

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

**LEVEL OF CARE
FOR CHILDREN WITH MEDICAL FRAGILITY (MedF)
PEDIATRIC PATIENT REVIEW INSTRUMENT**

BRIDGES TO HEALTH (B2H) HOME & COMMUNITY BASED SERVICES MEDICAID WAIVER PROGRAM

| | | |
|----------------------------------|---|-----------------|
| CHILD'S NAME (LAST, FIRST, MI.): | | |
| DATE OF BIRTH: / / | SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female | MEDICAID CIN #: |

INSTRUCTION: Based on the following criteria, indicate whether the child, in your clinical opinion, meets the Level of Care requirements for participation in the B2H Medicaid Waiver Program. This form must be completed on an annual basis. This form is part of the Enrollment and Reauthorization Packet that must be sent to the Local Department of Social Services (LDSS) for authorization.

1. ADMINISTRATIVE DATA

If child could not be cared for at home he/she would require:

Skilled Nursing Facility Hospital

COUNTY OF RESIDENCE:

DIAGNOSIS:

Primary Other

BRIEF DESCRIPTION OF CHILD'S ILLNESS: (INCLUDING AGE OF ON-SET):

FAMILY STRUCTURE: (INVOLVEMENT, LIMITATIONS, ETC.)

MEDICAL TREATMENTS (Check all which apply):

| | YES | NO | | YES | NO |
|------------------------|--------------------------|--------------------------|---|--------------------------|--------------------------|
| Trach Care | <input type="checkbox"/> | <input type="checkbox"/> | Total Parenteral Nutrition (TPN) | <input type="checkbox"/> | <input type="checkbox"/> |
| Suctioning | <input type="checkbox"/> | <input type="checkbox"/> | Home Dialysis | <input type="checkbox"/> | <input type="checkbox"/> |
| -Oral/Nasal | <input type="checkbox"/> | <input type="checkbox"/> | Monitoring device(s) | <input type="checkbox"/> | <input type="checkbox"/> |
| -Trach. | <input type="checkbox"/> | <input type="checkbox"/> | -Oximeter | <input type="checkbox"/> | <input type="checkbox"/> |
| Oxygen | <input type="checkbox"/> | <input type="checkbox"/> | -Apnea | <input type="checkbox"/> | <input type="checkbox"/> |
| -Daily | <input type="checkbox"/> | <input type="checkbox"/> | -Cardiac | <input type="checkbox"/> | <input type="checkbox"/> |
| -Intermittently | <input type="checkbox"/> | <input type="checkbox"/> | Shunt Care | <input type="checkbox"/> | <input type="checkbox"/> |
| Ventilator | <input type="checkbox"/> | <input type="checkbox"/> | -VP | <input type="checkbox"/> | <input type="checkbox"/> |
| -Continuous | <input type="checkbox"/> | <input type="checkbox"/> | -VA | <input type="checkbox"/> | <input type="checkbox"/> |
| -Intermittent | <input type="checkbox"/> | <input type="checkbox"/> | Shunt has functioned without a problem for last 6 months: | <input type="checkbox"/> | <input type="checkbox"/> |
| Feeding | <input type="checkbox"/> | <input type="checkbox"/> | Other | <input type="checkbox"/> | <input type="checkbox"/> |
| -By Mouth | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| -Nasal gastric feeding | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| -Parenteral (IV) | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| -Gastric Tube | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |

2. FUNCTIONING

DOMAINS OF FUNCTIONING: Check the box/number of the answer best describing this child's functioning compared to a peer of the same age without problems. Answers should be based on personal knowledge and available documentation. Severe problems are those requiring intensive treatment efforts, lots of hands-on care and close supervision.

