointestinal or genitourinary tract. Do NOT code gastrostomies or other feeding “ostomies” here.
- e. **Pads/briefs:** any type of absorbent, disposable or reusable undergarment or item, whether worn by the resident (e.g., incontinence garments, adult brief) or placed on the bed or chair for protection from incontinence; does not include the routine use of pads on the beds when a resident is never or rarely incontinent

Programs:

- f. **Bladder retraining:** a retraining program where the client is taught to consciously delay urinating (voiding) or resist the urgency to void. Clients are encouraged to void on a schedule rather than according to their urge to void. This form of training is used to manage urinary incontinence due to bladder instability. This is not the ordinary “potty” or toilet training a child receives as part of the normal developmental process.

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- g. Bowel retraining:** a retraining program where the client is taught (or re-taught) to evacuate their bowels on a schedule to manage bowel incontinence. This is not the ordinary “potty” or toilet training a child receives as part of the normal developmental process.
- h. Scheduled toileting:** a plan for bowel and/or bladder elimination whereby family members at scheduled times each day either take the client to the toilet room, give the client a urinal, or remind the client to go to the toilet
- i. Toilet training:** a plan to teach a child how to take care of his or her own toileting needs independently. This is the training or assistance a client may receive to achieve continence (or reduce episodes of incontinence) for the first time. A client aged 4-20 who is being toilet trained may have a developmental delay that resulted in having initial toilet training now.
- j. Other (specify)**

Code: **0 = Not needed**

1 = Appliance is available and adequate

2 = New or different appliance may be needed because of condition or problem

L.2 Urinary Continence

Intent: To determine and record the client’s pattern of urinary continence over 24 hours a day for the last 7 days, with assistive device or continence program, if applicable

Definition: **Bladder Continence:** Refers to control of urinary bladder function and whether the client has episodes of being wet. This item describes the bladder continence pattern with scheduled toileting plans or continence training programs.

It does not refer to the person's ability to toilet themselves (e.g., a person can receive extensive assistance in toileting and yet be continent, perhaps as a result of recognizing the need to void and receiving help from others).

Process: Review urinary elimination pattern with caregiver/responsible adult and, if relevant, the client. Some, perhaps many, clients may try to hide their problems out

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of embarrassment, and this may be a sensitive issue with the client. Be sure to ask about performance over all 24 hours.

- If the client is your source of information, you may want to validate continence patterns with the caregiver or responsible adult.
- Note that the response codes separate continence/dryness from that achieved naturally or by programs/reminders from dryness achieved through use of a device, such as an indwelling catheter.
- Remember to consider continence patterns over the last 7-day period, 24 hours a day, including weekends.

Code:

0 = Continent: Complete control and does not use any type of catheter, urinary collection device, or toileting program

1 = Complete control with device or program: (e.g., catheter, ostomy, scheduled toileting)

2 = Usually continent: Incontinent episodes once a week or less frequently

3 = Occasionally incontinent: Episodes 2 or more times a week but not daily

4 = Frequently incontinent: Tended to be incontinent daily, but some control present (e.g., during daytime)

5 = Always/almost always incontinent: Had inadequate control, multiple daily episodes

8 = Did not occur: No urine output from bladder during last 7 days (e.g., dialysis)

Choose one response to code level of bladder continence over the last 7 days. Code for the actual bladder continence pattern (e.g., the frequency with which the client is wet or dry during the 7-day period). Do not record the level of control that the client might have achieved under optimal circumstances.

If the client stays dry by going to the toilet every two hours (e.g., scheduled toileting) or because a caregiver/responsible adult has developed an individualized plan based on the client's urination pattern (e.g., morning, 30 minutes after each meal, 3:00 each afternoon, and so on) and reminds the client to go to the toilet, the client should be coded as "0" (Continent).

Someone with "stress incontinence" might experience anything from infrequent to frequent incontinence, depending on the frequency of the episodes of wetness.

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(Stress incontinence is involuntary leakage of urine from the bladder accompanying some type of physical activity [e.g., laughing, coughing, sneezing, and physical exercise] which places increased pressure on the abdomen/bladder.)

For bladder incontinence, the difference between a code of “4” (Frequently incontinent) and “5” (Always/almost always incontinent) is determined by the presence or absence of any bladder control. For example, a client may be continent during the day when he/she goes to the bathroom on a schedule to prevent incontinent episodes; however, he/she may be incontinent at night when he/she uses a diaper. For control present during the day but with incontinence each night, code “4” (Frequently incontinent).

Code “8” is a special code to indicate the functional activity (urination) did NOT occur during the last 7 days. It is not sequential with the other response codes – by intention – since it represents not a greater level of dependency but instead that the activity did NOT occur.

Examples of Bladder Continence Coding

Four-year-old Zach's mother took him to the toilet first thing in the morning, after every meal, in mid-afternoon, before bed, and once during the night. He also wore pull-up diapers during the night. He was never wet.

Code "0" for Continent

Rationale: The fact that he wore a diaper does not mean that he was incontinent. If he was dry, he should be coded as "continent."

Ten-year-old Jennifer had an indwelling catheter in place during the entire 7-day assessment period. There was no leakage from her catheter.

Code "1" for Complete control with device or program

Although she is generally continent of urine, every once in a while (about once in the last week, 6 days ago) Julia will have an episode of stress incontinence if she has an episode of hard and prolonged coughing. Probe to find out whether this happened ever during the last 7 days. The mother reports that it happened once 6 days ago.

Code "2" for Usually continent

Tom has renal failure and is undergoing peritoneal dialysis on a daily basis at home.

Code "8" for Did not occur

Sally has muscular dystrophy, and any kind of activity that places stress on her abdomen, such as laughing, coughing or sneezing, causes her to leak urine. Probe to find out whether the "leaks" make her clothing (e.g., underpants, diapers) wet. Then probe to find out how often this occurred during the last 7 days. Sally had daily episodes of urinary incontinence, but sometimes she was continent.

Code "4" for Frequently incontinent

L.3 Bowel Continence

Intent: To determine and record the client's pattern of bowel continence (control) over the last 7 days.

Definition: **Bowel Continence:** Refers to control of the client's bowel movements. This item describes the person's bowel continence pattern even with scheduled toileting plans, continence training programs, or appliances. It does not refer to the client's ability to toilet him or herself (e.g., a person can receive extensive assistance in toileting and be continent as a result of family help).

Code: **0 = Continent control without any device/program/medication:** (e.g., ostomy)

1 = Complete control with device/program/medication: (e.g., ostomy)

2 = Usually continent: Incontinent episodes once a week or less

3 = Occasionally incontinent: Episodes 2 or more times a week, but not daily

4 = Frequently incontinent: Tended to be incontinent daily, but some control present (e.g., during daytime)

5 = Always/almost always incontinent: Had inadequate control, multiple daily episodes

8 = Did not occur: No bowel movement during last 7 days

L.4 Nighttime Incontinence (Bowel/Bladder)

Intent: To determine whether the client had episodes of incontinence during the nighttime.

Definition: Note the definitions of bladder and bowel incontinence provided above.

Code: **0 = No**

1 = Yes

COMPLETE ITEM O.1.h.(3) NOW

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Process: Review the section just completed and transfer the relevant information to Section O.1. If one or more potential problems or conditions are noted in the section, the proper code for Item O.1.h column (3) is “1.” You may also complete O.1 column (4) with any specific information that you consider relevant to the child’s needs that are not captured by the response codes used in the assessment.

Code: **0 = No problems noted**

1 = At least one problem noted

SECTION M

PHYSICAL FUNCTION

M.1 Instrumental Activities of Daily Living (IADLs) - Code for assistance provided to client in routine activities around the home or in the community during the last 7 days. Consider assistance provided over 24-hours per day (**NOTE:** You will also be coding M.2 on the same activities).

Intent: The intent of these items is to examine the areas of function that are most commonly associated with independent living. These are often referred to as “instrumental” activities of daily living (IADLs) and include items associated with normal tasks and activities in maintaining a household. Many of these IADL tasks are ones that a younger child would not be expected to perform independently. Remember, the intent of this question is to determine the amount of assistance provided on a regular basis, not whether or not it is appropriate for the child to be performing the task independently.

The need for PCS is a separate determination, although it does require accurate information on this and the other items. Younger children may receive total assistance (exhibit Total dependence) in all of these activities simply because of their age. If that is the case, then record it as such – Total dependence.

- Definition:**
- a. **Meal preparation:** prepared light meals/snacks (e.g., planning, cooking, assembling ingredients, setting out food & utensils).
 - b. **Medication assistance:** managed medications (e.g., remembering to take medicines, opening bottles).
 - c. **Telephone use:** made and received telephone calls (using assistive devices, such as large numbers, amplification); includes finding number, making calls.
 - d. **Escort to medical appointments**
 - e. **Laundry:** sorting, washing, folding, putting away personal laundry (e.g., clothing, underwear), bedding and towels.
 - f. **Ordinary/light housework:** ordinary work around the home (e.g., doing dishes, dusting, sweeping/vacuuming, making bed, cleaning bathroom, tidying up).

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g. Grocery shopping: shopping for food and household items (e.g., could take longer because of client's special diet or behavior).

Process: The client and the caregiver or responsible adult are questioned directly about the assistance provided and the client's performance of normal activities around the home or in the community in the last 7 days. You also should use your own observations as you are gathering information for other items.

The codes below often refer to "≥3 times" or provided three or more times. This means that the specific type of assistance was provided during three or more episodes of care or IADL assistance. A client might receive medication once a day. The caregiver might cue the client to get the medication bottle, get a glass of water, indicate the number of tablets to be taken, cue him to close the bottle, return it to the medicine cabinet, and take the empty water glass to the kitchen. Three or more cues were given, but that is ONE episode of assistance with medication. Three or more episodes of medication assistance with one or more cues provided are required to code toileting as code "2."

Code: There is a special code to be used throughout Section M, for the IADLs and ADLs: code "8." That code means that the activity (e.g., grocery shopping in IADLs or locomotion outside the home in ADLs) did NOT occur during the last 7 days. It is intentionally not sequential with the codes that represent the different levels of assistance the client might have received.

0 = No help/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: Client highly involved in activity; received hands-on help on some occasions (at least ≥ 3 times) but not all the time

4 = Extensive assistance: Client 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 of the activity by others during entire period

8 = Activity did not occur: During entire 7 day period

General coding rules for IADLs and ADLs: If a client received two types of assistance during the last 7 days (e.g., “Intervention/Cueing/ Redirection” 4 times and “Limited assistance” 2 times, code to the level which the client received three or more times. If the child received assistance at two levels an equal number of times (“Limited Assistance” 3 times and “Extensive Assistance” 3 times), code for the higher level of assistance.

Example on Coding

- Here is a possible conversation between the case manager (CM) and the client concerning meals and how they are prepared. Kayla is 12 years old.

CM: Do you prepare your own meals?

Kayla: Well, sometimes. I make good pancakes.

CM: Think about breakfast in the last 7 days. Who gets your breakfast?

Kayla: I get myself some cold cereal with milk most mornings, except the weekends. My daddy makes omelets for us on Sundays.

CM: Do you get your breakfast without any help?

Kayla: Well, my mom puts out the cereal box and gets the bowl down for me, and she pours the milk in a little cup so I can pour it over my cereal.

CM: How about lunch?

Kayla: I get lunch at school.

CM: What about lunch on the weekends?

Kayla: Saturday we got to order pizza. Sunday we went to my grandma's.

Stop and think – do you even need to ask about how dinner is prepared in order to code the meal preparation item?

What do you know at this point? Kayla is clearly not independent – nor is she totally dependent. Moving in from these ends of the continuum, where do you think she falls? Does she receive more or less than 50% of the tasks of meal preparation without assistance – considering just breakfast and lunch in the last 7 days?

How much of the dinner preparation would Kayla have to do to change your answer? What would you

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ask?

Coding Suggestion: If the client performed some of the task during the last 3 days, the client cannot be coded as a “5”- total dependence. Similarly, if the client received any assistance from someone else with a task, the client cannot be coded as a “0”- independent. So, work your way to the correct code from the extremes.

Coding Example: Medication assistance

Wyatt is a 10-year old with ADHD, and he takes a low dose of Ritalin three times a day. When you ask him how he manages his medications, he says he takes care of it himself. So, you ask how he does that. He tells you that each week, his mother puts his morning and afternoon pills in a medication caddy. For each day, he takes one in the morning before breakfast and one in the afternoon when he comes home from school. At school, he remembers to go to the school nurse who dispenses a pill at lunchtime. When you check with his mother, she agrees with what Wyatt said and reports that he is very good about remembering, and on the weekend he even remembers to take the three pills she puts in the caddy for Saturday and Sunday.

Code Medication assistance: “3” for Limited assistance.

Rationale: Wyatt gets set-up help from his mother. The only hands-on help he gets is from the school nurse who dispenses the medication. Wyatt remembers to go to the nurse and, if he had access to the medication might be able to take it himself, but you are coding his performance, not capacity.

M.2 Effects of Illness or Condition in IADL Needs/Care (Last 7 Days)

Intent: To determine if the client’s condition or illness affects the need for assistance on these tasks. **NOTE:** You will be coding M.1 on these same activities.

Process: Investigate M.2 as you determine the child’s level of performance on M.1. Then, ask or record the response to M.2. The impact of the child’s condition may be on the child’s performance of the activity or on the amount of help needed from a caregiver with performance of the activity.

Code: **0 = Client’s condition did not affect the performance of the task**
(i.e., time it takes to do task or the number of persons needed to do task)

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1 = Client's condition affected the performance of the task

(because of client's condition, task regularly takes longer to perform
OR two-person assistance regularly provided/needed)

Coding Example: Meal preparation

Jackson is a 4-year old who, because of absorption problems in his intestinal tract, must be fed foods on a special diet list that takes considerable time to prepare.

Code Meal preparation: "1" - Client/Child's condition affected the performance of the task

Rationale: Jackson's condition affects the frequency and difficulty of the performance of meal preparation.

Coding Example: Medication assistance

Wylie is a 5-year old who must receive medication 4 times a day to avoid seizures. His parents administer the medication. He takes the medication without resistance.

Code Medication assistance: "0" - Client/Child's condition did not affect the performance of the task

Rationale : Wylie must take medication because of his condition, but his condition does not affect the level of assistance required with the task. At five-years old, he does not yet read and is unable to manage his own medications.

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COMPLETE ITEMS O.2.a.(2) – O.2.g.(2) NOW

Process: Review the section just completed.

In any instance in which an M.1 IADL score equals zero, there is no functional limitation and thus a “0” is recorded in Columns M.1 and M.2 and would be transferred to O.2, Column 2 as a “0” – *no functional limitation*.

For any IADL in which M.1 is greater than 0, then a functional limitation is present. If a functional limitation is present but is not affected by the child’s condition or problem, the proper code in Column O.2 Column 2 is “1” = *functional limitation present but...not affected by client’s condition or problem*.

If a functional limitation in IADLs is present and is related to the child’s condition or problem, then “2” is the proper code in O.2, Column 2 for that IADL.

Code: **0 = No functional limitation**

1 = Functional limitation present but the functional limitation is not affected by the client’s condition or problem.

2 = Functional limitation is present and is affected by the client’s condition or problem.

Example of M.1 information transfer to Section O: Esmeralda is a 4-year old client. She is totally dependent in “laundry” but the dependence is not related to any health condition or problem. So, Esmeralda has a functional limitation in laundry, but, though present, the functional limitation is not affected by the child’s condition or problem.

Section O.2 PERSONAL CARE ASSISTANCE IN AVERAGE/USUAL WEEK				
	(1) Activity	(2) Need	(3) PCS	(4) Additional Information
e.	Laundry	1	0	

M.3 Activities of Daily Living (ADL) (last 7 Days)

Intent: To record the client's performance and assistance received in basic activities of daily living (ADLs). This item addresses what the client actually did for himself or herself and how much help was provided by family members or others during the last 7 days. Younger children may not be able to perform some of these tasks due to their age, but remember the intent of this section is to determine how much assistance the child receives in performing each task over the last 7 days. Include all 24 hours of the day. The goal is not to estimate how much help they should receive, but rather to indicate how much assistance they are currently receiving. **NOTE:** You will also be coding M.4 on the same activities.

Definition: **ADL PERFORMANCE:** measures what the person actually did (not what he or she might be capable of doing) within each ADL category over the last 7 days according to the performance-based scale.

- a. **Bed mobility:** how client moved to and from a lying position in bed, turns side to side, and positions his/her body while in bed
- b. **Positioning:** how client moved to and from different positions while sitting in a chair or other piece of furniture or equipment
- c. **Eating:** how the client ate and drank (regardless of skill), including intake of nourishment by any method (e.g., tube feedings, total parenteral nutrition). This includes the use of adaptive utensils, if used
- d. **Transfers:** how client moved between surfaces, to/from bed, chair, wheelchair, standing position; (EXCLUDES bath/shower transfers)
- e. **Locomotion/mobility inside the home:** how client moved between locations in the home. If client uses a wheelchair/electric cart, it is treated as any other assistive device. Transfer into and out of the wheelchair/cart should be coded in Transfers.
- f. **Locomotion/mobility outside the home:** how client moved between locations outside the home (like the driveway, the yard or to the busstop. If client uses a wheelchair/electric cart, it is treated as any other assistive device. Transfer into and out of the wheelchair/cart should be coded in Transfers
- g. **Toilet use:** how the client used the toilet, including using the toilet room or commode, bedpan, urinal; transferred on and off the toilet or commode chair; cleaning self after toilet use (includes cleansing after incontinence episode and changing pad or diaper); managing any special devices required (e.g., ostomy or catheter); and adjusting clothes

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- h. Dressing:** how client put on, fastened, and took off all items of clothing, including donning/removing shoes, prostheses
- i. Personal hygiene:** how the client managed personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands, managing feminine hygiene; (EXCLUDE baths and showers)

Process: First identify what the client actually does for himself or herself, noting when assistance is received and then clarifying the types of assistance provided (verbal cueing, physical support, etc.) and how often it was provided during the last 7 days. Be sure to consider performance across 24-hours a day.

A client's ADL self-performance may vary from day to day, or within the day. There are many possible reasons for these variations, including mood, medical condition, stamina, relationship issues (e.g., the child obeys and cooperates with his mother but resists care from his sister who provides care most afternoons before the mother gets home from work).

The responsibility of the case manager is to capture the total picture of the client's ADL performance over the 7 day period, 24 hours a day — e.g., not just how the case manager sees the client during the assessment visit.

In order to accomplish this, it is necessary to gather information carefully and, where possible, from multiple sources — e.g., interviews/discussion with the client, when possible, and the caregiver/responsible adult, as well as observation of the client. Ask questions pertaining to all aspects of the ADL activity definitions. For example, when discussing *Bathing*, be sure to inquire specifically how the client gets in and out of the tub or shower and score that under “bathing.” Then ask about the other activities associated with bathing. A client can be independent in one aspect of bathing yet require extensive assistance in another.

Since accurate coding is an important basis for making decisions on the type and amount of PCS the client may need, be sure to consider each activity definition fully.

The wording used in each coding options reflects real-world situations, where slight variations in a client's performance over the day or week are common. Where variations occur, the coding ensures that the client is not assigned to an excessively independent or dependent category. By definition, the codes permit one or two exceptions for the provision of heavier care during the 7-day observation period. Examples of this are shown below.

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To evaluate a client's ADL performance, begin by observing how the client is performing physical tasks during your visit. Talk with the client and caregiver to ascertain what the client does for himself or herself in each ADL activity as well as the type and level of assistance provided by others.

The following chart provides general guidelines for recording accurate ADL Self-Performance.

As noted in the discussion of IADLs, the codes below often refer to “ ≥ 3 times” or provided three or more times. This means that the specific type of assistance was provided during three or more episodes of care or ADL assistance. A client might use the toilet once. The caregiver might cue the client to clean himself with tissue, pull-up his clothes, tuck-in his shirt, zip-up his pants, button his pants, and wash his hands. Three or more cues were given, but that is ONE episode of assistance with toileting. Three or more episodes of toileting assistance with one or more cues provided are required to code toileting as code “2.”

Guidelines for Assessing ADL Performance

- The coding scale for ADLs records the client's actual level of involvement in self-care and the type and amount of support actually received during the last 7 days.
- Do not record your assessment of the client's *capacity* for involvement in self-care — e.g., what you believe the client *might or should be able to do* for himself/herself.
- Do not record the type and level of assistance that the client “should” be receiving according to your expectations of what assistance current health care providers or family members should provide. The type and level of assistance actually provided may be quite different from what is indicated in a service plan (e.g., current home health care agency plan of care) or even from what you may think the client *needs*. Record what is actually happening. (You may, however, refer the client for further assessment or review of services based on your observation of what the client needs that he/she is not receiving.)
- Engage the caregiver or other household members who have cared for the client over the last 7 days in discussions regarding the client's ADL performance. Remind these respondents that the focus is on the last 7 days and covers performance across the full 24-hours each day. To clarify your own understanding and observations about each ADL activity (bathing, dressing, locomotion, transfer, etc.), ask probing questions, beginning with the general and proceeding to the more specific.

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- Code:**
- 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:** Stand-by assistance, encouragement, redirection, cueing provided ≥ 3 times.
- 3 = Limited assistance:** Client 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 by caregiver 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 during the last 7 days).
- 8 = Activity did not occur:** during entire 7-day period

Definition cues/crib sheet for coding ADLs, remembering the qualifiers above:

No help: client performed the ADL activity without any type of assistance or received help (set-up, supervision/cueing, or hands-on assistance) only 1-2 times.

Set-up: think in terms of someone doing nothing but providing or setting out the things or equipment the client needed to perform the task, such as bringing the client his mobility appliance or setting out her clothing.

Examples of “set-up” help:

- For dressing: selecting and setting out clothing
- For eating: cutting food, opening bottles or cartons
- For locomotion: bringing an assistive device or equipment to the client (e.g., wheelchair, cart, walker)
- For positioning: bringing client wedge or other assistive device to help client maintain position in bed or chair

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Cueing/Redirection: think in terms of *Verbal Help* (e.g., cueing, redirection) or *Active Monitoring* (e.g., stand-by assistance) for the task. This is not baby-sitting.

Limited: think in terms of *Hands-On assistance but no help that involved weight-bearing*.

Extensive: think in terms of *Weight-Bearing* or full task performance by a caregiver for some but not all of the time. Also, with extensive assistance, the client is involved physically in some way in the activity.

Total dependence: think in terms of *someone else doing the entire task all the time* for the client – the client did not physically perform any part of the task.

Activity did not occur: for example: A client who was restricted to bed for the entire 7-day period and was never transferred from the bed (e.g., to a bed-side commode or chair) would receive a code of “8” for locomotion inside, locomotion outside, and transfers. However, do not confuse a client who is totally dependent in an ADL activity

(Code 5 - Total Dependence) with the activity itself not occurring. For example: even a client who receives tube feedings and no food or fluids by mouth is engaged in eating (that is, receiving nourishment), and must be evaluated under the Eating category for his or her level of assistance in the process. A client who is highly involved in giving himself a tube feeding is not totally dependent and should NOT be coded as a “5” – totally dependent.

NOTE: each of these ADL Self-Performance scoring categories is exclusive. There is no overlap between response categories. Changing from one performance code to another code demands that there was an increase or decrease in the number of times that help was provided or in the type of assistance provided (e.g., non-weight-bearing to weight-bearing). In general, code the assistance that is provided three or more times.

There will be times when there is no one type or level of assistance provided to the client 3 or more times during a 7-day period. However, the sum total of support of various types (e.g., a combination of supervision/cueing and limited physical assistance) may equal three or more times. This means that the client cannot be coded as “0” – Independent. If the client received help of one type two times and help that was more extensive twice, code for the **most dependent assistance category**.

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If the client received help of two different types an equal number of times (e.g., limited assistance four times and extensive assistance four times), code for the highest level of assistance that was provided (i.e., extensive assistance in this case).

- j. Bathing:** How client took full bath/shower, including transfer in and out. Bathing includes washing of back and hair. This also includes turning faucets on and off and regulating water temperature. Code for the **most dependent** performance in last 7 days – using codes below. These codes are different from codes used for the other items **a-i**).

0 = Independent

1 = Set-up help only

2 = Cueing/Redirection/Standby assistance

3 = Physical/hands-on help limited to transfer

4 = Physical/hands-on help in part of bathing activity

5 = Total dependence – full performance by other

8 = Activity (full bath) did not occur during entire 7 days

Use codes listed above for “Bathing” item only

The following examples are intended to help. However, short scenarios never give you the kind of clear picture you will get in meeting with a client and responsible adult. Do not get distracted by the examples. The response codes are reasonably clear, and in “real” interviews, the correct response to use for each item will be much easier to identify.

Examples

The client received standby assistance for walking in the house on four separate occasions because he tends to have balance problems and falls. He received guided maneuvering (e.g., hand on arm) non-weight bearing assistance on one occasion.

Code “2” for Cueing/Redirection

Rationale: There were 5 total episodes of help, and Cueing/Redirection -- the code that includes stand-by assistance -- was the only category that occurred three or more times. Note that this decision rule is expressed in each code with the modifier (e.g., “help \geq 3 times”).

The client received cueing and redirection in dressing every time he dressed. He received non-weight bearing assistance (e.g., buttoning and unbuttoning the client’s shirt and pants) on two days.

Code “3” for Limited Assistance

Rationale: There were multiple episodes of cueing/redirection. (You would need to probe to see how often he dressed during the last 7 days and whether he got the same help with undressing. But assume he got cueing and redirection at least 7 times for dressing in the morning; we don’t know about undressing.) He received physical assistance that was non-weight bearing on two DAYS – or four occasions (note, buttoning and unbuttoning). (You would have to probe to make sure that it occurred at least twice each of the two days.) If so, the correct answer is **Limited Assistance** because it reflects the most dependent support category that includes 3 or more types of assistance.

Example

Here is a possible conversation between the assessor and family member regarding locomotion outside the home. (This example assumes you have already discussed this with the client/child and have some concerns about the accuracy of her responses.)

CM: “Tell me how Susan gets around outside the house. Has she been outside during the last seven days?”

Parent: “Yes, she went out yesterday and the day before. And then of course, each day for school.”

CM: “How did she get around when she went out? Did you help her?”

Parent: “Well, for the last three days, she had to use her wheelchair. Her breathing was so bad, she could not walk on her own. Saturday is typical. We were going to the mall. So, I brought her wheelchair to the door. And of course, I put the wheelchair in and took it out of the car. Same thing yesterday. We went to church in the morning, and then we went out to a movie last night.”

CM: “So, once she was in the wheelchair at the mall, did you push the wheelchair?”

Parent: “No. Susan is real particular. It’s electric, and she manages it herself. She always runs that chair where she wants and how fast. She’s a pistol.”

CM: “How many times during the last 7 days did you give this type of help with bringing the chair to the door and getting it in and out of the car?”

Parent: “Each time we went out on Friday, Saturday and Sunday. So, three.”

For Locomotion Outside of Home – the correct code would be “1” – **Set-up help only**

Rationale: The item asks about the client’s self-sufficiency one he or she is in the wheelchair and the only assistance Susan received was that her mother got the wheelchair and brought it to her.

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Example	Rationale	Code
<i>Eating</i>		
Bobby is a 16-year-old boy who gives himself tube feedings four times per day. He requires no assistance or reminders.	Bobby is independent in eating, requiring no help or cueing/redirection. CM would code eating as “0.”	0
Sally is a 7-year-old with severe cerebral palsy. She is unable to effectively use utensils and requires one-on-one assistance to eat and supervision to ensure she does not choke	Sally is unable to perform this task alone due to her health condition. She is totally dependent on the responsible caregiver for assistance. CM would code eating as “5.”	5
<i>Personal Hygiene</i>		
Timmy is a 9-year-old boy who is combative daily during grooming tasks. He clamps his mouth shut and flails around, requiring that one person hold him while the other brushes his teeth, combs hair, etc.	Timmy requires two-person assist on a daily basis to perform personal hygiene tasks. CM would code Personal Hygiene as “5.” <i>Note that with M.5.b, was there any two-person assist with any other ADL care, the answer would be “yes.”</i>	5
Joe is a six-year-old boy who has a mild intellectual disability, mental retardation/developmental disability, or developmental delay. He is physically capable of brushing his teeth and combing his hair, but requires daily reminders and cueing for each step.	Joe requires only cueing/redirection for these tasks on a daily basis. CM would code Personal Hygiene as “2.”	2
<i>Dressing</i>		
Because of 8-year-old Jean’s severe contractures, she is unable to dress herself independently. Jean is able to select appropriate clothing and is able to lift her limbs but requires assistance with guiding limbs into clothing, zipping, buttoning, etc., on a daily basis.	Jean requires Limited Assistance from her caregiver for dressing. CM would code Dressing as “4.”	4
Fifteen-year-old John is physically capable of dressing tasks but has Autism and will not dress himself unless he has one-on-one assistance for cueing and redirection. His father selects his	John requires cueing/redirection with dressing, as his father’s assistance is mostly with set-up and cueing/redirection, but occasionally (but not more than two times per week)	2

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clothing and directs each step of the process frequently having to redirect John to the task at hand. Approximately two times per week John's father will have to physically assist him by pulling his shirt over his head or zipping his pants.	with pulling shirt over head or zipping pants. CM would probe to make sure that hands-on assistance was not provided more than twice, and if not, code Dressing as "2."	
<p>Four-year-old Grace wears braces on both legs. Although she likes to try to dress herself, she requires assistance with getting pants on over her braces. She wears pants most every day.</p> <p><i>What would the CM need to ask at this point?</i></p> <p>The person helping Grace put on her pants must help Grace lift her legs into the pants because of the weight of the braces.</p>	Grace's mom or dad provides Extensive Assistance (weight - bearing) with dressing daily, allowing Grace to do as much as possible on her own but assisting with getting her pants over her braces every day. CM would code Dressing as "4."	4
<i>Bathing</i>		
15-year old Marcie likes to bathe herself. She has juvenile rheumatoid arthritis, and she needs help transferring into and out of the combination tub/shower. Every day but one, she managed everything else on her own. However, one day, her arthritis was particularly painful, and her mother had to turn the water on and adjust the temperature, help her into and out of the tub/shower, and wash her feet, calves and back. She did her upper body on her own.	<p>Marcie gets help with transfers into and out of the tub every day (which would be a code of "3"). But on one day, Marcie received help with part of the bathing activity, which is a code of "4."</p> <p>Rationale: Code bathing for the <u>most dependent</u> episode over the 7 days.</p>	4

M.4 Effects of Illness or Condition in ADL Needs/Care in Last 7 Days

Intent: To determine whether the client's condition or illness affects the need for assistance on these tasks. **NOTE:** You will be coding M.3 on these same activities.

Code: Code "0," when the client's condition has no impact the amount of assistance needed.

0 = Client's condition did not affect the performance of the task
(e.g., time it takes to do task or the number of persons needed to do task)

1 = Client's condition affected the performance of the task
(e.g., because of child's condition, task regularly takes longer to perform
OR two-person assistance regularly provided/needed)

Coding Example 1: Eating

Bobby is a 16-year-old boy who gives himself tube feedings four times per day. He requires no assistance or reminders.

Code Eating: "0" - Client/Child's condition did not affect the performance of the task

Rationale: Bobby's condition demands the tube-feeding. But, his condition doesn't affect the amount of assistance he requires for eating.

Coding Example 2: Eating

Emilio is a 10-year old who has cerebral palsy. He lacks the amount of control over his arms he would need to eat unassisted. His mother must spoon-feed him.

Code Eating: "1" - Client/Child's condition affected the performance of the task

Rationale: Emilio is ten-years old. His mother says that if it weren't for the CP, Emilio could eat unassisted.

COMPLETE ITEMS O.2.h.(2) – O.2.o.(2) NOW

Process: Review the section just completed.

In any instance in which an M.3 ADL score equals zero, there is no functional limitation and thus a “0” is recorded in Columns M.3 and 4 and would be transferred to O.2, Column 2 as a “0” – *no functional limitation*.

For any ADL in which M.3 is greater than zero, then a functional limitation is present. If a functional limitation is present but is not affected by the child’s condition or problem, the proper code in Column O.2 Column 2 is “1” = *functional limitation present but...not affected by client’s condition or problem*.

If a functional limitation is present and is related to the child’s condition or problem, then “2” is the proper code in O.2, Column 2 for that ADL.

Code: **0 = No functional limitation**

1 = Functional limitation present but limitation is not affected by the client’s condition or problem.

2 = Functional limitation is present and is affected by the client’s condition or problem.

M.5 Any Two-Person Assistance Received

Intent: To determine if at any time during the last 7 days the client received assistance from two or more individuals (at the same time) with transfers or any other form of ADL care.

Definition:

- a. With any transfer:** Such as from the bed, chairs and any other furniture, or the toilet; include two-person assistance with standing from the sitting position
- b. With any other ADL:** Two-person assistance with any ADL (other than transfers) (e.g., bed mobility, positioning, eating, locomotion inside and out, toilet use, dressing, personal hygiene, and bathing)

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Code: **0 = No**

1 = Yes

M.6 Client Needs Cueing/Redirection During ADLs or IADLs due to a Mental, Behavioral, or Developmental problem/condition

Intent: To determine whether there is a need for special assistance during the performance of ADLs or IADLs due to a mental, behavioral, or developmental condition. For example, one person is required to hold the hands of a child while another attends to bathing needs because the child becomes agitated when bathing and often strikes out, or a female client who is 17 years old can take the bus to school but someone must stay with the client until she boards the bus or she will wander away from the stop.

Process: Talk with the client and caregiver/responsible adult and observe the client to determine whether any special assistance is needed because of some mental, behavioral, or developmental health condition during the performance of ADLs or IADLs.

Code: **0 = No**

1 = Yes

M.7 Main Mode of Locomotion/Mobility in Last 7 Days

Intent: To record the main mode of locomotion utilized by the client to get around inside and outside the home. If you want to monitor the client's status over time, it is important to know whether the main mode is walking or using a wheelchair or cart.

- Definition:**
- a. Walking was *main* mode of locomotion/Mobility** – although the client might use a wheelchair or other mobility aid, walking was the main way the child got around
 - b. Wheelchair/cart/scooter was *main* mode of locomotion/Mobility**
 - c. Walking and wheelchair/cart used about equally**

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Process: Talk with the client and caregiver/responsible adult and observe the client to determine whether any assistive devices are used to aid the client in locomotion.

Code: 0 = No

1 = Yes

M.8 Use of & Need for Assistive Devices to Maximize/Support Functioning

Intent: To identify any assistive devices currently used or that may be needed for the client to perform ADL and IADL tasks as independently as possible.

Definition: Assistive Devices for ADL Activities

- a. Hospital bed
- b. Bed mobility aids: e.g., bed rails, special mattress, postural supports like foam wedges, bed enclosure
- c. Transfer aids: e.g., trapeze, transfer board, seat lift chair, Hoyer lift
- d. Wheelchair, cart
- e. Mobility aids/devices: e.g., cane, quad cane, crutches, walker
- f. Bathing aids: e.g., shower chair, tub transfer bench
- g. Medication management: e.g., talking clock, daily medication organizer.
- h. Meal preparation; e.g., rocker knife, devices to open jars, to reach things on high shelves for someone in a wheelchair.
- i. Telephone use: e.g. any device the client uses to successfully use telephone, like a voice-activated telephone.
- j. Transportation: e.g., any device that assists with accessing transportation, like a ramp, special chair, or swivel cushion.
- k. Augmentative communication device: e.g., Picture Exchange System (PECS), Blissymbols, portable text-to-speech communication aids

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l. Gait trainer

m. Transcutaneous Electrical Nerve Stimulation (TENS) unit: typically used in the management of chronic pain

n. Chest Physio Therapy (CPT) vest: to help a client clear his/her airways

o. Other (specify)

p. Other (specify)

Code: Code “0” when a DME item is not needed or “1” when the client has the appropriate DME. This equipment must be available and adequate to help in the relevant task. Code “2” when need DME is not available or when the available DME needs to be replaced with new or different equipment.

0 = Not needed

1= Assistive device is available and adequate

2= Referral to assess for unmet DME needs

M.9 Results of Discussion of DME Needs with Client/Family

Intent: This item records the family/client’s responses to an inquiry about DME needs. Report the conclusion reached by the family/client about DME needs.

Code: **0 = No concerns expressed about current DME needs**

1 = Yes, client/caregiver believes new or additional DME needed

COMPLETE ITEM O.3.d NOW

Process: In O.3.d, indicate whether a referral is needed.

Code: **0 = No**

1 = Yes

SECTION N

HOUSEHOLD RESOURCES

**If the client is 18 years of age or older,
then skip to Section O.**

Intent: To determine the characteristics of the responsible adult/primary caregiver for the client/. To determine whether any challenges or conditions may prevent the responsible adult(s) charged with the client's care from providing needed assistance to the client. If only one responsible adult, then record barriers for that person. If multiple responsible adults are in the household, then record all barriers affecting all responsible adults. With multiple responsible adults, you should clarify the situation using the space on p. 16.

Items N.1 through N.3 refer to the person who assumes the most responsibility for the care of the client. Item N.4 concerns all responsible adults.

N.1 Responsible Adult Age

Intent: Record the age of the responsible adult. Age at last birthday. If over 99 years of age, then record "99."

N.2 Responsible Adult Gender

Intent: Record the gender of the responsible adult.

Code: 1 = Female

2 = Male.

N.3 Responsible Adult Relationship To Client

Intent: Record the relationship of the responsible adult to the client.

Code: 1 = Parent

2 = Grandparent

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3 = Sibling

4 = Other family member

5 = Other relationship (e.g., foster parent, guardian, family friend, etc)

N.4 Responsible Adult Status/Challenges

- Definition:**
- a. **School full-time:** Responsible adult is enrolled and attending school (e.g., high school, GED course, college, vocational training) on a full-time basis according to the definition used by the institution (e.g., usually > 12 semester in Fall and Spring semesters or ≥ 9 quarter hours for three quarters per year).
 - b. **School part-time:** In school part-time, but not full time.
 - c. **Working full-time:** Outside the home (e.g., > 35 hours per week).
 - d. **Working part-time:** Outside the home, but not full time.
 - e. **Other work situation:** (specify)
 - f. **Responsible adult for other children:** If item “f” is coded as “Yes,” record the number of children in the household who are either (1) other children OR (2) children with special needs. This count does NOT include the client being assessed for PCS. Notice that there are two columns, so use “0” as a filler if needed. (*This would not include someone operating a child daycare center, which would be a work situation.*)

0	2
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- g. **Caregiving for a disabled or challenged adult family member in household** (specify)
- h. **Responsible person’s sleep is interrupted frequently throughout the night because of caregiving responsibilities related to client’s condition** (e.g., *could include behaviors that disrupt sleep; caregiver unable to get 6-8 hours of uninterrupted sleep*)
- i. **Because of physical limitations or disabilities (strength/stamina), responsible person(s) unable to assist client with some ADL or IADL tasks**

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j. Other (specify)

Code: **0 = No**

1 = Yes

Code “1” (Yes) in the corresponding right hand column space for all statements that describe the responsible adult accurately. Code “0” (No) in the corresponding right hand column space for all statements that do not accurately describe the responsible adult.

SECTION O

STRENGTHS AND NEEDS

Section O is at the heart of PCS determination. In item O.1 the case manager has noted problems recorded in earlier section of the PCAF that may affect PCS needs. In item O.2, the case manager determines for which tasks PCS assistance will be provided. In O.6, the case manager works with the client/responsible adult to determine the number of hours of PCS services that will be authorized for the client. Referrals for other services and DME are also addressed in Section O.

O.1 Additional Considerations and Potential Complexities

Intent: To identify problems noted earlier in the assessment that may affect the child's or client's need for PCS services. The goal is to help you identify and bring together information from other sections of the assessment that may affect your decisions.

Definition: O.1 coincides with sections in the PCAF that may affect ADL and IADL needs or need for referral for additional services. O.1 is completed as the assessment is conducted by transferring information from earlier assessment sections (C – L) to Section O.

Column 1 specifies the issues or potential complexities, while Column 2 provides the item numbers for those issues/complexities

- a. Diagnoses/Conditions
- b. Decision-making
- c. Communication
- d. Hearing/Vision
- e. Behavior
- f. Weight/Height
- g. Medications
- h. Continence
- i. Other

Process: Review the information in Sections C - L and provide the appropriate code in O.1. Column 3:

Code: Codes for Problems that May Affect Client/child Needs (Column 3)

0 = No problems noted

1 = At least one problem noted

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NOTE: Additional comments about how this issue affects the clients need for PCS or referral may be made in O.1 column (4) (or in O.9 if you need more space).

O.2 Personal Care Assistance in Average or Usual Week

Intent: PCS policies indicate that PCS services can be provided when a client's functional limitations and care needs are related to the client's conditions or problems. Family/Responsible Adult resources and limitations, as discussed in Section N (*Household Resources*) also play a role in determinations.

Definition: O.2, Column 2 items coincide with (or are informed by) the items found in Sections M.1 through M.4, and M.6 in the PCAF.

Column 1 lists the IADL, ADL or Special Need items in Section M.

Column 2 links information on the clients need for assistance because of a functional limitation with the issue of whether any limitation is related to a client's condition(s) or problem(s)

Column 3 summarizes the various decisions that could be made about PCS services and included whether the client/responsible adult requests services and the case manager's decision (approval/denial), along with a rationale. (*Note that decisions about the number of PCS hours authorized and specific referrals are made elsewhere in this Section.*)

Code: **Column (2) Potential** PCS Need (based on functional limitation related to condition/problem)

0 = No functional limitation

1 = Functional limitation present but the limitation is not affected by client's condition or problem

2 = Functional limitation is present and is affected by client's condition or problem

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Process: These responses will be completed as Section M is completed in the instrument.

Definition: In general, Sections M.2 and M.4 indicate whether any functional limitation and need for assistance is associated in some way with the client's condition. In the earlier example, a 4-year old was totally dependent in the IADL of laundry; however, her need for assistance with laundry was not associated with her underlying physical or mental/behavioral health conditions or problems. Further, her health condition did not increase the time it takes to do the task or how many people's help is needed to complete the task. However, in some cases the responses in M.2 and M.4 may not fully reveal the way in which the client's conditions affects the client's functional limitation and resulting need for assistance. Thus, the case manager must use her/his best judgment in making this coding decision.

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Example. Coding Section O.2

Tonya is a 5-year old client. She is totally dependent in most IADLs, including meal preparation, laundry, ordinary housework and so on; however, but the dependence is not related to any health condition or problem. She also needs assistance with medications. She has seizure disorder and requires medications at 8 am, Noon, 4 pm, and at 8 pm. At midnight, she is given a different long-lasting medication. Tonya receives extensive assistance from her mother in medication. She needs someone to get the medication, hand it to her and remind her to take it on time. However, she can open the blister pack, put the pill in her mouth and swallow without help. But the *amount* or type of assistance that she needs and receives is not affected by her condition. At kindergarten, she receives the medication from the school nurse; in the morning and at night, she receives the medication from her mother. The problem is in the afternoon, when a teenager from the neighborhood “babysits” but is not qualified to give Tonya her medication because she forgets to do it on a regular schedule.

(1) Activity		(2) Need	(3) PCS	(4) Additional Information
b.	Medication assistance	1	1	Tonya has seizure disorder. (C.I.k). Mother in vocational education program from Noon to 5 on M-TH; 13-year old neighbor babysits after school but does not always remember to give Tonya her afternoon (4pm) anti-seizure medication on time. Med is in a blister-pack and a personal care attendant can hand the medication to the child with a glass of water and cue her to take it. Tonya can open and take the med on her own.
d.	Ordinary housework	1	0	

Ignore for a moment the issue of nurse-delegated tasks and focus on the coding issue and rationale.

Rationale: Tonya was dependent on help from others for all IADLs, including ordinary housework and medications. Her condition did not affect whether it was difficult or time consuming to help her with housework – so she got a code of “0”. You could argue that the same was true for medications. So, in M.2.b, you might have selected the response of “0” – “*Client/child’s condition did not affect the performance of the task.*” However, the fact that Tonya has seizure disorder and requires medication on a regular basis every 4 hours during the day means that her condition did affect her need for medication assistance. Thus, she would receive a “1” in O.2 - Column 3.

The Graphical Presentation of the PCS Decision Process is ***ILLUSTRATIVE*** of the most common cases. Usually the codes in M.2 and M.4 on whether the client’s condition or problem has an effect on their functional limitation and need for assistance will determine what you code in terms of whether there is a potential need for PCS assistance in O.2 – Column 2. But in some instances, the issues or complexities noted in O.1 will affect your decision on whether the child’s conditions or problems are related to their need for assistance with an ADL or IADL task – and hence your decision on PCS eligibility and hours.

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O.2 - Column (3)

Intent: Column (3) of O.2 is where the case manager records the determination of whether PCS services were requested and will be approved for specific activities/tasks. The completion of this column will inform the case manager's decisions about hours of service (the worksheet in O.6) where PCS is authorized.

Code: **Column (3)**

0 = No PCS assistance requested

1 = PCS assistance requested and approved

2 = PCS assistance requested but denied because of no functional limitation

3 = PCS assistance requested but denied because requested assistance is not covered by PCS services

4 = PCS assistance requested but denied because functional limitation is not related to client's condition/problem

5 = PCS assistance requested but denied because functional limitation must be addressed by a skilled health professional

6 = PCS assistance requested but denied because PCS need is currently being met by another agency or program

7 = PCS assistance requested but denied because caregiver can meet needs (not applicable to client ≥ 18)

8 = PCS assistance requested but denied for other; specify in Column (4).

Coding Example				
(1) ACTIVITY		(2) NEED	(3) PCS	(4) ADDITIONAL INFORMATION
a.	Meal preparation	1	4	Tom needs help with meal preparation because of his age, not because of any health problem. He has asthma but can independently use his "rescue" inhaler, and the twice-daily inhaled corticosteroid can be scheduled when his parents are there to help.
b.	Medication assistance	2	6	

In the illustration above the client has a functional limitation in meal preparation (needs assistance in set-up). The parent has requested assistance with that task so that the 10-year old child can
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prepare light supper for himself before the mother gets home from work. However, the client's need for set-up help is unrelated to the child's condition, so PCS is not approved. The child has medication assistance needs. He has asthma and needs reminders to shake his new long-acting inhaler for five seconds before taking a puff. Then he needs to wait, shake it again, and take another puff, but he forgets to do this – and he must take this inhaler twice a day. He does need assistance, and it is related to his health condition (asthma), but this is an inhaler whose use can be scheduled to occur when the parent is at home. Thus, PCS is denied.

The coding scheme for column (3) may seem complex. However, it is designed to mirror the case manager's decision process in their determination about whether to approve or deny PCS determination. Also, it provides a written record documenting the rationale behind the PCS decision, which may later be important in any dispute or appeal.

Column (4) and the pages available in 0.9 can be used to provide any further detail needed concerning the decision about the types of needs for which PCS is being considered.

O.3 Referrals Needed

Intent: To determine, based on the assessment, what health or educational referrals the case manager recommended for the client.

Process: Review the completed sections of the PCAF instrument and make note of any recommended referrals for assessments concerning the following:

Definition:

- a. **Mental or behavioral health specialist services (G.3)**
- b. **Nursing services assessment (See J.3)**
- c. **Therapies or Treatments (See K.2)**
- d. **Durable Medical Equipment (DME) assessment (See M.8 and M.9)**
- e. **Other referrals related to PCS (specify) _____**

Code:

0 = No

1 = Yes

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O.4. Enhanced Rate Eligibility

- Intent:* To document the client's formal caregivers are eligible for the Enhanced Rate
- Process:* Review responses for items C.6 and M.6
- Code:* 0 = No, C.6 does not equal two (2) or three (3) at the same time that M.6 equals one (1)
- 1 = Yes, C.6 equals two (2) or three (3) and M.6 equals one (1).

O.5 Target Date for Next Assessment

- Code:* Record the next follow-up assessment date in accordance with the standard time frame between assessments and reassessments set by DSHS.

O.6 PERSONAL CARE WORKSHEET

- Intent:* To determine and record the number of minutes of PCS care that is to be authorized because of the client's condition(s) or problem(s) and the caregiver/responsibilities, resources and limitations. This set of seven worksheets, one for each day of the week, is where a case manager records the hours of PCS that the case manager believes appropriate for the client.

- Process:* Discuss needs with the client and caregiver/responsible adult. Keep results in Sections O.1 and O.2 as you complete this Section. For example, if a client's condition creates no IADL needs, and the child has no need for assistance in eating or dressing, then the number of PCS hours needed in the morning will probably be lower. The reverse is equally true. If a client needs assistance with eating and dressing, the PCS hours needed in the morning episode of care may increase if the caregiver/responsible adult is unable to meet those needs during part or all of the time.

Any mobility\locomotion assistance related to another IADL/ADL is recorded here as part of the care time provided for that other IADL/ADL. For example, if it takes five minutes to assist a person to the toilet from where they are located, ten minutes to help them use the toilet, and five minutes to move them to that or another location, then toileting takes 20 minutes.

If no other IADL/ADL is being performed, then that time is recorded as assistance in locomotion. If it takes 10 minutes to move someone from the dining room table

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to the porch where they will sit until their next episode of care, then that is ten minutes devoted to locomotion\mobility assistance. No other IADL/ADL assistance is being provided. It is simply assistance in getting from one place to another.

Enter the start time of the episode of care in Column (i). Enter the code for each IADL/ADL being performed (ii) during that care episode. Enter the time required for each IAL/ADL in parentheses in Column (ii). In Column (iii) record the total minutes of PCS care authorized for that episode of care. In Column (iv) indicate the caregiver barrier that prevents the responsible person(s) from performing those tasks listed in Column (ii). Enter the end time for the episode of care in Column (i).

Repeat the above for as many care episodes and days as necessary to record all the PCS care the client will receive during the week.

If the PCS care in any day of the week is identical to that provided in an earlier day of the week, then put a diagonal line thru the later day and write in "SAME AS ...DAY." For example, if the PCS care to be authorized for Tuesday is the same as that for Monday, then a diagonal line would go across from O.6.2a to O.6.2h. SAME AS MONDAY would be written in that space.

In the same vein, if during one day, one episode of care is exactly the same as another, then the details of that episode need not be duplicated in O.6. For example, a child on Wednesday evening from 7:00 to 8:30pm might receive the same care the child received on Wednesday from 8:30 to 10:00am. If so, then the case manager may indicate the time for the second episode of care in Column (i), draw a line though the rest of the row, and write on that row, SAME AS 8:30AM.

Code: The seven Personal Care Worksheets provides space for recording PCS services approved for up to eight episodes of care (a-h) for each day of the week O.6.1-O.6.7).

Column (i) = time during which PCS is provided (e.g., 8:00-9:30am)

Column (ii) = IADL/ADL codes with the PCS time required in parentheses. For example, 14 (15) would indicate that the child was approved for 15 minutes of assistance with toilet use. Enter the code for each IADL/ADL performed during the time period and the time for that activity in parentheses next to it. IADL/ADL codes appear at the bottom of each Worksheet page.

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Column (iii) = The sum of all the minutes of care for this time period appearing in parentheses in Column (ii).

Column (iv) = The barriers that keep the responsible person(s) from providing care during the time noted in Column (i). Codes for Column (iv) appear in the center right of each page of the Worksheet.

Items O.6.1i.(iii), O.6.2i.(iii)...O.6.7i.(iii) = The sum of the number of minutes recorded in Column (iii) for each day.

Item O.6.8 = total of items O.6.1i(iii)O.6.7i(iii) or the total number of minutes of PCS care authorized for each day (total PCS for week)

[SEE THE EXAMPLE ON THE NEXT PAGE]

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0.6 PERSONAL CARE SERVICES WORKSHEET [EXAMPLE]

SUNDAY					COMMENTS/ELABORATION (May be continued on later pages, if necessary)
	Time PCS Needed (i)	ADL/IADL task(s) (task time in minutes) (ii)	Total minutes (iii)	Caregiver Barrier(s)(iv)	
1a.	8:00-9:30am	14 (10) 17(20) 15(10) 16 (10)	50	3	
1b.	1200-1:00pm	1 (20) 6(30)	50	2	
1c.					
1d.					
1e.					
1f.	800pm	SAME AS 8:00AM	_____	_____	
1g.					
1h.					
1i.	TOTAL PCS TIME FOR DAY (IN MINUTES) (SUM OF 0.6.1a.iii – 0.6.1h.iii)		150		
MONDAY					
	Time PCS Needed (i)	ADL/IADL task(s) (task time in minutes) (ii)	Total minutes (iii)	Caregiver Barrier(s)(iv)	
2a.					
2b.					
2c.					
2d.					
2e.					
2f.		SAME AS SUNDAY			
2g.					
2h.					
2i.	TOTAL PCS TIME FOR DAY (IN MINUTES) (SUM OF 0.6.2a.iii – 0.6.2h.iii)				

O.7 PCS Hours Authorized (*relative to client/responsible adult request*)

Intent: The intent of the item is to record whether the amount of time authorized by the case manager is in accord with the request of the client/ responsible adult at the time of the assessment. Note that what seems to the case manager to be agreement at the time of the assessment does not affect the responsible person's ability to subsequently disagree with these PCS decisions.

Code: **0 = Responsible person/client made no request for a specific amount of PCS assistance**

1 = PCS hours authorized equal or exceed hours requested by responsible person/client

2 = PCS hours authorized are fewer than hours requested by responsible person/client

O.8 Nature of Any Disagreement About PCS Hours/Rationale for Difference

Process: Record any relevant comments regarding disagreement about PCS hours. Additional space is available in O.9

O.9 Additional Comments Related to Client's need for PCS, Nursing Services or DME

Code: Record any additional observations that could be relevant to the client's needs.

O.10 Case Manager Information (Current Assessment)

Definition:

- a. Case manager signature**
- b. Case manager printed name**
- c. Date**

Code: Sign and print your name and record the date in the corresponding spaces provided. The date recorded will ideally be the same as the assessment date.

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CHAPTER 3

ITEM-BY-ITEM DEFINITIONS FOR THE PCAF AGES 0-3[©]

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SECTION AA

CLIENT/CASE MANAGER INFORMATION

The information in Section AA is descriptive, factual information required by the Department of State Health Services. No instruction on the completion of these items is included in this manual.

SECTION A

OTHER PROGRAM/AGENCY INVOLVEMENT

A.1 Other Program/Agency Involvement

Intent: To identify any other agencies/programs (DARS, DADS, WIC, ECI, MHA, MRA, DFPS, IHFS, Waiver program, etc.) with which the child or his/her family is involved.

Code: Record the agency or program providing services to the child or family in the “Agency/Program” column. In the “Client/Family Member” column record the name of the child or other family member involved with the agency or program identified in the previous column.

In the “Receiving/Referred/Applied/Waiting” column, record the individual’s (client or family member) status with the agency/program by recording one of the four words (receiving, referred, applied, or waiting) best describing their status. In the “Contact Person” column, record the name of an individual associated with the agency/program involved with the child or family. Provide the phone number for the individual identified in the column labeled “Phone Number.”

Note: For any information that is not applicable or is not available (and will remain unavailable), record a “9” in the corresponding space. If only two other agencies are involved, then only rows ‘a’ and ‘b’ will be completed. For rows ‘c’ through ‘f,’ Put a “9” in column 1 and draw a line through columns 2 through 5.

SECTION B

REASON FOR ASSESSMENT

B.1 Reason for Assessment

Intent: To record the reason for the assessment.

Code: Record the current reason for the assessment with the number in the box. If the reason is “other” please specify the reason in the space provided.

0 = Intake assessment

1 = Scheduled reassessment

2 = Change in status assessment

3 = Other (specify)

SECTION C

DIAGNOSES & HEALTH CONDITIONS

NOTE:

For **C.1, C.2, C.3, C.4**: Code only for those active diagnoses that **currently** affect the client's functional, cognitive, behavioral status or need treatment/therapy/medication or on-going behavior management interventions **AND** were diagnosed by a licensed health care professional. For **C.5** - code only those conditions or problems that currently affect the client's functional, cognitive, or behavioral status or require treatment, therapy, or medication.

C.1 Medical Diagnoses

Intent: To document the presence of diseases, infections, or health conditions relevant to the child's current ADL status, cognitive status, mood or behavior status, medical treatments, nursing supervision, or risk of death. In general, these types of conditions are associated with the type and level of care needed by the person. Do not include conditions that have been resolved or no longer affect the child's function or care needs.

The disease conditions in this section require a diagnosis by a licensed health professional (usually a physician), although you will be relying on the caregiver to relay this information to you. Probe, however, to determine whether a physician told the family member child that this was a diagnosis made by a physician. Remember that these diagnoses must affect the child's current health or functional status.

You do not need a medical background to complete this section, since you are asking the family to report a physician's diagnoses. The definitions below are provided merely for your information and, if necessary, to help you probe if a family member is describing the health diagnosis without using the precise words on the form.

- Definition:**
- a. **Anemia:** includes anemia of any origin
 - b. **Apnea:** temporary suspension of breathing, occurring in some newborns (infant apnea)
 - c. **Arthritis:** either rheumatoid or osteoarthritis

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- d. **Asthma/respiratory disorder:** includes chronic bronchitis, reactive airway disease
- e. **Cancer:** any malignant growth or tumor caused by abnormal or uncontrolled cell division; must be a **current** cancer, not a cancer for which the child was treated and has recovered
- f. **Cerebral Palsy:** paralysis believed to be caused by a prenatal brain defect or by brain injury during birth, most marked in certain motor areas and characterized by difficulty in control of the voluntary muscles. It may be acquired after birth from brain damage in the first few months or years of life. CP often follows infections of the brain, such as bacterial meningitis or viral encephalitis, or it may be the result of a head injury.
- g. **Cleft Palate:** deformity of the palate at birth
- h. **Congenital heart disorder:** heart disorder of any type present at birth
- i. **Cystic Fibrosis:** hereditary disease affecting mucus glands, usually results in thick mucus in lungs
- j. **Diabetes:** includes insulin-dependent diabetes (IDDM) and diet-controlled diabetes (NIDDM)
- k. **Epilepsy or other chronic seizure disorder:** neurological disorder resulting in recurrent, unprovoked seizures
- l. **Explicit terminal prognosis:** physician indicates that child has six months or less to live
- m. **Failure to thrive:** describes children whose current weight or rate of weight gain is significantly below that of other children of similar age and sex; growth failure, or failure to thrive (FTT), *is a descriptive term and not a specific diagnosis*
- n. **Hemophilia:** refers to a group of bleeding disorders in which it takes a long time for the blood to clot. This may cause abnormal bleeding. In most cases, the disorder is passed down through families (inherited) and most often affects males
- o. **Hydro/microcephaly:** Hydrocephalus is a build-up of fluid inside the skull, which causes brain swelling. Hydrocephalus means "water on the brain."

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Microcephaly describes a head size significantly smaller than normal for a person's age and sex, based on standardized charts.

- p. Metabolic disorders:** hereditary disorders that affect the body's ability to metabolize specific types of substances (e.g., PKU)
- q. Muscular Dystrophy:** a group of disorders that involve progressive muscle weakness and loss of muscle tissue
- r. Paraplegia/tetraplegia/quadruplegia:** paralysis of the lower half of the body with involvement of both legs usually due to disease of or injury to the spinal cord; **tetra/quadruplegia** is paralysis of all four limbs.
- s. Pathological bone fracture:** bone fracture (often repetitive) due to problems with bone structure or strength.
- t. Renal failure:** acute (sudden) kidney failure is the sudden loss of the ability of the kidneys to remove waste and concentrate urine
- u. Spina Bifida or other spinal cord dysfunction:** birth defect involving the backbone and spinal canal; includes any congenital defect involving insufficient closure of the spine
- v. Substance-abuse related problems at birth:** (e.g., fetal alcohol syndrome, cocaine dependency)
- w. Traumatic brain injury:** damage to the brain as a result of physical injury to the head

Code: **0 = No**

1 = Yes, condition active and diagnosed

Code "1" in the right-hand corresponding column space for any condition with an active diagnosis from a licensed health professional. For all conditions listed that are not present or diagnosed, code "0" in the right-hand corresponding column space.

C.2 Other Medical Diagnosis

Definition: a-c. Specify any other relevant diagnoses in these spaces

Process: Consult the caregiver charged with the child's care to determine the presence of any medical diagnosis not listed in the previous item (C.1). This condition must be an active diagnosis made by a licensed medical professional.

Code: Use the three lines labeled "specify" to record an active medical diagnosis not documented in item C.1.

C.3 Infections

Definition: a. **Antibiotic resistant infection (e.g., including but not limited to Methicillin Resistant Staphylococcus Aureus [MRSA]):** an infection in which bacteria have developed a resistance to the effective actions of an antibiotic

b. **Other (specify):** e.g., cellulitis, urinary tract infection

Code: 0 = No

1 = Yes, condition active and diagnosed

Code "Yes, condition active and diagnosed" only if the infection has a relationship to current ADL status, cognitive status, mood and behavior status, medical treatment, nursing supervision, or risk of death. Do not record any conditions that have been resolved and no longer affect the child's functional status or care plan. For example, do not code "1" in the right hand corresponding column space for "other" if the child had TB several years ago, unless the TB is either currently being controlled with medication or is being regularly monitored to detect reoccurrence. For infections not defined above, such as TB, record the name of the diagnosed infection in the space provided next to "Other (specify)."

C.4 Psychiatric/Behavioral Diagnoses

Definition: a. **Attention Deficit Disorder or Attention Deficit-Hyperactivity Disorder:** Attention Deficit Hyperactivity Disorder (ADHD), sometimes called Attention Deficit Disorder (ADD) - is a problem with inattentiveness, distractibility,

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over-activity, impulsivity, or a combination of these behaviors as diagnosed by a medical professional.

- b. Autistic disorder or other pervasive developmental disorders (e.g., Asperger's, Rett's):** Autistic Spectrum Disorder (ASD), Pervasive Developmental Disorder (PDD). The main signs and symptoms of autism involve problems in communication, problems in social interactions, or repetitive behaviors. Asperger's syndrome is a milder version of autism. Rett's syndrome is a rare inherited disease related to autism that causes developmental and nervous system problems, mostly in females.
- c. Disruptive behavior disorder (e.g., conduct disorder, oppositional defiant disorder):** Conduct disorder involves chronic behavior problems, such as defiant, impulsive, or antisocial behavior; drug use; or criminal activity. Oppositional defiant disorder is a pattern of disobedient, hostile, and defiant behavior toward authority figures.
- d. Down Syndrome:** This is a genetic syndrome that is usually accompanied by specific physical characteristics and some impairment in intellectual functioning.
- e. Intellectual disability/MR/DD:** Intellectual disability is also called mental retardation (MR) or mental retardation/development disability (MR/DD) or developmental delay. It is a condition diagnosed before age 18 that includes below-average general intellectual function, accompanied by impairment in the person's ability to acquire the skills necessary for daily living.
- f. Other (specify)**
- g. Other (specify)**

Process: These are psychiatric/behavioral conditions and should be based on a formal diagnosis by a qualified health care professional. Ask the child's caregiver about whether the child has a history of psychiatric/behavioral disorders formally diagnosed by a medical or mental health professional.

Code: **0 = No**

1 = Yes, condition active and diagnosed

C.5 Health Conditions

- Definition:**
- a. **Fracture(s):** (self-explanatory)
 - b. **Recurrent aspiration:** often occurs in individuals with swallowing difficulties or who receive tube feeding (e.g., esophageal reflux of stomach contents). Clinical indicators include productive cough, shortness of breath, wheezing. It is not necessary that there be an X-ray evidence of lung aspiration for this item to be checked.
 - c. **Bed-bound or chair-fast:** because of health condition; at least 23 hours per day
 - d. **Shortness of breath during normal activities:** difficulty breathing occurring at rest or in response to normal activities
 - e. **Contracture(s):** permanent shortening of tissue (muscle, tendon, scar) that results in a deformity
 - f. **Pressure ulcers, wounds, skin lesions:** wounds from pressure or immobility
 - g. **Other (specify)**

Process: Gather information from child or caregiver/responsible adult. These conditions do not demand a diagnosis by a health professional. But, they must affect the child's current function, treatments, or health.

Code: **0 = No**

1 = Yes, currently active

COMPLETE ITEM O.1.a.(3) NOW

Process: Review the section just completed and note if any problems are present. If one or more potential problems or conditions are noted, the proper code for Item O.1.a column (3) is “1.” You may also complete O.1 column (4) with any specific information that you consider relevant to the child’s needs that are not captured by the response codes in Section O.

Code: **0 = No problems noted**

1 = At least one problem noted.

C.6 Client’s Current Condition

Intent: To document the type of current condition(s) that form the basis for the assessment.

Process: Consult caregiver/responsible adult to determine the type of condition(s) from which child suffers. Review responses sections C.1- C.5. You may also need to review documents.

Code: **1 = Medical**

2 = Psychiatric/Developmental/Behavioral

3 = Both

Code for the response that most accurately describes the child’s condition(s) requiring assessment concerning PCS, nursing services, therapies, and DME needs. Code “9,” if unknown.

SECTION D

COGNITIVE FUNCTION

D.1 Comatose or Persistent Vegetative State

Intent: To determine whether the child's clinical record includes a documented neurological diagnosis of coma or persistent vegetative state.

Definition: Comatose (coma) is a pathological state in which neither arousal (wakefulness, alertness) or awareness (cognition of self and environment) is present. The comatose person is unresponsive and cannot be aroused; he/she does not open his/her eyes, does not speak, and does not move his/her extremities on command or in response to noxious stimuli (e.g., pain).

Code: 0 = No

1 = Yes

Enter the appropriate number in the box provided. Code "1" (Yes) if the child has been diagnosed as comatose or in a persistent vegetative state and **Skip to Section H**. Code "0" (No) if child is not comatose or in a persistent vegetative state and proceed to next item (E.1).

SECTION E

COMMUNICATION

E.1 Making Self Understood (Expression)

Intent: To document the child's performance with respect to expressing or communicating needs. Communication may be through spoken words, body language and sounds that are consistently interpreted correctly or other communication method (e.g., sign language, device).

Process: Observe and listen to the child's efforts to communicate with you. Observe his or her interactions with family. Ask the family.

Code: Enter the code corresponding to the most correct response.

0 = Understood: The child expressed basic needs (e.g., hunger, thirst, need to urinate) without difficulty. Child was always/almost always understood by others.

1 = Difficulty making needs known: The child had difficulty expressing needs clearly; only understood some of the time.

2 = Rarely/Never Understood: Others rarely/never understand what child is trying to communicate. At best, only a limited number of others understand child; communication limited to interpretation of highly individual, person-specific sounds, behaviors, or body language (e.g., indicated presence of pain or need to toilet).

E.2 Ability to Understand Others (Comprehension)

Intent: To describe the child's performance in terms of comprehending information whether communicated to the child orally or in sign language. This item measures not only the child's performance in terms of capturing messages but also in terms of processing and understanding language. ***This is a test of comprehension, not hearing.***

Process: Interact with the child. Consult the child's family or the responsible adult.

Code: Enter the code corresponding to the most correct response.

0 = Understood: clearly comprehended the speaker's statements, requests or directions and demonstrated comprehension by words or actions/behaviors

1 = Difficulty understanding others: understood and responded to simple, direct communication, such as simple statements or requests

2 = Rarely/never understands/responds: rarely or never understood or responded to statements or requests. Assessor has difficulty determining whether the child comprehends messages, based on verbal and nonverbal responses.

COMPLETE ITEM O.1.b.(3) NOW

Process: Review the section just completed and note if any problems are present. If one or more potential problems or conditions are noted, the proper code for Item O.1.b. column (3) is "1." You may also complete O.1 column (4) with any specific information that you consider relevant to the child's needs that are not captured by the response codes in Section O.

Code: **0 = No problems noted**

1 = At least one problem noted.

SECTION F

HEARING AND VISION

F.1 Hearing

Intent: To evaluate the child's hearing (with environmental adjustments, if necessary) during the past 7-day period. The hearing assessment should be conducted with any hearing appliance normally used by the child.

Process: Evaluate hearing after the child has any hearing appliance in place and turned on (if the person uses an appliance). Be sure to ask if the battery works and the hearing aid is turned on. Observe the child, and ask the caregiver about hearing function. Consult the child's family. Test the accuracy of your findings by observing the child during your verbal interactions.

Be alert to what you have to do to communicate with the child. For example, do you have to speak more clearly, use a louder tone, speak more slowly, or use more gestures; does the child need to see your face to know what you are saying; do you have to take the child to a more quiet area to conduct the interview? All of these are cues that there is a hearing problem and should be so indicated in the coding.

Also, if possible, observe the child interacting with others (e.g., the family members).

Code: Enter the number that corresponds to the most correct response.

0 = Appears to hear adequately: responded to sounds (e.g., turns head, tracks sound; responds to speech)

1 = Impaired: absence of response to normal sounds

F.2 Vision

Intent: To evaluate the child's ability to see close objects in adequate lighting, using the child's customary visual appliances for close vision (e.g., glasses).

Definition: **“Adequate” lighting:** Lighting that is sufficient or comfortable for a person with normal vision, excludes both lighting that is too low and light that is glaring.

Process: Ask the caregiver about child's visual abilities. Observe the child's eye movements to see if his or her eyes seem to follow movement and objects. Though these are gross measurements of visual acuity, they may assist you in assessing whether the child has any visual ability.

Code: Enter the code corresponding to the most correct response.

0 = Adequate: eyes appear to follow objects, both near and far

1 = Impaired: eyes do not appear to follow objects

COMPLETE ITEM O.1.c.(3)NOW

Process: Review the section just completed and note if any problems are present. If one or more potential problems or conditions are noted, the proper code for Item O.1.c column (3) is “1.” You may also complete O.1 column (4) with any specific information that you consider relevant to the child's needs that are not captured by the response codes in Section O.

Code: **0 = No problems noted**

1 = At least one problem noted.

SECTION G

BEHAVIOR PATTERNS

To identify the presence of behavioral symptoms during the last 7 days that may cause distress to the child or are distressing or disruptive to others with whom the child lives. Such behaviors include those that are potentially harmful to the person or disruptive to others. These items are designed to pick up problem behaviors exhibited by the child that may be considered as “combative or agitated” by some health professionals.

G.1 Signs/Symptoms in Last 7 Days

Intent: To identify the frequency of behavioral symptoms during the last 7 days that cause distress to the child, or are distressing or disruptive to others with whom the child lives. Such behaviors include those that are potentially harmful to the person or disruptive to others. Acknowledging and documenting behavioral symptoms provides a basis for further evaluation, care planning, and delivery of consistent, appropriate care towards alleviating behavioral symptoms.

- Definition:**
- a. **Repetitive behavior that interferes with normal activities:** e.g., finger flicking, rocking, spinning objects, hand flapping
 - b. **Resisted ADL care:** resisted assistance with ADLs, such as bathing, dressing, toileting, eating
 - c. **Injury to self:** self-abusive acts; non-accidental injuries (e.g., head- banging)
 - d. **Sleep disturbances:** awake/active all or most of the night
 - e. **Disruptive behavior:** disruptive noisiness; screaming; temper tantrums that escalate into aggressive or violent behaviors
 - f. **Other challenging behavioral problem(s) (specify)**

Process: Ask the family member/caregiver if each specified problem behavior occurred. Take an objective view of the child's behavioral symptoms, and focus on the child's actions, not intent. It is often difficult to determine the meaning behind a particular behavioral symptom. The fact that some family members have become accustomed to the behavior or minimize the child's behavior (“He doesn't really mean to hurt anyone, he's just frightened”) should not be considered in coding items. Rather, code each item based on whether the child manifested the behavioral symptom.

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Observe the child and how the child responds to attempts by family members or others to deliver care. Ask caregivers if they know what occurred throughout the day and night for the past 7 days.

Code: **0 = No**

1 = Yes

G.2 Urgent Mental/Behavioral Health Service Use in the Last 30 Days

Intent: To determine whether urgent/unscheduled/unplanned mental or behavioral health services have been used in the last 30 days

Definition: **a. Admission to inpatient treatment for mental or behavioral health problem (includes hospital)**

b. Visit to emergency room for care or treatment of a mental or behavioral health problem

c. Urgent visit to a physician, psychiatrist, or mental or behavioral health specialist office because of a mental or behavioral health issue: Note that this is not a regularly scheduled visit or assessment

d. Other (specify)

Code: **0 = No occurrence in last 30 days**

1 = Occurred in the last 30 days

G.3 Referral to mental or behavioral health specialist

Intent: To determine if a referral to a mental or behavioral health specialist is needed because of the child's behaviors or concerns that some identified behaviors may directly interfere with meeting the child's personal care needs.

Code: **0 = No**

1 = Yes

COMPLETE ITEM O.1.d.(3) AND ITEM O.3.a NOW

Process: Review the section just completed and transfer the relevant information to Section O. If one or more potential problems or conditions are noted in the section, the proper code for item O.1.d column (3) is “1.” You may also complete O.1 column (4) with any specific information that you consider relevant to the child’s needs that are not captured by the response codes used in the assessment. In O.3.a, indicate whether a referral is needed.

Code: **O.1.d(3)**

0 = No problems noted

1 = At least one problem noted

O.3.a

0 = No

1 = Yes

SECTION H

HEIGHT AND WEIGHT

H.1 & H.2 Weight and Height (based on last 30 days)

Intent: To record a current height and weight in order to monitor nutrition and hydration status over time; also, to provide a mechanism for supervision stability of weight over time. Unintended weight loss can signify a significant health problem. Other weight changes may be expected and intended as the child grows.

Process: For weight, base weight on most recent weight taken within last 30 days, preferably by the child's physician. Ask the caregiver. If the physician's weight record occurred more than 30 days ago, ask for any recent weight taken by the caregiver. For height, follow the same process.

Code: Report weight in pounds or kilos (whichever unit the measurement is provided or measured in). Use "0" as a filler if the child weighs less than one hundred pounds or kilos. The measurement recorded in one unit will suffice; do not try to convert pounds to kilos or vice versa.

0	4	5		0	2	0
Weight in lbs.			OR	Weight in kilos		

Report height or length in inches or centimeters (whichever unit the measurement is provided or measured in). Use "0" as a filler if the child is less than one hundred centimeters in length. For example: for a child that is 36 inches in length, code as follows (Be careful regarding your response on this item. It was unreliably recorded in the previous trial of the instrument):

	3	6		0	9	1
Feet	Inches		OR	Centimeters		

COMPLETE ITEM O.1.e.(3) NOW

Process: Review the section just completed and note if any problems are present. If one or more potential problems or conditions are noted, the proper code for Item O.1.e column (3) is “1.” You may also complete O.1 column (4) with any specific information that you consider relevant to the child’s needs that are not captured by the response codes in Section O. A problem is present if there is there some indication that the client’s height or weight are not within normal bounds for his or her age. Case managers should use their best judgment in making this determination.

Code: **0 = No problems noted**

1 = At least one problem noted.

SECTION I MEDICATIONS

I.1 Number of Different Medications Taken

Intent: To determine the number of different medications taken in the last 7 days. This includes prescription and over-the-counter medications, as well as any medications prescribed on an “as-needed” or PRN basis. Medications considered can be administered by any route (e.g., pills, injections, ointments, and inhalation).

Process: Ask the caregiver to identify the medications actually taken in the last 7 days. Be certain that you specify that this is not just prescription medications, but any medications consumed regardless of how they were obtained.

Code: Record the number of medications the child is currently taking in the boxes provided. Use “0” as a filler if the child is currently taking less than ten different medications. For example: for an individual taking eight different medications record:

0	8
---	---

COMPLETE ITEM O.1.f.(3) NOW

Process: Review the section just completed and note if any problems are present. If one or more potential problems or conditions are noted, the proper code for Item O.1.f column (3) is “1.” You may also complete O.1 column (4) with any specific information that you consider relevant to the child’s needs that are not captured by the response codes in Section O.

Code: **0 = No problems noted**

1 = At least one problem noted.

SECTION J

LICENSED/PROFESSIONAL NURSING NEEDS

J.1 Care Activities Needed or Provided during Last 7 Days that May Require Nursing Care

Intent: To determine if the child is receiving or should possibly receive services provided by (or under the authority of) a licensed or professional nurse.

- Definition:**
- a. **Medication Management:** includes injections and other nursing activities related to medication management
 - b. **Intravenous medications:** includes any drug or biological (e.g., contrast material) given by intravenous push or drip through a central or peripheral port
 - c. **Intravenous feeding:** Parenteral or IV (feeding through a vein). This also sometimes called “parenteral alimentation or parenteral nutrition.”
 - d. **Feeding tube:** called enteral or tube feeding; the presence of any type of tube that can deliver food/nutritional substances/fluids/medications directly into the gastrointestinal system. Examples include, but are not limited to, nasogastric tubes, gastrostomy tubes, jejunostomy tubes, and percutaneous endoscopic gastrostomy (PEG) tubes.
 - e. **Nasopharyngeal suctioning:** suctioning of secretions from the upper-most part of the throat, behind the nose (e.g., often used with pediatric bronchitis patients)
 - f. **Tracheostomy care:** includes removal of cannula and cleansing of tracheostomy site and surrounding skin with appropriate solutions
 - g. **Wound or skin lesion care:** treatment or dressing of stasis or pressure/decubitus ulcer, surgical wound, burns, open lesions
 - h. **Oxygen:** administration or supervision
 - i. **Urinary catheter care:** insertion or maintenance (e.g., change, irrigation)

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- j. Comatose or persistent vegetative state:** care to manage the condition
- k. Ventilator or respirator - to manage equipment:** mechanical device designed to provide adequate ventilation in persons who are, or may become, unable to support their own respiration. Include any child who was in the process of being weaned off of the ventilator or respirator in the last 7 days. This does not include nebulizers or CPAP machines (used for apnea).
- l. Uncontrolled seizure disorder:** care and supervision for safe management
- m. Unstable medical condition:** assessment, observation, and management on a daily basis
- n. Other periodic assessment, management, supervision:** once or twice a month
- o. Other (specify)**

Process: Consult the caregiver for each item. Ask if the child has received each type of care activity within the last 7 days.

Code: **0 = Not needed**

1 = Needed and provided

2 = Needed but not provided

Code “0” to indicate that the child does not need the service. Code “1” indicates that the service is both needed and provided. Code “2” indicates that the service is needed but not provided.

J.2 Urgent Medical Care Use in Last 30 Days

Intent: To identify the occurrence of urgent or unplanned medical care usage in the past 30 days.

Definition:

- a. Visit to emergency room for care or treatment of a medical problem**
- b. Admission to hospital for medical care**
- c. Urgent visit to physician's office for physical illness (not a regularly scheduled visit or checkup)**
- d. Other (specify):**

Code:

0 = No occurrence in last 30 days

1 = Occurred in last 30 days

J.3 Referral for Nursing Assessment

Intent: To identify the need for referral for assessment to determine whether new or additional nursing services are needed, for example, an unstable medical condition; significant change in health or functional status; or the need for more/different care, additional services, or supervision.

Code:

0 = No

1 = Yes

COMPLETE ITEM O.3.b NOW

Process: In O.3.b, indicate whether a referral is needed.

Code:

0 = No

1 = Yes

SECTION K

TREATMENTS AND THERAPIES

K.1 Treatments or Therapies Received or Needed in Last 30 Days

Intent: To review prescribed treatments the child has received or needed in the last 30 days. This section includes special treatments, therapies and programs received or scheduled during the last 30 days. Includes services received in the hospital, in the home, or on an outpatient basis, but not within a day program/school.

- Definition:**
- a. **Chemotherapy:** includes any type of chemotherapy (anticancer drug) given by any route
 - b. **Radiation therapy:** includes radiation therapy or having a radiation implant
 - c. **Hemodialysis:** removal of blood from artery and return after it has been altered to achieve some therapeutic end (e.g., cleared of waste)
 - d. **Peritoneal dialysis:** dialysis in which the peritoneum is permeable membrane used for fluid transfer
 - e. **Hospice:** comfort care for those dying that is palliative, not curative.
 - f. **Physical therapy:** therapy services that are provided or directly supervised by a qualified physical therapist. A qualified physical therapy assistant may provide therapy but not supervise others giving therapy.
 - g. **Occupational therapy:** therapy services that are provided or directly supervised by a qualified occupational therapist. A qualified occupational therapy assistant may provide therapy but not supervise others giving therapy.
 - h. **Speech therapy:** services provided by a qualified speech-language pathologist. Services may involve assessing swallowing ability or hearing ability; providing swallowing therapy, speech therapy, or communication therapy; or providing hearing appliances and education.
 - i. **Mental health services:** services provided by a licensed mental health professional; includes counseling, development of behavior management program, etc.
 - j. **Home health aide:** traditionally provides “hands-on” assistance/support with activities of daily living (ADLs), such as bathing, dressing, using the toilet, etc.

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- k. Restorative nursing care/habilitative care:** services provided by a licensed nurse (or under direct supervision of an RN) to help maintain function (e.g., range of motion exercises)

l. Other (specify)

Code: **0 = Not needed**

1 = Needed and provided

2 = Needed but not provided

Code “0” to indicate that the child does not need the service. Code “1” indicates that the service is both needed and provided. Code “2” indicates that the service is needed but not provided. A code of “2” may indicate the need for a referral.

K.2 Referral to Consider Need for New/Different Treatment or Therapy

Code: **0 = No**

1 = Yes

COMPLETE ITEM O.3.c NOW

Process: In O.3.c, indicate whether a referral is needed.

Code:

0 = No

1 = Yes

SECTION L

CONTINENCE

L.1 Bladder and Bowel Appliances in the last 7 days

Intent: To determine and record the types of toileting assistance provided over 24 hours a day for the last 7 days

Definition: **Appliances:**

- a. **Indwelling catheter:** a catheter that is maintained within the bladder for the purpose of continuous drainage of urine, includes catheters inserted through the urethra by supra-pubic incision
- b. **Intermittent catheter:** a catheter that is used periodically for draining urine from the bladder. This type of catheter is usually removed immediately after the bladder has been emptied; includes intermittent catheterization, whether performed by a licensed professional or by caregiver or responsible adult. Catheterization may occur as a one-time event (e.g., obtain a sterile specimen) or as part of a bladder-emptying program.
- c. **External catheter:** a urinary collection appliance worn over the penis
- d. **Ostomy:** any type of excretory ostomy of the gastrointestinal or genitourinary tract. Do NOT code gastrostomies or other feeding “ostomies” here.
- e. **Other (specify):**

Code: Record appropriate code in the corresponding right hand column. A code of “2” may indicate the need for a referral.

0 = Not needed

1= Appliance is available and adequate

2 = New or different appliance may be needed because of condition or problem.

SECTION M

PHYSICAL FUNCTION

M.1 Instrumental Activities of Daily Living (Last 7 Days)

Intent: The intent of these items is to examine the areas of function often referred to as “instrumental” activities of daily living (IADLs) and include items associated with normal tasks and activities in maintaining a household. The intent of these items is to determine whether the amount of assistance required to perform the tasks is affected by *that is due to the child’s physical, mental, or behavioral health condition*.

- Definition:**
- a. **Meal preparation:** preparing meals or snacks (planning, assembling ingredients, cooking/preparing, setting out food and utensils)
 - b. **Medication assistance:** assistance with the child’s medications (e.g., giving medicines at the correct time and dosage, opening bottles, giving injections, applying ointments)
 - c. **Laundry:** sorting, washing, folding, putting away child’s personal laundry (e.g., clothing, underwear) and child’s bedding and towels
 - d. **Ordinary/light housework:** ordinary work around the home (e.g., doing dishes, dusting, sweeping/vacuuming, making beds, cleaning bathroom, or tidying up)
 - e. **Grocery shopping:** shopping for food and household items (e.g., could take longer because of child’s special dietary requirements)
 - j. **Escort to medical appointments**

Process: Talk to the caregiver. You also should use your own observations as you are gathering information for items. Your task is to determine whether the child’s physical, mental, or behavioral health condition causes the caregiver to be unable to perform the task alone or need help because the child’s condition makes the task require excessive time.

Code: Code for whether the type or level of assistance provided with IADLs during the last 7 days was affected by the child’s condition.

0 = Child's condition did not affect the performance of the task (e.g., time it takes to do task or the number of persons needed to do task)

1 = Child's condition affected task performance (because of child's condition, task regularly takes longer to perform OR two person assistance regularly provided/needed)

COMPLETE ITEMS O.2.a.(2) – O.2.f.(2) NOW

Process: Review the section just completed and note if any problems are present. If the code for a task in Section M.1 equals one, then the proper code for the corresponding item in Section O.2 is "1." You may also complete O.2 column (4) with any specific information that you consider relevant to the child's needs that are not captured by the response codes in Section O.

Code: **0 = Child's condition/problem does not affect performance of the task**

1 = Child's condition/problem does affect performance of the task.

M.2 Assistance with Activities of Daily Living (Last 7 Days)

Intent: The intent of these items is to examine the areas of function often referred to as basic activities of daily living (IADLs). The intent of these items is to determine whether the level or type of assistance required to perform these tasks *is affected by the child's physical, mental, or behavioral health condition.*

- Definition:**
- a. Bed mobility:** moved to or from a lying position, turns side to side, and positions while in bed
 - b. Positioning:** moved/positioned in chair or other piece of furniture or equipment
 - c. Eating:** ate and drank (regardless of skill), including intake of nourishment by any method (e.g., tube feedings; total parenteral nutrition)
 - d. Transfers:** moved between surfaces, to/from bed, chair, wheelchair, standing position (EXCLUDE bath/shower transfers)

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- e. **Locomotion/mobility inside:** moved between locations in the home or day program.
- f. **Toilet use:** used the toilet room (potty chair, bedpan); transferred on and off toilet; adjusted clothing
- g. **Dressing:** put on, fastened, and took off all items of street clothing, including donning/removing shoes, prostheses
- h. **Personal hygiene:** including combing hair, brushing teeth, washing/drying face and hands (EXCLUDE bathing).
- I. **Bathing:** took full bath including transfer in and out.

Process: Talk to the caregiver. You also should use your own observations as you are gathering information for items. Your task is to determine if the child's physical, mental, or behavioral health condition causes the caregiver to be unable to perform the task alone due to the need for a second person's assistance or need help because of the child's condition makes the task require excessive time.

Code: Code for whether the type or level of assistance provided with ADLs during the last 7 days was affected by the child's condition.

0 = Child's condition did not affect the performance of the task (i.e., time it takes to do task or the number of persons needed to do task)

1 = Child's condition affected task performance (because of child's condition, task regularly takes longer to perform OR two-person assistance regularly provided/needed)

COMPLETE ITEMS O.2.g.(2) – O.2.n.(2) NOW

Process: Review the section just completed and note if any problems are present. If the code for a task in Section M.2 equals one, then the proper code for the corresponding item in Section O.2 is "1." You may also complete O.2 column (4) with any specific information that you consider relevant to the child's needs that are not captured by the response codes in Section O.

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Code: **0 = Child's condition/problem does not affect performance of the task**

1 = Child's condition/problem does affect performance of the task

M.3 Main Mode of Locomotion/Mobility in Last 7 Days (with assistive device, if used)

Intent: To record the main mode of locomotion utilized by the child to get around in the home.

Process: Observe the child while consulting the primary caregiver and determine if any assistive devices are used to aid the child in locomotion.

Definition: **a. Crawling, scooting, rolling, or walking was *main* mode of locomotion/mobility**

b. Wheelchair/cart was *main* mode of locomotion /mobility

Code: **0 = No**

1 = Yes

M.4 Any Two-Person Assistance Received (code as you complete M.3)

Intent: To identify whether two-person assistance was needed

Definition: **a. With any transfer:** This can include bed to chair to standing, toilet, or bathing in the last 7 days.

b. With any other ADL during the last 7 days

Code: **0 = No**

1 = Yes

M.5 Client Needs Cueing/Redirection during ADLs or IADLs due to a Mental, Behavioral, or Developmental Health Problem/Condition

Intent: To determine if there is a need for special assistance during the performance or administration of ADLs or IADLs due to a mental, behavioral, or developmental health problem or condition. For example, one person is required to hold the hands of a child while another attends to toileting needs in order to avoid being scratched, hit or bitten by the child.

Process: Talk with the child and caregiver/responsible adult and observe the child to determine whether any special assistance is needed for the safety of self or others during the performance of ADLs or IADLs.

Code: **0 = No**

 1 = Yes

M.6 Durable Medical Equipment (DME)/Assistive Devices

Intent: To identify any assistive devices currently used or that may be needed for the child to perform ADL and IADL tasks as independently as possible.

Definition: **Assistive Devices for ADL Activities**

- a. Hospital bed**
- b. Bed mobility aids:** e.g., bed rails, special mattress, postural supports like foam wedges, bed enclosure
- c. Transfer aids:** e.g., trapeze, transfer board, seat lift chair, Hoyer lift
- d. Locomotion/mobility devices:** wheelchair, cart
- e. Walking aids/devices:** e.g., cane, walker, splint, stander
- f. Bathing aids:** e.g., shower chair, tub transfer bench
- g. Augmentative communication device:** e.g., Picture Exchange System (PECS), Blissymbols, portable text-to-speech communication aids

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h. Gait trainer

i. Transcutaneous Electrical Nerve Stimulation (TENS) unit: typically used in the management of chronic pain

j. Chest Physio Therapy (CPT) vest: to help a child clear his/her airways

k. Other (specify)

l. Other (specify)

Code: **0 = Not needed**

1 = Assistive Device is available and adequate

2 = Referral to assess for unmet DME needs

Code “0” when a DME item is not needed. Code “1” when the child has the appropriate DME. This equipment must be available and adequate to help in the relevant task. Code “2” when need DME is not available or when the available DME needs to be replaced with new or different equipment.

M.7 Results of discussion of DME needs with Client/Caregiver

Code: **0 = No concerns expressed about current DME needs**

1 = Yes, client/caregiver believes new or additional DME needed

COMPLETE ITEM O.3.d NOW

Process: In O.3.d, indicate whether a referral is needed.

Code:

0 = No

1 = Yes

SECTION N

HOUSEHOLD RESOURCES

Items N.1 through N.3 refer to the person who assumes the most responsibility for the care of the client. Item N.4 concerns all responsible adults.

N.1 Responsible Adult's Age

Intent: Record the age of the responsible adult. Age at last birthday. If over 99 years of age, then record "99."

N.2 Responsible Adult's Gender

Intent: Record the gender of the responsible adult.

Code: 1 = Female

2 = Male.

N.3 Responsible Adult's Relationship To Client

Intent: Record the relationship of the responsible adult to the child.

Code: 1 = Parent

2 = Grandparent

3 = Sibling

4 = Other family member

5 = Other relationship (e.g., foster parent, guardian, family friend, etc)

N.4 Responsible Adult(s) Status/Challenges

Intent: To indicate the characteristics of the responsible adult or primary caregiver. To identify any challenges or conditions may prevent the responsible adult(s) charged with the child's care from providing needed assistance to the child. If only one responsible adult, then record barriers for that person. If multiple responsible adults, then record all barriers affecting all responsible adults. With multiple responsible adults, you should clarify the situation using the space available for comments on pp. 7, 9 or 14.5.

Definition:

- a. In school full-time:** Responsible adult/caregiver is enrolled and attending school (e.g., high school, GED course, college, vocational training) on a full-time basis according to the definition used by the institution (e.g., usually ≥ 12 hours in Fall and Spring semesters or ≥ 9 quarter hours for three quarters per year).

- b. In school part-time:** In school part-time, but not full time.

- c. Working full-time:** Outside the home (e.g., > 35 hours per week).

- d. Working part-time:** Outside the home, but not full time.

- e. Other work situation (specify)**

- f. Responsible adult for other children:** If coded as "Yes," record the number of other children. Use "0" as a filler if needed. (This would not include someone operating a child daycare center, which would be a work situation.) This item also calls for recording the number of other special needs children in the household. Neither of these counts includes the child being assessed.

- g. Caregiving for disabled or challenged adult family member in household (specify):** for example, need to care for grandmother with dementia, or 25 year old uncle with severe mental retardation and limited mobility who lives in the household

- h. Caregiver's sleep is interrupted frequently throughout the night because of caregiving responsibilities related to child's condition.** Due to the demands of the child's health condition (*could include behaviors that disrupt sleep*), the caregiver is unable to get 6-8 hours of uninterrupted sleep.

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- i. Because of physical disability or limitations (strength, stamina, or range of motion) caregiver is unable to assist child with some ADL or IADL tasks
- j. Other (specify)

Code: **0 = No**

1 = Yes

Code “1” (Yes) in the corresponding right hand column space for all statements that describe the responsible adult accurately. Code “0” (No) in the corresponding right hand column space for all statements that do not accurately describe the responsible adult.

SECTION O

STRENGTHS AND NEEDS

Section O is at the heart of PCS determination. In item O.1 the case manager has noted problems recorded in earlier section of the PCAF that may affect PCS needs. In item O.2, the case manager determines for which tasks PCS assistance will be provided. In O.6, the case manager works with the responsible adult to determine the number of hours of PCS services will be authorized for the client.

O.1 Additional Considerations and Potential Complexities

Intent: To identify problems noted earlier in the assessment that may affect the child's need for PCS services.

Definition: O.1 coincides with most of the different sections in the PCAF. O.1 is completed as the assessment is conducted. It includes information on needs or problems discovered in:

- a. Diagnoses/Conditions
- b. Communication
- c. Hearing/Vision
- d. Behavior
- e. Height/Weight
- f. Medications
- g. Other

Code: Codes for Task Need (Column 3)

0 = No problems noted

1 = At least one problem noted

NOTE: Any additional comments may be made in O.1 column (4) or made in O.9 on page 14.

O.2 Personal Care Assistance In Average or Usual Week

Intent: PCS services for children are provided to meet functional needs related to the child's condition or problem. PCS may only be authorized for those activities in which a "1" appears in O.2 column (2). However, a "1" in column (2) does not guarantee that PCS will be provided.

Definition: O.2 items coincide with the items for section M. in the PCAF.

Column (2)

Code:

0 = Child's condition/problem does not affect performance of this task

1 = Child's condition or problem does affect performance of the task

Process: These responses will be completed as Section M is completed in the instrument.

Column (3)

Intent: Column (3) of O.2 is where the case managers record the determination of whether PCS services will be approved for specific needs. The completion of this column will assist as the case managers move to the worksheet in O.6.

Code:

0 = No PCS assistance requested

1 = PCS assistance requested and approved

2 = PCS assistance requested but denied because of no functional limitation

3 = PCS assistance requested but denied because requested assistance is not covered by PCS services (e.g., baby-sitting)

4 = PCS assistance requested but denied because functional limitation is not related to child's condition/problem (e.g., giving medications to a 5 year old)

5 = PCS assistance requested but denied because functional limitation must be addressed by skilled health professional (e.g., ostomy care)

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6 = PCS assistance requested but denied because PCS need is currently being met by another agency or program

7 = PCS assistance requested but denied because caregiver can meet child's needs

8 = PCS assistance requested but denied for other reasons; specify in Column (4).

(1) ACTIVITY		(2) NEED	(3) PCS	(4) ADDITIONAL INFORMATION
a.	Meal preparation	0	4	
b.	Medication assistance	1	1	
--	-----	-----	-----	
c.	Dressing	1	3	
d.	Escort to medical services	0	4	

In the illustration above the child has a functional limitation in meal preparation that is not related to the child's condition or problem. The caregiver has requested assistance with that task but since the need is unrelated to the child's condition, PCS is not approved. The child has medication assistance needs that are related to the child's condition and which can't be met by the responsible person, so PCS assistance is approved. The caregiver has requested assistance with dressing the child on weekend evenings so that the caregiver can go to social events. The child's needs in dressing are related to the child's condition, but this service is not covered by PCS, and column (3) is scored three. The caregiver requests assistance in arranging transport to the physician. The child does have a limitation in arranging transportation, but the need is not affected by the child's condition and the caregiver has no barriers to providing this assistance, so the code for column (3) is four.

The coding scheme for column (3) seems relatively complex. However, it is designed to mirror the case manager's decision process in their PCS determination. Also, it provides a written record documenting the rationale behind the PCS decision, which may later be important in any appeal or dispute.

Column (4) and the pages available in 0.9 can be used to provide any further detail needed concerning the decision about the types of needs for which PCS is being considered.

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O.3 Referrals & Services Needed

Intent: To determine, based on the assessment, what health or educational referrals the case manager recommended for the child.

Definition:

- a. **Mental or behavioral health specialist services (G.3)**
- b. **Nursing services assessment (See J.3)**
- c. **Therapies or Treatments (See K.2)**
- d. **Durable Medical Equipment (DME) assessment (See M.8 and M.9)**
- e. **Other referrals related to PCS (specify) _____**

Process: Review the completed sections of the PCAF instrument and make note of any recommended referrals for assessments concerning the following:

Code: **0 = No**

 1 = Yes

O.4 Enhanced Rate Eligibility

Intent: To document the child's formal caregivers are eligible for the Enhanced Rate

Process: Review responses for items C.6 and M.5

Code: 0 = No, C.6 does not equal two (2) or three (3) at the same time that M.5 equals one (1)

 1 = Yes, C.6 equals two (2) or three (3) and M.5 equals one (1).

O.5 Target Date for Next Assessment

Code: Record the next follow-up assessment date in accordance with the standard time frame between assessments and reassessments set by DSHS.

O.6 PERSONAL CARE WORKSHEET

Intent: To determine and record the number of minutes of PCS care that is to be authorized because of the child's condition(s) or problem(s) and the caregiver/responsibilities, resources and limitations. This set of seven worksheets, one for each day of the week, is where a case manager records the hours of PCS that the case manager believes appropriate for the child.

Process: Discuss needs with the caregiver/responsible adult. Keep results in Sections O.1 and O.2 as you complete this Section. For example, if a child's condition creates no IADL needs, and the child has no need for assistance in eating or dressing, then the number of PCS hours needed in the morning will probably be lower. The reverse is equally true. If a child needs assistance with eating and dressing, the PCS hours needed in the morning episode of care may increase if the caregiver/responsible adult is unable to meet those needs during part or all of the time.

Any mobility locomotion assistance related to another IADL/ADL is recorded here as part of the care time provided for that other IADL/ADL. For example, if it takes five minutes to assist a person to the toilet from where they are located, ten minutes to help them use the toilet, and five minutes to move them to that or another location, then toileting takes 20 minutes.

If no other IADL/ADL is being performed, then that time is recorded as assistance in locomotion/mobility. If it takes 10 minutes to move someone from the dining room table to the porch where they will sit until their next episode of care, then that is ten minutes devoted to locomotion or mobility assistance. No other IADL/ADL assistance is being provided. It is simply assistance in getting from one place to another.

Enter the start time of the episode of care in Column (i). Enter the code for each IADL/ADL being performed (ii) during that care episode. Enter the time required for each IAL/ADL in parentheses in Column (ii). In Column (iii) record the total minutes of PCS care authorized for that episode of care. In Column (iv) indicate the caregiver barrier that prevents the responsible person(s) from performing those tasks listed in Column (ii). Enter the end time for the episode of care in Column (i).

Repeat the above for as many care episodes and days as necessary to record all the PCS care the child will receive during the week.

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If the PCS care in any day of the week is identical to that provided in an earlier day of the week, then put a diagonal line thru the later day and write in "SAME AS ...DAY." For example, if the PCS care to be authorized for Tuesday is the same as that for Monday, then a diagonal line would go across from O.6.2a to O.6.2h. SAME AS MONDAY would be written in that space.

In the same vein, if during one day, one episode of care is exactly the same as another, then the details of that episode need not be duplicated in O.6. For example, a child on Wednesday evening from 7:00 to 8:30pm might receive the same care the child received on Wednesday from 8:30 to 10:00am. If so, then the case manager may indicate the time for the second episode of care in Column (i), draw a line through the rest of the row, and write on that row, SAME AS 8:30AM.

Code: The seven Personal Care Worksheets provides space for recording PCS services approved for up to eight episodes of care (a-h) for each day of the week O.6.1-O.6.7).

Column (i) = time during which PCS is provided (e.g., 8:00-9:30am)

Column (ii) = IADL/ADL codes with the PCS time required in parentheses. For example, 14 (15) would indicate that the child was approved for 15 minutes of assistance with toilet use. Enter the code for each IADL/ADL performed during the time period and the time for that activity in parentheses next to it. IADL/ADL codes appear at the bottom of each Worksheet page.

Column (iii) = The sum of all the minutes of care for this time period appearing in parentheses in Column (ii).

Column (iv) = The barriers that keep the responsible person(s) from providing care during the time noted in Column (i). Codes for Column (iv) appear in the center right of each page of the Worksheet.

Items O.6.1i.(iii), O.6.2i.(iii)...O.6.7i.(iii) = The sum of the number of minutes recorded in Column (iii) for each day.

Item O.6.8 = total of items O.6.1i(iii)O.6.7i(iii) or the total number of minutes of PCS care authorized for each day (total PCS for week)

[SEE THE EXAMPLE ON THE NEXT PAGE]

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O.6 PERSONAL CARE SERVICES WORKSHEET [EXAMPLE]

SUNDAY					COMMENTS/ELABORATION (May be continued on later pages, if necessary)
	Time PCS Needed (i)	ADL/IADL task(s) (task time in minutes) (ii)	Total minutes (iii)	Caregiver Barrier(s)(iv)	
1a.	8:00-9:30am	14 (10) 17 (20) 15 (10) 16 (10)	50	3	
1b.	1200-1:00pm	1 (20) 6 (30)	50	2	
1c.					
1d.					
1e.					
1f.	800pm	SAME AS 8:00AM	_____	_____	
1g.					
1h.					
1i.	TOTAL PCS TIME FOR DAY (IN MINUTES) (SUM OF O.6.1a.iii – O.6.1h.iii)		150		
MONDAY					
	Time PCS Needed (i)	ADL/IADL task(s) (task time in minutes) (ii)	Total minutes (iii)	Caregiver Barrier(s)(iv)	
2a.					
2b.					
2c.					
2d.					
2e.					
2f.		SAME AS SUNDAY			
2g.					
2h.					
2i.	TOTAL PCS TIME FOR DAY (IN MINUTES) (SUM OF O.6.2a.iii – O.6.2h.iii)				

O.7 PCS Hours Requested & PCS Hours Authorized

Intent: The intent of the item is to record whether the amount of time authorized by the case manager is in accord with the request of the responsible adult at the time of the assessment. Note that what the case manager considers agreement at the time of the assessment does not affect the responsible person's ability to subsequently disagree with these PCS decisions.

Code: **0 = Responsible person made no request for a specific amount of PCS assistance**

1 = PCS hours authorized equal or exceed hours requested by responsible person

2 = PCS hours authorized are less than hours requested by responsible person

O.8 Nature of Any Disagreement About PCS Hours/Rationale for Difference

Process: Record any relevant comments regarding disagreement about PCS hours. Additional space is available in O.9

O.9 Additional Comments Related to Client's need for PCS, Nursing Services or DME

Code: Record any additional observations that could be relevant to the child's needs.

O.10 Case Manager Information (Current Assessment)

Definition:

- a. Case manager signature**
- b. Case manager printed name**
- c. Date**

Code: Sign and print your name and record the date in the corresponding spaces provided. The date recorded will ideally be the same as the assessment date.

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CHAPTER 4

MOVING FROM THE PCAF[©] TO DECISIONS

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Personal Care Assessment Form (PCAF) Manual

This chapter is devoted to providing additional information on how case managers might move from the information on the PCAF to a decision concerning Medicaid nursing services, DME, and personal care services (PCS).

4.1 NEW PROCESSES

Some of the processes outlined below are relatively straightforward. For example, if any durable medical equipment (DME) need is discovered, then a referral occurs. When any nursing service may be needed, a referral is triggered. Whenever a new treatment or service may be needed, a referral for assessment is automatic.

However, the decision processes about PCS, outlined below, is not a simple formula in the sense that – “A” always leads directly to “B,” and “B” leads directly to “C times 2.” However, a clear process and sequence for making PCS decisions is set out that includes the consideration of items in various portions of the PCAF.

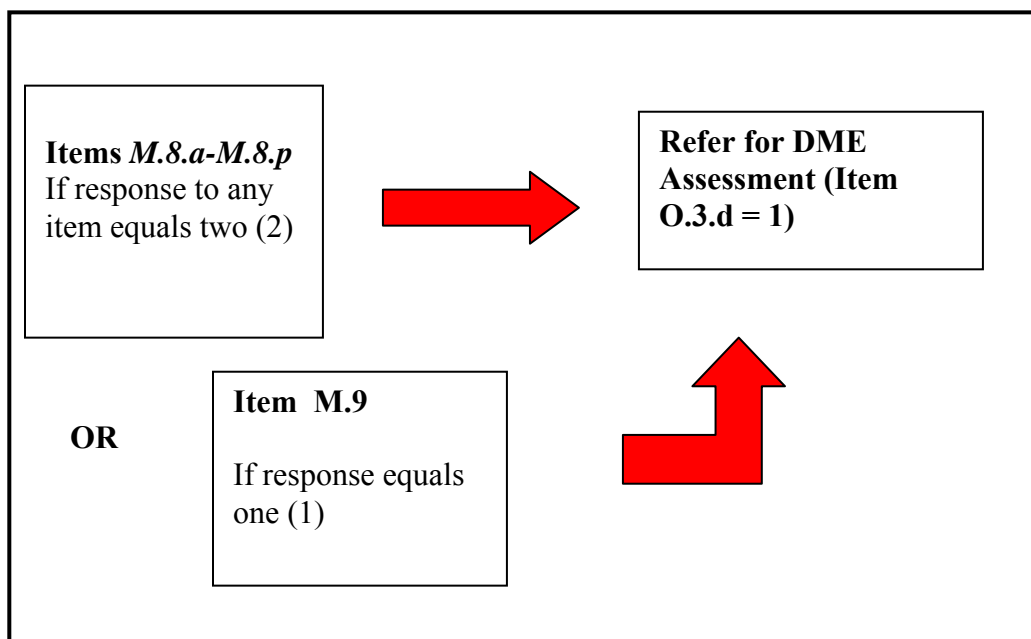
It is important to remember that an element of discretion is involved in making decisions concerning referrals and PCS services, as well as professional judgment. But, this use of discretion and professional judgment is not unique to PCS. Any service delivery system that emphasizes person-centered care involves some discretion. Many case managers’ decisions related to their case management activities involve elements of discretionary decision-making and the use of professional judgment. The PCS process, though less familiar than traditional case management decision-making, is a little different.

4.2 REFERRAL FOR DME

PCAF 4-20. The decisions concerning the referral for a review of the client's need for durable medical equipment (Figure 4.1) is relatively simple. If any item in **M.8** equals two (2), then refer for an assessment of the client's DME needs. If the client or responsible adult indicates that they believe an unmet need for DME exists (**M.9=1**), then refer for an assessment of DME needs (**O.3.d=1**).

PCAF 0-3. The same decision process is used for the PCAF 0-3, only the item numbers differ. The relevant items are items **M.6.a-M.6.i** and **M.7**. If any item in M.6 equals two (2) or M.7 equals one (1), then Item **O.3.d** (referral for DME review) should equal one (1).

Exhibit 4.1: Decision-making concerning DME with PCAF 4-20

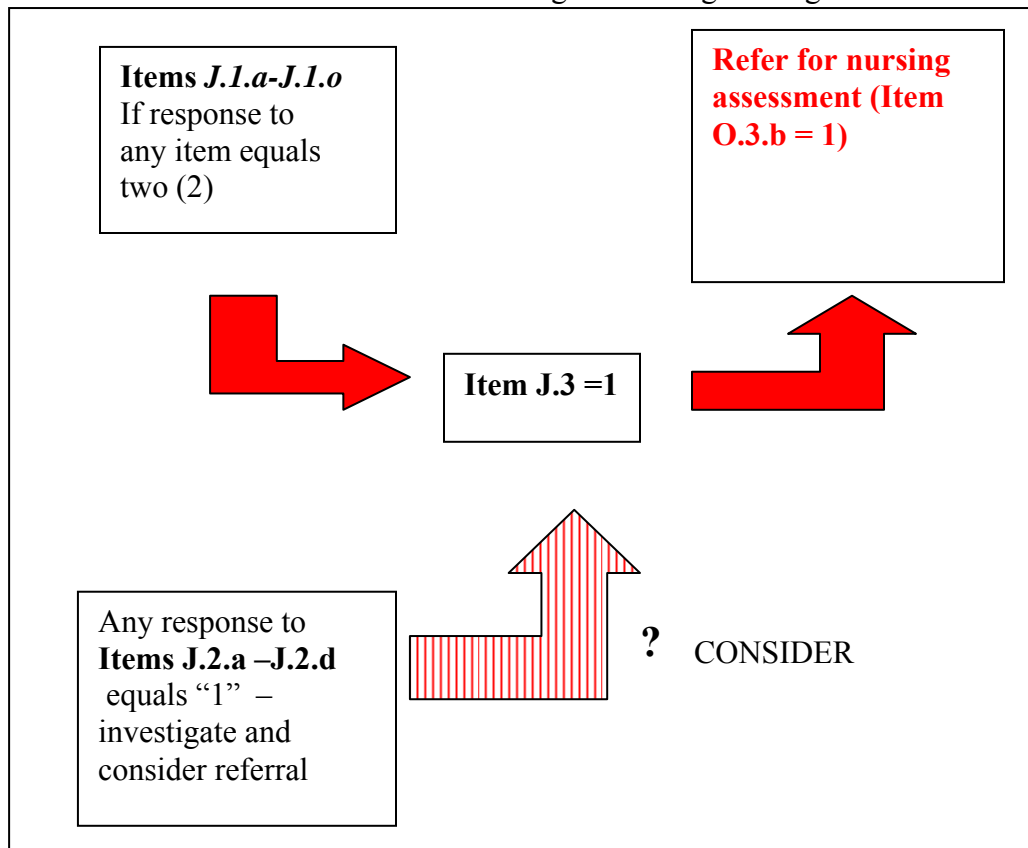


4.3 REFERRAL CONCERNING NURSING SERVICES

PCAF 4-20. The same basic format will apply in considering nursing services (see Figure 4.2). An unmet need for any nursing service should result in a referral for assessment of nursing needs. If the response to any of the Items from Item **J.1.a** through Item **J.1.o** equals two (2), then Item **J.3** equals 1 and Item **O.3.b** (referral for nursing services) should equal one (1). If any response to **J.2.a** through Item **J.2.d** equals “1,” then further investigation is called for. Responses of one (1) to any of the items in **J.2** may indicate an acute or unstable medical condition or a chronic condition that is poorly controlled. If such a problem is uncovered, then Items **J.3** and **O.3.b** (refer for nursing assessment) should equal one (1).

PCAF 0-3. The same items are used in the same process for the PCAF 0-3.

Exhibit 4.2: Decision-making concerning nursing services

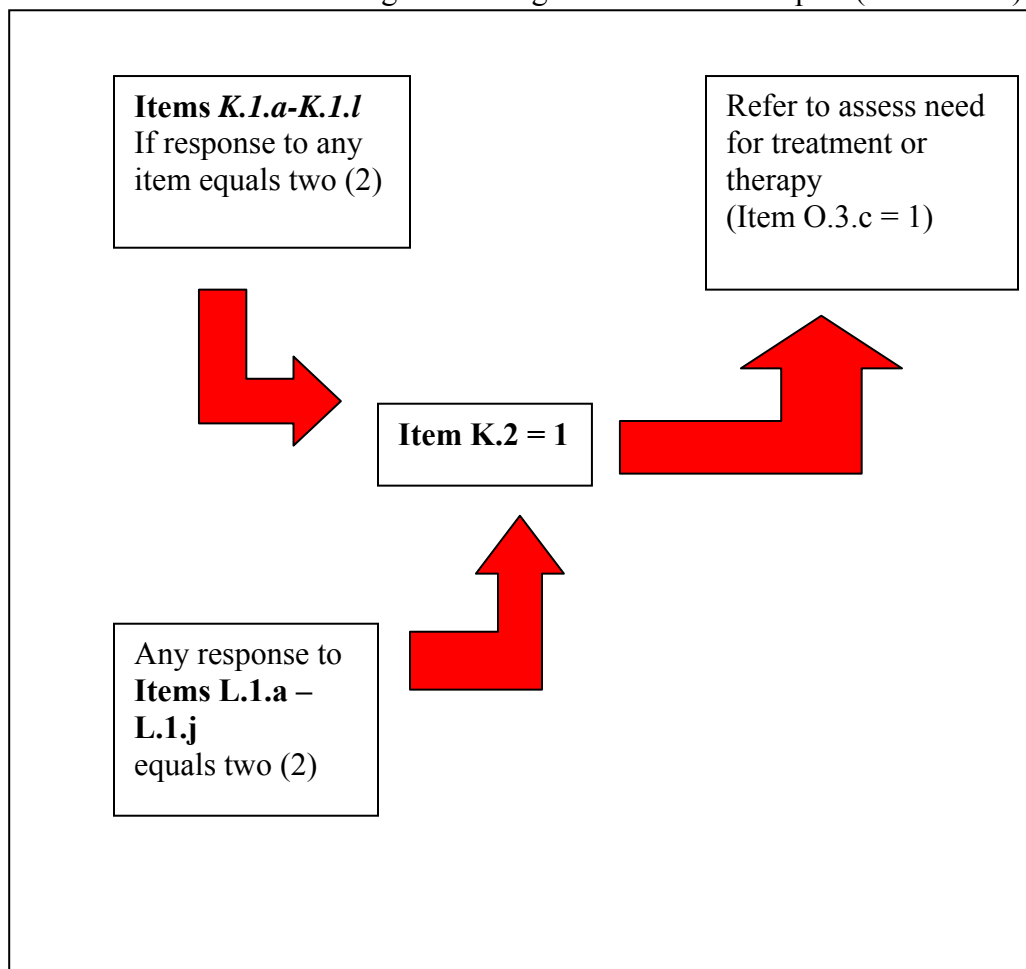


4.4 REFERRAL FOR ASSESSMENT CONCERNING TREATMENTS OR THERAPIES

PCAF 4-20. The same basic format will apply in considering treatments and therapies (see Figure 4.3). An unmet need for any therapies or treatments listed should result in a referral to consider the need for that therapy or treatment. If the response to any of the Items from Item **K.1.a** through Item **K.1.i** equals two (2), then Item **O.3.c** (referral needed) should equal one (1). If none of those items equals two (2), but if any response to **L.1.a** through Item **L.1.j** equals two (2), then a referral is necessary and Item **K.2** (refer) should equal one (1). Item **O.3.c** should also equal one (1).

PCAF 0-3. The same items are used in the same process for the PCAF 0-3. The only exception is that **L.1.e** is the final option on the PCAF 0-3.

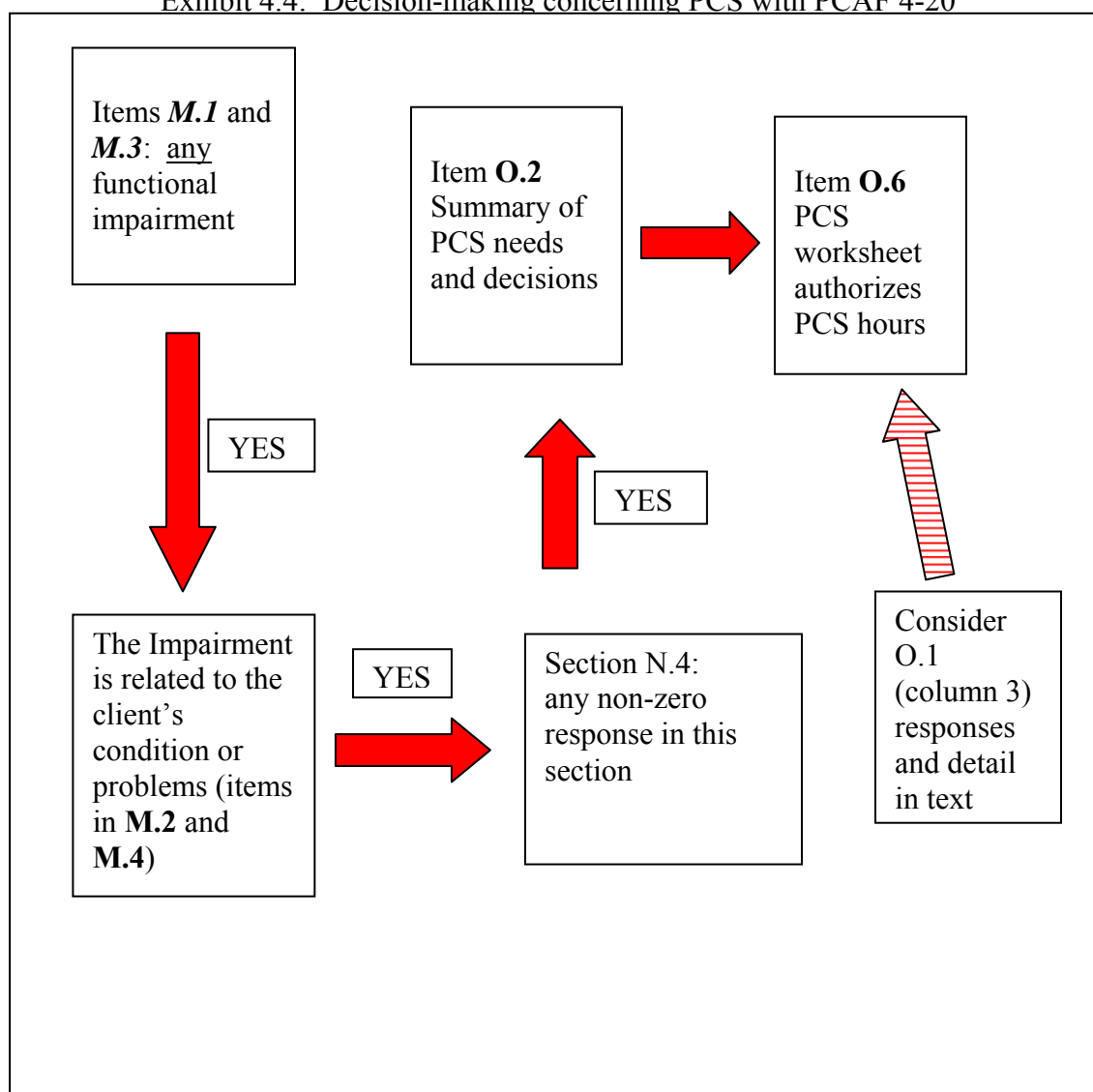
Exhibit 4.3: Decision-making concerning treatments or therapies (PCAF 4-20)



4.5 DETERMINING PCS HOURS

PCAF 4-20. The general decision process for allocation of PCS resources begins with consideration of the impairments recorded in items in **M.1** through the items in **M.4**. Any impairment in any of these items in **M.1** or in **M.3** (any item not equal to zero) that is related to the client's condition(s) or problem(s) (see **M.2** and **M.4**) creates a *potential* PCS need. If this potential need occurs in conjunction with any barriers to care for the caregivers or responsible adults (any response to **Items N.4.a** through **Items N.4.j** equals one), then there may be a need for PCS care. Any need and the case manager's general decision about approval/denial of PCS would be summarized in the items in **O.2 Personal Care Assistance in Average Week**. The results in O.1 would then be considered, and hours of PCS assistance would be allocated to meet needs noted in the responses to the items in **O.2** by approving PCS time in the worksheet in **O.6 Personal Care Services Worksheet**.

Exhibit 4.4: Decision-making concerning PCS with PCAF 4-20



PCAF 0-3. The same fundamental pattern is used for the PCAF 0-3. In that instrument, any indication of a need in **M.1 IADLs** or **M.2 ADLs** is an indication that the child's condition(s) have placed extraordinary demands on the caregiver (e.g., additional time to perform task(s) or need for an additional person's help). The case manager must consider the caregiver's ability to provide that care (**N.4**) and any complicating factors noted in **O.1**. The case manager and caregiver/responsible person then summarize these needs in **O.2**. Any PCS authorized is recorded in **O.5**.

4.6 SUMMARY CONCERNING DECISION-MAKING

Given any case managers unfamiliarity with the PCAF instruments, much of this may seem overwhelming or too complex. But, the experience in the reliability trial of the PCAF indicates that these instruments can be used effectively by DSHS case managers. The initial assessments done using the PCAFs by new case managers will be time-consuming. However, the results of the reliability trial indicate that after the first eight to ten assessments, the process will seem more natural, and the time to complete the instrument will decrease significantly.

While the project team has tried to include as much assistance as possible with decision-making in the instrument and in the manual, there will still be instances that don't fit the rules or where the rules create unintended results that lead to what the case manager believes to be an unreasonable decision.

Review those cases with your supervisor and do what you can to assure that eligible families in need receive all the help that the Medicaid policy allows. The purpose of the discussion of decision-making in this chapter is not to develop rules that deny services to eligible individuals in need of assistance. The purpose is to provide guidance so that decision-making across the State can be as consistent as possible and assure that all those who are eligible and in need receive the available services. But, no set of rules covers all contingencies. Be prepared to use your professional judgment in those exceptional circumstances that will undoubtedly arise.

APPENDIX A

PCAF[©] INSTRUMENTS

VERSIONS 10.27.09

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PCAF 4-20[©]

VERSION.10.27.09

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PERSONAL CARE ASSESSMENT FORM (PCAF) FOR CHILDREN AGES 4-20[®]

AA. CLIENT/CASE MANAGER INFORMATION

Client Information	
Client Name (Last, First, MI):	
Client's Gender (circle one):	Female Male Age:
Medicaid Number (PCN):	Date of Birth:
Address:	Phone Number:
Name of Client's Parent/Guardian:	
PCS Provider Information—(Providers Selected by Client/Parent/Guardian)	
Name:	Telephone Number:
Address:	Fax Number:
TPI:	NPI:
Taxonomy:	Benefit Code:
Name:	Telephone Number:
Address:	Fax Number:
TPI:	NPI:
Taxonomy:	Benefit Code:
Name:	Telephone Number:
Address:	Fax Number:
TPI:	NPI:
Taxonomy:	Benefit Code:
Name:	Telephone Number:
Address:	Fax Number:
Assessment Date	
Date of this Assessment:	

Client/Parent/Guardian Acknowledgment—(must be signed by the client/parent/guardian)

By signing this acknowledgment, the client/parent/guardian agrees with the following:

- I understand information from this assessment may be needed to help with obtaining PCS and other referrals. I give my consent for my case manager to share this information as needed to help with these. I understand the information will be shared only with agencies listed on this sheet, the primary practitioner, and other referrals deemed necessary by me and my case manager. The information shared will be only what is needed to complete the referral, determine eligibility, or provide services to my child or to me. I understand I may take back or cancel this consent anytime. To cancel, I must write to my case manager. I understand this consent will not affect my (or my child's) treatment, payment, enrollment, or eligibility for benefits. I understand anyone who gets information as a result of this consent may share it with others as the law allows.
- If PCS is approved, the client/parent/guardian has chosen the following PCS provider option based on a review of the roles and responsibilities of the client/caregiver and PCS providers in each option:

Home Health Agency or
PCS-only Provider ☐

Consumer Directed Services ☐

Service Responsibility Option ☐

Signature of Client/Parent/Guardian:

Printed Name of Client/Parent/Guardian:

Date:

PCS Services Determination

Dates of Service

Approved/Denied/Modified Hours:

From: / /

To: / /

DSHS Information

Signature of DSHS Case Manager:

Printed Name of DSHS Case Manager:

Date:

DSHS Health Services Region:

Regional Telephone:

Regional Fax:

Signature of Translator:

Printed Name of Translator:

Date:

PERSONAL CARE ASSESSMENT FORM (PCAF) FOR CHILDREN AGES 4-20

A. OTHER PROGRAM/AGENCY INVOLVEMENT

A.1 OTHER CURRENT PROGRAM/AGENCY INVOLVEMENT WITH CLIENT/PARENT/GUARDIAN

(DARS, DADS, WIC, MRA, MHA, DFPS, IHFS, Waiver Programs, Other)

AGENCY/PROGRAM (1)	CLIENT/FAMILY MEMBER (2)	RECEIVING/REFERRED/ APPLIED/WAITING (3)	CONTACT PERSON (4)	PHONE NUMBER (5)
a.				
b.				
c.				
d.				
e.				
f.				

Code for last 7 days, unless otherwise indicated, throughout remainder of assessment

B. REASON FOR ASSESSMENT AND SCHOOL SERVICES

B.1 REASON FOR ASSESSMENT

Code: 0 = Intake assessment

1 = Scheduled reassessment

2 = Change in status assessment

3 = Other (specify): _____

The information in Item B.2 is **CONFIDENTIAL**. The caregiver or the client is **NOT** required to respond to these in order to qualify for services.

B.2 SERVICES PROVIDED AT SCHOOL/DAY PROGRAM

Code: 0 = Not needed at school/day program

1 = Provided at school/day program

2 = Needed but not provided at school/day program

a.	Personal care attendant	
b.	Nursing services	
c.	Durable medical equipment	
d.	Other (specify):	

B.3 NAME OF SCHOOL OR DAY PROGRAM

C. DIAGNOSES & HEALTH CONDITIONS

For C1, C2, C3, and C4: Code only for those active diagnoses that currently affect the client's functional, cognitive, or behavioral status or require treatment, therapy, or medication **AND** were diagnosed by a licensed or certified health care professional.

For C5, code only for conditions or problems that currently affect the client's functional, cognitive, or behavioral status or require treatment, therapy, or medication.

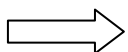
Code: 0 = No 1 = Yes, condition active and diagnosed

C.1	MEDICAL DIAGNOSES	
a.	Anemia	
b.	Apnea	
c.	Arthritis	
d.	Asthma/respiratory disorder	
e.	Cancer	
f.	Cerebral Palsy	
g.	Cleft Palate	
h.	Congenital heart disorder	
i.	Cystic Fibrosis	
j.	Diabetes	
k.	Epilepsy or other chronic seizure disorder	
l.	Explicit terminal prognosis	
m.	Failure to thrive	
n.	Hemophilia	
o.	Hydro/microcephaly	
p.	Metabolic disorders (e.g., PKU)	
q.	Muscular Dystrophy	
r.	Paraplegia/tetraplegia/quadruplegia	
s.	Pathological bone fracture	
t.	Renal failure	
u.	Spina Bifida or other spinal cord dysfunction	
v.	Substance abuse related problems at birth (e.g., fetal alcohol syndrome, cocaine dependency)	
w.	Traumatic brain injury	

C.2	OTHER MEDICAL DIAGNOSES	
a.	Specify:	
b.	Specify:	
c.	Specify:	
C.3	INFECTIONS	
a.	Antibiotic resistant infection (e.g., MRSA)	
b.	Other (specify):	
C.4	PSYCHIATRIC, DEVELOPMENTAL, OR BEHAVIORAL DIAGNOSES	
a.	Anxiety disorders (e.g., OCD, separation anxiety)	
b.	Autistic disorder or other pervasive developmental disorders (e.g., Asperger's, Rett's)	
c.	Attention Deficit Disorder (ADD or ADHD)	
d.	Disruptive behavior disorder (e.g., conduct disorder, oppositional defiant disorder)	
e.	Down Syndrome	
f.	Intellectual disability/MR/DD (If YES, enter diagnosed level, based on test, below)	
	(1) If YES, record diagnosed ID level. "1" = Mild; "2" = Moderate; "3" = Severe; "4" = Profound; "9" = Unknown. If NO (0), record "0"	
g.	Mood disorders (e.g., depression, bipolar disorder)	
h.	Schizophrenic, delusional (Paranoid), schizoaffective, or other psychotic disorders	
i.	Somatoform, eating, and tic disorders (e.g., anorexia nervosa, bulimia, pica)	
j.	Other (specify):	
k.	Other (specify):	
C.5	HEALTH CONDITIONS/PROBLEMS Code: 0 = No 1 = Yes, currently active	
a.	Bed-bound or chair-fast (because of health condition; spends at least 23 hours per day in bed or in chair – not wheelchair)	
b.	Contracture(s)	
c.	Fall(s) related to client's condition	
d.	Fracture(s)	
e.	Limitation in range of motion – limitations that interfered with daily functions or placed client at risk of injury	
f.	Pain interferes with normal activities (e.g., school, work, social activities, ADLs)	
g.	Pressure ulcers, wounds, or skin lesions	
h.	Recurrent aspiration	
i.	Shortness of breath during normal activities	
j.	Other (specify):	

C.6 CLIENT'S CURRENT CONDITION

Code: 1 = Medical
2 = Psychiatric/Developmental/Behavioral
3 = Both

☐
**COMPLETE ITEM O.1.a.(3) NOW****D. COGNITIVE FUNCTION****D.1 COMATOSE OR PERSISTENT VEGETATIVE STATE**

Code: 0 = No 1 = Yes

☐
IF "YES"(1) – SKIP TO SECTION H

FOR D.2-D.5, IF UNABLE TO DETERMINE BY INTERACTION WITH CLIENT, ASK CAREGIVER.

D.2 SHORT-TERM MEMORY – Recalls very recent events (e.g., most recent meal or activity)

Code: 0 = Memory/recall ok

1 = Memory/recall problem

☐

D.3 LONG-TERM MEMORY – Recalls information beyond recent events (e.g., age, town, own family name, neighbors' names, pets' names)

Code: 0 = Memory/recall ok

1 = Memory/recall problem

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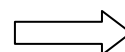
D.4 PROCEDURAL TASK PERFORMANCE – Ability to perform steps in a multi-step sequence without cueing, redirection or monitoring (e.g., retrieving specific object from other room; dressing self properly; preparing snacks)

Code: 0 = Performs most or all multiple-step tasks without cueing, redirection or monitoring
1 = Needs cueing, redirection or monitoring for most or all multiple-step tasks

☐
D.5 COGNITIVE SKILLS FOR DAILY DECISION-MAKING

– About such issues/daily tasks as when to get up, clothing to wear, how to organize the day, activities to do, or how to remain safe

Code: 0 = Independent – Decisions consistent/reasonable
1 = Modified independent – Consistent/reasonable decisions in customary situations or environments but experienced difficulty with new/unfamiliar tasks or in specific situations (e.g., crowds)
2 = Moderately dependent – Decisions consistently poor; cues, redirection or monitoring required frequently
3 = Completely dependent – Never/rarely made decisions; cueing, redirection or monitoring required continually

☐
**COMPLETE ITEM O.1.b.(3) NOW**

E. COMMUNICATION

E.1 MAKING SELF UNDERSTOOD – Expressing information content, however able (with appliance if normally used) ☐

Code: 0 = Understood – Expressed desires/needs without difficulty

1 = Usually understood – Some difficulty finding words or finishing thoughts but usually understood

2 = Sometimes understood – Ability was limited to making concrete requests understood (e.g., hunger)

3 = Rarely/never understood – Communication limited to interpretation of highly individual, person-specific sounds, behaviors, or body language understood by a limited number of people

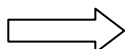
E.2 ABILITY TO UNDERSTAND OTHERS – Understanding verbal information content, however able (with hearing appliance, if normally used) ☐

Code: 0 = Understands – Clear comprehension

1 = Usually understands – Sometimes missed some part or intent of message

2 = Sometimes understands – Responded only to simple, direct messages or communication

3 = Rarely/never understands – Observer has difficulty determining whether the client comprehended messages. Or, the client can hear sounds but did not understand messages



COMPLETE ITEM O.1.c.(3) NOW

F. HEARING AND VISION

F.1 HEARING – Ability to hear (with hearing appliance, if normally used) ☐

Code: 0 = Hears adequately – No difficulty in normal conversation, social interaction, TV, phone

1 = Some impairment – Problems with specific types of sounds (e.g., low register) or with specific situations (e.g., requires quiet setting to hear well)

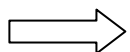
2 = Highly impaired – Absence of useful hearing

F.2 VISION – Ability to see near or far in adequate light (with glasses or with other visual appliance, if normally used) ☐

Code: 0 = Vision adequate – Saw fine detail, including fine detail in pictures, regular print in books

1 = Some impairment – Limited vision; was able to see large print or numbers in books; identify large objects in pictures

2 = Highly impaired – No vision or saw only light, colors, or shapes; eyes do not appear to follow objects



COMPLETE ITEM O.1.d.(3) NOW

G. BEHAVIOR PATTERNS**G.1 SIGNS AND SYMPTOMS IN LAST 30 DAYS**

Code: 0 = No occurrence in last 30 days

1 = Occurred in last month but not during last 7 days

2 = Occurred once or more in the last 7 days

a.	Wandering – moved (locomotion) with no apparent rational purpose; seemingly oblivious to needs for safety	
b.	Elopement – attempted to or exited/left home, school, etc. at inappropriate time, without notice/permission, with impaired safety awareness	
c.	Verbally abusive – threatened, screamed at, or cursed others	
d.	Physically abusive or injuries to others –e.g., shoved, scratched, pinched, bit others	
e.	Bullying/Menacing behavior – no physical contact, but others made to feel unsafe/at-risk; invaded personal space of others in a threatening manner	
f.	Socially inappropriate or disruptive behavior – e.g., disruptive acts or sounds; noisiness; screaming; smeared /threw food/feces; hoarding; rummaging through other's belongings	
g.	Repetitive behavior that interferes with normal activities – e.g., finger flicking, rocking, spinning objects	
h.	Inappropriate sexual behavior – e.g., sexually abused/attacked others; inappropriate sexual activity or disrobing; masturbating in public	
i.	Resists ADL care – resisted assistance with ADLs, such as bathing, dressing, toileting, eating	
j.	Physically resists prescribed treatments and therapies – e.g., range-of-motion exercises, chest percussion	
k.	Injury to self – self-abusive acts; non-accidental injuries (e.g., cutting arms, head banging) that are not suicide attempts	
l.	Suicide attempt – effort(s) by client to end his/her life	
m.	Suicidal ideation – recurrent thoughts of death or suicide; saying that they wished they were dead or that they are going to kill or hurt themselves	
n.	Injury to animals – deliberate physical injury to/torture of animals	
o.	Dangerous, non-violent behavior – e.g., falling asleep while smoking, leaving candle lit or range burner turned on, playing with fire	
p.	Deliberate damage to property – e.g., intentional fire-setting, smashing furniture, breaking household objects	
q.	Other (specify):	

G.2 URGENT MENTAL/BEHAVIORAL HEALTH SERVICE USE IN LAST 30 DAYS

Code: 0 = No occurrence in last 30 days

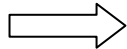
1 = Occurred in last 30 days

a.	Admission to inpatient treatment for mental or behavioral health problem (includes hospital)	
----	--	--

b.	Visit to emergency room for care or treatment of a mental or behavioral health problem	
c.	Urgent visit to physician, psychiatrist, or mental or behavioral health specialist office (not a regularly scheduled visit or assessment) because of a mental or behavioral health issue	
d.	Other (specify):	

G.3 CLIENT MAY REQUIRE REFERRAL TO A MENTAL OR BEHAVIORAL HEALTH SPECIALIST

Code: 0 = No 1 = Yes

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COMPLETE ITEMS O.1.e.(3) AND O.3.a NOW

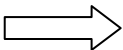
H. WEIGHT & HEIGHT

H.1 WEIGHT – Base weight on most recent measurement in last 30 days

Weight in lbs.	OR	Weight in kilos				

H.2 HEIGHT – Base height on most recent measurement in last 30 days

Feet	inches	OR	Centimeters			

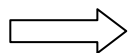


COMPLETE ITEM O.1.f.(3) NOW

I. MEDICATIONS

Count all medications taken in the last 7 days, including all prescribed medications and over-the-counter (OTC) medications, as well as any medications prescribed on an “as needed” or PRN basis. Include medications by any route of administration (e.g., pills, injections, ointments, inhaler).

I.1 NUMBER OF DIFFERENT MEDICATIONS TAKEN



COMPLETE ITEM O.1.g.(3) NOW

J. LICENSED/PROFESSIONAL NURSING NEEDS

J.1 CARE ACTIVITIES NEEDED OR PROVIDED DURING LAST 7 DAYS THAT MAY REQUIRE NURSING CARE (i.e., nursing services or nurse delegated tasks)

Code: 0 = Not needed
1 = Needed and provided
2 = Needed but not provided

a.	Medication management – includes injections and other nursing activities	
b.	Intravenous medications	
c.	Intravenous feeding (parenteral or IV)	
d.	Feeding tube	
e.	Nasopharyngeal suctioning	

f.	Tracheostomy care	
g.	Wound or skin lesion care – treatment or dressing of stasis or pressure/decubitus ulcer, surgical wound, burns, open lesions	
h.	Oxygen – administration or supervision	
i.	Urinary catheter care – insertion or maintenance (e.g., change, irrigation)	
j.	Comatose or persistent vegetative state – care to manage the condition	
k.	Ventilator or respirator – to manage equipment	
l.	Uncontrolled seizure disorder – care and supervision for safe management	
m.	Unstable medical condition – assessment, observation, and management on a daily basis	
n.	Other periodic assessment, management, supervision – once or twice a month	
o.	Other (specify):	

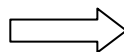
J.2 URGENT MEDICAL CARE USE IN LAST 30 DAYS

Code: 0 = No occurrence in last 30 days
1 = Occurred in last 30 days

a.	Visit to emergency room for care or treatment of a medical problem	
b.	Admission to hospital for medical care	
c.	Urgent visit to physician's office for physical illness (not a regularly scheduled visit or checkup)	
d.	Other (specify):	

J.3 REFERRAL FOR NURSING ASSESSMENT – (e.g., unstable medical condition; significant change in health or functional status; needs more/different care, additional services, or monitoring)

Code: 0 = No 1 = Yes

☐


COMPLETE ITEM O.3.b NOW

K. TREATMENTS AND THERAPIES

K.1 TREATMENTS OR THERAPIES RECEIVED OR NEEDED IN LAST 30 DAYS – outside of day program/school

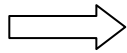
Code: 0 = Not needed
1 = Needed and provided
2 = Needed but not provided

a.	Chemotherapy	
b.	Radiation therapy	
c.	Hemodialysis	
d.	Peritoneal dialysis	
e.	Hospice	
f.	Physical therapy	
g.	Occupational therapy	
h.	Speech therapy	

i.	Mental health services (includes substance abuse treatment)	
j.	Home health aide	
k.	Restorative nursing care/habilitative care	
l.	Other (specify):	

K.2 REFERRAL TO CONSIDER NEED FOR NEW/DIFFERENT TREATMENT OR THERAPY

Code: 0 = No 1 = Yes

☐
**COMPLETE ITEM O.3.c NOW****L. CONTINENCE****L.1 BLADDER AND BOWEL PROGRAMS & APPLIANCES IN LAST 7 DAYS**

Code: 0 = Not needed

1 = **Appliance is available and adequate**2 = **New or different appliance may be needed because of condition or problem**

Appliances		Programs	
a.	Indwelling catheter	f.	Bladder retraining
b.	Intermittent catheter	g.	Bowel retraining
c.	External catheter	h.	Scheduled toileting
d.	Ostomy	i.	Toilet training
e.	Pads/briefs	j.	Other (specify):

L.2 URINARY CONTINENCE – Code client's performance over 24 hours a day during last 7 days (with device or continence program, if used)

☐

Code: 0 = Continent – Complete control and did not use any type of catheter, urinary collection device, or toileting program

1 = Complete control with device or program – (e.g., catheter, ostomy, scheduled toileting)

2 = Usually continent – Incontinent episodes once a week or less frequently

3 = Occasionally incontinent – Episodes 2 or more times a week but not daily

4 = Frequently incontinent – Tended to be incontinent daily but some control present (e.g., during daytime)

5 = Always/almost always incontinent – Had inadequate control, multiple daily episodes

8 = Did not occur – No urine output from bladder during last 7 days (e.g., dialysis)

L.3 BOWEL CONTINENCE – Code client's performance over 24 hours a day during last 7 days (with device or continence program, if used)

☐

Code: 0 = Complete control without any device/program/medication (e.g., ostomy)

1 = Complete control with device/program/medication (e.g., ostomy)

2 = Usually continent – Incontinent episodes once a week or less

3 = Occasionally incontinent – Episodes 2 or more times a week but not daily

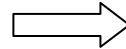
4 = Frequently incontinent – Tended to be incontinent daily but some control present (e.g., during daytime)

5 = Always/almost always incontinent – Had inadequate control, multiple daily episodes

8 = Did not occur – No bowel movement during last 7 days

L.4 NIGHTTIME INCONTINENCE (BOWEL/BLADDER) IN LAST 7 DAYS

Code: 0 = No 1 = Yes

☐
**COMPLETE ITEM O.1.h.(3) NOW****M. PHYSICAL FUNCTION****M.1 INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs)**

– Code for assistance provided to client in routine activities around the home or in the community during the last 7 days. Consider assistance provided over 24-hours per day

Code: 0 = No help/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 – Client highly involved in activity; received help on some occasions (at least ≥ 3 times) but not all the time

4 = Extensive assistance – Client 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 of the activity by others during entire period

8 = Activity did not occur – During 7 day period

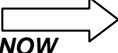
M.2 EFFECTS OF ILLNESS OR CONDITION ON IADL NEEDS/CARE (Code M.2 as you complete M.1)

Code: 0 = Client's condition did not affect the performance of the task (i.e., time it takes to do task or the number of persons needed to do task)

1 = Client's condition affected the performance of the task (because of client's condition, task regularly takes longer to perform **OR** two-person assistance regularly provided/needed)

IADLs		M.1 Help	M.2 Effect?
a.	Meal preparation – prepared light meals/snacks (e.g., planning, cooking, assembling ingredients, setting out food & utensils)		
b.	Medication assistance (e.g., remembering to take medicines, opening bottles)		

IADLs		M.1 Help	M.2 Effect?
c.	Telephone use – made and received telephone calls (using assistive devices, such as large numbers, amplification); includes finding number, making calls		
d.	Escort to medical appointments		
e.	Laundry – sorting, washing, folding, putting away personal laundry (e.g., clothing, underwear), bedding, and towels		
f.	Ordinary/light housework – ordinary work around the home (e.g., doing dishes, dusting, sweeping or vacuuming, making bed, cleaning bathroom, tidying up)		
g.	Grocery shopping – shopping for food and household items (e.g., could take longer because of client's special diet or behavior)		

 **COMPLETE ITEMS O.2.a.(2) through O.2.g.(2) NOW**

M.3 ACTIVITIES OF DAILY LIVING (ADL) – Code for assistance provided to client in last 7 days, including all 24 hours in a day

Code: 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 – Client 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 7 days

M.4 EFFECTS OF ILLNESS OR CONDITION ON ADL NEEDS/CARE IN LAST 7 DAYS
(Code M.4 as you complete M.3)

Code: 0 = Client's condition did not affect the performance of the task (i.e., time it takes to do task or the number of persons needed to do task)

1 = Client's condition affected the performance of the task (because of client's condition, task regularly takes longer to perform **OR** two-person assistance regularly provided/needed)

ADLs		M.3 Help	M.4 Effect?
a.	Bed mobility – moved to/from lying position, turns side to side and positions in bed		
b.	Positioning – moved/positioned in chair or other piece of furniture or equipment		
c.	Eating – ate and drank (regardless of skill)		
d.	Transfers – moved between surfaces, to/from bed, chair, wheelchair, standing position (EXCLUDE bath/shower transfers)		
e.	Locomotion/mobility inside the home – moved between locations in the home; if uses wheelchair/electric cart, self-sufficiency once in chair/cart		
f.	Locomotion/mobility outside the home (e.g. in yard, driveway, to busstop)		
g.	Toilet use – used the toilet room (or commode, bedpan, urinal); transferred on and off toilet; cleansed; changed pad/incontinence supplies; adjusted clothing		
h.	Dressing – put on, fastened, and took off all items of clothing, including donning/removing shoes, prostheses		
i.	Personal hygiene – maintained personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, managing feminine hygiene, washing/drying face, hands, perineum (EXCLUDE bathing)		
j.	Bathing – took full bath/shower, including transfer in and out. Code for most dependent performance in last 7 days – using codes below: 0. Independent 1. Set-up help only 2. Cueing/Redirection/Standby Assistance 3. Physical/hands-on help limited to transfer 4. Physical/hands-on help in part of bathing activity 5. Total dependence – full performance by other 8. Activity (full bath) did not occur during entire 7 days		

 **COMPLETE ITEMS O.2.h.(2) through O.2.o.(2) NOW**

M.5 ANY TWO-PERSON ASSISTANCE RECEIVED

Code: 0 = No 1 = Yes

a.	With any transfer – bed/chair/standing, toilet, or bathing, during the last 7 days	
b.	With any other ADL – during the last 7 days	

M.6 CLIENT NEEDS CUEING/ REDIRECTION DURING ADLs OR IADLs DUE TO A MENTAL, BEHAVIORAL, OR DEVELOPMENTAL PROBLEM/CONDITION

Code: 0 = No 1 = Yes

☐**M.7 MAIN MODE OF LOCOMOTION/MOBILITY IN LAST 7 DAYS**

Code: 0 = No 1 = Yes

a.	Walking was main mode of locomotion/mobility	
b.	Wheelchair/cart/scooter was main mode of locomotion/mobility during last 7 days	
c.	Walking and wheelchair/cart used about equally	

M.8 USE OF & NEED FOR ASSISTIVE DEVICES TO MAXIMIZE/SUPPORT FUNCTIONING

Code: 0 = Not needed
 1 = Assistive device is available and adequate
 2 = Referral to assess for unmet DME needs

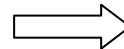
Durable Medical Equipment (DME)/Assistive Devices		
a.	Hospital bed	
b.	Bed mobility aids – e.g., bed rails, special mattress, postural supports like foam wedges, bed enclosure	
c.	Transfers aids – e.g., trapeze, transfer board, seat lift chair, Hoyer lift	
d.	Wheelchair, cart	
e.	Mobility aids/devices—e.g., cane, quad cane, crutches, walker	
f.	Bathing aids – e.g., shower chair, tub transfer bench	
g.	Medication management – e.g., talking clock, daily medication organizer	
h.	Meal preparation – e.g., rocker knife	
i.	Telephone use – e.g., voice activated telephone	
j.	Transportation – e.g., swivel cushion	
k.	Augmentative communication device	
l.	Gait trainer	
m.	Transcutaneous Electrical Nerve Stimulation (TENS) unit	
n.	Chest Physio Therapy (CPT) vest	
o.	Other (specify):	
p.	Other (specify):	

M.9 RESULTS OF DISCUSSION OF DME NEEDS WITH CLIENT/CAREGIVER

Code: 0 = No concerns expressed about current DME needs
 1 = Yes, client/caregiver believes new or additional DME needed

☐

Specify: _____

**COMPLETE ITEM O.3.d NOW****N. HOUSEHOLD RESOURCES****IF CLIENT IS 18 OR OLDER SKIPTO SECTION O****N.1 RESPONSIBLE ADULT'S AGE****N.2 RESPONSIBLE ADULT'S GENDER**

1=Female 2 = Male

N.3 RESPONSIBLE ADULT'S RELATIONSHIP TO CLIENT

1 = Parent
 2 = Grandparent
 3 = Sibling
 4 = Other family member
 5 = Other relationship (e.g foster, guardian, family friend)

N.4 RESPONSIBLE ADULT(S) STATUS/CHALLENGES

Code: 0 = No 1 = Yes

a.	In school full-time	
b.	In school part-time (not full-time)	
c.	Working full-time outside home	
d.	Working part-time outside home (not full-time)	
e.	Other work situation (specify):	
f.	Responsible adult for other children	
	(1) If YES, record number of other children (use "0" to fill); if none, record "00"	
	(2) Number of dependent children in household, other than client, with special needs	
g.	Caregiving for a disabled or challenged <u>adult</u> family member in household (specify):	
h.	Responsible person(s) sleep interrupted frequently throughout the night because of caregiving related to client's condition	
i.	Because of physical limitations or disabilities (strength/stamina) responsible person(s) unable to assist client with some ADL or IADL tasks	
j.	Other (specify):	

P. 16 CAN BE USED FOR COMMENTS RELATED TO N.4

O. STRENGTHS AND NEEDS**O.1 ADDITIONAL CONSIDERATIONS AND POTENTIAL COMPLEXITIES**

Column (3): Review items noted in Column (2)

Code: 0 = No problems noted 1 = At least one problem noted

(1) ISSUES		(2) ITEMS	(3) PROBLEMS	(4) Impact on ADL/IADL needs (may be continued on p. 16)
a.	Diagnoses/Conditions	C.1 - C.5		
b.	Decision-making	D.1 - D.5		
c.	Communication	E.1 - E.2		
d.	Hearing/Vision	F.1 - F.2		
e.	Behavior	G.1 - G.3		
f.	Weight /Height	H.1 - H.2		
g.	Medications	I.1		
h.	Continence	L.1 - L.4		
i.	Other			

O.2 PERSONAL CARE ASSISTANCE IN AVERAGE OR USUAL WEEK

Column (2): Potential PCS need (based on PCAF assessment)

Code: 0 = No functional limitation

1 = Functional limitation present but the limitation is not affected by client's condition or problem

2 = Functional limitation is present and is affected by client's condition or problem

Column (3): PCS decision

Code: 0 = No PCS assistance requested

1 = PCS assistance requested and approved

2 = PCS assistance requested but denied because of no functional limitation

3 = PCS assistance requested but denied because requested assistance is not covered by PCS services

4 = PCS assistance requested but denied because functional limitation is not related to client's condition/problem

5 = PCS assistance requested but denied because functional limitation must be addressed by a skilled health professional

6 = PCS assistance requested but denied because PCS need is currently being met by another agency or program

7 = PCS assistance requested but denied because caregiver can meet needs (not applicable to client ≥18)

8 = PCS requested by denied for other reason; specify in Column (4)

(1) ACTIVITY		(2) NEED	(3) PCS	(4) ADDITIONAL INFORMATION
a.	Meal preparation			
b.	Medication assistance			
c.	Telephone use			
d.	Escort to medical appointments			
e.	Laundry			
f.	Light housework			
g.	Grocery shopping			
h.	Bed mobility/positioning in chair			
i.	Eating			

(1) ACTIVITY		(2) NEED	(3) PCS	(4) ADDITIONAL INFORMATION
j.	Transfers			
k.	Locomotion/mobility			
l.	Toileting needs			
m.	Dressing			
n.	Personal hygiene			
o.	Bathing			
p.	Other (specify):			
q.	Other (specify):			

O.3 REFERRALS AND SERVICES NEEDED

Code: 0 = No 1 = Yes

Referrals will be made for:			Notes:
a.	Mental or behavioral health specialist services (G.3)		
b.	Nursing services assessment (See J.3)		
c.	Therapies or Treatments (See K.2)		
d.	Durable Medical Equipment (DME) assessment (See M.8 and M.9)		
e.	Other referrals related to PCS (specify):		

O.4 ENHANCED RATE ELIGIBILITY

Code: 0 = No 1 = Yes

a.	Client eligible for enhanced rated -- If C.6 = 2 or 3 and M.6 = 1, then Yes (1), Otherwise No (0)	
	(1) If YES for O.4.a, then record which option: "1"=UA; "2" = UB. If NO for O.4.a, then record "0"	

O.5 TARGET DATE FOR NEXT ASSESSMENT

Date:

0.6 PERSONAL CARE SERVICES WORKSHEET

SUNDAY					COMMENTS/ELABORATION (May be continued on later pages, if necessary)
	Time PCS Needed (i)	ADL/IADL task(s) (task time in minutes) (ii)	Total minutes (iii)	Caregiver Barrier(s)(iv)	
1a.					
1b.					
1c.					
1d.					
1e.					
1f.					
1g.					
1h.					
1i.	TOTAL PCS TIME FOR DAY (IN MINUTES) (SUM OF O.6.1a.iii – O.6.1h.iii)				
MONDAY					
	Time PCS Needed (i)	ADL/IADL task(s) (task time in minutes) (ii)	Total minutes (iii)	Caregiver Barrier(s)(iv)	
2a.					
2b.					
2c.					
2d.					
2e.					
2f.					
2g.					
2h.					
2i.	TOTAL PCS TIME FOR DAY (IN MINUTES) (SUM OF O.6.2a.iii – O.6.2h.iii)				

Codes for Caregiver Barriers (iv)	
1	Caregiver is in school
2	Caregiver is at work
3	Caregiver is responsible for other child(ren)
4	Caregiver is responsible for other child(ren) with special needs
5	Caregiver is responsible for disabled adult(s)
6	Caregiver's sleep is interrupted frequently throughout night because of caregiving responsibilities
7	Caregiver is unable to assist client with ADL/IADL because of physical limitations, disabilities, or illness
8	Other

Codes for ADLS/IADLS (ii)					
1	Meal preparation	7	Grocery shopping	13	Locomotion/mobility outside
2	Medication assistance	8	Bed mobility	14	Toilet use
3	Telephone use	9	Positioning	15	Dressing
4	Escort to medical appointments	10	Eating	16	Personal hygiene
5	Laundry	11	Transfers	17	Bathing
6	Light housework	12	Locomotion/mobility inside	18	Other

TUESDAY					COMMENTS/ELABORATION (May be continued on later pages, if necessary)
	Time PCS Needed (i)	ADL/IADL task(s) (task time in minutes) (ii)	Total minutes (iii)	Caregiver Barrier(s)(iv)	
3a.					
3b.					
3c.					
3d.					
3e.					
3f.					
3g.					
3h.					
3i.	TOTAL PCS TIME FOR DAY (IN MINUTES) (SUM OF O.6.3a.iii – O.6.3h.iii)				
WEDNESDAY					
	Time PCS Needed (i)	ADL/IADL task(s) (task time in minutes) (ii)	Total minutes (iii)	Caregiver Barrier(s)(iv)	
4a.					
4b.					
4c.					
4d.					
4e.					
4f.					
4g.					
4h.					
4i.	TOTAL PCS TIME FOR DAY (IN MINUTES) (SUM OF O.6.4a.iii – O.6.4h.iii)				

Codes for Caregiver Barriers (iv)	
1	Caregiver is in school
2	Caregiver is at work
3	Caregiver is responsible for other child(ren)
4	Caregiver is responsible for other child(ren) with special needs
5	Caregiver is responsible for disabled adult(s)
6	Caregiver's sleep is interrupted frequently throughout night because of caregiving responsibilities
7	Caregiver is unable to assist client with ADL/IADL because of physical limitations, disabilities, or illness
8	Other

Codes for ADLS/IADLS (ii)					
1	Meal preparation	7	Grocery shopping	13	Locomotion/mobility outside
2	Medication assistance	8	Bed mobility	14	Toilet use
3	Telephone use	9	Positioning	15	Dressing
4	Escort to medical appointments	10	Eating	16	Personal hygiene
5	Laundry	11	Transfers	17	Bathing
6	Light housework	12	Locomotion/mobility inside	18	Other

THURSDAY					COMMENTS/ELABORATION (May be continued on later pages, if necessary)
	Time PCS Needed (i)	ADL/IADL task(s) (task time in minutes) (ii)	Total minutes (iii)	Caregiver Barrier(s)(iv)	
5a.					
5b.					
5c.					
5d.					
5e.					
5f.					
5g.					
5h.					
5i.	TOTAL PCS TIME FOR DAY (IN MINUTES) (SUM OF O.6.5a.iii – O.6.5h.iii)				
FRIDAY					
6a.					
6b.					
6c.					
6d.					
6e.					
6f.					
6g.					
6h.					
6i.	TOTAL PCS TIME FOR DAY (IN MINUTES) (SUM OF O.6.6a.iii – O.6.6h.iii)				

Codes for Caregiver Barriers (iv)	
1	Caregiver is in school
2	Caregiver is at work
3	Caregiver is responsible for other child(ren)
4	Caregiver is responsible for other child(ren) with special needs
5	Caregiver is responsible for disabled adult(s)
6	Caregiver's sleep is interrupted frequently throughout night because of caregiving responsibilities
7	Caregiver is unable to assist client with ADL/IADL because of physical limitations, disabilities, or illness
8	Other

Codes for ADLS/IADLS (ii)					
1	Meal preparation	7	Grocery shopping	13	Locomotion/mobility outside
2	Medication assistance	8	Bed mobility	14	Toilet use
3	Telephone use	9	Positioning	15	Dressing
4	Escort to medical appointments	10	Eating	16	Personal hygiene
5	Laundry	11	Transfers	17	Bathing
6	Light housework	12	Locomotion/mobility inside	18	Other

SATURDAY				
	Time PCS Needed (i)	ADL/IADL task(s) (task time in minutes) (ii)	Total minutes (iii)	Caregiver Barrier(s)(iv)
7a.				
7b.				
7c.				
7d.				
7e.				
7f.				
7g.				
7h.				
7i.	TOTAL PCS TIME FOR DAY (IN MINUTES) (SUM OF O.6.7a.iii – O.6.7h.iii)			

8.	TOTAL TIME FOR WEEK (IN MINUTES) (SUM OF O.6.1i – O.6.7i)		
----	--	--	--

Codes for Caregiver Barriers (iv)	
1	Caregiver is in school
2	Caregiver is at work
3	Caregiver is responsible for other child(ren)
4	Caregiver is responsible for other child(ren) with special needs
5	Caregiver is responsible for disabled adult(s)
6	Caregiver's sleep is interrupted frequently throughout night because of caregiving responsibilities
7	Caregiver is unable to assist client with ADL/IADL because of physical limitations disabilities or illness
8	Other

Codes for ADLS/IADLS (ii)					
1	Meal preparation	7	Grocery shopping	13	Locomotion/mobility outside
2	Medication assistance	8	Bed mobility	14	Toilet use
3	Telephone use	9	Positioning	15	Dressing
4	Escort to medical appointments	10	Eating	16	Personal hygiene
5	Laundry	11	Transfers	17	Bathing
6	Light housework	12	Locomotion/mobility inside	18	Other

O.7 PCS HOURS REQUESTED AND PCS HOURS AUTHORIZED

Code: 0 = Responsible person made no request for a specific amount of PCS assistance
 1 = PCS hours authorized equal or exceed hours requested by responsible person
 2 = PCS hours authorized are less than hours requested by responsible person

☐
O.8 NATURE OF ANY DISAGREEMENT ABOUT PCS HOURS/RATIONALE FOR DIFFERENCE

0.9 ADDITIONAL COMMENTS RELATED TO CLIENT'S NEEDS FOR PCS, NURSING SERVICES, OR DME

(If notes or comments are related to a specific item/section, then reference the item/section before the comment)

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O.10 CASE MANAGER (CURRENT ASSESSMENT)

a. SIGNATURE:		c. DATE:
b. PRINTED NAME:		

PCAF 0-3[©]

VERSION.10.27.09

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PERSONAL CARE ASSESSMENT FORM (PCAF) FOR CHILDREN AGES 0-3[®]

AA. CLIENT/CASE MANAGER INFORMATION

Client Information		
Client Name (Last, First, MI):		
Client's Gender (circle one):	Female Male	Age:
Medicaid Number (PCN):	Date of Birth:	
Address:	Phone Number:	
Name of Client's Parent/Guardian:		
PCS Provider Information — (Providers Selected by Parent/Guardian)		
Name:	Telephone Number:	
Address:	Fax Number:	
TPI:	NPI:	
Taxonomy:	Benefit Code:	
Name:	Telephone Number:	
Address:	Fax Number:	
TPI:	NPI:	
Taxonomy:	Benefit Code:	
Name:	Telephone Number:	
Address:	Fax Number:	
TPI:	NPI:	
Taxonomy:	Benefit Code:	
Name:	Telephone Number:	
Address:	Fax Number:	
TPI:	NPI:	
Taxonomy:	Benefit Code:	
Assessment Date		
Date of this Assessment:		

Parent/Guardian Acknowledgment—(must be signed by the parent/guardian)

By signing this acknowledgment, the parent/guardian agrees with the following:

- I understand information from this assessment may be needed to help with obtaining PCS and other referrals. I give my consent for my case manager to share this information as needed to help with these. I understand the information will be shared only with agencies listed on this sheet, the primary practitioner, and other referrals deemed necessary by me and my case manager. The information shared will be only what is needed to complete the referral, determine eligibility, or provide services to my child or to me. I understand I may take back or cancel this consent anytime. To cancel, I must write to my case manager. I understand this consent will not affect my (or my child's) treatment, payment, enrollment, or eligibility for benefits. I understand anyone who gets information as a result of this consent may share it with others as the law allows.
- If PCS is approved, the caregiver has chosen the following PCS provider option based on a review of the roles and responsibilities of the caregiver and PCS providers in each option:

Home Health Agency or
PCS-only Provider ☐

Consumer Directed Services ☐

Service Responsibility Option ☐

Signature of Parent/Guardian:

Printed Name of Parent/Guardian:

Date:

PCS Services Determination

Dates of Service

Approved/Denied/Modified Hours:

From: / /

To: / /

DSHS Information

Signature of DSHS Case Manager:

Printed Name of DSHS Case Manager:

Date:

DSHS Health Services Region:

Regional Telephone:

Regional Fax:

Signature of Translator:

Printed Name of Translator:

Date:

PERSONAL CARE ASSESSMENT FORM (PCAF) FOR CHILDREN AGES 0-3

A. OTHER PROGRAM/AGENCY INVOLVEMENT

A.1 OTHER CURRENT PROGRAM/AGENCY INVOLVEMENT WITH CLIENT/PARENT/GUARDIAN

(e.g., DARS, DADS, WIC, ECI, MHA, MRA, DFPS, IHFS, Waiver Programs, Other)

AGENCY/PROGRAM (1)	CLIENT/FAMILY MEMBER (2)	RECEIVING/REFERRED/ APPLIED/WAITING (3)	CONTACT PERSON (4)	PHONE NUMBER (5)
a.				
b.				
c.				
d.				
e.				
f.				

Code for last 7 days, unless otherwise indicated, throughout remainder of assessment

B. REASON FOR ASSESSMENT

B.1 REASON FOR ASSESSMENT

Code: 0 = Intake assessment

1 = Scheduled reassessment

2 = Change in status assessment

3 = Other (Specify): _____

C. DIAGNOSES & HEALTH CONDITIONS

For C1, C2, C3, and C4: Code only for those active diagnoses that currently affect the client's functional, cognitive, or behavioral status or require treatment, therapy, or medication **AND** were diagnosed by a licensed or certified health care professional. For C5, code only those conditions or problems that currently affect the client's functional, cognitive, or behavioral status or require treatment, therapy, or medication.

Code: 0 = No 1 = Yes, condition active and diagnosed

C.1	MEDICAL DIAGNOSES
a.	Anemia
b.	Apnea
c.	Arthritis
d.	Asthma/respiratory disorder
e.	Cancer
f.	Cerebral Palsy
g.	Cleft Palate
h.	Congenital heart disorder
i.	Cystic Fibrosis

j.	Diabetes
k.	Epilepsy or other chronic seizure disorder
l.	Explicit terminal prognosis
m.	Failure to thrive
n.	Hemophilia
o.	Hydro/microcephaly
p.	Metabolic disorders (e.g., PKU)
q.	Muscular Dystrophy
r.	Paraplegia/tetraplegia/quadriplegia
s.	Pathological bone fracture
t.	Renal failure
u.	Spina Bifida or other spinal cord dysfunction
v.	Substance-abuse-related problems at birth (e.g., fetal alcohol syndrome, cocaine dependency)
w.	Traumatic brain injury
C.2	OTHER MEDICAL DIAGNOSES
a.	Specify:
b.	Specify:
c.	Specify:
C.3	INFECTIONS
a.	Antibiotic resistant infection (e.g., MRSA)
b.	Other (specify):
C.4	PSYCHIATRIC, BEHAVIORAL, OR DEVELOPMENTAL DIAGNOSES
a.	Attention deficit disorder (ADD) or ADHD
b.	Autistic disorder or other pervasive developmental disorder (e.g., Asperger's, Rett's)
c.	Disruptive behavior disorder (e.g., oppositional defiant disorder)
d.	Down Syndrome
e.	Intellectual disability/MR/DD
f.	Other (specify):
g.	Other (specify):

C.5	HEALTH CONDITIONS Code: 0 = No 1 = Yes, currently active	
a.	Fracture(s)	
b.	Recurrent aspiration	
c.	Bed-bound or chair-fast (because of health condition; at least 23 hours per day)	
d.	Shortness of breath during normal activities	
e.	Contracture(s)	
f.	Pressure ulcers, wounds, skin lesions	
g.	Other (specify):	

➡ **COMPLETE ITEM O.1.a.(3) (on pg.8) NOW**

C.6 CLIENT'S CURRENT CONDITIONS

Code: 1 = Medical
2 = Psychiatric/Developmental/Behavioral
3 = Both

☐
D. COGNITIVE FUNCTION**D.1 COMATOSE OR PERSISTENT VEGETATIVE STATE**

Code: 0 = No 1 = Yes

☐

IF "YES(1)" – SKIP TO SECTION H

E. COMMUNICATION

E.1 MAKING SELF UNDERSTOOD – Expressing information content, however able

☐

Code: 0 = Understood – Expressed needs without difficulty; child was always/almost always understood by others
1 = Difficulty making needs known – Difficulty expressing needs clearly; only understood some of the time
2 = Rarely/never understood – Others rarely/never understand what child is trying to communicate

E.2 ABILITY TO UNDERSTAND OTHERS – Understand verbal information content, however able (with hearing appliance, if normally used)

☐

Code: 0 = Understood – Clearly comprehended statements or requests
1 = Difficulty understanding others – Understood and responded to simple statements or requests
2 = Rarely/never understands/responds – Rarely/never understood or responded to statements or requests

➡ **COMPLETE ITEM O.1.b.(3) (on pg.8) NOW**

F. HEARING AND VISION

F.1 HEARING – Ability to hear (with hearing appliance, if normally used)

☐

Code: 0 = Appears to hear adequately – Responded to sounds (e.g., turns head, tracks sound, responds to speech)
1 = Impaired – Absence of response to sounds

F.2 VISION – Ability to see near or far in adequate light (with glasses or with other visual appliance, if normally used)

☐

Code: 0 = Adequate – Eyes appear to follow objects, both near and far
1 = Impaired – Eyes do not appear to follow objects

➡ **COMPLETE ITEM O.1.c.(3) (on pg.8) NOW**

G. BEHAVIOR PATTERNS**G.1 SIGNS AND SYMPTOMS IN LAST 7 DAYS**

Code: 0 = No 1 = Yes

a.	Repetitive behavior that interferes with normal activities – e.g., finger flicking, rocking, spinning objects, hand flapping	
b.	Resisted ADL care – resisted assistance with ADLs, such as bathing, dressing, toileting, eating	
c.	Injury to self – self-abusive acts; non-accidental injuries (e.g., head banging)	
d.	Sleep disturbances – awake/active all or most of the night	
e.	Disruptive behavior – disruptive noisiness; screaming; temper tantrums that escalate into aggressive or violent behaviors	
f.	Other challenging behavioral problem(s) (specify):	

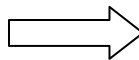
G.2 URGENT MENTAL/BEHAVIORAL HEALTH SERVICE USE IN LAST 30 DAYS

Code: 0 = No occurrence in last 30 days
1 = Occurred in last 30 days

a.	Admission to inpatient treatment for mental or behavioral health problem (includes hospital)	
b.	Visit to emergency room for care or treatment of a mental or behavioral health problem	
c.	Urgent visit to physician, psychiatrist, or mental or behavioral health specialist office (not a regularly scheduled visit or assessment) because of a mental or behavioral health issue	
d.	Other (specify):	

G.3 CHILD MAY REQUIRE REFERRAL TO A MENTAL OR BEHAVIORAL HEALTH SPECIALIST

Code: 0 = No 1 = Yes

☐
 **COMPLETE ITEMS O.1.d.(3) (on pg.8) AND O.3.a (on pg.9) NOW**
H. HEIGHT & WEIGHT**H.1 WEIGHT** – Base weight on most recent measurement in last 30 days

Weight in lbs.	OR	Weight in kilos		

H.2 HEIGHT/LENGTH – Base height on most recent measurement in last 30 days

Inches	OR	Centimeters		

 **COMPLETE ITEM O.1.e.(3) (on pg.8) NOW**
I. MEDICATIONS

Count all medications taken in the last 7 days, including all prescribed medications and over-the-counter (OTC) medications, as well as any medications prescribed on an “as needed” or PRN basis. Include medications by any route of administration (e.g., pills, injections, ointments, inhaler).

I.1 NUMBER OF DIFFERENT MEDICATIONS TAKEN
 **COMPLETE ITEM O.1.f.(3) (on pg.8) NOW**
J. LICENSED/PROFESSIONAL NURSING NEEDS**J.1 CARE ACTIVITIES NEEDED OR PROVIDED DURING LAST 7 DAYS THAT MAY REQUIRE NURSING CARE** (i.e., nursing services or nurse delegated tasks)

Code: 0 = Not needed
1 = Needed and provided
2 = Needed but not provided

a.	Medication Management – includes injections and other nursing activities	
b.	Intravenous medications	
c.	Intravenous feeding (parenteral or IV)	
d.	Feeding tube	
e.	Nasopharyngeal suctioning	
f.	Tracheostomy care	
g.	Wound or skin lesion care – treatment or dressing of stasis or pressure/decubitus ulcer, surgical wound, burns, open lesions	

h.	Oxygen – administration or monitoring	
i.	Urinary catheter care – insertion or maintenance (e.g., change, irrigation)	
j.	Comatose or persistent vegetative state – care to manage the condition	
k.	Ventilator or respirator – to manage equipment	
l.	Uncontrolled seizure disorder – care and monitoring for safe management	
m.	Unstable medical condition – assessment, observation, and management on a daily basis	
n.	Other periodic assessment, management, monitoring – once or twice a month	
o.	Other (specify):	

J.2 URGENT MEDICAL CARE USE IN LAST 30 DAYS

Code: 0 = No occurrence in last 30 days
1 = Occurred in last 30 days

a.	Visit to emergency room for care or treatment of a medical problem	
b.	Admission to hospital for medical care	
c.	Urgent visit to physician's office for physical illness (not a regularly scheduled visit or checkup)	
d.	Other (specify):	

J.3 REFERRAL FOR NURSING ASSESSMENT – (e.g., unstable medical condition; significant change in health or functional status; needs more/different nursing care, additional services, or monitoring)

Code: 0 = No 1 = Yes

☐
 **COMPLETE ITEM O.3.b (on pg.9) NOW**
K. TREATMENTS AND THERAPIES**K.1 TREATMENTS OR THERAPIES RECEIVED OR NEEDED IN LAST 30 DAYS** – outside of day program/school/ECI

Code: 0 = Not needed
1 = Needed and provided
2 = Needed but not provided

a.	Chemotherapy	
b.	Radiation therapy	
c.	Hemodialysis	
d.	Peritoneal dialysis	
e.	Hospice	
f.	Physical therapy	
g.	Occupational therapy	
h.	Speech therapy	
i.	Mental health services	

j.	Home health aide	
k.	Restorative nursing care/habilitative care	
l.	Other (specify):	

K.2 REFERRAL TO CONSIDER NEED FOR NEW/DIFFERENT TREATMENT OR THERAPY

Code: 0 = No 1 = Yes

☐
COMPLETE ITEM O.3.c (on pg.9) NOW**L. CONTINENCE****L.1 BLADDER AND BOWEL APPLIANCES IN THE LAST 7 DAYS**

Code: 0 = Not needed
 1 = Appliance is available and adequate
 2 = New or different appliance may be needed because of condition or problem

Appliances			
a.	Indwelling catheter		e. Other (specify): <input type="checkbox"/>
b.	Intermittent catheter		
c.	External catheter		
d.	Ostomy		

M. PHYSICAL FUNCTION**M.1 INSTRUMENTAL ACTIVITIES OF DAILY LIVING –**

Code for whether type/level of assistance provided during the last 7 days by caregiver or others was affected by child's condition

Code: 0 = Child's condition did not affect the performance of the task (i.e., time it takes to do task or the number of persons needed to do task)
 1 = Child's condition affected task performance (because of child's condition, task regularly takes longer to perform OR two-person assistance regularly provided/needed)

a.	Meal preparation – preparing meals or snacks (planning, assembling ingredients, cooking/preparing, setting out food and utensils)	
b.	Medication assistance - assistance with the child's medications (e.g., giving medicines at the correct time, opening bottle)	
c.	Laundry – sorting, washing, folding, putting away child's personal laundry (e.g., clothing, underwear) and child's bedding and towels	
d.	Ordinary/light housework – ordinary work around the home (e.g., doing dishes, dusting, sweeping or vacuuming, making beds, cleaning bathroom, or tidying up)	
e.	Grocery shopping – shopping for food and household items (e.g., could take longer because of child's special dietary requirements or behavior)	

f.	Escort to medical appointments	
----	--------------------------------	--

COMPLETE ITEMS O.2.a.(2) through O.2.f.(2) (on pg.8) NOW

M.2 ASSISTANCE WITH ACTIVITIES OF DAILY LIVING (ADLs) –

Code for whether assistance provided in last 7 days was affected by child's condition; include assistance across 24 hours a day

Code: 0 = Child's condition did not affect the performance of the task (i.e., time it takes to do task or the number of persons needed to do task)
 1 = Child's condition affected task performance (because of child's condition, task regularly takes longer to perform OR two-person assistance regularly provided/needed)

a.	Bed mobility – moved to/from lying position, turns side to side and positions in bed	
b.	Positioning – moved/positioned in chair or other piece of furniture or equipment	
c.	Eating – ate and drank (regardless of skill)	
d.	Transfers – moved between surfaces, to/from bed, chair, wheelchair, standing position (EXCLUDE bath/shower transfers)	
e.	Locomotion/mobility inside – moved between locations in the home or day program	
f.	Toilet use – used the toilet room (potty chair, bedpan); transferred on and off toilet; adjusted clothing	
g.	Dressing – put on, fastened, and took off all items of street clothing	
h.	Personal hygiene – including combing hair, brushing teeth, washing/drying face, hands (EXCLUDE bathing)	
i.	Bathing – took full bath/shower, including transfer in and out	

COMPLETE ITEMS O.2.g.(2) through O.2.n.(2) (on pg.8 and 9) NOW

M.3 MAIN MODE OF LOCOMOTION/MOBILITY IN LAST 7 DAYS (WITH ASSISTIVE DEVICE, IF USED)

Code: 0 = No 1 = Yes

a.	Crawling, scooting, rolling, or walking was main mode of locomotion/mobility	
b.	Wheelchair/cart was main mode of locomotion/mobility	

M.4 ANY TWO-PERSON ASSISTANCE RECEIVED

Code: 0 = No 1 = Yes

a.	With any transfer – bed/chair/standing, toilet, or bathing, during the last 7 days	
b.	With any other ADL care – during the last 7 days	

M.5 CLIENT NEEDS CUEING/ REDIRECTION DURING ADLs OR IADLs DUE TO A MENTAL, BEHAVIORAL, OR DEVELOPMENTAL HEALTH PROBLEM/CONDITION

Code: 0 = No 1 = Yes

☐
M.6 DURABLE MEDICAL EQUIPMENT (DME)/ASSISTIVE DEVICES

Code: 0 = Not needed

 1= Assistive Device is available and adequate
 2 = Referral to assess for unmet DME needs

a.	Hospital bed	
b.	Bed mobility aids – e.g., bed rails, special mattress, postural supports like foam wedges, bed enclosure	
c.	Transfers aids – e.g., trapeze, transfer board, seat lift chair, Hoyer lift	
d.	Locomotion/mobility devices – wheelchair, cart	
e.	Walking aids/devices – e.g., cane, walker, splint, stander	
f.	Bathing aids – e.g., shower chair, tub transfer bench	
g.	Augmentative communication device	
h.	Gait trainer	
i.	Transcutaneous Electrical Nerve Stimulation (TENS) unit	
j.	Chest Physio Therapy (CPT) vest	
k.	Other (specify):	
l.	Other (specify):	

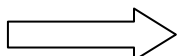
M.7 RESULTS OF DISCUSSION OF DME NEEDS WITH CLIENT/CAREGIVER

Code: 0 = No concerns expressed about current DME needs

1 = Yes, client/caregiver believes new or additional DME needed

☐

Specify: _____

**COMPLETE ITEM O.3.d (on pg.9) NOW****N. HOUSEHOLD RESOURCES****N.1 RESPONSIBLE ADULT'S AGE**

N.2 RESPONSIBLE ADULT'S GENDER

1=Female 2 = Male

N.3 RESPONSIBLE ADULT'S RELATIONSHIP TO CHILD
 1 = Parent
 2 = Grandparent
 3 = Sibling
 4 = Other family member
 5 = Other relationship (e.g., foster parent, guardian, family friend)

N.4 RESPONSIBLE ADULT(S) STATUS/CHALLENGES

Code: 0 = No 1 = Yes

a.	In school full-time	
b.	In school part-time (not full-time)	
c.	Working full-time outside home	
d.	Working part-time outside home (not full-time)	
e.	Other work situation (specify):	
f.	Responsible adult for other children	
	(1) If YES(1), record number of other children (use "0" to fill); if none, record "00"	
	(2) Number of dependent children in household, other than client, with special needs	
g.	Caregiving for a disabled or challenged <u>adult</u> family member in household (specify):	
h.	Caregiver's sleep is interrupted frequently throughout the night because of caregiving responsibilities related to child's condition	
i.	Because of physical disability/limitations (strength, stamina, or range of motion) caregiver is unable to assist child with some ADL or IADL tasks	
j.	Other (specify):	

COMMENTS OR NOTES ON HOW ISSUES OR BARRIERS MAY AFFECT MEETING CLIENT'S ADL AND IADL NEEDS MAY BE ADDED BELOW

(May be continued on pg. 9 or pg. 14 if necessary)

O. STRENGTHS AND NEEDS**O.1 ADDITIONAL CONSIDERATIONS AND POTENTIAL COMPLEXITIES****Column (3):** Review items noted in Column (2)**Code:** 0 = No problems noted 1 = At least one problem noted

(1) ISSUE		(2) ITEMS	(3) PROBLEM	(4) Impact on ADL/IADL needs (may be continued on pg. 9)
b.	Diagnoses/Conditions	C.1- C.5		
b.	Communication	E.1- E.2		
c.	Hearing/Vision	F.1- F.2		
d.	Behavior	G.1- G.3		
e.	Height/Weight	H.1- H.2		
f.	Medications	I.1		
g.	Other (specify):			

O.2 PERSONAL CARE ASSISTANCE IN AVERAGE OR USUAL WEEK**Column (2):** Potential PCS need (based on PCAF assessment)**Code:** 0 = Child's condition/problem does not affect performance of the task
1 = Child's condition/problem does affect performance of task**Column (3):** PCS decision

Code: 0 = No PCS assistance requested
 1 = PCS assistance requested and approved
 2 = PCS assistance requested but denied because of no functional limitation
 3 = PCS assistance requested but denied because requested assistance is not covered by PCS services
 4 = PCS assistance requested but denied because functional limitation is not related to child's condition/problem
 5 = PCS assistance requested but denied because functional limitation must be addressed by skilled health professional
 6 = PCS assistance requested but denied because PCS need is currently being met by another agency or program
 7 = PCS assistance requested but denied because caregiver can meet child's needs
 8 = PCS request by denied for other reason; specify in Column (4)

(1) ACTIVITY		(2) NEED	(3) PCS	(4) ADDITIONAL INFORMATION
a.	Meal preparation			
b.	Medication assistance			
c.	Laundry			
d.	Escort to medical appointments			
e.	Ordinary/light housekeeping			
f.	Grocery shopping			
g.	Bed mobility or positioning in chair/wheelchair			
h.	Eating			

(1) ACTIVITY		(2) NEED	(3) PCS	(4) ADDITIONAL INFORMATION
i.	Transfers			
j.	Locomotion/mobility			
k.	Toileting needs			
l.	Dressing			
m.	Personal hygiene			
n.	Bathing			
o.	Other (specify):			
p.	Other (specify):			

O.3 REFERRALS AND SERVICES NEEDED

Code: 0 = No 1 = Yes

Referrals will be made for:			Notes:
a.	Mental or behavioral health specialist services (G.3)		
b.	Nursing services assessment (See J.3)		
c.	Therapies or Treatments (See K.2)		
d.	Durable Medical Equipment (DME) assessment (See M.6 and M.7)		
e.	Other referrals related to PCS (specify):		

O.4 ENHANCED RATE ELIGIBILITY

Code: 0 = No 1 = Yes

a.	Client eligible for enhanced rated -- If C.6 = 2 or 3 and M.5 = 1, then Yes(1), Otherwise No(0)	
	(1) If YES for O.4.a, then record which option: "1"=UA; "2" = UB. If NO for O.4.a, then record "0"	

O.5 TARGET DATE FOR NEXT ASSESSMENT

Date:

0.6 PERSONAL CARE SERVICES WORKSHEET

SUNDAY					COMMENTS/ELABORATION (May be continued on later pages, if necessary)																		
	Time PCS Needed (i)	ADL/IADL task(s) (task time in minutes) (ii)	Total minutes (iii)	Caregiver Barrier(s)(iv)																			
1a.																							
1b.																							
1c.																							
1d.																							
1e.																							
1f.																							
1g.																							
1h.																							
1i.	TOTAL PCS TIME FOR DAY (IN MINUTES) (SUM OF 0.6.1a.iii – 0.6.1h.iii)				<table border="1"> <thead> <tr> <th colspan="2">Codes for Caregiver Barriers (iv)</th> </tr> </thead> <tbody> <tr><td>1</td><td>Caregiver is in school</td></tr> <tr><td>2</td><td>Caregiver is at work</td></tr> <tr><td>3</td><td>Caregiver is responsible for other child(ren)</td></tr> <tr><td>4</td><td>Caregiver is responsible for other child(ren) with special needs</td></tr> <tr><td>5</td><td>Caregiver is responsible for disabled adult(s)</td></tr> <tr><td>6</td><td>Caregiver's sleep is interrupted frequently throughout night because of caregiving responsibilities</td></tr> <tr><td>7</td><td>Caregiver is unable to assist client with ADL/IADL because of physical limitations, disabilities, or illness</td></tr> <tr><td>8</td><td>Other</td></tr> </tbody> </table>	Codes for Caregiver Barriers (iv)		1	Caregiver is in school	2	Caregiver is at work	3	Caregiver is responsible for other child(ren)	4	Caregiver is responsible for other child(ren) with special needs	5	Caregiver is responsible for disabled adult(s)	6	Caregiver's sleep is interrupted frequently throughout night because of caregiving responsibilities	7	Caregiver is unable to assist client with ADL/IADL because of physical limitations, disabilities, or illness	8	Other
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MONDAY																							
	Time PCS Needed (i)	ADL/IADL task(s) (task time in minutes) (ii)	Total minutes (iii)	Caregiver Barrier(s)(iv)																			
2a.																							
2b.																							
2c.																							
2d.																							
2e.																							
2f.																							
2g.																							
2h.																							
2i.	TOTAL PCS TIME FOR DAY (IN MINUTES) (SUM OF 0.6.2a.iii – 0.6.2h.iii)																						

Codes for ADLS/IADLS (ii)					
1	Meal preparation	7	Grocery shopping	13	NOT USED IN 0-3
2	Medication assistance	8	Bed mobility	14	Toilet use
3	Telephone use	9	Positioning	15	Dressing
4	Escort to medical appointments	10	Eating	16	Personal hygiene
5	Laundry	11	Transfers	17	Bathing
6	Light housework	12	Locomotion/mobility	18	Other

TUESDAY					COMMENTS/ELABORATION (May be continued on later pages, if necessary)
	Time PCS Needed (i)	ADL/IADL task(s) (task time in minutes) (ii)	Total minutes (iii)	Caregiver Barrier(s)(iv)	
3a.					
3b.					
3c.					
3d.					
3e.					
3f.					
3g.					
3h.					
3i.	TOTAL PCS TIME FOR DAY (IN MINUTES) (SUM OF O.6.3a.iii – O.6.3h.iii)				
WEDNESDAY					
	Time PCS Needed (i)	ADL/IADL task(s) (task time in minutes) (ii)	Total minutes (iii)	Caregiver Barrier(s)(iv)	
4a.					
4b.					
4c.					
4d.					
4e.					
4f.					
4g.					
4h.					
4i.	TOTAL PCS TIME FOR DAY (IN MINUTES) (SUM OF O.6.4a.iii – O.6.4h.iii)				

Codes for Caregiver Barriers (iv)	
1	Caregiver is in school
2	Caregiver is at work
3	Caregiver is responsible for other child(ren)
4	Caregiver is responsible for other child(ren) with special needs
5	Caregiver is responsible for disabled adult(s)
6	Caregiver's sleep is interrupted frequently throughout night because of caregiving responsibilities
7	Caregiver is unable to assist client with ADL/IADL because of physical limitations, disabilities, or illness
8	Other

Codes for ADLS/IADLS (ii)					
1	Meal preparation	7	Grocery shopping	13	NOT USED IN PCAF 0-3
2	Medication assistance	8	Bed mobility	14	Toilet use
3	Telephone use	9	Positioning	15	Dressing
4	Escort to medical appointments	10	Eating	16	Personal hygiene
5	Laundry	11	Transfers	17	Bathing
6	Light housework	12	Locomotion/mobility	18	Other

THURSDAY					COMMENTS/ELABORATION (May be continued on later pages, if necessary)																		
	Time PCS Needed (i)	ADL/IADL task(s) (task time in minutes) (ii)	Total minutes (iii)	Caregiver Barrier(s)(iv)																			
5a.																							
5b.																							
5c.																							
5d.																							
5e.																							
5f.																							
5g.																							
5h.																							
5i.	TOTAL PCS TIME FOR DAY (IN MINUTES) (SUM OF O.6.5a.iii – O.6.5h.iii)				<table border="1"> <thead> <tr> <th colspan="2">Codes for Caregiver Barriers (iv)</th> </tr> </thead> <tbody> <tr><td>1</td><td>Caregiver is in school</td></tr> <tr><td>2</td><td>Caregiver is at work</td></tr> <tr><td>3</td><td>Caregiver is responsible for other child(ren)</td></tr> <tr><td>4</td><td>Caregiver is responsible for other child(ren) with special needs</td></tr> <tr><td>5</td><td>Caregiver is responsible for disabled adult(s)</td></tr> <tr><td>6</td><td>Caregiver's sleep is interrupted frequently throughout night because of caregiving responsibilities</td></tr> <tr><td>7</td><td>Caregiver is unable to assist client with ADL/IADL because of physical limitations, disabilities, or illness</td></tr> <tr><td>8</td><td>Other</td></tr> </tbody> </table>	Codes for Caregiver Barriers (iv)		1	Caregiver is in school	2	Caregiver is at work	3	Caregiver is responsible for other child(ren)	4	Caregiver is responsible for other child(ren) with special needs	5	Caregiver is responsible for disabled adult(s)	6	Caregiver's sleep is interrupted frequently throughout night because of caregiving responsibilities	7	Caregiver is unable to assist client with ADL/IADL because of physical limitations, disabilities, or illness	8	Other
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8	Other																						
FRIDAY																							
	Time PCS Needed (i)	ADL/IADL task(s) (task time in minutes) (ii)	Total minutes (iii)	Caregiver Barrier(s)(iv)																			
6a.																							
6b.																							
6c.																							
6d.																							
6e.																							
6f.																							
6g.																							
6h.																							
6i.	TOTAL PCS TIME FOR DAY (IN MINUTES) (SUM OF O.6.6a.iii – O.6.6h.iii)																						

Codes for ADLS/IADLS (ii)					
1	Meal preparation	7	Grocery shopping	13	NOT USED IN PCAF 0-3
2	Medication assistance	8	Bed mobility	14	Toilet use
3	Telephone use	9	Positioning	15	Dressing
4	Escort to medical appointments	10	Eating	16	Personal hygiene
5	Laundry	11	Transfers	17	Bathing
6	Light housework	12	Locomotion/mobility	18	Other

SATURDAY				
	Time PCS Needed (i)	ADL/IADL task(s) (task time in minutes) (ii)	Total minutes (iii)	Caregiver Barrier(s)(iv)
7a.				
7b.				
7c.				
7d.				
7e.				
7f.				
7g.				
7h.				
7i.	TOTAL PCS TIME FOR DAY (IN MINUTES) (SUM OF O.6.7a.iii – O.6.7h.iii)			
8.	TOTAL TIME FOR WEEK (IN MINUTES) (SUM OF O.6.1i -- O.6.7i)			

Codes for Caregiver Barriers (iv)	
1	Caregiver is in school
2	Caregiver is at work
3	Caregiver is responsible for other child(ren)
4	Caregiver is responsible for other child(ren) with special needs
5	Caregiver is responsible for disabled adult(s)
6	Caregiver's sleep is interrupted frequently throughout night because of caregiving responsibilities
7	Caregiver is unable to assist client with ADL/IADL because of physical limitations, disabilities, or illness
8	Other

Codes for ADLS/IADLS (ii)					
1	Meal preparation	7	Grocery shopping	13	NOT USED IN PCAF 0-3
2	Medication assistance	8	Bed mobility	14	Toilet use
3	Telephone use	9	Positioning	15	Dressing
4	Escort to medical appointments	10	Eating	16	Personal hygiene
5	Laundry	11	Transfers	17	Bathing
6	Light housework	12	Locomotion/mobility	18	Other

O.7 PCS HOURS REQUESTED AND PCS HOURS AUTHORIZED

Code: 0 = Responsible person made no request for a specific amount of PCS assistance
 1 = PCS hours authorized equal or exceed hours requested by responsible person
 2 = PCS hours authorized are less than hours requested by responsible person

O.8 NATURE OF ANY DISAGREEMENT ABOUT PCS HOURS/RATIONALE FOR DIFFERENCE

(If notes or comments are related to a specific item/section, then reference the item/section before the comment)

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a. SIGNATURE:

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b. PRINTED NAME:

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