| DEVELOPMENTAL DOMAIN | SUSPECTED PROBLEM/ ASSESSMENT PENDING | MODERATE PROBLEM | SEVERE PROBLEM | NOT APPLICABLE/ AGE INAPPROPRIATE/ DON'T KNOW |
|-----------------------------|--|----------------------------|----------------------------|---|
| A. Gross Motor | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 0 |
| B. Fine Motor | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 0 |
| C. Receptive Communication | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 0 |
| D. Expressive Communication | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 0 |
| E. Self-care Toileting | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 0 |
| Personal Hygiene | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 0 |
| Grooming | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 0 |
| Eating | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 0 |
| Bathing | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 0 |
| Dressing | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 0 |
| F. Vision | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 0 |
| G. Hearing | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 0 |

| | YES | NO | COMMENTS |
|--|--------------------------|--------------------------|----------|
| Mobility | <input type="checkbox"/> | <input type="checkbox"/> | |
| a) Child is age appropriate | <input type="checkbox"/> | <input type="checkbox"/> | |
| b) If child is not age appropriate continue: | <input type="checkbox"/> | <input type="checkbox"/> | |
| Requires assistance of another human to ambulate | <input type="checkbox"/> | <input type="checkbox"/> | |
| Ambulate | <input type="checkbox"/> | <input type="checkbox"/> | |
| Requires device to ambulate: | <input type="checkbox"/> | <input type="checkbox"/> | |
| Wheelchair | <input type="checkbox"/> | <input type="checkbox"/> | |
| Walker | <input type="checkbox"/> | <input type="checkbox"/> | |
| Prosthesis | <input type="checkbox"/> | <input type="checkbox"/> | |
| Respiratory Care: | <input type="checkbox"/> | <input type="checkbox"/> | |
| Postural drainage | <input type="checkbox"/> | <input type="checkbox"/> | |
| Inhalation therapy | <input type="checkbox"/> | <input type="checkbox"/> | |
| Wound Care: | <input type="checkbox"/> | <input type="checkbox"/> | |
| Sterile | <input type="checkbox"/> | <input type="checkbox"/> | |
| Unsterile | <input type="checkbox"/> | <input type="checkbox"/> | |
| Catheter Care | <input type="checkbox"/> | <input type="checkbox"/> | |
| Seizures: | <input type="checkbox"/> | <input type="checkbox"/> | |
| Intervention daily | <input type="checkbox"/> | <input type="checkbox"/> | |
| 1X month | <input type="checkbox"/> | <input type="checkbox"/> | |
| 1X in past 3 months | <input type="checkbox"/> | <input type="checkbox"/> | |
| 1X in past year | <input type="checkbox"/> | <input type="checkbox"/> | |
| Ostomy | <input type="checkbox"/> | <input type="checkbox"/> | |
| Orthotics | <input type="checkbox"/> | <input type="checkbox"/> | |
| Ongoing medication by NG: | <input type="checkbox"/> | <input type="checkbox"/> | |
| G-tube | <input type="checkbox"/> | <input type="checkbox"/> | |
| Mental Status: | <input type="checkbox"/> | <input type="checkbox"/> | |
| Alert | <input type="checkbox"/> | <input type="checkbox"/> | |
| Lethargic | <input type="checkbox"/> | <input type="checkbox"/> | |
| Stuperous | <input type="checkbox"/> | <input type="checkbox"/> | |
| Comatose | <input type="checkbox"/> | <input type="checkbox"/> | |
| Agitated | <input type="checkbox"/> | <input type="checkbox"/> | |

| | YES | NO | COMMENTS |
|---|--------------------------|--------------------------|----------|
| a. Daily intravenous medication or nutritional supplement | <input type="checkbox"/> | <input type="checkbox"/> | |
| b. Requires constant observation for: | <input type="checkbox"/> | <input type="checkbox"/> | |
| c. Physical, occupational or speech therapy. | <input type="checkbox"/> | <input type="checkbox"/> | |

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|---|--|
| REGISTERED NURSE (R.N.) NAME, (LAST, FIRST, MI.): | REGISTERED NURSE (R.N.) SIGNATURE: X |
|---|--|

| | |
|----------------------------------|------------------------|
| TITLE OF PERSON COMPLETING FORM: | DATE COMPLETED: / / |
|----------------------------------|------------------------|

INSTRUCTION – The effective date should be determined in conjunction with the H.C.I.A.

| | | |
|---|--|--|
| DATE LEVEL OF CARE APPROVED / EFFECTIVE: / / | | |
|---|--|--|

ADDITIONAL COMMENTS ABOUT CHILD: