ARIZONA LONG TERM CARE SYSTEM

APPENDIX 10 B

PREADMISSION SCREENING MANUAL

FOR

DEVELOPMENTALLY DISABLED

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INTRODUCTION

A. Legislation

The Arizona State Legislature passed legislation in 1987 expanding the federally funded AHCCCS services to include long term care (LTC). As a result, the Arizona Long Term Care System (ALTCS) was established with an initial implementation date of December 19, 1988. To receive federal long term care Medicaid funds for an individual, AHCCCS Administration must demonstrate that the customer has a medical need for services and is at immediate risk of placement in a nursing facility (NF) or an intermediate care facility (ICF)

On September 1, 1995, federally funded LTC services were expanded to include the ALTCS Transitional Program. This program allows currently eligible members who have improved and are no longer at risk of institutionalization but still require some LTC services, to receive HCBS services at a lower level of care. For more information on the Transitional Program see Arizona's Eligibility Policy Manual for MA, NA and CA, Chapter 1000.

B. LTC

Long Term Care refers to ongoing services comparable to those received in a NF or an ICF-IID. These services represent a wide range of health-related services above the level of room and board and include professional services directed towards the maintenance, improvement, or protection of health or lessening of illness, disability or pain.

C. Preadmission Screening

Customers are determined by the Department of Economic Security, Division of Developmental Disabilities (DES/DDD) to be eligible for their services. These are customers who have been diagnosed with Intellectual Cognitive Disability, Cerebral Palsy, Seizure Disorder or Autism, and have significant impairment in their functions. For children under six years of age, a diagnosis of developmental delay or the risk for developmental disability may serve as the qualifying diagnosis for DES/DDD. The PAS process is intended to determine whether or not a customer's current functional and medical condition, resulting from a developmental disability, indicates a need for services at the ICF level. Frequently Individuals with developmental disabilities will be eligible to receive services from DES/DDD but not be at risk of institutionalization at the ICF-IID level and therefore not ALTCS eligible.

There are three (3) preadmission screening tools or instruments, which are designed to evaluate customers of different age groups. The tools are statistically valid tools, developed by a process of multivariate analysis. The groups are as follows:

Age 0-5…….. (birth through five or up to the 6th birthday)

Age 6-11…….(six through eleven or up to the 12th birthday)

Age12+……..(beyond the 12th birthday) and older

Children under six years of age who are not clients of DES/DDD (e.g., physically disabled children) are also assessed using the 0-5 tool.

Refer to Appendix B1 for the PAS Tool Matrix by DD Status and Age to ensure the appropriate tool is used.

D. PAS Eligibility

The DD PAS tools are used to assess the functional, medical and nursing needs of the customer. Meeting or exceeding a threshold score on this screening tool establishes initial eligibility for institutional level of services (Arizona Revised Statutes §36-2936). A combination of weighted functional and medical factors are evaluated and assigned a numerical value to reach totaled scores. The purpose of the functional/medical threshold score is to ensure that all individuals deemed eligible for ALTCS require an ICF level of care.

The eligible applicant needs long term care at a level of care comparable to that provided in an ICF-IID, but **below** an acute care setting (hospitalization or intense rehabilitation) and **above** a supervisory/custodial/personal care setting, intermittent outpatient medical intervention, or benevolent oversight. An initial applicant who is already enrolled with an AHCCCS acute health plan and needs less than 90 days of convalescent care may also be ineligible for ALTCS. A customer who does not have a non-psychiatric medical condition or developmental disability also may not be eligible.

In the aggregate, the eligible ALTCS customer will have a functional and/or medical condition resulting in such a degree of impairment as to interfere substantially with the capacity to remain in the community, and results in long term limitation of capacity for self care.

E. Eligibility Review

When a customer's medical eligibility for Title XIX services is not adequately defined by the scoring criteria, but in the ALTCS assessor's professional opinion the individual's overall condition may indicate need for ICF level of care, the case may be referred for eligibility review to a consultant physician or an administrative review.

It is important to remember that there is no singular definition for the level of care for ALTCS medical eligibility. An eligible individual might have a combination of factors that impact functional ability and medical need for services.

F. Population Assessed

The population assessed with the DD tools includes persons with developmental disabilities (DD) and physically disabled children under 6 years of age who apply for or are recipients of ALTCS. Developmentally disabled adults who are placed in a nursing facility (NF) are not assessed using this tool, but are assessed on the Elderly/Physically Disabled (EPD) tool. The PAS tool may also be used to determine whether individuals not applying for Title XIX services are at risk for ICF-IID care. These individuals will be assessed upon request (Private Request PAS).

G. Assessment Team

The tool is completed by a registered nurse and/or a social worker who will use professional judgment based on education, experience and ongoing in-service training to describe the customer's functional ability and current medical status. If the customer is ventilator dependent, the assessment will be conducted by a registered nurse and/or social worker but the ventilator worksheet will be completed by a registered nurse.

H. HCBS

Long term care services may include home and community-based services (HCBS) that offer an alternative to institutional care. ALTCS offers this alternative in order to ensure that the recipient in need of institutional level of care may be treated in the least restrictive environment. HCBS is

appropriate for those who would require institutionalization, but who can retain a more independent lifestyle with services provided in the home or community settings.

I. Customer Issue Referral (CIR)

When situations are identified that pose immediate and/or serious threat to the applicant's well-being (e.g., quality of care, suicidal threats, environmental hazard, or suspected physical abuse or neglect), appropriate health providers and/or authorities (Adult/Child Protective Services, police, paramedics, guardians) as well as the assessor's supervisor, should be notified as soon as possible. Documentation of the referral (person notified, date and description of the incident) should be entered into the PAS case notes and/or an AHCCCS Customer (Client) Issue Referral Form completed. For more information on CIR, see Arizona's Eligibility Policy Manual for MA, NA and CA, Chapter 1008.

J. PASRR

The assessor should be aware that all nursing facility residents and applicants to Medicaid certified nursing facilities must be assessed through the Preadmission Screening and Resident Review (PASRR) process. The PASRR is a two-level screening process for mental illness/cognitive disability and mandated by the Omnibus Budget Reconciliation Act of 1987 (OBRA '87) as a portion of NF reform measures. Although individuals with developmental disabilities are infrequently placed in NFs, the assessor must be aware of cases where the customer is in a NF or is likely to enter one to ensure that the PASRR has been completed. For further information regarding PASRR, see Arizona's Eligibility Policy Manual for MA, NA and CA, Chapter 1009.

K. PAS Tool Sections

The ALTCS Preadmission Screening tool consists of several sections. These sections are:

- Intake information
- Functional assessment including developmental, independent living skills, behavioral and communication domains
- Medical assessment
- Eligibility review (if indicated)

This manual provides instructions for completing the PAS tool and guidelines for making assessment decisions. For more information regarding PAS and reassessments, see Arizona's Eligibility Policy Manual for MA, NA and CA, Chapter 1000.

L. Health-e-Arizona PLUS (HEAplus)

The information obtained will be entered into HEAplus, which is the system supporting the PAS.

M. FORTIS

The medical and financial case documentation obtained is stored by converting paper documents into an electronic database called Fortis. All applicable information obtained will be scanned into this computerized AHCCCS database using the HEAplus barcode separator sheets.

I. INTAKE INFORMATION

INTAKE/ASSESSMENT INFORMATION

AHCCCS ID	This is the unique identifier for the AHCCCS system. A customer has only one AHCCCS ID. New customers who have not been AHCCCS members will not have an AHCCCS ID at this point.
AHCCCS Member	This identifies if an ALTCS customer is already eligible for AHCCCS acute services. Usually, these customers are enrolled with an AHCCCS health plan. The application, including PAS, is expedited for these members. If the customer is not expected to need more than 90 days of long term care, the individual may not qualify for ALTCS. The acute health plan is responsible for up to 90 days of convalescent care per calendar year. Eligible cases that might belong in this category should be referred to the physician for eligibility review (Please refer to Physician Review on page 65. Any customer that seems to need less than 90 days of convalescent care should have the AHCCCS health plan enrollment verified by reviewing PMMIS screens RP160, RP245 or RP285 in the Recipient subsystem.
Health Plan Name	This is the name of the Health Plan in which the AHCCCS member is enrolled.
Health Plan Phone	This is the phone number for the Health Plan.
Application Date	This is the date the ALTCS application is received in the local office.
Referral Date	This is the date the financial eligibility specialist requests a PAS.
PAS Due Date	This is the date the PAS is due. This date is six days before the end of the application period for the case. The application period is 45 days from the application date.
DD (Developmental Disability) Status:	This is the DD status at the time the PAS is referred. • Potential DD • DD • DD in a Nursing Facility • Not DD (EPD) If there is any question about DD status, this should be investigated and reconciled immediately. FOCUS, DDD's customer information system, should always be checked. Status may also be investigated by asking the Financial Eligibility Specialist or the Department of Economic Security, Division of Developmental Disabilities (DES/DDD). For more information on DD status see Arizona's Eligibility Policy Manual for MA, Chapter 1000.

DOB	Date of Birth
Age	This is the customer's age in years (at the time the referral for PAS is made). For children under 3 years old, the age will be displayed in months. NOTE: If the child is close to changing age groups, the PAS may need to be delayed to ensure assessment with the proper tool. These cases should be discussed with a supervisor.
SSN	The customer's Social Security Number
Gender	Male or Female
Marital Status	The customer's marital status
Language	The customer's primary language
Financial Eligibility Specialist Name	The name of the financial worker who requested the PAS, also known as the Program Services Evaluator (PSE).
Office	The local office to which the financial eligibility specialist is assigned.
Phone	The phone number of the financial eligibility specialist who made the PAS referral

DEMOGRAPHIC INFORMATION

Residence Address (City, State, Zip code)	This is the customer's address at the time of referral. If the applicant is in a facility, the facility address will be the residence address.
Mailing Address (City, State, Zip Code)	The customer's mailing address
Phone	This is the customer's phone number.
County	This is the county in which the customer currently resides.
Authorized Representative	A person authorized by the customer, legal representative, or responsible relative of the customer to act on the customer's behalf in the AHCCCS eligibility process.
Residence Phone Number	This is the authorized representative's phone number (if applicable).
Relationship	This is the relationship of the authorized representative to the customer.

Business Phone Number	This is the business phone number of the authorized representative (if applicable).
Cell Phone/Pager (Alternate Telephone Number)	This is the authorized representative's cell phone, pager or alternate number (if applicable).
Location	This is the location of the customer at the time of the application.
Facility	If the applicant is in an ICF-IID, hospital or nursing facility the facility name will appear here.
Phone	This is the facility phone number (if applicable).
*Admission Date	The date of admission to the facility (if applicable).
* Date of Death	The date of death will be on the PAS Intake Notice if the financial eligibility specialist was aware at the time of the referral that the applicant was deceased.
If Different from Above	Any changes or corrections to the information must be communicated to the financial eligibility worker and can be done by e-mail.

A. Open PAS Battery

a. This is where the customer's PAS information is found, including:
    i. Application IDs (if more than one application)
    ii. Person ID number (Does not change with applications)
    iii. Assessment type (initial or reassessment PAS)
    iv. PAS Tool used
    v. DD Status of each application
    vi. Status of the PAS
        1. "Continue PAS" indicates it is open, and has not been completed yet
        2. "View PAS" indicates it is closed and has been completed.

B. Developmental Disabilities Battery

This battery in HEAplus includes if the applicant has had a DD-qualifying diagnosis, what it is, whether the person is receiving DD services, program start/end dates, and the reason terminated from DDD (if applicable).

<u>DD Support Coordinator</u>

Contact information is provided here: name and phone number

<u>DD History</u>

Includes any changes to the DD status, including begin and end dates.

C. ASSESSMENT BATTERY

Applicant This is the name of the person who has applied, and for whom the PAS is conducted.

Assessment

This is the current PAS date.

Applicant Age

This is the customer's age at the time of the PAS. This is shown in parentheses next to the applicant's name. This is not the current age of the applicant.

DD Status

This field is populated by HEAplus as a result of the DD Status chosen when the application was originally registered.

Tool Used

This field is populated by HEAplus as a result of the DD Status chosen when the application was originally registered and at the time the PAS is created.

Assessor

This field is automatically populated by the system when the assessor creates the PAS.

Assessor

This field is usually blank, but if a second assessor assisted with the PAS, the name is selected from the drop down list.

Location at time of assessment

This is the setting where the PAS interview was conducted. The assessor selects the appropriate setting from a drop down list in Heaplus.

Telephone

This is the telephone number at the location where the PAS interview was conducted.

Usual Living Arrangement (Select the applicable setting)

'Usual' refers to the customer's living arrangement for approximately the last six months, or if there is no planned discharge or relocation from the present living arrangement.

Community refers to a customer who lives in a private home, mobile home or apartment.

Group Home refers to a customer who lives in a residential placement with a group of other people. The most common community living arrangement that social service or private organizations establish for individuals who are intellectually disabled or have other disabling

conditions. In these homes, a group lives within a residential neighborhood, receiving support and supervision.

ICF/IID refers to an Intermediate Care Facility for Individuals with Intellectual Disability (ICF-IID), or related conditions

Nursing facility may be a certified or uncertified facility.

Other supervised setting refers to board and care homes, adult foster homes, adult care homes, supervisory care homes, apartments for assisted living, etc.

Residential Treatment Center is a facility that provides behavioral health services (mental health and substance abuse) to individuals who are under age 21, or under age 22 if admitted prior to age 21. An inpatient psychiatric facility for persons under the age of 21, accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO), and licensed by ADHS as a residential treatment center pursuant to ADHS R9-5041

Usual Living Situation

This refers to with whom the customer has resided for approximately the last six months. If the customer has been in a living situation for less than 6 months and there are no plans to make a change, consider that the usual living situation. If a customer resides in a nursing facility or assisted living setting where a spouse or other family member also resides, "with non-relatives" should be indicated rather than living with spouse or other relative.

In all cases, the applicant must be observed and preferably the interview would occur in the usual living arrangement. **It is important that the interview be conducted with caregiver(s) or others familiar with the applicant.** It is required that family or legal guardian be contacted to be present at the PAS interview if they choose. If the family member or legal guardian is not available to attend the PAS, the assessor should contact them to go over the information obtained at the interview. For school age children, the interview may be done in the pre-school or after school setting with parent being interviewed at the home. It may also be necessary to speak to teachers, therapists or others familiar with the child.

D. DD / EPD Information Battery

Medical Assessment

Is the customer currently hospitalized or in an intensive rehabilitation facility?

Answer yes or no as applicable.

Imminent discharge from acute care facility? Answer yes or no, as applicable.

When the customer is in an acute care facility at the time the PAS is completed, answer "Yes" and enter the projected discharge date as follows:

- When there is a planned discharge date AND the projected date is before the PAS will be completed (closed) in HEAplus, enter the date provided by the representative or facility.
- When there is a planned discharge date, but it is after the PAS is completed (closed) in HEAplus, enter the date of the PAS interview.
- When there is no firm or planned discharge date, enter the date of the PAS interview.

Ventilator Dependent – Answer yes or no, as applicable

This is defined as being on a ventilator at least 6 hours a day for 30 consecutive days. The ventilator worksheet battery for a customer who is dependent on a ventilator must be completed by a registered nurse. The registered nurse must research the respiratory therapy/pulmonology records to verify the start date and number of continuous days on the ventilator. This information is recorded on the Ventilator Worksheet Battery and included in the PAS. It may be necessary for the registered nurse to obtain information from multiple facilities in order to accurately determine when the customer started on the ventilator and if the criteria are met.

Physical Measurements

Height - Record approximate height if actual is unknown. Respond in feet or inches. If not available in feet or inches, use the metric system.

Weight - Record approximate weight if actual is unknown. Respond in pounds. If not available in pounds, use the metric system.

Birth Weight and Gestational age – estimated if exact numbers are unknown; confer with medical records.

E. Ventilator Worksheet Battery

This battery will display as "(Read Only)" if the customer is indicated to not be on a ventilator at the time of the PAS, which does not require any entry of information.

If the customer is on a ventilator, this section would be entered and not be showing as Read Only. This is defined as being on a ventilator **at least 6 hours a day for 30 consecutive days**. The ventilator worksheet for a customer who is dependent on a ventilator must be completed by a registered nurse. The registered nurse must research the respiratory therapy/pulmonology records to verify the start date and number of continuous days on the ventilator. This information is recorded on the Ventilator Worksheet and included in the PAS. It may be necessary for this assessor to obtain information from multiple facilities in order to accurately determine when the customer started on the ventilator and if the criteria are met.

F. FUNCTIONAL SCORE BATTERY - Part 1 (Ages 0-5)

DEVELOPMENTAL DOMAIN

The Developmental Domain is completed for children at least 6 months old, but younger than age six (6) years, and therefore is found on the 0-5 tool for ages zero (0) through five (5). The assessor should answer each question "yes" or "no" based on information provided by the caregiver, observation of the customer, and information obtained from the medical records.

NOTE: If a child is close to a change in age that would indicate more developmental areas or a different PAS tool would be required, it is usually beneficial to wait to do the assessment until after the age change. These cases should be discussed with a supervisor or PAS QAT.

INFANTS LESS THAN SIX (6) MONTHS OLD

The PAS Assessor should **not** complete Section A (Developmental Domain) **for infants less than six (6) months old** (although developmental information is required as described below), but should proceed to the Medical Assessment section of the PAS and complete that as accurately as possible. All pertinent medical documentation, including any evaluations and assessments completed on the infant, must be obtained. **These documents are then scanned into Fortis and the case submitted for physician review.**

Additionally for children under 6 months of age, a description of their emerging developmental patterns is required to be documented regarding muscle tone, visual perception, sleep and feeding habits, and social interaction. For example, does the child roll from stomach to side? Does the child follow moving objects with her/his eyes? Does the child smile or coo at a face or a touch? Use the Summary in the PAS tool (ages 0 to 5) to record this information. Refer to the Emerging Patterns of Behavior Supplement for normal developmental milestones, which describes age appropriate milestones by weeks of age for infants.

CHILDREN SIX (6) MONTHS UP TO 70 MONTHS (UNDER SIX YEARS)

There are nine sections of developmental questions. **The assessor must determine the customer's exact age in months at the time of the PAS, and then complete only the particular section(s) applicable to the child at that age.** The questions are divided at the following points:

For Children

- 6 months but less than 9 months old, only the first section is to be completed. (Questions 1-9)
- 9 months, but less than 12 months old, the first two sections are to be completed. (Questions 1-19)
- 12 months, but less than 18 months old, the first three sections are to be completed. (Questions 1-28)
- 18 months, but less than 24 months, the first four sections are to be completed. (Questions 1-44)

- 24 months, but less than 30 months, the first five sections are to be completed. (Questions 1-56)
- 30 months, but less than 36 months, the first six sections are to be completed. (Questions 1-65)
- 36 months, but less than 48 months, the first seven sections are to be completed.(Questions 1-79)
- 48 months, but less than 60 months, the first eight sections are to be completed.(Questions 1-93)
- 60 months and older, complete all the questions, 1-101.

All items are to be answered based on the child's performance now, not as s/he did or did not perform the skills at the ages indicated on the tool. All available, pertinent medical records, therapy notes, school records, etc., should be reviewed prior to completing the PAS scoring to supplement information gathered at the interview.

No sections or individual items required by the child's age may be skipped. If, for example, a 24 month old appears to have some basic skills at the 18 month level, all the earlier sections and items must still be accurately completed. **The assessor should try to avoid assuming that a child can perform skills based on her/his performance in other areas, as children may have scattered skills.** Scattered skills means the child may have varying levels of skills in several developmental areas.

The tool is designed to assess gross motor skills, fine motor skills, communication, socialization, daily living skills and behaviors at different ages and therefore may show strengths and weaknesses within any section. Remember, this area is not assessing whether the child performed these skills at the developmental age indicated, but rather how they are performing now. Some questions may be assessing more than one skill.

At the PAS interview, read all the questions completely to the parent(s) or caregiver(s). Do not paraphrase the questions. Paraphrasing could change the intent of the question and create inconsistency in implementation of the assessment. The questions are to be taken literally. Further explanation can be given if the question is not understood however that should be done only after reading the full question as it is written.

If the parent or caregiver's response to the question is "sometimes" the assessor must ask more questions to determine what is meant by "sometimes" in order to determine how to score. If the child has just begun to perform the milestone, but appears to be performing it, the answer would be that they do it. They do not need to do it all the time for the response to be "Yes". For example, if the response is "sometimes" to question #14 "When a loud noise occurs, does your child respond? (For example, act startled, cry or turn toward the sound.)", the answer would be "Yes". Question #56 "Does your child look at you when you talk to them?" in most cases the response will be "sometimes" as the child will not always look at the parent or caregiver, especially if the child is being disciplined or is being asked to do something they do not want to do.

For questions that give examples, there may be other examples and the assessor needs to judge whether the example given fits the intent of the question. For example, question #27 "Does your child

play with a doll or stuffed animal by hugging it?", the child may hug a blanket or other toy and this would still be indicated as "Yes" with comments to explain.

For question # 71, "Does your child follow instructions with two actions or an action and two objects? (For example, "Bring me the crayons and the paper"; "Sit down and eat your lunch"; etc.)" it is important that the assessor is determining that the child is following two step instructions and not just always doing these activities together and therefore associating the activities by rote rather than following the instructions. Parents may give examples that indicate the child is really not following two step instructions but could appear to in some cases such as "put on your shoes and socks".

Other questions are more specific and are intended to be asked and answered that way. Question #39, "Does your child ever use their index finger to point, to indicate interest in something?" specifically means the index finger. If the child points with their whole hand the answer would be "No" with comments to explain. Question #45 "Does your child run?" is specific to running, not walking fast nor does it say anything about falling, so the child may be clumsy or may fall but answer specifically whether or not they run.

Precursor Skills

There are a few items which may be confusing to answer as the child gets older and learns more skills. As children progress they may learn new skills and no longer perform the **precursors** to those skills. Some examples are:

12. Does your child creep or move on their stomach across the floor?

16. Does your child make non-word sounds? (That is, babble or jabber.)

36. Does your child say "Da-da" or "Ma-ma" or another name for parent or caregiver (including parents or caregiver's first name or nickname)?

If the child is walking, they have progressed beyond the creeping stage and the answer to question #12 would be "Yes" even though they may no longer creep or move across the floor on their stomach. Even if the parent or caregiver indicates they never crept it would be inaccurate to indicate "No" to this question if they are now walking. The child who now has meaningful words probably no longer babbles. Yet it would be a misrepresentation of the child's development to answer question #16 "No," when item 36 is "Yes." In this case, the assessor does not need to determine whether the child did babble or can babble because s/he has moved beyond this stage to a higher level of development. In nearly all cases, if question #36 is answered "yes," question #16 should also be answered "yes".

Some children may never have performed the precursor skills, but now have the advanced skills. The precursor questions need to be answered "yes" in these instances.

Other examples of items that must be reviewed in this way are:

22. Does your child hold a bottle or cup? (Now uses a spoon to feed themselves [question 61].)

3. If you hold both hands just to balance your child, does s/he support their own weight while standing? (That is, can s/he bear weight?) (Now walks around furniture while holding on with only one hand [question 20].)

The child's performance of the higher skills is usually evidence that s/he is capable of performing similar skills that are more basic. Often a child may have scattered skills and be unable to perform some milestones in the younger groups while having accomplished some higher skills. Care must be taken to indicate the responses to all questions accurately as they are important indicators.

While asking these questions of parents or caregivers the assessor must explain how these will be considered for scoring. Explaining the PAS process for eligibility is an important role the assessor is continually performing.

Reverse Scoring

For several questions (e.g., 9, 63, 64, 65, 76, 77, 78, 79) the scoring is **reversed**, that is the Yes response is the negative answer. The reverse questions are also important indicators of possible serious problems. It is important to record responses accurately and ensure data entry is accurate. For example, if an older child has mastered all the milestones in the six to nine month age group care must be taken to ensure that question #9, “Does your child stiffen and arch their back when picked up” is not inadvertently answered “Yes” also. A “Yes” answer to this question could be an indicator of a very serious neurological disorder or a severe gastrointestinal problem.

The reverse questions for older groups are also all very important questions and care must be taken to answer them accurately. All the questions are important and should be answered accurately however some affect other scoring criteria. Extra emphasis is being made regarding these questions due to the greater chance for errors.

Communications Skills

On questions pertaining to language and communication (e.g.36, 50, 58, 59, 69, 70, 85, 86, 89, 95), if the child uses Sign Language or other methods of communication this should be considered in the scoring. Thus, if the child signs the name of at least three objects, question #50 would be answered “Yes”. If the child points to and signs the most common colors (that is, red, blue, green, yellow), question #95 would be answered “Yes”.

Stereotypical, repetitive, echolalic sounds that are not for communication or do not indicate social intent may require a negative response to questions regarding language and communication. Comments should also clearly describe this type of behavior and explain the scoring response.

Socialization Skills

Question #18 “Does your child enjoy playing peek-a-boo/pat-a-cake?” is asking if the child “enjoys” one of these games and is not asking if they physically participate. The parent may be doing all the activity but the child still enjoys the game.

For question #38, “If you point at a toy across the room, does your child look at it?” it is typical for the parent to be speaking to the child when pointing and not the intent of this question to be asking if they are only pointing and not speaking. For question #40, “Does your child ever bring objects over to you?” the question is really about showing interest in the item. So if the child takes the parent over to the object to show them, it would be answered “Yes” with comments to explain. For question #42 “Does your child take an interest in other children? *(Includes siblings.)”,* it is important to ensure the child is not just interested in an object another child may be holding (like a toy) and showing no interest in the other child. The assessor must ask enough questions of the parent(s)/caregiver(s) to determine accurate scoring. (This is important throughout the Developmental Domain.)

Motor Skills (Fine and Gross)

For question #3 “If you hold both hands just to balance your child, does s/he support their own weight while standing? (That is, can s/he bear weight?)” this would be answered “Yes” if the child can bear weight and balance no matter how briefly. A typical child at six to nine months old cannot do this for long. If assessing an older child and they still cannot do this for very long, the answer would still be “Yes” with comments to explain anything that is atypical.

For questions that ask can the child do one thing OR another, they do not have to do both to achieve a “Yes” response. For example, question #4, “Does you child reach for or grasp a toy?” if they do one and not the other the response would still be “Yes”. Again, comments should explain anything that is not typical for the age of the child being assessed. If an older child has a physical impairment and is unable to reach for an object but does grasp, the “Yes” answer should be clarified with comments.

For question #9, “Does your child stiffen and arch their back when picked up”, it is important to understand that this question is not assessing if an older child does this on some occasions because they are upset and do not want to stop what they are doing or are for some reason just being resistive to being picked up. While we do not assess an older child based on how they functioned at an earlier age, the assessor does need to keep in mind the age range where the question is first asked to understand the intent of the question. As indicated above, this question could reflect serious impairment.

Most children will have a dominant side and tasks will primarily be performed with that hand. Most fine motor milestones are not asking whether the child can perform a skill with both hands. For example, question #4, “Does your child reach for or grasp a toy?” or question #24 “Does your child pick up a small object with thumb and fingers? “. Therefore if the child has the use of only one hand but can complete the milestone with that hand, the answer would be “Yes”. Comments should be included to clarify.

Behavioral Questions

For questions #63, “Does your child do things over and over and can’t seem to stop?”, #64, “Does your child destroy or damage things on purpose?”, #65, “Does your child hurt themselves on purpose?”, and #77, “Does your child act physically aggressive?”, we are generally looking for repeated behaviors. We are not assessing a one time or rare occurrence which most children might have. We are looking at behaviors that go beyond normal ‘bad days’, ‘terrible two’s’, sibling rivalry or accidents.

For question #64 there has to be actual damage and for #65 there has to have been injury. Also both questions relate to intentional behavior not something that happened inadvertently. The intervention for these behaviors will help determine whether it fits the intent of the question and the intervention should be described in comments.

For question #78, “Does your child have eating difficulties? (For example, eats too fast or too slowly, hoards food, overeats, refuses to eat, etc.)”, we are again looking for atypical performance and a problem behavior. Many kids may eat a little too fast or slowly at times or refuse certain foods and be ‘picky eaters’. Does their behavior put them at risk or disrupt the family? Is it being treated by a physician and/or a nutritionist? Additional questions will often need to be asked to get the full picture to determine how to most accurately answer this question and provide the necessary clarification in comments.

Services/Treatments Algorithm & Weights

UPDATING THE DD PAS

Algorithm & Weights – Services/Treatments

Age Cohort	Services and Treatments						
	Drug Reg. + Admin.	Non-B/B Ostomy Care	Tube Feeding	PT or OT	Acute Hospital Admits*	Direct Care Staff Train	Special Diet
Under 9 Mos	1.0	7.0	7.0	1.0	1 x #	0.5	2.0
9 – 11 Mos	1.0	7.0	7.0	1.0	1 x #	0.5	2.0
12 – 17 Mos	1.0	7.0	7.0	1.0	1 x #	1.0	2.0
18 – 23 Mos	1.0	7.0	7.0	1.0	1 x #	1.0	2.0
24 – 29 Mos	1.0	7.0	7.0	1.0	1 x #	1.0	2.0
30 – 35 Mos	1.0	7.0	7.0	1.0	1 x #	1.0	2.0
36 – 47 Mos	1.5	5.0	5.0	1.5	1 x #	1.0	2.0
48 – 59 Mos	1.5	5.0	5.0	1.5	1 x #	1.0	2.0
60 Mos+	1.5	5.0	5.0	1.5	1 x #	1.0	2.0

*Capped at 2 points

Algorithm & Weights-Developmental Milestones

UPDATING THE DD PAS

Algorithm & Weights – Medical

	Medical Conditions / Medical + Developmental Combinations				
Age Cohort	Cerebral Palsy	Epilepsy	Moderate/ Severe/ Profound MR	Autism + MCHAT*	Autism + Behaviors*
Under 9 Mos	5.0	5.0			
9 – 11 Mos	5.0	5.0			
12 – 17 Mos	5.0	5.0			
18 – 23 Mos	5.0	5.0		7.0	
24 – 29 Mos	5.0	5.0		7.0	
30 – 35 Mos	5.0	5.0		7.0	5.0
36 – 47 Mos	5.0	5.0	15.0	7.0	10.0
48 – 59 Mos	5.0	5.0	15.0	7.0	10.0
60 Mos+	5.0	5.0	15.0	7.0	10.0

*See next slides for definitions

Autism + MCHAT – 18 months and Older

- ✓ Diagnosis of Autism, PDD or Autism-like behaviors
- ✓ Fails at least six of the following eight MCHAT (or MCHAT-based) milestones:

34. Does your child respond to their name when you call?
38. If you point at a toy across the room, does your child look at it?
39. Does your child ever use their index finger to point, to indicate interest in something?
40. Does your child ever bring objects over to you?
41. Does your child ever imitate you? For example, you make a face – will your child imitate it?
42. Does your child take an interest in other children?
44. Does your child like being hugged or cuddled?
56. Does your child look at you when you talk to them?

Autism + Behaviors – 30 to 35 Months

- ✓ Diagnosis of Autism, PDD or Autism-like behaviors
- ✓ Exhibits at least three of the following four behaviors:

62. Does your child sleep at least 8 hours in a 24-hour period? (“No” response indicates presence of behavior)
63. Does your child do things over and over and can’t seem to stop? (Examples are rocking, hand flapping or spinning)
64. Does your child destroy or damage things on purpose?
65. Does your child hurt themselves on purpose?

Autism + Behaviors – 36 Months and Older

- ✓ Diagnosis of Autism, PDD or Autism-like behaviors
- ✓ Exhibits at least six of the following eight behaviors:

62. Does your child sleep at least 8 hours in a 24-hour period?
63. Does your child do things over and over and can't seem to stop?
64. Does your child destroy or damage things on purpose?
65. Does your child hurt themselves on purpose?
76. Does your child cry, scream or have tantrums that last for 30 minutes or longer?
77. Does your child act physically aggressive? (For example, hits, kicks, bites etc.)
78. Does your child have eating difficulties? (For example, eats too fast or too slowly, hoards food, overeats, refuses to eat etc.)
79. Does your child sometimes stare at nothing or wander with no purpose?

UPDATING THE DD PAS

Algorithm & Weights – Developmental Milestones

Age Cohort	6mos+	9mos+	12mos+	18mos+	24mos+	30mos+	36mos+	48mos+	60mos+
	9 milestones	19 milestones	28 milestones	44 milestones	56 milestones	65 milestones	79 milestones	93 milestones	101 milestones
Under 9 Mos	5.000								
9 – 11 Mos	4.100	4.100							
12 – 17 Mos	2.900	2.900	2.900						
18 – 23 Mos	2.125	2.125	2.125	2.125					
24 – 29 Mos	1.750	1.750	1.750	1.750	1.750				
30 – 35 Mos	1.550	1.550	1.550	1.550	1.550	1.550			
36 – 47 Mos	1.340	1.340	1.340	1.340	1.340	1.340	1.340		
48 – 59 Mos	1.140	1.140	1.140	1.140	1.140	1.140	1.140	1.140	
60 Mos+	1.030	1.030	1.030	1.030	1.030	1.030	1.030	1.030	1.030

FOR AGES SIX (6) MONTHS AND OLDER

1.	Does your child lift their head when lying on their back?	Yes	No
2.	When your child is on their tummy, does s/he straighten both arms and push their whole chest off the bed or floor?	Yes	No
3.	If you hold both hands just to balance your child, does s/he support their own weight while standing? (That is, can s/he bear weight?)	Yes	No
4.	Does your child reach for or grasp a toy?	Yes	No
5.	Does your child try to pick up a crumb or Cheerio by using their thumb and all their fingers in a raking motion, even if they aren't able to pick it up? (If they already pick up the crumb or Cheerio, check "yes" for this item.)	Yes	No
6.	Does your child make high-pitched squeals?	Yes	No
7.	Does your child show two or more emotions? (For example, laughs, cries, screams, etc.)	Yes	No
8.	Does your child act differently toward strangers than s/he does with you and other familiar people? (Reactions to strangers may include, for example, staring, frowning, withdrawing or crying.)	Yes	No
9.	Does your child stiffen and arch their back when picked up? ***REVERSE SCORING***	Yes	No

STOP HERE IF CHILD IS LESS THAN NINE (9) MONTHS

FOR AGES NINE (9) MONTHS AND OLDER

10.	Does your child roll from their back to their tummy, getting both arms out from under them?	Yes	No
11.	When you stand your child next to furniture or the crib rail, does s/he stand, holding onto the furniture for support?	Yes	No
12.	Does your child creep or move on their stomach across the floor?	Yes	No
13.	Does your child sit supported (for example, in a chair with pillows, etc.) for at least 1 minute?	Yes	No
14.	When a loud noise occurs, does your child respond? (For example, act startled, cry or turn toward the sound.)	Yes	No
15.	If you call your child when you are out of their line-of-sight, does s/he look in the direction of your voice?	Yes	No
16.	Does your child make non-word sounds? (That is, babble or jabber?)	Yes	No
17.	Does your child look toward you (parent or caregiver) when hearing your (parent or caregiver's) voice?	Yes	No
18.	Does your child enjoy playing peek-a-boo/pat-a-cake?	Yes	No
19.	Does your child feed themselves a cracker or cookie?	Yes	No

STOP HERE IF CHILD IS LESS THAN TWELVE (12) MONTHS

FOR AGES TWELVE (12) MONTHS AND OLDER

20.	Does your child walk around the furniture while holding on with only one hand?	Yes	No
21.	Does your child crawl at least 5 feet on hands and knees, without stomach touching the floor?	Yes	No
22.	Does your child hold a bottle or cup?	Yes	No
23.	Does your child move an object from one hand to the other?	Yes	No
24.	Does your child pick up a small object with thumb and fingers?	Yes	No
25.	Does your child coo or laugh or make other sounds of pleasure?	Yes	No
26.	Does your child reach for familiar person when person holds out arms to them?	Yes	No
27.	Does your child play with a doll or stuffed animal by hugging it?	Yes	No
28.	Does your child suck or chew on finger foods? (For example, crackers, cookies, toast, etc.)	Yes	No

STOP HERE IF CHILD IS LESS THAN EIGHTEEN (18) MONTHS

FOR AGES EIGHTEEN (18) MONTHS AND OLDER

29.	Does your child stand up in the middle of the room by themselves and take several steps forward?	Yes	No
30.	Does your child climb on furniture?	Yes	No
31.	Does your child turn the pages of a board, cloth or paper book by **himself/herself? (S/he may turn more than one page at a time.)**	Yes	No
32.	Without showing them how, does your child scribble back and forth when you give them a crayon (or pencil or pen)?	Yes	No
33.	Does your child stack a small toy, block, cup, dish or other object on top of another one?	Yes	No
34.	Does your child respond to their name when you call?	Yes	No
35.	When playing with sounds, does your child make grunting, growling or deep-toned sounds? *(Examples may include a car, a motor, a train, an animal.)*	Yes	No
36.	Does your child say “Da-da” or “Ma-ma” or another name for parent or caregiver (including parents or caregiver’s first name or nickname)?	Yes	No
37.	When you ask your child to point to their nose, eyes, hair, feet, ears and so forth, does your child correctly point to at least *one* body part? (They can point to themselves, you or a doll.)	Yes	No
38.	If you point at a toy across the room, does your child look at it?	Yes	No
39.	Does your child ever use their index finger to point, to **indicate interest in something?**	Yes	No

40.	Does your child ever bring objects over to you?	Yes	No
41.	Does your child imitate you? For example, you make a face or a sound will your child imitate it?	Yes	No
42.	Does your child take an interest in other children? *(Includes siblings.)*	Yes	No
43.	Does your child eat solid foods? (For example, cooked vegetables, chopped meats, etc. *Not assessing nutritional value or adequate intake*.)	Yes	No
44.	Does your child like being hugged or cuddled?	Yes	No

STOP HERE IF CHILD IS LESS THAN Twenty-Four (24) MONTHS

FOR AGES TWENTY-FOUR (24) MONTHS AND OLDER

45.	Does your child run?	Yes	No
46.	Does your child jump, with both feet leaving the floor at the same time? (That is, can s/he jump up?)	Yes	No
47.	Does your child flip light switches off and on?	Yes	No
48.	Does your child put a small object in a cup and dump it out? (You may show them how.)	Yes	No
49.	Does your child stack at least four small toys, blocks, cups, dishes or other objects on top of each other?	Yes	No
50.	Does your child name at least three objects? (For example, bottle, dog, favorite toy, etc.)	Yes	No
51.	Does your child follow instructions with one action and one object? (For example, “Bring me the book”; “Close the door”; etc.)	Yes	No
52.	Does your child demonstrate understanding of the meaning of *no,* or word or gesture with the same meaning? (For example, stops current activity briefly.)	Yes	No
53.	Does your child copy the activities you do, such as wipe up a spill, sweep, shave or comb hair? *(May not be at the same time.)*	Yes	No
54.	Does your child play near another child, each doing different things? *(In the same room, on a playground, do not have to be next to each other.)*	Yes	No
55.	Does your child hold and drink from a cup or glass? (Includes “sippy” cups.)	Yes	No
56.	Does your child look at you when you talk to them?	Yes	No

STOP HERE IF CHILD IS LESS THAN THIRTY (30) MONTHS

FOR AGES THIRTY MONTHS AND OLDER

57.	While standing, does your child throw a ball or toy?	Yes	No
58.	Does your child ask questions beginning with *what* or *where?* (For example, "What's that?"; "Where doggie go?"; etc.)	Yes	No
59.	Does your child call themselves "I" or "me" more often than their own name? (For example, "I do it" more than "Mary (John) do it".)	Yes	No
60.	Does your child take off clothing that opens in the front (for example, a coat or sweater)? (Does not have to unbutton or unzip the clothing.)	Yes	No
61.	Does your child use a spoon to feed themselves?	Yes	No
62.	Does your child sleep at least 8 hours in a 24-hour period? *(This Includes naps, total sleep even if not continuous.)*	Yes	No
63.	**Does your child do things over and over and can't seem to stop? (Examples are rocking, hand flapping or spinning.)** ***REVERSE SCORING***	Yes	No
64.	**Does your child destroy or damage things on purpose?** ***REVERSE SCORING***	Yes	No
65.	**Does your child hurt themselves on purpose?** ***REVERSE SCORING***	Yes	No

STOP HERE IF CHILD IS LESS THAN THIRTY (36) MONTHS

FOR AGES THIRTY-SIX MONTHS AND OLDER

66.	Does your child stand (balance) on one foot for about 1 second without holding onto anything?	Yes	No
67.	Does your child walk up stairs, using only one foot on each stair? (The left foot is on one step, and the right foot is on the next.) S/he may hold onto the railing or wall.	Yes	No
68.	Does your child turn the pages of a book one at a time?	Yes	No
69.	Does your child use simple words to describe things? (For example, *dirty, pretty, big, loud,* etc.)	Yes	No
70.	Does your child state their own first name or nickname?	Yes	No
71.	Does your child follow instructions with two actions or an action and two objects? (For example, "Bring me the crayons and the paper"; "Sit down and eat your lunch"; etc.)	Yes	No
72.	Does your child pretend objects are something else? (For example, does your child hold a cup to their ear, pretending it is a telephone? Does s/he put a box on their head, pretending it is a hat? Does s/he use a block or small toy to stir food?)	Yes	No
73.	Does your child know if s/he is a boy or a girl?	Yes	No

74.	Does your child pull up clothing with elastic waistbands? (For example, underwear or sweatpants)	Yes	No
75.	Does your child suck from a straw?	Yes	No
76.	**Does your child cry, scream or have tantrums that last for 30 minutes or longer?** ***REVERSE SCORING***	Yes	No
77.	**Does your child act physically aggressive? (For example, hits, kicks, bites, etc.)** ***REVERSE SCORING***	Yes	No
78.	**Does your child have eating difficulties? (For example, eats too fast or too slowly, hoards food, overeats, refuses to eat, etc.)** ***REVERSE SCORING***	Yes	No
79.	**Does your child sometimes stare at nothing or wander with no purpose?** ***REVERSE SCORING***	Yes	No

STOP HERE IF CHILD IS LESS THAN FORTY-EIGHT (48) MONTHS

FOR AGES FORTY-EIGHT MONTHS AND OLDER

80.	Does your child hop up and down on one foot?	Yes	No
81.	Does your child pedal a tricycle or other three-wheeled toy at least 6 feet?	Yes	No
82.	Does your child walk down stairs, using only one foot on each stair? (The left foot is on one step, and the right foot is on the next.) S/he may hold onto the railing or wall.	Yes	No
83.	Does your child wiggle their thumb, for example when using a TV remote or video game controller?	Yes	No
84.	Does your child unbutton one or more buttons, or unfasten one or more Velcro straps? Your child may use their own clothing or a doll's clothing.	Yes	No
85.	Does your child use *in, on* or *under* in phrases or sentences? (For example, "Ball go under chair"; "Put it on the table"; etc.)	Yes	No
86.	Does your child say their first and last name?	Yes	No
87.	Does your child follow instructions in "if-then" form? (For example, "If you want to play outside, then put your things away"; etc.)	Yes	No
88.	Does your child share toys or possessions when asked?	Yes	No
89.	Does your child tell you the names of two or more playmates, including brothers and sisters? (Ask this question without providing help by suggesting names of playmates or friends.)	Yes	No
90.	Does your child brush their teeth?	Yes	No
91.	Does your child urinate in a toilet or potty chair?	Yes	No
92.	Does your child defecate in a toilet or potty chair?	Yes	No

93. Does your child put on clothing that opens in the front (for example a coat or sweater)? (Does not have to button or zip the clothing.) Yes No

STOP HERE IF CHILD IS LESS THAN SIXTY (60) MONTHS

FOR AGES SIXTY MONTHS AND OLDER

94. Does your child open doors by turning door knobs? (Includes doors that open/close with levers rather than traditional round knobs.) Yes No

95. Does your child identify and name most common colors (that is, red, blue, green, yellow)? Yes No

96. Does your child follow three-part instructions? (For example, “Brush your teeth, get dressed and make your bed”; etc.) Yes No

97. Does your child take turns when asked while playing games or sports? Yes No

98. Does your child play informal group games? (For example, hide-and-seek, tag, jump rope, catch, etc.) Yes No

99. Does your child put shoes on correct feet? (Does not need to tie laces.) Yes No

100. Does your child wash their hands using soap and water? (May be reminded.) Yes No

101. Does your child use the toilet by themselves? (S/he goes to the bathroom, sits on the toilet, wipes and flushes. May be reminded.) Yes No

II. FUNCTIONAL SCORE BATTERY - PART 2 (AGES 6 TO 11)

In scoring the functional section of the PAS, assessors should give credit for the highest level of a skill performed at least 75% of the time. **Credit should be given for what the customer actually does, not what s/he "can do" or "could do" or "might be able to do".**

Rate activities/behavior as generally performed over the last year with emphasis on <u>current</u> functioning.

<u>NOTE</u>: If a child is close to a change in age that would indicate a different PAS tool would be required, it may be beneficial to <u>wait to do the assessment</u> until after the age change. These cases should be discussed with a supervisor or PAS QAT.

A. MOTOR/INDEPENDENT LIVING SKILLS DOMAIN (ONE YEAR)

When an item groups many similar tasks into one (for example, Personal Hygiene is made up of brushing teeth, combing hair, washing face and hands), rate the customer on the ability to complete each of the tasks. For example, a customer who needs hands-on help for brushing teeth, but only

verbal prompts or no assistance for combing hair or washing face and hands should be scored a "2" on Personal Hygiene (requires hands-on assistance to initiate/complete the task).

When a customer's skills are uneven (s/he can complete some parts of the task but not others) or variable (sometimes s/he does better than other times) **the assessor must determine the best response and explain in comments. If a customer has characteristics of more than one response, the assessor must try to obtain more information in order to select the response that most closely describes the customer's typical functioning and explain in comments. Investigative interviewing is essential to gather enough information for the PAS.**

If it is clearly evident that a customer is in need of more assistance than is received, the assessor may take that into consideration in scoring. This should be done conservatively as it may be difficult to determine the exact amount of assistance needed (e.g., only verbal assistance, not hands on assistance may be needed to attain a generally acceptable level of hygiene). **Justification for this need must be documented in the comments and/or summary, and an explanation provided for the reason the assistance is needed and not received**

Terms frequently used in this domain are defined below.

"Limited/Occasional"	a small portion of an entire task (e.g., washing back only during bathing or washing feet only during bathing) or assistance required less than daily (e.g., shampooing).
"Physical Participation"	active participation, not just being passive or cooperative.

ROLLING and SITTING

The customer's ability to roll and sit independently. "Sitting with support" may include either the physical support of another person or other types of support such as pillows or a specially made chair. **Indicate only one answer that best describes the highest level of skill attained.**

SCORING

0) Assumes and maintains sitting position independently.

1) Sits without support for at least five (5) minutes.

2) Maintains sitting position with minimal support for at least five (5) minutes.

3) Rolls from front to back and back to front.

4) Rolls from front to back only.

5) Rolls from side to side.

6) Lifts head and chest using arm support when lying on stomach.

7) Lifts head when lying on stomach.

8) Does not lift head when lying on stomach.

CRAWLING AND STANDING

The customer’s ability to crawl and stand. "Support" may include the help of another person or mechanical support, such as holding on to furniture.

SCORING

0) Stands well alone; balances well for at least five (5) minutes.

1) Stands unsteadily alone for at least one (1) minute.

2) Stands with support for at least one (1) minute.

3) Pulls to a standing position.

4) Crawls, creeps, or scoots.

5) Does not crawl, creep or scoot.

AMBULATION

The customer’s ability to walk. Consider the quality of the ambulation ("walks well" vs. "walks unsteadily") and the degree of independence of the ambulation ("walks alone" vs. "walks only with physical assistance from others"). Independent ambulation with an assistive device, such as a walker or cane, would still be considered "walking alone".

SCORING

0) Walks well alone for normal distances on all terrains.

1) Walks well alone for a short distance (10-20 feet); balances well; distance limitation may be due to terrain.

2) Walks unsteadily alone for short distance (10-20 feet).

3) Walks only with physical assistance from others.

4) Does not walk.

CLIMBING STAIRS OR RAMPS

The customer's ability to move up and down stairs or ramps. Rate for the use of ramps, rather than stairs, if the customer uses a wheelchair or other assistive device not used on stairs. "Physical assistance" refers to assistance from another person.

SCORING

0) Moves up and down stairs or ramps without need for handrail.

1) Moves up and down stairs or ramps with handrail independently.

2) Moves up and down stairs or ramps with physical assistance.

3) Unable to move up or down stairs or ramps.

WHEELCHAIR MOBILITY

The customer's mobility using a wheelchair. Do not score the customer's ability to transfer to the wheelchair. If a wheelchair is not used, indicate "0". The wheelchair may be motorized or manual. **If both are used, score according to the chair used the majority of the time.**

SCORING

0) Wheel chair is not used, or moves wheelchair independently.

1) Moves wheelchair independently, but with some difficulty (may move wheelchair with some bumping and/or difficulty in steering).

2) Individual needs some, but not total assistance, in moving wheelchair.

3) Needs total assistance for moving wheelchair.

DRESSING

The customer's ability to dress. This includes putting on and removing regular articles of clothing such as underwear, pants, shirts, dresses, socks, shoes. **This does not include braces, nor does it reflect the customer's ability to match colors or choose clothing appropriate for the weather.**

The use of adaptive clothing (elastic waist pants, Velcro shoes or non-button shirts) does not disqualify the customer from being considered independent. **The care of clothing (e.g., folding, putting away) is not rated.**

SCORING

0) Completes the task independently.

1) Able to complete the task with verbal prompts, cue by touch, materials setup, or other modifications (e.g., laying out of clothes).

2) Requires hands-on assistance to initiate/complete the task (e.g., help with fasteners).

3) Is not able to actively perform any part of this task but can physically participate.

4) Requires total hands-on assistance and does not physically participate.

PERSONAL HYGIENE

The customer's ability to perform Personal Hygiene tasks. This includes brushing teeth, washing face and hands, combing or brushing hair, nail care and use of deodorant if appropriate. **If the customer performs the tasks at varying levels of independence, indicate the answer that best describes the customer's overall ability in personal hygiene and explain in comments.**

SCORING

0) Completes the task independently.

1) Able to complete the task with verbal prompts, cue by touch, materials setup, or other modifications.

2) Requires hands-on assistance to initiate/complete the task (e.g., put toothpaste on toothbrush or hands-on assistance to comb hair).

3) This task must be done for the individual but individual can physically participate.

4) Requires total hands-on assistance and does not physically participate.

BATHING OR SHOWERING

The customer's ability to complete the bathing process. This includes drawing the bath water, washing, rinsing and drying all parts of the body and shampooing hair. This also includes sponge or bed baths. The ability to wash face and hands when not bathing should be rated under Personal Hygiene, not bathing or showering. **The ability to transfer into the tub or shower is not rated.**

SCORING

0) Completes the task independently.

1) Requires verbal prompts for washing and drying or physical help with drawing water, checking temperature.

2) Requires extensive verbal prompts or limited/occasional hands-on assistance to complete task (e.g., shampooing or washing back).

3) Requires hands-on assistance during entire bathing process but can physically participate.

4) Requires total hands-on assistance and does not physically participate.

TOILETING

The customer's **ability to initiate** and care for bladder and bowel functions. The ability to wash hands after toileting should be rated under Personal Hygiene, not Toileting. **The ability to transfer on and off the toilet should not be rated here.**

SCORING

0) Completes the task independently.

1) Able to complete the task with verbal prompts, cue by touch, materials setup, or other modifications.

2) Can indicate the need for toileting, but requires hands-on assistance to complete/perform the task (e.g., help with fasteners, toilet paper, flushing the toilet).

3) Does not indicate the need for toileting, but usually avoids accidents through a toileting schedule (e.g., periodic tripping by caregiver) and requires hands-on assistance to complete/perform the task.

4) Does not perform nor indicate the need for toileting and requires total caregiver intervention.

LEVEL OF BLADDER CONTROL

The customer's ability to control the elimination of urine. Evaluate the **typical/usual** bladder control level. Do NOT rate temporary occurrences due to acute illness or medication. **Make comments to indicate if accidents occur during day or at night, or both.**

SCORING

0) Complete control (no more than two accidents per year).

1) Some bladder control; accidents occur not as often as seven times per week (day or night).

2) Some bladder control; accidents occur at least seven times per week (day or night).

3) No control.

ORIENTATION TO SETTINGS FAMILIAR TO INDIVIDUAL

The customer's orientation to **familiar** settings. This would usually include the customer's own home, the school setting, and any other setting where the customer spends enough time to be considered a familiar setting.

SCORING

0) No problem in this area; knows way in all areas of familiar settings independently.

1) Knows way in part of, but not all of, familiar settings without prompting or physical assistance (e.g., to bathroom, bedroom or cafeteria).

2) Knows way from room to room within familiar settings with prompting; does not need physical assistance.

3) Does not know way from room to room within familiar settings without physical assistance.

COMMUNICATION DOMAIN (ONE YEAR)

EXPRESSIVE VERBAL COMMUNICATION

Indicate the response that best describes the customer's ability to communicate thoughts **verbally** with words or sounds (other forms of communication will be assessed in "Clarity of Communication").

SCORING

0) Carries on a complex or detailed conversation.

1) Carries on a simple brief conversation, such as talking about everyday events (e.g. the clothes you are wearing).

2) Uses simple two-word phrases (e.g., "I go", "give me").

3) Uses a few simple words and associates words with appropriate objects, such as names of common objects and activities.

4) Uses no words, but does use a personal language or guttural sounds to communicate very basic concepts.

5) Makes no sounds which are for communication; may babble, cry or laugh.

CLARITY OF COMMUNICATION

Indicate the response that corresponds to the customer's ability to speak in a recognizable language or use a formal symbolic substitution, such as American Sign Language. If the customer has more than one form of communication, score on what is best understood.

SCORING

0) Uses speech in a normal manner intelligible to an unfamiliar listener; no special effort is required to understand individual.

1) Speech understood by strangers with some difficulty; unfamiliar individuals can understand, but due to the lack of clarity, not all of the words are understood and the listener must pay close attention in order to understand.

2) Uses a non-speech communication system that is understood by an unfamiliar listener (e.g., writing, communication board/device, gestures, or pointing).

3) Speech or other communication system understood only by either those who know the person well or who are trained in the alternate communication system.

4) Does not communicate using a recognizable language or formal symbolic substitutions.

D. BEHAVIORAL DOMAIN (ONE YEAR)

The purpose of this section is to identify the presence of certain behaviors that may reflect the need for caregiver supervision and intervention. In selecting the best answers for children in this age group, the assessor must try to view the child's behavior in the context of the reasonable expectation of a child this age. For example, sibling teasing or arguing that does not escalate to serious threats or acts of aggression may be considered normal in a child within this age group.

Responses for this section are based on both the frequency and the intensity of the behavior; that is the amount or degree of intervention required to control the problem behavior.

NOTE: It is important to note that to score behaviors, the assessor must determine if the behavior is **minor**, **moderate**, **serious** or **extremely urgent**. This is determined generally by the intensity of the intervention and to a lesser degree, the frequency of the behavior. For example, a minor behavior such as whining may occur daily but not be a serious problem.

Reminder: Rate activities/behaviors as generally performed over the last year with emphasis on current functioning.

The following definitions should be applied when answering questions related to behavior:

Intervention	Therapeutic treatment, including the use of medication, behavior modification and physical restraints to control the behavior. Intervention may be formal or informal and includes actions taken

	by friends or family to control the behavior (e.g., verbal or physical redirection; physical interruption).
Physical Interruption	Requires immediate hands-on interaction of the caregiver to stop the customer's behavior or the customer is receiving a chemical restraint for the behavior.
Occasional	Less than weekly.
Frequent	Weekly to every other day.
Constant	At least once a day.
Medical Attention	examination by a physician or Primary Care Provider (PCP) and treatment, if necessary.

NOTE: ALL BEHAVIORS IN THIS SECTION SCORED ABOVE A ZERO MUST BE DESCRIBED IN THE COMMENT SECTION AND INTERVENTION MUST BE SPECIFIED.

AGGRESSION

Aggressive behaviors include physical attacks on others, such as throwing objects, punching, biting, pushing, pinching, pulling hair, scratching. **Do not rate threatening or self injurious behavior, as they are rated separately. Destruction of property alone or abuse of animals is not rated but should be described in comments or summary section.**

SCORING

0) Problem does not occur or occurs at a level not requiring intervention.

1) **Minor problem;** occasional aggression which requires some additional supervision or verbal redirection in a few situations, or a combination of both.

2) **Moderate problem;** frequent aggression that requires close supervision, verbal redirection or physical redirection, or a combination of these interventions.

3) **Serious problem;** constant aggression that requires close supervision, or constant verbal redirection or physical interruption, or a combination of these interventions.

4) **Extremely urgent problem;** has had episode(s) causing injury in the last year; requires close supervision and physical interruption.

VERBAL OR PHYSICAL THREATENING

Behavior in which the customer verbally or physically threatens to harm self, others or objects. **Do not rate actual acts of physical aggression or self-injurious behavior as they are rated elsewhere.**

SCORING

0) Problem does not occur or occurs at a level not requiring intervention.

1) **Minor problem;** makes occasional threats, which are not taken seriously and do not frighten others or result in aggression from others; requires some additional supervision or verbal redirection, or a combination of both.

2) **Moderate problem;** makes frequent threats that sometimes cause fear or aggression in others; requires close supervision, verbal or physical redirection, or a combination of these interventions.

3) **Serious problem;** makes constant threats that sometimes cause fear or aggression in others; requires close supervision, constant verbal redirection or physical interruption, or a combination of these interventions.

4) **Extremely urgent problem;** has had serious incident(s) in the last year; incidents always generate fear or are likely to result in aggression from others; requires close supervision and physical interruption.

SELF-INJURIOUS BEHAVIOR

Self-injurious behavior is defined as **repeated** behaviors that **cause injury**, and may include biting, scratching, putting inappropriate objects in the ear, mouth or nose, repeatedly picking at skin, head slapping or banging.

SCORING

0) Problem does not occur or occurs at a level not requiring intervention.

1) **Minor problem;** occasional incidents which requires some additional supervision or verbal redirection in a few situations, or a combination of both.

2) **Moderate problem;** frequent incidents that require close supervision, verbal redirection or physical redirection, or a combination of these interventions.

3) **Serious problem;** constant incidents; requires close supervision, constant verbal redirection or physical interruption, or a combination of these interventions.

4) **Extremely urgent problem;** has had episode(s) causing serious injury requiring immediate medical attention in the last year; requires close supervision and physical interruption.

RUNNING OR WANDERING AWAY

Running or wandering away is defined as **leaving the situation or environment inappropriately without either notifying or receiving permission** from appropriate individuals as would normally be expected.

SCORING

0) Problem does not occur or occurs at a level not requiring intervention.

1) **Minor problem;** occasional occurrences which may not pose a safety problem but do require some additional supervision or verbal redirection, or both.

2) **Moderate problem;** frequent occurrences pose minor safety issues to self or others; requires close supervision or physical redirection, or both.

3) **Serious problem;** constant occurrences pose safety issues to self or others; requires close supervision and physical redirection.

4) **Extremely urgent problem;** occurs constantly or poses a very serious threat to the safety of self or others; requires close supervision and locked area.

DISRUPTIVE BEHAVIORS

Disruptive behaviors inappropriately interfere with the customer's own activity or the activity of the caregiver or others and may include excessive whining, crying or screaming, persistent pestering, teasing, constant demands for attention, repetitious motions. Excessive hyperactivity, repetitive/stereotypic behaviors, or temper tantrums may be rated here. **Do not include verbal threatening or acts of physical aggression which are scored elsewhere.**

SCORING

0) Problem does not occur or occurs at a level not requiring intervention.

1) **Minor problem;** occurs occasionally and requires occasional intervention.

2) **Moderate problem;** occurs frequently and requires frequent intervention.

3) **Serious problem;** occurs constantly and requires constant intervention.

FUNCTIONAL SCORES BATTERY - PART 3 (AGES 12 AND OLDER)

In scoring the functional section of the PAS, the assessors should give credit for the highest level of a skill **performed at least 75% of the time**. The goal is to describe the customer's typical or usual functioning level. **Credit should only be given for what the customer actually does, not what s/he "can do" or "could do" or "might be able to do."**

Rate activities/behaviors as generally performed over the last year with <u>emphasis on current</u> functioning.

A. MOTOR/INDEPENDENT LIVING SKILLS DOMAIN (ONE YEAR)

When an item groups many similar tasks into one (for example, Personal Hygiene includes hair care, brushing teeth, washing face and hands, shaving, nail care, menses care and use of deodorant), rate the customer on the ability to complete the entire task. An example might be the customer who needs hands-on help for brushing teeth, but only verbal prompts or no assistance for combing hair or washing face and hands. The customer should be scored a "2" on Personal Hygiene (requires hands-on assistance to initiate/complete the task).

When the customer's skills are uneven (s/he can complete some parts of the task but not others) or variable (sometimes s/he does better than other times), **the assessor must determine the <u>best</u> response and explain in comments. If the customer has characteristics of more than one response, the assessor must try to obtain more information in order to select the response that most closely describes the customer's functioning and explain in comments. Investigative interviewing is essential to gather enough information for the PAS.**

If it is clearly evident that the customer is in need of more assistance than is received, the assessor may take that into consideration in scoring. This should be done **conservatively** as it may be difficult to determine the exact amount of assistance needed (e.g., only verbal prompts, not hands on assistance may be needed to attain a generally acceptable level of hygiene). **Justification for this need must be documented in the comments and/or summary, and an explanation provided for the reason the assistance is needed and not received.**

NOTE: If a service animal has been specifically trained to assist with specific ADL functions exclusively for the customer, then this assistance can be considered in scoring. This does not include emotional therapy animals and household pets.

Terms relating to the frequency of a skill or behavior are defined below.

"Limited/Occasional"	A small portion of an entire task (e.g., washing back only during bathing or washing feet only during bathing) or assistance required less than daily (e.g., shampooing).
"Physical Participation"	Active participation, not just being passive or cooperative.
"Physical Lift"	Actively bearing some part of the customer's weight during movement/activity (excluding bracing and guiding activity).

HAND USE

The customer's ability to use her/his hands. Note that if the customer has only one hand or has the use of only one hand, then scoring should be based on the use of the better hand. If that is the case, **it must be explained in comments.**

SCORING

0) Uses fingers independently of each other.

1) Uses thumbs and fingers of hand(s) in opposition.

2) Uses raking motion or grasps with hand(s).

3) No functional use of hand(s).

AMBULATION

The customer's ability to walk. Consider the quality of the ambulation ("walks well" vs. "walks unsteadily") and the degree of independence of the ambulation ("walks alone" vs. "walks only with physical assistance from others"). Independent ambulation with an assistive device, such as a walker or cane, would still be considered "walking alone".

SCORING

0) Walks well alone for normal distances and on all terrains.

1) Walks well alone for a short distance (10-20 feet); balances well; distance limitation may be due to terrain.

2) Walks unsteadily alone for a short distance (10-20 feet).

3) Walks only with physical assistance from others.

4) Does not walk

WHEELCHAIR MOBILITY

The customer's mobility using a wheelchair. Do not score the customer's ability to transfer to the wheelchair. If a wheelchair is not used, indicate "0". The wheelchair may be motorized or manual. **If both are used, score according to the chair used the majority of the time.**

SCORING

0) Wheelchair is not used, or moves wheelchair independently.

1) Moves wheelchair independently, but with some difficulty (may move wheelchair with some bumping and/or difficulty in steering).

2) Individual needs some, but not total assistance in moving wheelchair.

3) Needs total assistance for moving wheelchair.

TRANSFER

The customer's ability to transfer into the wheelchair, on and off the toilet, into and out of bed, and in and out of the shower/tub. Rate the degree of assistance necessary on a consistent basis. **Rate these items only with regard to the need for human intervention, not the need for assistive devices. Ability to transfer in and out of a vehicle is not rated.**

SCORING

0) No problem in this area; does transfer self independently but may require use of assistive devices.

1) Needs hands-on physical guidance, but does not have to be physically lifted, OR needs supervision with more than half of transferring activities.

2) Needs to be physically lifted or moved, but can participate physically.

3) Must be totally transferred by one or more persons OR is bedfast.

EATING/DRINKING

The customer's eating and drinking abilities. Select 4 "tube fed" if tube feeding is the primary means of nourishment.

SCORING

0) completes the task independently.

1) Able to complete the task with verbal prompts, cue by touch, materials setup, or other modifications (e.g., plate guard, built-up spoon, cutting of food).

2) Requires hands-on assistance to initiate/complete the task (e.g., place utensils in hand, hand-over-hand scooping, or other assistance).

3) Does not perform this task even when assisted; is fed.

4) Customer is tube fed.

DRESSING

The customer's ability to dress. This includes putting on and removing regular articles of clothing such as underwear, pants, shirts, dresses, socks, shoes. **This does not include braces, nor does it reflect the customer's ability to match colors or choose clothing appropriate for the weather.**

The use of adaptive clothing (elastic waist pants, Velcro shoes or non-button shirts) does not disqualify the customer from being independent. **The care of clothing (e.g., laundering, ironing) is not rated.**

SCORING

0) completes the task independently.

1) Able to complete the task with verbal prompts, cue by touch, materials setup or other modifications (e.g., laying out of clothes).

2) Requires hands-on assistance to initiate/complete this task (e.g., help with fasteners).

3) is not able to actively perform any part of this task but can physically participate.

4) Requires total hands-on assistance and does not physically participate.

PERSONAL HYGIENE

The customer's ability to perform Personal Hygiene tasks. This includes hair care, brushing teeth, washing face and hands, shaving, nail care, menses care and use of deodorant. **If the customer performs the tasks at varying levels of independence, indicate the answer that best describes customer's overall ability in personal hygiene and explain in comments.**

SCORING

0) completes the task independently.

1) Able to complete the task with verbal prompts, cue by touch, materials setup, or other modifications.

2) Requires hands-on assistance to initiate/complete the task (e.g., put toothpaste on toothbrush or hands-on assistance to shave).

3) This task must be done for the individual but individual can physically participate.

4) Requires total hands-on assistance and does not physically participate.

BATHING OR SHOWERING

The customer's ability to complete the bathing process. This includes drawing the bath water, washing, rinsing and drying all parts of the body and shampooing hair. This also includes sponge or bed baths. The ability to wash face and hands when not bathing should be rated under Personal Hygiene, not bathing or showering. **The ability to transfer into the tub or shower is rated under Transfer.**

SCORING

0) completes the task independently.

1) Requires verbal prompts for washing and drying or physical help with drawing water, checking temperature.

2) Requires extensive verbal prompts or limited/occasional hands-on assistance to complete task (e.g., shampooing or washing back).

3) Requires hands-on assistance during entire bathing process but can physically participate.

4) Requires total hands-on assistance and does not physically participate.

FOOD PREPARATION

The customer's ability to prepare simple meals for self. Simple meals may include sandwiches, hot dogs, cereals, frozen meals, eggs. **Do not rate the customer's ability to select a balanced menu or diet, or to include a variety of food items.** Rate the item independent of the heating sources used (e.g., a customer may use only the microwave and still be independent). **Explain such limitations in the comments.**

Note: 75% of the time, for this area, would be one simple meal a day, 5 days a week.

SCORING

0) completes the task independently.

1) Able to complete the task with verbal prompts, cue by touch, materials setup, or other modifications.

2) Requires hands-on assistance to initiate/complete the task.

3) Does not perform this task, even when assisted; the task must be done for the person.

COMMUNITY MOBILITY

The customer's ability to move about the neighborhood or community independently, by any mode of transportation. This includes movement around the neighborhood or community, including accessing buildings, stores and restaurants using any mode of transportation (walking, wheelchair/scooter, cars, bus, taxi, bicycle, etc.) **Score based on what s/he actually does, rather than what s/he "could do" or "might be able to do" if allowed.**

SCORING

0) Moves about the neighborhood or community independently without assistance.

1) Moves about the neighborhood or community independently for a complex trip (several stops, unfamiliar places, bus transfers) with instructions and/or directions.

2) Moves about the neighborhood or community independently for a simple direct trip and/or familiar locations with instructions and/or directions.

3) Moves about the neighborhood or community with some physical assistance and/or occasional accompaniment.

4) Moves about the neighborhood or community only with accompaniment.

TOILETING

The customer's ability to initiate and care for bladder and bowel functions. The ability to wash hands after toileting should be rated under Personal Hygiene, not Toileting. **The ability to transfer on and off the toilet should be rated under Transfer.**

If the customer has bladder accidents, indicate the approximate frequency and Select day [D], month [M] or year [Y] . Indicate in comments if accidents are only at night or in special situations (e.g., when on outing and away from familiar setting).

SCORING

0) completes the task independently.

1) Able to complete the task with verbal prompts, cue by touch, materials setup, or other modifications.

2) Can indicate the need for toileting, but requires hands-on assistance to complete/perform task (e.g., help with fasteners, toilet paper, flushing toilet).

3) Does not indicate the need for toileting, but basically avoids accidents through a toileting schedule (e.g., periodic tripping by caregiver) and requires hands-on assistance to complete/perform task.

4) Does not perform nor indicate the need for toileting and requires total caregiver intervention.

COMMUNICATION/COGNITIVE DOMAIN (ONE YEAR)

EXPRESSIVE VERBAL COMMUNICATION

Indicate the response that best describes the customer's ability to communicate thoughts **verbally** with words or sounds (other forms of communication will be assessed in "Clarity of Communication").

SCORING

0) carries on a complex or detailed conversation.

1) Carries on a simple brief conversation, such as talking about everyday events (e.g., the clothes you are wearing).

2) Uses simple two-three word phrases (e.g., "I go", "give me", "I want juice.").

3) Uses a few simple words and associates words with appropriate objects, such as names of common objects and activities. (ball, juice, dog).

4) Uses no words, but does use a personal language or sounds to communicate very basic concepts.

5) Makes no sounds which are for communication, may babble, cry or laugh.

CLARITY OF COMMUNICATION

Indicate the response that corresponds to the customer's ability to speak in a recognizable language or use a formal symbolic substitution, such as American Sign Language. If the customer has more than one form of communication, score on what is best understood.

SCORING

0) Uses speech in a normal manner intelligible to an unfamiliar listener; no special effort is required to understand individual.

1) Speech understood by strangers with some difficulty; unfamiliar individuals can understand, but due to the lack of clarity, not all of the words are understood and the listener must pay close attention in order to understand.

2) Uses a non-speech communication system that is understood by an unfamiliar listener (e.g., writing, communication board/device, gestures, or pointing).

3) Speech or other communication system understood only by either those who know the person well, or who are trained in the alternate communication system.

4) Does not communicate using a recognizable language or formal symbolic substitutions.

ASSOCIATING TIME WITH EVENTS AND ACTIONS

Indicate the response that best describes the customer's **ability to associate time with events and actions.**

Note that the customer's ability to actually tell time is not being assessed here.

SCORING

0) Associates events with specific time (e.g., the concert starts at 7:45).

1) Associates regular events with specific hours (e.g., dinner is at six, work starts at eight, bedtime is at ten).

2) Associates regular events with morning, noon, or night (e.g., daily or weekly events, such as we go to school in the morning or I go to bed at night); does not understand time but knows the sequence of daily events.

3) Does not associate events and actions with time.

REMEMBERING INSTRUCTIONS AND DEMONSTRATIONS

Select the response that corresponds to the customer's ability to recall instructions or demonstrations on **how to complete specific tasks**. **Comments must include examples of tasks assessed.**

This is **not** remembering **to do** a task, but remembering **how to do** the task. It is also not how long it took to learn, but whether the task can now be done without prompts as to how to do the task. Examples of a task would be an independent living skill not previously assessed, household chore or vocational task. **It should not be a complex task or learning a new task.**

SCORING

0) Displays memory of instructions or demonstrations without prompting if they are given once.

1) Displays memory of instructions or demonstrations if they are given once and if prompted to recall.

2) Displays memory of instructions or demonstrations if they are repeated three or more times and if prompted to recall.

3) Displays no or extremely limited (rare or very incomplete) memory of instructions or demonstrations.

BEHAVIORAL DOMAIN (ONE YEAR)

The purpose of this section is to identify the presence of certain behaviors that may reflect the need for caregiver supervision and/or intervention. **Responses for this section are based on <u>both</u> the frequency and the intensity of the behavior; that is the amount or degree of intervention required to control the problem behavior.**

NOTE: It is important to note that to score behaviors, the assessor must determine if the behavior is **minor**, **moderate**, **serious** or **extremely urgent**. This is determined primarily by the intensity of the intervention and to a lesser degree, the frequency of the behavior. For example, a minor behavior such as whining may occur daily but not be a serious problem.

Reminder: Rate activities/behaviors as generally <u>performed over the last year</u> with emphasis on <u>current</u> functioning.

The following definitions should be applied when answering questions related to behavior:

"Intervention"	Therapeutic treatment, including the use of medication, behavior modification and physical restraints to control the customer's behavior. Intervention may be formal or informal and includes actions taken by friends or family to control the customer's behavior (e.g., verbal or physical redirection; physical interruption).
"Physical Interruption"	Requires immediate hands-on interaction of the caregiver to stop the customer's behavior or the customer is receiving a chemical restraint for the behavior.
"Occasional"	Less than weekly.
"Frequent"	Weekly to every other day.
"Constant"	At least once a day.
Medical Attention	examination by a physician or Primary Care Provider (PCP) and treatment, if necessary.

NOTE: ALL BEHAVIORS IN THIS SECTION SCORED ABOVE A ZERO MUST BE DESCRIBED IN THE COMMENT SECTION AND INTERVENTION MUST BE SPECIFIED.

AGGRESSION

Aggressive behaviors include physical attacks on others, such as throwing objects, punching, biting, pushing, pinching, pulling hair, scratching. **Do not rate threatening or self-injurious behavior, as**

they are rated separately. Destruction of property alone or abuse of animals is NOT rated, but should be described in comments or summary section.

SCORING

0) Problem does not occur or occurs at a level not requiring intervention.

1) **Minor problem;** occasional aggression which requires some additional supervision or verbal redirection in a few situations, or a combination of both.

2) **Moderate problem;** frequent aggression that requires close supervision, verbal redirection or physical redirection, or a combination of these interventions.

3) **Serious problem;** constant aggression that requires close supervision, or constant verbal redirection or physical interruption, or a combination of these interventions.

4) **Extremely urgent problem;** has had episode(s) causing injury in the last year; requires close supervision and physical interruption.

VERBAL OR PHYSICAL THREATENING

Behavior in which the customer verbally or physically threatens to harm self, others or objects. **Do not rate actual acts of physical aggression or self-injurious behavior as they are rated elsewhere.**

SCORING

0) Problem does not occur or occurs at a level not requiring intervention.

1) **Minor problem;** makes occasional threats, which are not taken seriously and do not frighten others or result in aggression from others; requires some additional supervision or verbal redirection, or a combination of both.

2) **Moderate problem;** makes frequent threats that sometimes cause fear or aggression in others; requires close supervision, verbal or physical redirection, or a combination of these interventions.

3) **Serious problem;** makes constant threats that sometimes cause fear or aggression in others; requires close supervision, constant verbal redirection or physical interruption, or a combination of these interventions.

4) **Extremely urgent problem;** has had serious incident(s) in the last year; incidents always generate fear or are likely to result in aggression from others; requires close supervision and physical interruption.

SELF-INJURIOUS BEHAVIOR

Self-injurious behavior is defined as **repeated** behaviors that **cause injury**. Self-injurious behaviors may include biting, scratching, putting inappropriate objects into ear, mouth or nose, repeatedly picking at skin, head slapping or banging. **Do not include medical non-compliance issues or behaviors that might be considered life style choices (e.g., sexual activity, smoking, non-compliance with dietary restrictions).**

SCORING

0) Problem does not occur or occurs at a level not requiring intervention.

1) **Minor problem;** occasional incidents which requires some additional supervision or verbal redirection in a few situations, or a combination of both.

2) **Moderate problem;** frequent incidents that require close supervision, verbal redirection or physical redirection, or a combination of these interventions.

3) **Serious problem;** constant incidents; requires close supervision, constant verbal redirection or physical interruption, or a combination of these interventions.

4) **Extremely urgent problem;** has had episode(s) causing serious injury requiring immediate medical attention in the last year; requires close supervision and physical interruption.

RESISTIVENESS ORREBELLIOUSNESS

Resistiveness or Rebelliousness is defined as inappropriate stubborn or uncooperative behaviors, including passive or active obstinate behaviors. Do not include difficulties with processing of information (those who are slow to respond) or reasonable expressions of self-advocacy. **Do not rate threatening or aggressive behaviors, as they are rated elsewhere. Comments for this item must specifically describe the behaviors and the intervention required.**

SCORING

0) Problem does not occur or occurs at a level not requiring intervention.

1) **Minor problem;** occurs occasionally and requires occasional attention, prompting or verbal redirection for cooperation.

2) **Moderate problem;** occurs frequently and requires frequent attention, prompting or physical redirection for cooperation, or a combination of these interventions.

3) **Serious problem;** occurs constantly and requires constant attention, prompting or physical redirection for cooperation, or a combination of these interventions.

MEDICAL CONDITIONS BATTERY

The primary source of information for the Medical Assessment section of the PAS should be the customer's medical records. The purpose of this section is to determine the customer's medical status by evaluating the medical conditions, sensory functions and need for medical services. If the customer is in an ICF-Individual with Intellectual Disabilities or resides in a group home or other facility, much of the information may be obtained directly from their records. **If a home interview is conducted, customer and/or caregiver report may be used, but every attempt must be made to obtain verification of pertinent facts from the customer's medical records, physician or other health care providers, or others who are well informed regarding the customer (e.g., the Support Coordinator).** When completed, this section should give a thorough picture of the customer's current medical condition and immediate medical and nursing needs.

MEDICAL CONDITIONS

This section is used to record **only** the diagnoses and specific medical conditions that have a relationship to the customer's current developmental/ILS status, cognitive status, mood and behavior status, medical treatments, skilled nursing care or risk of death. The assessor should review each category of conditions listed to ensure that no **significant** diagnoses are omitted.

If a specific diagnosis is not found on the tool, but the diagnosis or condition is the same or essentially the same as one of the listed conditions, **select the condition from the list and use the comment section to specify**. For example, if the stated diagnosis is Muscular Dystrophy, select Genetic Anomalies; if Failure to Thrive is indicated select Developmental Delay. It is very important to carefully evaluate any condition that may relate to Cognitive/Intellectual Disabilities, Cerebral Palsy, Epilepsy/Seizure Disorder or Autism since these conditions could affect the score.

It is very important to group diagnoses in the categories listed if at all possible. For more examples of grouping diagnoses, see DD PAS Manual Supplement Medical Conditions and Associated Related Conditions.

NOTE: Significant historical conditions may be documented in the PAS summary.

NEUROLOGICAL/CONGENITAL/DEVELOPMENTAL CONDITIONS (1-6)

Most DD customers will have at least one of the conditions listed in this section, and many will have more than one. If a customer has an Intellectual disability (also referred to as cognitive disability, and formerly known as mentally retarded), but the level is not specified in the records reviewed, identify the diagnosis as "Unspecified Intellectual Disability". If the diagnosis is indicated as Educable Mentally Handicapped (EMH), indicate Mild Intellectual Disability. If the diagnosis is indicated as Trainable Mentally Handicapped (TMH), indicate Moderate Intellectual Disability. **Every effort must be made to identify the level of the customer's Intellectual Disability from the medical records. The customer's most current evaluation with test results relating to IQ must be used, however we cannot interpret an IQ by itself as a diagnosis**.

If there is conflicting information in the records available, the diagnosis must be reviewed by PAS QAT (or designee) to determine if there is enough information to indicate a level of intellectual disability. In most cases, there should be a psychological evaluation with the diagnosis indicated. If the diagnosis is indicated as mild to moderate, 3.E. Unspecified Intellectual Disability should be indicated. If the diagnosis is indicated as moderate to severe, then moderate intellectual disability would be scored. If the diagnosis give is severe to profound, indicate the higher level of functioning and explain in comments. For example 3.C. Severe Intellectual Disability should be indicated if the diagnosis is Severe to Profound.

Include comments for the diagnosis that indicate the title and date of the evaluation, the clinician making the diagnosis and the FS IQ, if available.

OTHER MEDICAL CONDITIONS (7-16)

Many customers will have other medical conditions as listed in Section III A 1-16 in addition to their specific developmental disability. These should be indicated. If a specific stated diagnosis is not listed in category 1 through 16, but the diagnosis or condition is the same or essentially the same as one of the listed conditions, the preprinted condition may be selected and the comment section used to elaborate. For example, if the stated diagnosis is atrial-septal defect, then indicate 8.C., Congenital Anomalies of the Heart **and note the specific defect in comments.** Consult the **DD Medical Conditions and Associated/Related Conditions** Supplement for guidance.

OTHER DIAGNOSES (17)

When there are significant diagnoses that cannot be correlated with the medical conditions in Section II A 1-16, the assessor should report them in Category 17 Other Diagnoses. An ICD-10 code and description of the diagnoses should be indicated in the Comments. Refer to the **ICD-10 CODES** Supplement for a list of the more common ICD-10 Codes. If the diagnosis is not included in this list, enter the code in the miscellaneous section at the bottom of the list in HEAplus.

DO NOT list surgical procedures (V codes) as diagnoses. These may be recorded in the summary comments section, if significant and relevant.

ACUTE (A), CHRONIC (C), HISTORY (H)

Effective 3/21/2011 this is no longer required for the 0-5 PAS Tool.

It will continue to be required for the 6-11 and 12+ Tools until they are redesigned.

The assessor should further describe the medical conditions indicated by selecting the appropriate selection of Acute, Chronic or History. The definitions are:

"Acute"	An active condition having a sudden onset, lasting a short time and requiring intervention. The condition may still be considered

	acute if the customer is in a convalescent stage of an acute illness.
"Chronic"	A condition which is either always present or occurs periodically, or is marked by a long duration. If a customer is being treated for a condition over a long period, the condition would probably be considered chronic. For example, a seizure disorder that is controlled with medication would be considered chronic rather than historical.
"History"	A condition which occurred in the past, may or may not have required treatment, but is not currently active. If possible, the approximate date of the condition should be noted for historical diagnoses. If the date is not available, then it must be documented in the comments approximately how long ago the condition occurred.

NOTE: Only one diagnosis in the category of intellectual disability can be indicated as chronic (C) and none can be indicated as acute (A).

NOTE: An individual may have multiple types of seizures which should all be indicated on the pas. Therefore, more than one category may indicated as chronic (C).

COMMENTS for Medical Conditions:

Comment fields are provided to clarify any diagnosis indicated. **Comments should <u>always</u> be included for any diagnosis of seizure disorder:**

The assessor should provide a description of:

- Each **Type** of seizure (It is important to obtain a description of each type of seizure);
- **Frequency** of each type;
- **Date of the last seizure**. If the seizures are infrequent, these may be approximates.

Based on the description of the seizure, from the three categories of seizures: Choose “Unspecified seizures” only if the customer has complex partial, psychomotor, temporal lobe, simple partial, Jacksonian or epilepsia partialis continual. Unspecified includes these specific types of seizure and is **NOT** a miscellaneous category.

Comments should always be included for any condition marked which are considered a general category. For example, items such as (16.d.) Behavior Disorders, (6.j.) Genetic Anomalies, or (6.l.) Congenital Anomalies should have a clarifying comment as to the specific condition.

As previously mentioned, conditions that are marked as historical must be explained with a date or with an approximate time frame, such as "about 4 years ago".

MAJOR DIAGNOSES

The assessor should select up to three (3) major diagnoses using the already selected category and condition codes from the prior section. The major diagnoses may be obtained from medical records or if not specified, the assessor may determine which diagnoses are most significant based on which ones are most resource intensive (requiring the most medications and treatments) or causing the most significant medical and functional problems for the customer. **The customer's DD qualifying diagnosis MUST always be indicated as a major diagnosis.**

By Arizona Revised Statue, an eligible person **must** have a non-psychiatric medical condition or developmental disability, that by itself or in combination with other medical conditions, places the person at risk of institutionalization in a nursing facility or intermediate care facility for individuals with Intellectual Disabilities. Therefore, an eligible person must have a non-psychiatric major diagnosis. See page **Error! Bookmark not defined.** for more information on physician review on eligible cases with SMI diagnosis.

H. MEDICATIONS BATTERY

Medications list:

Note: If customer does not take any medications, click the "No Medications added" box and "save" in HEAplus.

This section identifies the medications currently taken by the customer. **If in a facility, medications may be obtained from the physician orders list.** If the interview is in-home, request prescription containers and copy label information.

If there is a discrepancy between the verbal report, prescription bottles and/or the medical records, note it as a comment. Also ask if the customer is taking any type of non-prescription medication.

The assessor should include dosage, frequency, duration, route and form of each medication. If the applicant receives a PRN medication, note the prescribed frequency as well as the actual frequency taken. Include comments related to blood sugar levels, discontinued medications (taken in last 30 days).

I. SERVICES AND TREATMENTS BATTERY

Indicate (R) Receives or (N) Needs for each service or treatment that the customer is either currently receiving or for which s/he has a documented need. **If a Need is indicated, the assessor must explain this in comments. The determination of need should be based on documentation, such as physician order, the recommendation of a therapist, or a clearly defined medical condition for which the service is routine treatment.**

Effective 3/21/2011 this is no longer required for the 0-5 PAS Tool.

It will continue to be required for the 6-11 and 12+ Tools until they are redesigned.

Do not consider recently discontinued services; however, it may be pertinent to mention these in the PAS Summary. You may indicate as "Receives", services that are intermittent but ongoing (such as chemotherapy, SVN).

If a customer receives or needs none of the services in this section, make a note to that effect in comments. If a customer self-administers a service or treatment, it should be indicated that s/he receives the service and a comment should be made. If the customer is receiving a service which is not adequate, put an (R) in the space provided and use the comments section or summary to explain.

Marking "Receives" leads to entering the FREQUENCY OF SERVICE

Indicate the frequency of services by selecting (C) for Continuously, (D) for Daily to several times daily, (W) for Weekly to 3 times a week (if more often than 3 times a week consider daily), and (M) for Monthly or greater. An ongoing service or treatment which lasts several hours or more may be considered continuous (e.g., tube feeding or oxygen at night only). *Effective 3/21/2011 this is no longer required for the 0-5 PAS Tool.*

It will continue to be required for the 6-11 and 12+ Tools until they are redesigned.

Comments must be included that describe the frequency.

It may be necessary to include comments to clarify the frequency of some treatments in order to help identify the severity of the condition (e.g., apnea monitor during naps and at night).

Frequency does not need to be indicated when a service is indicated as (N) needs.

1. **Injections/IV**

    a. Intravenous Infusion Therapy - Fluid substance introduced into the body via a vein. This includes blood transfusions.

    b. Intramuscular or Subcutaneous Injections - Fluid substance injected into the muscle or beneath the skin via a hypodermic syringe.

2. **Medications/Monitoring**

    a. Drug Regulation - The necessity for close evaluation, monitoring or adjustment of medications to assure effective therapeutic value.

    Some examples of drug regulation might include:

    Periodic lab test: blood sugar levels (FBS, Accu-checks, HgA1c) for antidiabetic agents (Insulin, Glyburide, Avandia, Glucophage), anticonvulsant blood levels (e.g., Tegretol, Dilantin), psychotropic drug levels (e.g., Haldol, Lithium), cardiac drug levels (e.g., Digoxin, Lasix);

    Adjustment of medication dosage/schedule in direct relation to diagnostic testing or symptoms: Hold Lanoxin if pulse below 60, hold Procardia if systolic blood pressure below 150, sliding scale for insulin dosage;

Intense supervision or observation that is needed to evaluate: adverse reactions, interactions, or immediate response to a drug such as a narcotic or chemical restraint (e.g., Demerol, Haldol, Mellaril).

"Drug Regulation" is not meant to refer to routine monitoring, evaluation or adjustment that is appropriately and readily accomplished by non-professionals (e.g., "Aspirin upsets my stomach so I'll take Tylenol instead").

b. Drug Administration - Giving or applying medication to remedy an illness or condition. Includes self-administration.

3. **Dressings**

   a. Decubitus Care - Application of various materials or treatments such as Duoderm, Santyl, Collagenase, Betadine, ointments, bandages, heat application, whirlpool and debridement for therapeutic reasons to protect or assist in healing a pressure sore or stasis ulcer. Include preventative measures ordered by the physician for customers with histories of chronic difficulties which are likely to recur. **Use the comments section to describe the location, stage and size (approximate) of the ulcer.**

   b. Wound Care - Application of various materials such as medicated solutions, ointments, gauze and bandages to assist in the healing or protection of a wound (incision, skin tears, burns, IV sites, dialysis sites) for therapeutic reasons. This does **not** include simple first aid measures or medications applied to skin conditions such as acne or dry skin. **Use the comments section to describe the wound (location, size, age, cause, if known) and the specific treatment.**

   c. Non-Bladder/Bowel Ostomy Care - Specific care needs, such as irrigation, cleaning or bandaging to maintain an artificial opening or a stoma. This refers to ostomy care other than for bowel or bladder ostomies, (covered in 5.b.) or tracheostomies (covered in 6.e.). **Examples of other ostomies are gastrostomy and jejunostomy, PEG Tube, Mickey Button**. (Does not include a NG-tube which goes through the nose).

4. **Feedings**

   a. Parenteral Feeding or TPN - Nutrition administered intravenously.

   b. Tube Feeding - Nutrition administered through a tube (such as nasogastric (NG), gastrostomy (G-) or jejunostomy (J-) tubes) to the alimentary tract.

5. **Bladder/Bowel**

   a. Catheter Care - Maintenance of catheter patency and hygiene. Includes condom, indwelling and intermittent straight catheterization.

   b. Ostomy Care - Specific care (i.e., changing stoma ring, changing bag) necessary to maintain an artificial opening or stoma which is used for emptying bowel or bladder contents.

   c. Bowel Dilatation - Expansion of the anal orifice to promote evacuation.

6. **Respiratory**

   a. Suctioning - Removing or withdrawing secretions and waste material.

   b. Oxygen - Receiving O_2 per nasal prongs, face mask or tent.

c. SVN (small volume nebulizer) - Treatment using a machine that produces a fine spray or mist of a specific prescription for inhalation (exclude hand held atomizers/inhalers).

d. Ventilator - A mechanical device for artificial ventilation of the lungs usually administered per tracheostomy (excludes C-PAP and Bi-PAP without a rate setting).

e. Trach Care - Suctioning and cleaning the stoma and the apparatus that provides an artificial airway to the lungs through the trachea.

f. Postural Drainage - Positioning so that gravity will allow drainage from nasal passages, airways and sinuses. Drainage is usually stimulated by percussion to the lung areas.

g. Apnea Monitor - A monitoring device which sounds an alarm when respiration or heart rate goes above or below preset parameters. **Comments should be included as to use (e.g., continuously or at night only).**

7. **Therapies**

a. Physical - Treatment provided for specific physical problems by or under the direction of a registered physical therapist. Therapies may involve use of hydrotherapy, exercises, electricity, radiation, and training in use of assistive devices (e.g., braces, side lyer, stander).

b. Occupational - Treatment provided by or under the direction of a registered occupational therapist that will assist the customer in the management of personal care. This therapy helps to improve the customer's functional abilities, teaches adaptive techniques for ADLs and works with upper extremity mobility and fine motor skills.

c. Speech - Treatment provided by or under the direction of a registered speech therapist for various speech and swallowing or feeding difficulties. Therapy helps the customer with comprehension, speech and feeding difficulties, and provides diagnostic or evaluation services.

d. Respiratory - Treatment provided by or under the direction of a registered Respiratory Therapist to restore, maintain and improve respiratory function (Includes the use of Bi-PAP. C-PAP is an exception as it **MAY** or **MAY NOT** be under the direction of or provided by a registered respiratory therapist).

e. Alcohol/Drug Treatment - Medical or psychological counseling aimed at customers who abuse alcohol and/or mood altering drugs. May include self-help groups (treatment should be for the customer, not family members).

f. Vocational Rehabilitation - Therapy directed at developing or redeveloping job-related skills.

g. Individual/Group Therapy - Psychotherapy or counseling provided by a professional for treatment of mental or emotional disorders or maladjustment.

h. Behavior Modification Program - A specific program developed to address and redirect the customer's inappropriate behavior under the direction of a psychologist or mental health professional. The program must include written record keeping of behavioral incidents and progress.

8. **Rehabilitative Nursing**

a. Teaching or Training Program - Teaching a customer or caregiver routine tasks in relation to the customer's medical need (e.g. tube feeding, ostomy care, postural drainage, chest percussion, diet planning, Prader-Willi food precautions, use of prosthesis, self-administration of medication).

b. Bowel/Bladder Retraining - A formal method of reestablishing regular evacuation/urination. **Does not include routine/initial toilet training in children or tripping schedule.**

c. Turning and Positioning - Moving, turning or repositioning a customer who is not able to move independently. This is done to improve circulation and to avoid decubiti or contractures.

d. Range of Motion - Active or passive exercise with the goal of restoration of a specific function or maintenance of function usually prescribed by physical therapist or other professional. This excludes general exercises to promote overall fitness.

e. Other Rehab Nursing - Other rehab nursing services deemed appropriate to regain health or strength, under the direction of nurses or therapists, that is reasonable and justified (e.g. restorative ambulation, restorative feeding, deep breathing exercises, therapeutic splinting).

9. **Other Services And Treatments**

a. Peritoneal Dialysis - Removal of waste products from the body by infusing prescription solutions through the peritoneal cavity.

b. Hemodialysis - Removal of waste products by circulating the body's blood supply through special dialyzing tubes.

c. Chemotherapy or Radiation - The application of chemical or x-ray agents that have a specific and toxic effect on cancerous cells.

d. Restraints - Devices that hinder or restrict movement to protect a customer from injury.

Mechanical: Physical devices or barriers that restrict normal access to one's body or immediate environment and to protect from injury. May include devices (attached or adjacent to the body) that cannot be easily removed such as vest, seat belts, or barriers to normal, standard movement (e.g., locked rooms or areas). Usually, devices such as side rails or self-removable seat belts will **not** be considered restraints.

Chemical: Prescribed medication used for elimination or modification of **overt physical behaviors** likely to cause physical harm to self or others (e.g., combativeness, constant pacing, or self-mutilation).

- A specific drug must be linked with a particular behavior and used to eliminate or control the specific behavior , in order to be considered a chemical restraint
- Verbal reminders/redirection by others, shielding, deflecting, guiding or bracing a body part for completion of a procedure is not a restraint.

NOTE: The specific type of restraint and the reason it is being used must be documented in comments.

e. Fluid Intake and Output - Measuring and monitoring the oral and parenteral intake of fluids and/or all the fluid output (e.g., IV fluids, tube feedings, parenteral feedings, specific fluid intake or urine output, catheter output, vomitus and other fluid loss). Routine recording of

dietary intake or supplements is not I & O. Keep in mind that not everyone with a catheter is being monitored for both fluid intake and output or one or the other.

f. Other - Includes other treatments prescribed for a specific problem (e.g., special mattress, whirlpool). Any service or treatment received or needed **but not documented elsewhere** should be indicated here.

J. MEDICAL STABILITY BATTERY

A (Y) yes in this section requires an explanation in the comment section.

1. Hospitalizations	Indicate the number of hospitalizations the customer has had in the last year. This may be approximate, based on caregiver report. Make comments in the PAS Summary describing the reason for each hospitalization and approximate date if known. This does not include ER visits, but these may be mentioned in the Summary section. • **Do not include birth** as a hospitalization for an infant unless the hospitalization continued due to the **child's** medical problems (not the mother's)
2. Caregiver Training	Indicate **(Y)** yes for this item if the customer requires direct care staff or caregiver to be trained in **special health care procedures.** These procedures (e.g. ostomy care, positioning for medical necessity, use of adaptive devices, SVN, behavior modification, seizure precautions, [if current seizure activity]) **should be those normally performed or monitored by licensed staff, such as an R.N. or a Therapist**. • **Do** include training for procedures that are intermittent but on-going (i.e. SVN's seasonally). **Make comments as to the procedure and who is trained.** • **Do not** include personal care that would not require special training, such as routine help with ADLs or applying AFO's or a simple brace. • **Do not** include training for a procedure that the customer has received in the past **but no longer routinely requires.**
3. Special Diet	Indicate **(Y)** yes for this item if the individual requires a special diet ordered by a physician, planned by a dietitian, nutritionist or nurse (e.g., high fiber, low calorie, low sodium, pureed) and **write in the type of diet in the comments section. This would include formula for tube feedings, but would not include formula for infants and young children who typically receive one of a variety of infant formulas by bottle or sippy cup.**

SENSORY FUNCTIONS

This section will be used to evaluate hearing and vision. Assessment may be made by reviewing available information from the caregiver, applicant, medical records and observation.

- **If the assessor is unable to assess the impairment, this will be scored in the "0" or unimpaired category.**
- **Customers who are unable to respond due to coma will be scored as having maximum impairment.**

HEARING

Hearing refers to the ability to receive sounds, and does not refer to the ability to comprehend mentally the meaning of sound. If an assistive device is used, hearing should be rated while using the device.

SCORING

0) Unable to Assess/No Impairment. Hears all normal conversational speech, including when using the telephone, watching television, and participating in group activities, or unable to assess.

1) Minimal Impairment. Has difficulty hearing when not in quiet surrounding. May have impairment in one ear but may hear adequately with the other ear.

2) Moderate Impairment. Although hearing-deficient, compensates when speaker adjusts tonal quality and speaks distinctly; or can hear only when a speaker's face is clearly visible.

3) Severe Impairment. Highly impaired/absence of useful hearing; hears only some sounds; frequently fails to respond even when speaker adjusts tonal quality, speaks distinctly, or faces customer.

VISION

Vision refers to perceiving objects visually. In this section, the assessor will evaluate the customer's ability to see close objects and objects at a distance in adequate lighting, using any visual appliances (e.g., glasses, magnifying glass). **A medical condition or disease affecting the eye that does not affect the ability to see should not be considered in determining adequacy of sight.**

SCORING

0) Unable to Assess or No Impairment. There is no impairment or impairment is compensated by corrective lenses (e.g., can see newsprint, TV, medication labels) or unable to assess.

1) Minimum Impairment. Difficulty with focus at close (reading) range but can see large print and obstacles but not details. May be blind in one eye, but has been able to compensate.

2) Moderate Impairment. Very poor focus at close range. Unable to see large print and/or field of vision is limited (tunnel vision or central vision loss).

3) Severe Impairment. May only see light, shapes, colors, or has no vision.

L. PAS SUMMARY BATTERY

In this section the assessor will summarize the overall condition and needs of the customer. **The assessor should avoid making statements regarding eligibility, the advisability of any particular placement or need for institutionalization.**

The following factors **must** be included when completing the summary, if applicable to the case:

1. HEAplus auto-populates the diagnoses listed in the Medical Conditions battery into the middle box of this page in HEAplus. A brief description of the customer's current major medical condition and related problems; any conditions which are unstable or requiring significant treatment should be described. Any vital signs, pertinent lab data, and other diagnostic information should be noted if pertinent (i.e., blood sugars, blood pressures, MRI, CT scan); Miscellaneous ICD-10 codes need to be described here, as HEAplus does not pull the comments from those areas.
2. Functional and developmental limitations and capabilities; including information about their ILS, ER visits and Hospitalizations; if scores are based on need (reason).
3. Formal and informal support system (e.g., describe formal services received such as therapies, or any informal services or support provided by relatives, neighbors, and friends); Services and treatments listed in that Battery in HEAplus are pulled and auto-populated at the top box of the PAS Summary page. Any services or treatments listed under “other” should be described here.
4. Communication capabilities and sensory status (describe any significant sensory impairments);
5. Significant behavior problems and cognitive abilities (describe the impact upon health status and caregiving);
6. Nutritional status (e.g., chewing or swallowing problems, unusual eating patterns, major fluctuations in weight);
7. Environmental conditions;
8. Information on other sources of assistance given to customer; and
9. Any other information the assessor feels is necessary to document including statements made by the customer or caregiver such as what services are desired, any unmet needs observed or described.

The assessor should avoid statements which reflect any personal value judgments or biases. Assessors should remain objective, respectful and professional.

M. Person Contact Detail Battery

Personal Contacts

This section is designed to report information about personal contacts and the customer's physician(s). The personal contact may or may not be the same as the authorized representative who has been identified by the financial eligibility specialist.

Include the contact's name, relationship to customer and telephone number(s). Additional contacts may also be added to this page. Indicate as above for customer's primary physician. If medical records/diagnoses are obtained from other specialists, include the name(s) and telephone number(s) here.

N. PAS Eligibility Battery

PAS Scoring

All medical and functional scores are computed by HEAplus and appear on this window. Physician Review and Override information is also located on this window.

Three scores are given for the PAS screening tool:

- a functional score;
- a medical score; and
- a resulting total score.

No minimum functional or medical score is required for eligibility. **A customer must be at risk for institutionalization at the nursing facility or ICF-IID level of care.**

In order to qualify by score, a total score of 40 or higher must be achieved.

On reassessment, a customer must have a score of 30, but less than 40, to be eligible for the ALTCS Transitional program.

Special Status

This window displays ACUTE, VENTILATOR DEPENDENT or ALTCS Transitional program.

E. ELIGIBILITY REVIEW REQUESTED?

The assessor should indicate whether or not a review is requested. Eligibility review is an integral part of the PAS assessment process. It is designed to address those customers whose score outcome is not thought by the assessor to be a complete reflection of the customer's need for an ICF-IID level of care.

A customer who needs the entry level of care will require care greater than what is considered supervisory or custodial care, and may present a combination of the following needs or impairments:

1. Requires 24 hour supervision;
2. Requires an intensive, multidisciplinary, continuous training program;
3. Requires a trained caregiver;
4. Requires regular medical monitoring;
5. Requires intervention for significant behavior problems;
6. Has significant impairment in development or independent living skills; and
7. Has impaired communication.

Eligibility reviews may occur for Customers who score either below or above the entry level scoring threshold. Customers may have impairments in some aspects (as described above) that "overshadow" their strengths in other areas. These reviews will usually be performed by a physician consultant or an administrative process. No customer will be determined **ineligible** by an administrative process.

Reviews **must** be requested for:

- Ineligible DD cases scoring 38 or more on initial PAS.
- Any EPD customer with a diagnosis of Autism, Autistic-Like Behavior or Pervasive Developmental Disorder (PDD) and not eligible by score.
- **All children under 6 months of age**
- **All EPD children under 12 years of age.**
- All ALTCS customers who do not meet threshold score for ALTCS or the Transitional program **on Reassessment**.
- Customer meets threshold score but has a psychiatric condition (includes chemical dependence) and does not have a non-psychiatric medical condition or developmental disability that by itself or in combination with the psychiatric condition places the customer at risk of institutionalization.

Reviews **may** be requested for, but are not limited to these cases:

- Customer does not meet threshold score but the assessor thinks the individual may be at risk of institutionalization;
- Customer requests a hearing;
- Customer meets the threshold score on an initial ALTCS application and is already a member of an AHCCCS health plan and appears to need less than 90 days of convalescent care; and
- Atypical cases: traumatic brain injuries, HIV/AIDS, specialized treatments, e.g., halo brace, body cast, any cases requiring extensive and complex medical care, the dually diagnosed (SMI and IID).

IV. PHYSICIAN'S REVIEW

When requesting the Physician's Review, the assessor completes the following fields in the PAS Scoring window in HEAplus:

Requested Date

Date the case is actually sent to review, after medical records have been received, reviewed by the assessor and HPM, and scanned into Fortis.

Requestor Comments

When requesting an eligibility review, the assessor should provide a brief, specific reason based on the customer's functional and medical conditions. Any information recorded must be factual and objective. **Do not suggest an eligibility decision**.

When requesting an eligibility review, the assessor should provide the reviewer with current documentation in Fortis, if available and pertinent to the customer's condition. Documentation should be selected for its ability to **CLARIFY** the current medical condition or functional needs or both. **If documentation is NOT available note that in this section and provide a more thorough explanation in the PAS summary.**

This documentation may include:

- History and Physical;
- Discharge summary if the customer was hospitalized;
- Consultation Reports by specialists (e.g. psychological, neurological or cardiological);
- Therapy notes;
- Nursing Notes, only if addressing a specific incident or condition;
- Three months seizure diary or incident report log or both;
- Test results such as x-ray, laboratory, EEG, EKG or MRI results;
- Progress Notes, Physician, Support Coordinator;
- Prior PAS (ALL prior PAS's for children under 6, last PAS for over 6);
- Specialized treatment plan and progress notes (e.g., from vocational or behavioral programs).

Referral

Once the PAS and documentation have been reviewed by the Assessor's HPM, and supporting documents are scanned into Fortis, the local office notifies PAS QAT via - MARS when the case is ready to be reviewed. The physician reviewers and PARC are notified and review the case in HEAplus and Fortis.

F. ELIGIBILITY REVIEWER'S SUMMARY

In this section the reviewer determines, independent of score, if the customer is at immediate risk of institutionalization in an ICF-IID (or NF when applicable). The summary will describe significant factors that determined eligibility and may include:

- A brief summary of the significant medical conditions.
- Discussion of the extent of the impact the current medical condition has upon physical/mental functioning.
- A prognosis with an estimate of continued level of functioning or disability. This may include an opinion on whether the applicant may be served adequately through supervisory care facilities, periodic outpatient care or intermittent hospital stay.

  In conducting the review, the reviewer may consider all available information from the PAS as well as any additional documentation provided by the assessor. The reviewer may call to discuss the case with the medical professionals involved and the assessor. In making the determination, the reviewer may consider several areas such as functional limitations, cognitive deficits, stability of medical conditions, number, frequency and complexity of treatments, to list a few. The reviewer may place a different degree of significance on factors within each individual case. The reviewer must look at the case from the overall perspective of risk of institutionalization.

Review Results

After the review is completed, the reviewer will indicate the appropriate decision, eligible or ineligible, or Transitional if it’s a reassessment PAS

Reviewer's Signature and Title

The reviewer's signature, title and date the review was completed should be indicated.

V. POSTHUMOUS PAS AND REASSESSMENTS

A. POSTHUMOUS PAS

In some instances an initial PAS may need to be completed after the applicant has expired. The customer may have died after the application has been made, or in some cases a representative may have applied for the deceased customer.

If the financial eligibility specialist (PSE) is aware that the applicant is deceased, this information will be put on the PAS referral and the date of death will appear in HEAplus. In some cases, the applicant may die after the PAS referral has been made, and the financial eligibility specialist may be unaware of the death. In that case, the PAS assessor will be responsible for notifying the financial eligibility specialist of the death and source of this information.

Although the posthumous PAS may be an initial PAS, there are limitations on information availability and applicability. No comments are required on the Posthumous PAS and medications do not need to be completed. A brief summary should be included.

As of 1/1/2014, a deceased customer no longer must have been placed in a nursing facility/medical institution during the application period. A deceased applicant can be in any type of living arrangement and still be assessed on a Posthumous PAS. Title 9 28-401.01 A5.

G. REASSESSMENTS

PAS reassessments are required to determine continued eligibility for ALTCS. The same basic PAS criteria must be met in order for eligibility to continue, that is the customer must continue to be at risk of institutionalization at an ICF or NF level or have improved to a lower level of care in the Transitional program. Any changes in score or condition **must** be explained in comments and/or in the summary. Each reassessment should give a complete description of the customer's current medical and functional status. To insure consistency and to prepare for the interview, it is necessary to review the PAS records and the Prior PAS in HEAplus prior to conducting a reassessment.

Prior to dispositioning an ineligible reassessment, the assessor must have contacted the support coordinator to obtain collateral information and to discuss the potential ineligibility. The same is true should the customer score into the Transitional Program while in the ICF or NF.

ALTCS Transitional is a program for currently eligible ALTCS customers who have improved either medically, functionally or both to the extent that they are no longer at risk of institutionalization at a nursing facility (NF) or intermediate care facility for Individuals with Intellectual Disabilities (ICF) level of care. These customers continue to require some long-term care services, but at a lower level of care. The ALTCS Transitional program allows those customers who meet the lower level of care, as determined by the preadmission screening (PAS), to continue to receive all ALTCS covered services that are medically necessary. NF/ICF services are excluded, since reassessment has determined that NF services are not medically necessary.

The ALTCS Transitional program is not available to an ALTCS customer who fails the initial PAS and is not at risk of institutionalization.

For more information on Reassessments, see Arizona's Eligibility Policy Manual for MA, NA and CA, Chapter 1000.

Note: PAS Assessors are responsible for checking that HEAplus is generating the correct notice regarding PAS Reassessment eligibility determinations. If the notice is not correct, the HPM and PAS QAT must be notified. The notice must also be suppressed in HEAplus immediately.

VI. PRIOR QUARTER AND PRIVATE REQUEST PAS

A. Prior Quarter

A child or a woman who is pregnant or in the postpartum period may qualify for coverage for up to 3 months prior to the date of their application. This time period is called the Prior Quarter. In order to be eligible for Prior Quarter coverage, the following must be met:

- Have a medical expense in a Prior Quarter month. The medical expense can be paid or unpaid.
- Meet all eligibility requirements in the month the medical expense was incurred.

Coverage for Prior Quarter months is Fee for Service. Customers are not enrolled with a Program Contractor during the Prior Quarter months.

Private Request PAS

What is a Private Request PAS?

A private request PAS is a courtesy that ALTCS provides to customers not currently applying for ALTCS. These courtesy assessments are completed without a charge to the customer and are not a final determination of medical eligibility.

Why would someone ask for a Private Request PAS?

A customer might ask for a private request PAS if:

- they are planning on moving to Arizona and want to know if there is a likelihood of being medically eligible;
- they already know they are within the financial limits but are not sure about medical eligibility;
- they know they are over the resource limit and before they consider reducing resources, want to know whether potential medical eligibility exists.

As a PAS Assessor, what do I need to do when I am assigned a Private Request PAS?

- If the customer is a resident of Arizona, a private request PAS will be entered into the system. You will make an appointment to do a home visit and complete the PAS just as you would any other PAS. If the customer needs to go to physician review, either by rule or if you feel the customer is at risk of institutionalization, you will send it through PR. You will request medical records as usual.
- If the customer is **not** a resident of Arizona, you will need to complete the PAS on paper. You will contact the customer and any caregivers to obtain PAS information. You will request medical records as usual. These assessments also can go through the PR process; however, if the customer does not have solid plans on moving to Arizona, sending it through PR might not be warranted. You will need to discuss this with your HPM and/or PAS QAT.

What do I tell the customer about the PAS outcome?

- If the customer is an Arizona resident and you completed the PAS in the system, you can tell the customer that **at this time,** based on the courtesy assessment, they do/do not meet medical eligibility criteria. You need to make it clear that if/when they apply for ALTCS, a new PAS referral will be completed. The private request PAS information ***MAY*** be used but is not a guarantee of medical eligibility when they apply for ALTCS.
- If the customer is out of state, you can tell them that it appears they do/do not meet the medical eligibility criteria at this time. You need to tell them that if/when they apply for ALTCS; they ***will*** need another PAS assessment. The private request PAS is not a guarantee of medical eligibility. If they move here and apply, you will need to schedule a home visit and update the PAS with current information. After this visit, the PAS can be entered into the system.

VIII. PAS Completion

Before completing any PAS, the assessor **must** review the system to ensure accuracy of data entry on all screens. All scores must be reviewed for accuracy and the content of comments and summaries must also be reviewed. **If the assessor assigned to the PAS is not available to complete the PAS, whoever completes the PAS is responsible for reviewing and ensuring the accuracy of the information as defined above.**

If the assessor feels the customer's condition may improve (e.g., recent fracture or other acute episode) the case should be referred to his/her supervisor prior to completing as a reassessment in six months may be indicated.

Before completing a PAS that has had a Physician Review completed, the assessor must review the physician’s comments.

If the assessor questions the physician review decision, the PAS should be discussed with the supervisor, regional or branch manager, or ALTCS PAS QA **prior to completion**. It is important to note that the final dispositioning of the case and eligibility determination is done by Financial Eligibility except for reassessments that the Assessor is responsible for dispositioning.

ATTACHMENT 1 - DD PAS SCORE SHEETS

Score Sheet
6-8 months

Name: Date: _____

ID#: _____

Developmental Domain

Number of No and Yes reverse scoring questions X 5.0 = _____

Medical Conditions

Cerebral Palsy 5.0 = _____

Epilepsy 5.0 = _____

Subtotal = _____

Services and Treatments

Drug Reg. + Administration 1.0 = _____

Non-Bladder / Bowel Ostomy 7.0 = _____

Tube Feeding 7.0 = _____

PT or OT 1.0 = _____

Subtotal = _____

Medical Stability

Acute Hospitalizations 1 X # Cap @ 2 = _____

Direct Caregiver Trained 0.5 = _____

Special Diet 2.0 = _____

Subtotal = _____

Total Score = _____

Score Sheet
9-11 months

Name: Date: _____

ID#: _____

Developmental Domain

Number of No and Yes reverse scoring questions X 4.1 = _____

Medical Conditions

Cerebral Palsy 5.0 = _____

Epilepsy 5.0 = _____

Subtotal = _____

Services and Treatments

Drug Reg. + Administration 1.0 = _____

Non-Bladder / Bowel Ostomy 7.0 = _____

Tube Feeding 7.0 = _____

PT or OT 1.0 = _____

Subtotal = _____

Medical Stability

Acute Hospitalizations 1 X # Cap @ 2 = _____

Direct Caregiver Trained 0.5 = _____

Special Diet 2.0 = _____

Subtotal = _____

Total Score = _____

Score Sheet
12-17 months

Name: Date: _____

ID#: _____

Developmental Domain

Number of No and Yes reverse scoring questions X 2.9 = _____

Medical Conditions

Cerebral Palsy 5.0 = _____

Epilepsy 5.0 = _____

Subtotal = _____

Services and Treatments

Drug Reg. + Administration 1.0 = _____

Non-Bladder / Bowel Ostomy 7.0 = _____

Tube Feeding 7.0 = _____

PT or OT 1.0 = _____

Subtotal = _____

Medical Stability

Acute Hospitalizations 1 X # Cap @ 2 = _____

Direct Caregiver Trained 1.0 = _____

Special Diet 2.0 = _____

Subtotal = _____

Total Score = _____

Score Sheet
18-23 months

Name: Date: _____

ID#: _____

Developmental Domain

Number of No and Yes reverse scoring questions X 2.125 = _____

Medical Conditions

Cerebral Palsy	5.0 = _____
Epilepsy	5.0 = _____
Autism + MCHAT (6 of 8)	7.0 = _____
	Subtotal = _____

Services and Treatments

Drug Reg. + Administration	1.0 = _____
Non-Bladder / Bowel Ostomy	7.0 = _____
Tube Feeding	7.0 = _____
PT or OT	1.0 = _____
	Subtotal = _____

Medical Stability

Acute Hospitalizations	1 X # Cap @ 2 = _____
Direct Caregiver Trained	1.0 = _____
Special Diet	2.0 = _____
	Subtotal = _____

Total Score = _____

Score Sheet
24-29 months

Name: Date: _____

ID#: _____

Developmental Domain

Number of No and Yes reverse scoring questions X 1.75 =

Medical Conditions

Cerebral Palsy	5.0 = _____
Epilepsy	5.0 = _____
Autism + MCHAT (6 of 8)	7.0 = _____
	Subtotal = _____

Services and Treatments

Drug Reg. + Administration	1.0 = _____
Non-Bladder / Bowel Ostomy	7.0 = _____
Tube Feeding	7.0 = _____
PT or OT	1.0 = _____
	Subtotal = _____

Medical Stability

Acute Hospitalizations	1 X #	Cap @ 2 = _____
Direct Caregiver Trained		1.0 = _____
Special Diet		2.0 = _____
		Subtotal = _____

Total Score = _

Score Sheet
30-35 months

Name: Date: _____

ID#: _____

Developmental Domain

Number of No and Yes reverse scoring questions X 1.55 = _____

Medical Conditions

Cerebral Palsy	5.0 = _____
Epilepsy	5.0 = _____
Autism + MCHAT (6 of 8)	7.0 = _____
Autism + Behaviors (3 of 4)	5.0 = _____
	Subtotal = _____

Services and Treatments

Drug Reg. + Administration	1.0 = _____
Non-Bladder / Bowel Ostomy	7.0 = _____
Tube Feeding	7.0 = _____
PT or OT	1.0 = _____
	Subtotal = _____

Medical Stability

Acute Hospitalizations	1 X # Cap @ 2 = _____
Direct Caregiver Trained	1.0 = _____
Special Diet	2.0 = _____
	Subtotal = _____

Total Score = _____

Score Sheet
36-47 months 3y/o

Name: Date: _____

ID#: _____

Developmental Domain

Number of No and Yes reverse scoring questions X 1.34 = _____

Medical Conditions

Cerebral Palsy	5.0 = _____
Epilepsy	5.0 = _____
Cognitive Disability	15.0 = _____
Autism + MCHAT (6 of 8)	7.0 = _____
Autism + Behaviors (6 of 8)	10.0 = _____
	Subtotal = _____

Services and Treatments

Drug Reg. + Administration	1.5 = _____
Non-Bladder / Bowel Ostomy	5.0 = _____
Tube Feeding	5.0 = _____
PT or OT	1.5 = _____
	Subtotal = _____

Medical Stability

Acute Hospitalizations	1 X #	Cap @ 2 = _____
Direct Caregiver Trained		1.0 = _____
Special Diet		2.0 = _____
		Subtotal = _____

Total Score = _____

Score Sheet
48-59 months

Name: Date: _____

ID#: _____

Developmental Domain

Number of No and Yes reverse scoring questions X 1.14 = _____

Medical Conditions

Cerebral Palsy	5.0 = _____
Epilepsy	5.0 = _____
Cognitive Disability	15.0 = _____
Autism + MCHAT (6 of 8)	7.0 = _____
Autism + Behaviors (6 of 8)	10.0 = _____
	Subtotal = _____

Services and Treatments

Drug Reg. + Administration	1.5 = _____
Non-Bladder / Bowel Ostomy	5.0 = _____
Tube Feeding	5.0 = _____
PT or OT	1.5 = _____
	Subtotal = _____

Medical Stability

Acute Hospitalizations	1 X # Cap @ 2 = _____
Direct Caregiver Trained	1.0 = _____
Special Diet	2.0 = _____
	Subtotal = _____

Total Score = _____

Score Sheet
60-71 months 5 y/o

Name: Date: _____

ID#: _____

Developmental Domain

Number of No and Yes reverse scoring questions X 1.030 = _____

Medical Conditions

Cerebral Palsy	5.0 = _____
Epilepsy	5.0 = _____
Cognitive Disability	15.0 = _____
Autism + MCHAT (6 of 8)	7.0 = _____
Autism + Behaviors (6 of 8)	10.0 = _____
	Subtotal = _____

Services and Treatments

Drug Reg. + Administration	1.5 = _____
Non-Bladder / Bowel Ostomy	5.0 = _____
Tube Feeding	5.0 = _____
PT or OT	1.5 = _____
	Subtotal = _____

Medical Stability

Acute Hospitalizations	1 X # Cap @ 2 = _____
Direct Caregiver Trained	1.0 = _____
Special Diet	2.0 = _____
	Subtotal = _____

Total Score = _____

SCORING FOR 6-11 YEAR OLD AGE GROUP

DEVELOPMENTALLY DISABLED

DATE

NAME_____ PID

Motor/Independent Living Skills Domain			
Rolling/Sitting	_____	x 0.833	=
Crawling/Standing	_____	x 1.250	=
Ambulation	_____	x 1.5	=
Climbing Stairs	_____	x 1.875	=
W/C Mobility	_____	x 1.875	=
Dressing	_____	x 1.5	=
Bathing/Showering	_____	x 1.5	=
Toileting	_____	x 1.5	=
Bladder Control	_____	x 1.875	=
		Subtotal	
Communication Domain			
Expressive Verbal	_____	x 1.250	=
Clarity	_____	x 1.5	=
		Subtotal	
Behavioral Domain			
Running/Wandering Away	_____	x 6.0	=
Disruptive	_____	x 7.5	=
		Subtotal	
Diagnoses			
Cerebral Palsy		(2.5)	
Epilepsy/Seizure Disorder		(2.5)	
		Subtotal	
Threshold Score = 40		Total Score	

SCORING FOR 12+ YEAR OLD AGE GROUP

DEVELOPMENTALLY DISABLED

DATE

NAME _____ PID

Motor/Independent Living Skills Domain		
Hand Use	_____ x 3.5	=
Ambulation	_____ x 2.8	=
Eating/Drinking	_____ x 2.8	=
Dressing	_____ x 2.8	=
Personal Hygiene	_____ x 2.8	=
Food Preparation	_____ x 3.5	=
Toileting	_____ x 2.8	=
	Subtotal	
Communication/Cognitive Domain		
Associating Time	_____ x 0.5	=
Remembering Instructions	_____ x 0.5	=
	Subtotal	
Behavioral Domain		
Aggression	_____ x 2.8	=
Threatening	_____ x 2.8	=
Self-Injurious	_____ x 2.8	=
Resistive/Rebellious	_____ x 3.5	=
	Subtotal	
Diagnoses		
Cerebral Palsy	(0.4)	
Epilepsy/Seizure Disorder	(0.4)	
Moderate, Severe, Profound	(20.6)	
	Subtotal	
Threshold Score = 40	Total Score	

PreAdmission Screening Tool

Developmentally Disabled/Physically Disabled 0 – 5 (Under Age 6)

Case Information			
AHCCCS ID		Medicare Part D	☐ Yes ☐ No
Person/App ID:			
Type of PAS	☐ Initial ☐ Reassessment ☐ Posthumous		
PSE Name			
PSE Phone			

I. INTAKE INFORMATION

Customer Information			
PAS Date		PAS Time	
Customer Name:			
Age	months		
Birthdate			
Gender	☐ Male ☐ Female		
Location at time of Assessment			
Telephone Number			

DD Status:	☐ Not DD ☐ Potential DD ☐ DD in NF ☐ DD

Prior Quarter:	Month 1:		Month 2:		Month 3:	

Authorized Representative	
Name	
Telephone Number	

Physical Measurements	
Height	Feet Inches
Weight	lbs. oz.
Birth Weight (DD 0-5)	lbs.
Gestational Age (DD 0-5)	

Additional Information

I. Intake Information

PreAdmission Screening

Developmentally Disabled /Physically Disabled
0 – 5 (Under Age 6)

Customer Name

Person ID

1.	Is customer currently hospitalized or in an intensive rehabilitation facility?	☐ YES	☐ NO
2.	If in an acute care facility, is discharge imminent (within 7 days)?	☐ YES	☐ NO
	Projected discharge date:		
3.	Ventilator Dependent?	☐ YES	☐ NO
4.	Number of Emergency Room visits in last 6 months(EPD)		
5.	Number of Hospitalizations in last 6 months(last year for DD 0-5)		
6.	Number of Falls in last 90 days(EPD)		

Personal Contacts					
Contact #1					
Name					
Relationship					
Address					
City		State		Zip Code	
Phone Number(s)					
Contact #2					
Name					
Relationship					
Address					
City		State		Zip Code	
Phone Number(s)					
Contact #3					
Name					
Relationship					
Address					
City		State		Zip Code	
Phone Number(s)					
Contact #4					
Name					
Relationship					

Customer Name

Person ID

Address					
City		State		Zip Code	
Phone Number(s)					

Customer Name

Person ID

II. FUNCTIONAL ASSESSMENT
A. DEVELOPMENTAL DOMAIN

All the developmental questions must be answered for all children in this age group.

FOR AGES SIX MONTHS AND OLDER

1.	Does your child lift their head when lying on their back?	☐ Yes	☐ No
Comments:			

2.	When your child is on their tummy, does s/he straighten both arms and push their whole chest off the bed or floor?	☐ Yes	☐ No
Comments:			

3.	If you hold both hands just to balance your child, does s/he support their own weight while standing? (That is, can s/he bear weight?)	☐ Yes	☐ No
Comments:			

4.	Does your child reach for or grasp a toy?	☐ Yes	☐ No
Comments:			

5.	Does your child try to pick up a crumb or Cheerio by using their thumb and all their fingers in a raking motion, even if they aren't able to pick it up? (If they already pick up the crumb or Cheerio, check "yes" for this item.)	☐ Yes	☐ No
Comments:			

6.	Does your child make high-pitched squeals?	☐ Yes	☐ No
Comments:			

7.	Does your child show two or more emotions? (For example, laughs, cries, screams, etc.)	☐ Yes	☐ No
Comments:			

Customer Name

Person ID

8.	Does your child act differently toward strangers than s/he does with you and other familiar people? (Reactions to strangers may include, for example, staring, frowning, withdrawing or crying.)	☐ Yes	☐ No
Comments:			

9.	Does your child stiffen and arch their back when picked up? REVERSE SCORING	☐ Yes	☐ No
Comments:			

Stop here if child is less than nine months!

FOR AGES NINE MONTHS AND OLDER

10.	Does your child roll from their back to their tummy, getting both arms out from under them?	☐ Yes	☐ No
Comments:			

11.	When you stand your child next to furniture or the crib rail, does s/he stand, holding onto the furniture for support?	☐ Yes	☐ No
Comments:			

12.	Does your child creep or move on their stomach across the floor?	☐ Yes	☐ No
Comments:			

13.	Does your child sit supported (for example, in a chair with pillows, etc.) for at least 1 minute?	☐ Yes	☐ No
Comments:			

14.	When a loud noise occurs, does your child respond? (For example, act startled, cry or turn toward the sound.)	☐ Yes	☐ No
Comments:			

15.	If you call your child when you are out of their line-of-sight, does s/he look in the direction of your voice?	☐ Yes	☐ No

Comments:	

16. Does your child make non-word sounds? (That is, babble or jabber.) ☐ Yes ☐ No

Comments:	

17. Does your child look toward you (parent or caregiver) when hearing your (parent or caregiver's) voice? ☐ Yes ☐ No

Comments:	

18. Does your child enjoy playing peek-a-boo/pat-a-cake? ☐ Yes ☐ No

Comments:	

19. Does your child feed themselves a cracker or cookie? ☐ Yes ☐ No

Comments:	

Stop here if child is less than twelve months!

FOR AGES TWELVE MONTHS AND OLDER

20. Does your child walk around the furniture while holding on with only one hand? ☐ Yes ☐ No

Comments:	

21. Does your child crawl at least 5 feet on hands and knees, without stomach touching the floor? ☐ Yes ☐ No

Comments:	

22. Does your child hold a bottle or cup? ☐ Yes ☐ No

Comments:	

23. Does your child move an object from one hand to the other? ☐ Yes ☐ No

Comments:	

24.	Does your child pick up a small object with thumb and fingers?	☐ Yes ☐ No
Comments:		

25.	Does your child coo or laugh or make other sounds of pleasure?	☐ Yes ☐ No
Comments:		

26.	Does your child reach for familiar person when person holds out arms to them?	☐ Yes ☐ No
Comments:		

27.	Does your child play with a doll or stuffed animal by hugging it?	☐ Yes ☐ No
Comments:		

28.	Does your child suck or chew on finger foods? (For example, crackers, cookies, toast, etc.)	☐ Yes ☐ No
Comments:		

Stop here if child is less than eighteen months!

FOR AGES EIGHTEEN MONTHS AND OLDER

29.	Does your child stand up in the middle of the room by themselves and take several steps forward?	☐ Yes ☐ No
Comments:		

30.	Does your child climb on furniture?	☐ Yes ☐ No
Comments:		

31.	Does your child turn the pages of a board, cloth or paper book by himself/herself? (S/he may turn more than one page at a time.)	☐ Yes ☐ No
Comments:		

32.	Without showing them how, does your child scribble back and forth when you give	☐ Yes ☐ No

them a crayon (or pencil or pen)?	
Comments:	

33.	Does your child stack a small toy, block, cup, dish or other object on top of another one?	☐ Yes ☐ No
Comments:		

34.	Does your child respond to their name when you call?	☐ Yes ☐ No
Comments:		

35.	When playing with sounds, does your child make grunting, growling or deep-toned sounds? (Examples may include a car, a motor, a train, an animal.)	☐ Yes ☐ No
Comments:		

36.	Does your child say “Da-da” or “Ma-ma” or another name for parent or caregiver (including parent’s or caregiver’s first name or nickname)?	☐ Yes ☐ No
Comments:		

37.	When you ask your child to point to their nose, eyes, hair, feet, ears and so forth, does your child correctly point to at least one body part? (They can point to themselves, you or a doll.)	☐ Yes ☐ No
Comments:		

38.	If you point at a toy across the room, does your child look at it?	☐ Yes ☐ No
Comments:		

39.	Does your child ever use their index finger to point, to indicate interest in something?	☐ Yes ☐ No
Comments:		

40.	Does your child ever bring objects over to you?	☐ Yes ☐ No
Comments:		

Customer Name

Person ID

41.	Does your child imitate you? For example, you make a face – will your child imitate it?	☐ Yes	☐ No
Comments:			

42.	Does your child take an interest in other children? (Includes siblings.)	☐ Yes	☐ No
Comments:			

43.	Does your child eat solid foods? (For example, cooked vegetables, chopped meats, etc.)	☐ Yes	☐ No
Comments:			

44.	Does your child like being hugged or cuddled?	☐ Yes	☐ No
Comments:			

Stop here if child is less than twenty-four months!

FOR AGES TWENTY-FOUR MONTHS AND OLDER

45.	Does your child run?	☐ Yes	☐ No
Comments:			

46.	Does your child jump, with both feet leaving the floor at the same time? (That is, can s/he jump up?)	☐ Yes	☐ No
Comments:			

47.	Does your child flip light switches off and on?	☐ Yes	☐ No
Comments:			

48.	Does your child put a small object in a cup and dump it out? (You may show them how.)	☐ Yes	☐ No
Comments:			

Customer Name

Person ID

49.	Does your child stack at least four small toys, blocks, cups, dishes or other objects on top of each other?	☐ Yes	☐ No
Comments:			

50.	Does your child name at least three objects? (For example, bottle, dog, favorite toy, etc.)	☐ Yes	☐ No
Comments:			

51.	Does your child follow instructions with one action and one object? (For example, “Bring me the book”; “Close the door”; etc.)	☐ Yes	☐ No
Comments:			

52.	Does your child demonstrate understanding of the meaning of no, or word or gesture with the same meaning? (For example, stops current activity briefly.)	☐ Yes	☐ No
Comments:			

53.	Does your child copy the activities you do, such as wipe up a spill, sweep, shave or comb hair?	☐ Yes	☐ No
Comments:			

54.	Does your child play near another child, each doing different things?	☐ Yes	☐ No
Comments:			

55.	Does your child hold and drink from a cup or glass? (Includes “sippy” cups.)	☐ Yes	☐ No
Comments:			

56.	Does your child look at you when you talk to them?	☐ Yes	☐ No
Comments:			

Stop here if child is less than thirty months!

FOR AGES THIRTY MONTHS AND OLDER

Customer Name

Person ID

57.	While standing, does your child throw a ball or toy?	☐ Yes	☐ No
Comments:			

58.	Does your child ask questions beginning with what or where? (For example, “What’s that?”; “Where doggie go?”; etc.)	☐ Yes	☐ No
Comments:			

59.	Does your child call themselves “I” or “me” more often than their own name? (For example, “I do it” more than “Mary (John) do it”.)	☐ Yes	☐ No
Comments:			

60.	Does your child take off clothing that opens in the front (for example, a coat or sweater)? (Does not have to unbutton or unzip the clothing.)	☐ Yes	☐ No
Comments:			

61.	Does your child use a spoon to feed themselves?	☐ Yes	☐ No
Comments:			

62.	Does your child sleep at least 8 hours in a 24-hour period?	☐ Yes	☐ No
Comments:			

63.	Does your child do things over and over and can’t seem to stop? (Examples are rocking, hand flapping or spinning.) REVERSE SCORING	☐ Yes	☐ No
Comments:			

64.	Does your child destroy or damage things on purpose? REVERSE SCORING	☐ Yes	☐ No
Comments:			

65.	Does your child hurt themselves on purpose? REVERSE SCORING	☐ Yes	☐ No
Comments:			

Stop here if child is less than thirty-six months!

Customer Name

Person ID

FOR AGES THIRTY-SIX MONTHS AND OLDER

66.	Does your child stand (balance) on one foot for about 1 second without holding onto anything?	☐ Yes	☐ No
Comments:			

67.	Does your child walk up stairs, using only one foot on each stair? (The left foot is on one step, and the right foot is on the next.) S/he may hold onto the railing or wall.	☐ Yes	☐ No
Comments:			

68.	Does your child turn the pages of a book one at a time?	☐ Yes	☐ No
Comments:			

69.	Does your child use simple words to describe things? (For example, dirty, pretty, big, loud, etc.)	☐ Yes	☐ No
Comments:			

70.	Does your child state their own first name or nickname?	☐ Yes	☐ No
Comments:			

71.	Does your child follow instructions with two actions or an action and two objects? (For example, “Bring me the crayons and the paper”; “Sit down and eat your lunch”; etc.)	☐ Yes	☐ No
Comments:			

72.	Does your child pretend objects are something else? (For example, does your child hold a cup to their ear, pretending it is a telephone? Does s/he put a box on their head, pretending it is a hat? Does s/he use a block or small toy to stir food?)	☐ Yes	☐ No
Comments:			

73.	Does your child know if s/he is a boy or a girl?	☐ Yes	☐ No
Comments:			

74.	Does your child pull up clothing with elastic waistbands? (For example, underwear or sweatpants)	☐ Yes	☐ No
Comments:			

75.	Does your child suck from a straw?	☐ Yes	☐ No
Comments:			

76.	Does your child cry, scream or have tantrums that last for 30 minutes or longer? REVERSE SCORING	☐ Yes	☐ No
Comments:			

77.	Does your child act physically aggressive? (For example, hits, kicks, bites, etc.) REVERSE SCORING	☐ Yes	☐ No
Comments:			

78.	Does your child have eating difficulties? (For example, eats too fast or too slowly, hoards food, overeats, refuses to eat, etc.) REVERSE SCORING	☐ Yes	☐ No
Comments:			

79.	Does your child sometimes stare at nothing or wander with no purpose? REVERSE SCORING	☐ Yes	☐ No
Comments:			

Stop here is child is less than forty-eight months!

FOR AGES FORTY-EIGHT MONTHS AND OLDER

80.	Does your child hop up and down on one foot?	☐ Yes	☐ No
Comments:			

81.	Does your child pedal a tricycle or other three-wheeled toy at least 6 feet?	☐ Yes	☐ No
Comments:			

Customer Name

Person ID

82.	Does your child walk down stairs, using only one foot on each stair? (The left foot is on one step, and the right foot is on the next.) S/he may hold onto the railing or wall.	☐ Yes	☐ No
Comments:			

83.	Does your child wiggle their thumb, for example when using a TV remote or video game controller?	☐ Yes	☐ No
Comments:			

84.	Does your child unbutton one or more buttons, or unfasten one or more Velcro straps? Your child may use their own clothing or a doll's clothing.	☐ Yes	☐ No
Comments:			

85.	Does your child use in, on or under in phrases or sentences? (For example, "Ball go under chair"; "Put it on the table"; etc.)	☐ Yes	☐ No
Comments:			

86.	Does your child say their first and last name?	☐ Yes	☐ No
Comments:			

87.	Does your child follow instructions in "if-then" form? (For example, "If you want to play outside, then put your things away"; etc.)	☐ Yes	☐ No
Comments:			

88.	Does your child share toys or possessions when asked?	☐ Yes	☐ No
Comments:			

89.	Does your child tell you the names of two or more playmates, including brothers and sisters? (Ask this question without providing help by suggesting names of playmates or friends.)	☐ Yes	☐ No
Comments:			

90.	Does your child brush their teeth?	☐ Yes	☐ No

Comments:	

91. Does your child urinate in a toilet or potty chair? ☐ Yes ☐ No	
Comments:	

92. Does your child defecate in a toilet or potty chair? ☐ Yes ☐ No	
Comments:	

93. Does your child put on clothing that opens in the front (for example a coat or sweater)? (Does not have to button or zip the clothing.) ☐ Yes ☐ No	
Comments:	

Stop here if child is less than sixty months!

FOR AGES SIXTY MONTHS AND OLDER

94. Does your child open doors by turning door knobs? (Includes doors that open/close with levers rather than traditional round knobs.) ☐ Yes ☐ No	
Comments:	

95. Does your child identify and name most common colors (that is, red, blue, green, yellow)? ☐ Yes ☐ No	
Comments:	

96. Does your child follow three-part instructions? (For example, “Brush your teeth, get dressed and make your bed”; etc.) ☐ Yes ☐ No	
Comments:	

97. Does your child take turns when asked while playing games or sports? ☐ Yes ☐ No	
Comments:	

98. Does your child play informal group games? (For example, hide-and-seek, tag, jump rope, catch, etc.) ☐ Yes ☐ No

Customer Name

Person ID

Comments:	

99. Does your child put shoes on correct feet? (Does not need to tie laces.) ☐ Yes ☐ No	
Comments:	

100. Does your child wash their hands using soap and water? (May be reminded.) ☐ Yes ☐ No	
Comments:	

101. Does your child use the toilet by themselves? (S/he goes to the bathroom, sits on the toilet, wipes and flushes. May be reminded.) ☐ Yes ☐ No	
Comments:	

Bladder accidents?	Number: Frequency: ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly

Customer Name

Person ID

III. MEDICAL ASSESSMENT
A. MEDICAL CONDITIONS

Neurological/Congenital/Developmental Conditions	Comments	Major Dx
1. Cerebral Palsy		
a. Diplegia		
b. Hemiplegia		
c. Quadriplegia		
d. Paraplegia		
e. Unspecified Cerebral Palsy		
2. Epilepsy/Seizure Disorder		
a. Generalized non-convulsive (absence, petit mal, minor, akinetic, atonic)		
b. Generalized convulsive (clonic, myoclonic, tonic, tonic-clonic, grand mal, major)		
c. Unspecified (complex partial, psychomotor, temporal lobe, simple partial, Jacksonian, epilepsia partialis continual)		
3. Intellectual/Cognitive Disability		
a. Mild Intellectual/Cognitive Disability		
b. Moderate Intellectual/Cognitive Disability		
c. Severe Intellectual/Cognitive Disability		
d. Profound Intellectual/Cognitive Disability		
e. Unspecified Intellectual/Cognitive Disability		

f. Borderline Intelligence		

Autism, PDD, Autistic-Like Behaviors	Comments	Major Dx
4. Autism		
a. Autism		
b. Pervasive Developmental Disorder		
c. Autistic-Like Behaviors		
5. Attention Deficit Disorder (ADD)		
a. ADD with Hyperactivity		
b. ADD without Hyperactivity		
6. Other Neurological / Congenital / Developmental Conditions		
a. Prematurity		
b. Fetal Alcohol Syndrome		
c. Developmental Delays		
d. Hydrocephaly		
e. Macrocephaly		
f. Microcephaly		
g. Meningitis		
h. Encephalopathy		
i. Spina Bifida		
j. Genetic Anomalies		
k. Down's Syndrome		
l. Congenital Anomalies		
m. Near Drowning		
n. Head Trauma		
o. Dementia (Organic Brain Syndrome)		

Customer Name

Person ID

Other Medical Conditions	Comments	Major Dx
7. Hematologic		
a. Anemia		
b. HIV Positive		
c. AIDS		
d. Leukemia		
e. Hepatitis		
8. Cardiovascular		
a. CHF		
b. Hypertension		
c. Congenital Anomalies of Heart		
d. Cardiac Murmurs		
e. Rheumatic Heart Disease		
9. Musculoskeletal		
a. Arthritis		
b. Fracture		
c. Contracture		
d. Anomalies of Spine (Kyphoscoliosis, Scoliosis, Lordosis)		
e. Paralysis		
10. Respiratory		
a. Asthma		
b. Bronchitis		
c. Pneumonia		
d. Respiratory Distress Syndrome		
e. Bronchopulmonary Dysplasia		

f. Cystic Fibrosis		
g. Reactive Airway Disease		
h. Tracheomalacia		
i. Congenital Pulmonary Problems		
11. Genitourinary		
a. Urinary Tract Infection		
12. Gastrointestinal		
a. Constipation		
b. Ulcers		
c. Hernia		
d. Esophagitis		
e. Gastroesophageal Reflux		
13. EENT		
a. Blindness		
b. Cataract		
c. Hearing Deficit		
d. Ear Infection		
e. Disorders of Eye Movements (Exotropia, Strabismus, Nystagmus)		
f. Glaucoma		
14. Metabolic		
a. Hypothyroidism		
b. Hyperthyroidism		
c. Diabetes Mellitus		
d. Pituitary Problem		
15. Skin Conditions		
a. Decubitus		

Customer Name Person ID

b. Acne		
16. Psychiatric		
a. Major Depression		
b. Bipolar Disorder		
c. Schizophrenia		
d. Behavioral Disorders		
e. Conduct Disorder		
f. Alcohol Abuse		
g. Drug Abuse		

Diagnosis

ICD-10	a.					
ICD-10	b.					
ICD-10	c.					
ICD-10	d.					
ICD-10	e.					

	Category	Condition	Diagnosis
MAJOR DIAGNOSES			

Comments:	

Customer Name

Person ID

B. MEDICATIONS/TREATMENTS
Include PRN medications/treatments received in last thirty (30) days and any other current medications/treatments. Include dosage, frequency, duration, route, and form for each medication.

MEDICATIONS / TREATMENTS / COMMENTS
1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.
16.
17.
18.
19.
20.

Comments:	

Customer Name Person ID

C. SERVICES AND TREATMENTS
Mark appropriate answers. Provide explanation when "N" is marked.

1. Injections/IV	Receives	Needs	Frequency of Service			
			Cont.	Daily	Wkly.	Monthly
a. Intravenous Infusion Therapy	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
b. Intramuscular/Subcutaneous Injections	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M

Comments:	

2. Medications/Monitoring	Receives	Needs	Frequency of Service			
			Cont.	Daily	Wkly.	Monthly
a. Drug Regulation	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
b. Drug Administration	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M

Comments:	

3. Dressings	Receives	Needs	Frequency of Service			
			Cont.	Daily	Wkly.	Monthly
a. Decubitus Care	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
b. Wound Care	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
c. Non-Bladder/Bowel Ostomy Care	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M

Comments:	

4. Feedings	Receives	Needs	Frequency of Service			
			Cont.	Daily	Wkly.	Monthly
a. Parenteral Feedings/TPN	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
b. Tube Feedings	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M

Customer Name

Person ID

Comments:	

5. Bladder/Bowel	Receives	Needs	Frequency of Service			
			Cont.	Daily	Wkly.	Monthly
a. Catheter Care	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
b. Ostomy Care	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
c. Bowel Dilatation	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M

Comments:	

(Select appropriate answers) Provide explanation when (N) is marked.

6. Respiratory	Receives	Needs	Frequency of Service			
			Cont.	Daily	Wkly.	Monthly
a. Suctioning	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
b. Oxygen	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
c. SVN	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
d. Ventilator	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
e. Trach Care	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
f. Postural Drainage	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
g. Apnea Monitor	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M

Comments:	

7. Therapies	Receives	Needs	Frequency of Service			
			Cont.	Daily	Wkly.	Monthly
a. Physical Therapy	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
b. Occupational Therapy	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
c. Speech Therapy	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
d. Respiratory Therapy	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M

Customer Name Person ID

e. Alcohol/Drug Treatment	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
f. Vocational Rehabilitation	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
g. Individual/Group Therapy	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
h. Behavioral Modification Program	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M

Comments:	

8. Rehabilitative Nursing	**Receives**	**Needs**	**Frequency of Service**			
			Cont.	**Daily**	**Wkly.**	**Monthly**
a. Teaching/Training Program	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
b. Bowel/Bladder Retraining	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
c. Turning & Positioning	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
d. Range of Motion	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
e. Other Rehab Nursing (specify)	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M

Comments:	

9. Other	**Receives**	**Needs**	**Frequency of Service**			
			Cont.	**Daily**	**Wkly.**	**Monthly**
a. Peritoneal Dialysis	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
b. Hemodialysis	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
c. Chemotherapy/Radiation	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
d. Restraints	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
e. Fluid Intake/Output	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
f. Other (specify)	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M

Comments:	

Customer Name

Person ID

D. MEDICAL STABILITY

1. Record the number of acute hospitalizations that occurred over the past year		
2. Currently requires direct care staff or caregiver **trained in special health care procedures** (e.g., ostomy care, positioning, adaptive devices, G-tube feedings, SVN, seizure precautions [if current seizure activity], diabetic monitoring)	☐ YES	☐ NO
3. Currently **requires special diet** planned by dietitian, nutritionist, or nurse (e.g., high fiber, low calorie, low sodium, pureed)	☐ YES	☐ NO

Comments:	

Customer Name

Person ID

E. SENSORY FUNCTIONS
(Select appropriate answers)

Impairment	Unable to Assess/ No Impairment	Minimum Impairment	Moderate Impairment	Severe Impairment
1. Hearing Ability to perceive sounds	☐ 0	☐ 1	☐ 2	☐ 3
2. Vision Ability to perceive objects visually	☐ 0	☐ 1	☐ 2	☐ 3

Comments:	

Customer Name

Person ID

F. SUMMARY EVALUATION

PCP: and other informants names for Personal Contacts entries

ELIGIBILITY REVIEW REQUESTED?	☐ Yes ☐ No	DATE	

Signature	Title	Date
Signature and Title	Title	Date

Completion Time (minutes)		Travel Time (minutes)	

PreAdmission Screening

Developmentally Disabled - Ages 6-11

Case Information			
AHCCCS ID		Medicare Part D	☐ Yes ☐ No
Person/App ID:			
Type of PAS	☐ Initial ☐ Reassessment ☐ Posthumous		
PSE Name			
PSE Phone			

I. INTAKE INFORMATION

Customer Information			
PAS Date		PAS Time	
Customer Name:			
Age			
Birthdate			
Gender	☐ Male ☐ Female		
Location at time of Assessment			
Telephone Number			

DD Status:	☐ Not DD ☐ Potential DD ☐ DD in NF ☐ DD

Prior Quarter:	Month 1:		Month 2:		Month 3:	

Authorized Representative	
Name	
Telephone Number	

Physical Measurements	
Height	Feet Inches
Weight	lbs.
Birth Weight (DD 0-5)	lbs.
Gestational Age (DD 0-5)	

Revised May 2017

Customer Name Person ID

Additional Information			
1.	Is customer currently hospitalized or in an intensive rehabilitation facility?	☐ YES	☐ NO
2.	If in an acute care facility, is discharge imminent (within 7 days)?	☐ YES	☐ NO
	Projected discharge date:		
3.	Ventilator Dependent?	☐ YES	☐ NO
4.	Number of Emergency Room visits in last 6 months(EPD)		
5.	Number of Hospitalizations in last 6 months(last year for DD 0-5)		
6.	Number of Falls in last 90 days(EPD)		

Personal Contacts					
Contact #1					
Name					
Relationship					
Address					
City		State		Zip Code	
Phone Number(s)					
Contact #2					
Name					
Relationship					
Address					
City		State		Zip Code	
Phone Number(s)					
Contact #3					
Name					
Relationship					
Address					
City		State		Zip Code	
Phone Number(s)					
Contact #4					
Name					
Relationship					

Customer Name

Person ID

Address					
City		State		Zip Code	
Phone Number(s)					

Customer Name Person ID

II. FUNCTIONAL ASSESSMENT

A. MOTOR/INDEPENDENT LIVING SKILLS DOMAIN (CONSIDER ONE YEAR)

Circle the number corresponding to the appropriate answer. Give credit for the highest level of skill which is **performed at least 75 percent of the time**. Only give credit for **what the individual actually does**, not for what the individual "can do" or "might be able to do". When a question groups many activities, rate the individual on his/her ability to complete the task as a whole. **Rate activities/behaviors as generally performed over the last year with emphasis on current functioning**.

ROLLING AND SITTING

The Customer's ability to roll and sit independently. "Sitting with support" may include either the physical support of another person or other types of support such as pillows or a specially made chair. Indicate only one answer that best describes the highest level of skill attained.

☐	0	Assumes and maintains sitting position independently
☐	1	Sits without support for at least five (5) minutes
☐	2	Maintains sitting position with minimal support for at least five (5) minutes
☐	3	Rolls from front to back and back to front
☐	4	Rolls from front to back only
☐	5	Rolls from side to side
☐	6	Lifts head and chest using arm support when lying on stomach
☐	7	Lifts head when lying on stomach
☐	8	Does not lift head when lying on stomach

Comments:	

CRAWLING AND STANDING

"Support" may include the help of another person or mechanical support such as holding on to furniture

☐	0	Stands well alone, balances well for at least five (5) minutes
☐	1	Stands unsteadily alone for at least one (1) minute
☐	2	Stands with support for at least one (1) minute
☐	3	Pulls to a standing position
☐	4	Crawls, creeps, or scoots
☐	5	Does not crawl, creep, or scoot

Customer Name | Person ID

Comments:	

AMBULATION

Use of special assistive devices (e.g., canes, walkers, braces) should not affect rating.

☐ 0	Walks well alone for normal distances and on all terrains
☐ 1	Walks well alone for a short distance (10 - 20 feet); balances well; distance limitation may be due to terrain.
☐ 2	Walks unsteadily alone for a short distance (10 - 20 feet)
☐ 3	Walks only with physical assistance from others
☐ 4	Does not walk

Comments:	

CLIMBING STAIRS OR RAMPS

Rate use of ramps if individual uses wheelchair or other walking device which is not used on stairs.

☐ 0	Moves up and down stairs or ramps without need for handrail
☐ 1	Moves up and down stairs or ramps with handrail independently
☐ 2	Moves up and down stairs or ramps with physical assistance
☐ 3	Does not move up or down stairs or ramps

Comments:	

WHEELCHAIR MOBILITY

Wheelchair may be motorized or manual.

☐ 0	Wheelchair is not used or moves wheelchair independently
☐ 1	Moves wheelchair independently, but with some difficulty (may move wheelchair with some bumping and/or difficulty in steering)
☐ 2	Individual needs some, but not total assistance, in moving wheelchair
☐ 3	Needs total assistance for moving wheelchair

Comments:	

Customer Name Person ID

DRESSING

Putting on and removing regular articles of clothing, (e.g., skirt, blouse, shirt, pants, dress, shorts, socks and shoes, underwear). This does NOT include braces, nor does it reflect the individual's ability to match colors or choose clothing appropriate for the weather. Do NOT include care of clothing.

☐ 0	Completes the task independently
☐ 1	Able to complete the task with verbal prompts, cue by touch, materials setup, or other modifications (e.g., laying-out of clothes)
☐ 2	Requires hands-on assistance to initiate/complete the task (e.g., help with fasteners)
☐ 3	Is not able to actively perform any part of this task but can physically participate
☐ 4	Requires total hands-on assistance and does not physically participate

Comments:	

PERSONAL HYGIENE

Those tasks involved in basic grooming, including brushing teeth, washing face and hands, combing or brushing hair, use of deodorant, nail care.

☐ 0	Completes the task independently
☐ 1	Able to complete the task with verbal prompts, cue by touch, materials setup, or other modifications
☐ 2	Requires hands-on assistance to initiate/complete the task (e.g., put toothpaste on toothbrush Or hands on assistance to comb hair)
☐ 3	This task must be done for the individual but individual can physically participate
☐ 4	Requires total hands-on assistance and does not physically participate

Comments:	

BATHING OR SHOWERING

Washing body (e.g., bath, shower, sponge bath, or bed bath) includes shampooing hair.

☐ 0	Completes the task independently
☐ 1	Requires verbal prompts for washing and drying or help with drawing water, checking temperature
☐ 2	Requires extensive verbal prompts or limited/occasional hands-on assistance to complete task (e.g. shampooing.)
☐ 3	Requires hands-on assistance during entire bathing process but can physically participate.
☐ 4	Requires total hands on assistance and does not physically participate

Customer Name Person ID

Comments:	

Toileting

Involves initiating and caring for those bodily functions involving bowel and bladder control. NOTE: Do NOT rate ability to wash hands after toileting or the ability to transfer on and off the toilet.

☐ 0	Completes the task independently
☐ 1	Able to complete the task with verbal prompts, cue by touch, materials setup, or other modifications
☐ 2	Can indicate the need for toileting, but requires hands-on assistance to complete/perform the task (e.g., help with fasteners, toilet paper, flushing the toilet)
☐ 3	Does not indicate the need for toileting, but usually avoids accidents through a toileting schedule (e.g., periodic tripping by caregiver) and requires hands-on assistance to complete/perform the task.
☐ 4	Does not perform nor indicate the need for toileting and requires total caregiver intervention.

Comments:	

LEVEL OF BLADDER CONTROL

Rate typical/usual control level.

☐ 0	Complete control (no more than two accidents per year)
☐ 1	Some bladder control; accidents occur not as often as seven times per week (day or night)
☐ 2	Some bladder control: accidents occur at least seven times per week (day or night)
☐ 3	No control

Comments:	

ORIENTATION TO FAMILIAR SETTINGS FAMILIAR TO INDIVIDUAL

(e.g., in home or school setting)

☐ 0	No problem in this area; knows way in all areas of familiar settings independently
☐ 1	Knows way in part of, but not all of, familiar settings without prompting or physical assistance (e.g., to bathroom, bedroom, or cafeteria)
☐ 2	Knows way from room to room within familiar settings with prompting: does not need physical assistance
☐ 3	Does not know way from room to room within familiar settings without physical assistance

Customer Name

Person ID

Comments:	

Customer Name Person ID

B. COMMUNICATION DOMAIN

EXPRESSIVE VERBAL COMMUNICATION

Ability to communicate thoughts verbally with words or sounds.

☐	0	Carries on a complex or detailed conversation
☐	1	Carries on a simple brief conversation, such as talking about everyday events (e.g., the clothes you are wearing)
☐	2	Uses simple two-word phrases (e.g., "I go," "give me")
☐	3	Uses a few simple words and associates words with appropriate objects, such as names of common objects and activities
☐	4	Uses no words, but does use a personal language or guttural sounds to communicate very basic concepts
☐	5	Makes no sounds which are for communication; may babble, cry or laugh

Comments:	

CLARITY OF COMMUNICATION

Ability to speak in a recognizable language or use a formal symbolic substitute, such as American Sign Language or alternate communication system. If has more than one form of communication, score on what is best understood.

☐	0	Uses speech in a normal manner intelligible to an unfamiliar listener; no special effort is required to understand this individual.
☐	1	Speech understood by strangers with some difficulty; unfamiliar individuals can understand, but due to the lack of clarity, not all of the words are understood and the listener must pay close attention in order to understand
☐	2	Uses a non-speech communication system that is understood by an unfamiliar listener (e.g., writing, communication board/device, gestures, or pointing)
☐	3	Speech or other communication system understood only by either those who know the person well or who are trained in the alternate communication system
☐	4	Does not communicate using a recognizable language or formal symbolic substitutions

Comments:	

Customer Name Person ID

C. BEHAVIORAL DOMAIN

AGGRESSION

Physical attacks on others, including throwing objects, punching, biting, pushing, pinching, pulling hair, scratching. Do NOT include self-injurious behaviors, threatening or property destruction.

☐ 0	Problem does not occur or occurs at a level not requiring intervention
☐ 1	Minor problem; occasional aggression which requires some additional supervision in a few situations and/or verbal redirection
☐ 2	Moderate problem; frequent aggression that requires close supervision and/or physical redirection
☐ 3	Serious problem; constant aggression that requires close supervision and/or constant verbal or physical interruption
☐ 4	Extremely Urgent problem; has had episode(s) causing injury in the last year, requires close supervision and physical interruption

Comments:	

VERBAL OR PHYSICAL THREATENING

Threatens to do harm to self, others or objects. Do NOT Include actual acts of physical aggression or self-injury.

☐ 0	Problem does not occur or occurs at a level not requiring intervention
☐ 1	Minor problem; makes occasional threats which are not taken seriously and do not frighten others nor result in aggression from others; requires some additional supervision and/or verbal redirection
☐ 2	Moderate problem; makes frequent threats that sometimes cause fear and/or aggression from others; requires close supervision and physical redirection
☐ 3	Serious problem; makes constant threats that sometimes cause fear and/or aggression from others; requires close supervision and/or constant verbal or physical interruption
☐ 4	Extremely Urgent problem; has had serious incident(s) in the last year; incidents always generate fear and/or are likely to result in aggression from others; requires close supervision and physical interruption

Comments:	

Customer Name Person ID

SELF-INJURIOUS BEHAVIOR

Biting, scratching, putting inappropriate objects into ear, mouth, or nose, repeatedly picking at skin, head slapping or banging.

☐ 0	Problem does not occur or occurs at a level not requiring intervention
☐ 1	Minor problem; occasional incidents which require some additional supervision in a few situations and/or occasional verbal redirection
☐ 2	Moderate problem; frequent incidents that require close supervision and/or physical redirection
☐ 3	Serious problem; constant incidents; requires close supervision and/or verbal or physical interruption
☐ 4	Extremely Urgent problem; has had episode(s) causing serious injury requiring immediate medical attention in the last year, requires close supervision and physical interruption

Comments:	

RUNNING OR WANDERING AWAY

Leaves situation or environment inappropriately without either notifying or receiving permission from appropriate individuals as would normally be expected.

☐ 0	Problem does not occur or occurs at a level not requiring intervention
☐ 1	Minor problem; occasional occurrences which may not pose a safety problem but do require some additional supervision and/or Verbal redirection
☐ 2	Moderate problem; frequent occurrences pose minor safety issues to self or others; requires close supervision and/or physical redirection
☐ 3	Serious problem; constant occurrences poses safety issues to self or others; requires close supervision and physical redirection
☐ 4	Extremely Urgent problem; occurs constantly or poses a very serious threat to the safety of self or others requires close supervision and locked area.

Comments:	

DISRUPTIVE BEHAVIORS

Inappropriately interferes with others, including caregivers, or own activities through behaviors such as: excessive whining or crying, screaming, persistent pestering or teasing, constant demand for attention, repetitious motions. Excessive hyperactivity, repetitive/stereotypic behaviors, or temper tantrums that interfere with others' or own activities should be rated here. Do NOT include verbal threatening or acts of physical aggression to self or others.

☐ 0	Problem does not occur or occurs at a level not requiring intervention
☐ 1	Minor problem; occurs occasionally and requires occasional intervention

Customer Name

Person ID

☐ 2	Moderate problem; occurs frequently and requires frequent intervention
☐ 3	Serious problem; occurs constantly and requires constant intervention

Comments:	

Customer Name Person ID

III. MEDICAL ASSESSMENT

A. MEDICAL CONDITIONS

A = Acute, C = Chronic, H = History (Check appropriate answers)

		A, C, H	Comments	Major Dx
Neurological/Congenital/Developmental Conditions				
1. Cerebral Palsy				
a.	Diplegia	☐ A ☐ C ☐ H		
b.	Hemiplegia	☐ A ☐ C ☐ H		
c.	Quadriplegia	☐ A ☐ C ☐ H		
d.	Paraplegia	☐ A ☐ C ☐ H		
e.	Unspecified Cerebral Palsy	☐ A ☐ C ☐ H		
2. Epilepsy/Seizure Disorder NOTE: Indicate DATE of LAST Seizure and FREQUENCY of *EACH TYPE* of Seizure in Comments.				
a.	Generalized non-convulsive (absence, petit mal, minor, akinetic, atonic.)	☐ A ☐ C ☐ H		
b.	Generalized convulsive (clonic, myoclonic, tonic, tonic-clonic, grand mal, major)	☐ A ☐ C ☐ H		
c.	Unspecified (complex partial, psychomotor, temporal lobe, simple partial, Jacksonian, epilepsia partialis, continual	☐ A ☐ C ☐ H		
3. Mental Intellectual/Cognitive Disability				
a.	Mild Mental Intellectual/Cognitive Disability	☐ A ☐ C ☐ H		
b.	Moderate Intellectual/Cognitive Disability	☐ A ☐ C ☐ H		
c.	Severe Intellectual/Cognitive Disability	☐ A ☐ C ☐ H		

d.	Profound Intellectual/Cognitive Disability	☐ A ☐ C ☐ H		
e.	Unspecified Intellectual/Cognitive Disability	☐ A ☐ C ☐ H		
f.	Borderline Intelligence	☐ A ☐ C ☐ H		
4. Autism				
a.	Autism	☐ A ☐ C ☐ H		
b.	Pervasive Developmental Disorder	☐ A ☐ C ☐ H		
c.	Autistic-Like Behaviors	☐ A ☐ C ☐ H		
5. Attention Deficit Disorder (ADD)				
a.	ADD with Hyperactivity	☐ A ☐ C ☐ H		
b.	ADD without Hyperactivity	☐ A ☐ C ☐ H		
6. Other Neurological / Congenital / Developmental Conditions				
a.	Prematurity	☐ A ☐ C ☐ H		
b.	Fetal Alcohol Syndrome	☐ A ☐ C ☐ H		
c.	Developmental Delays	☐ A ☐ C ☐ H		
d.	Hydrocephaly	☐ A ☐ C ☐ H		
e.	Macrocephaly	☐ A ☐ C ☐ H		
f.	Microcephaly	☐ A ☐ C ☐ H		
g.	Meningitis	☐ A ☐ C ☐ H		
h.	Encephalopathy	☐ A ☐ C ☐ H		
i.	Spina Bifida	☐ A ☐ C ☐ H		
j.	Genetic Anomalies	☐ A ☐ C ☐ H		
k.	Down's Syndrome	☐ A ☐ C ☐ H		
l.	Congenital Anomalies	☐ A ☐ C ☐ H		
m.	Near Drowning	☐ A ☐ C ☐ H		
n.	Head Trauma	☐ A ☐ C ☐ H		
o.	Dementia (Organic Brain Syndrome)	☐ A ☐ C ☐ H		

Customer Name Person ID

Other Medical Conditions				
7. Hematologic				
a.	Anemia	☐ A ☐ C ☐ H		
b.	HIV Positive	☐ A ☐ C ☐ H		
c.	AIDS	☐ A ☐ C ☐ H		
d.	Leukemia	☐ A ☐ C ☐ H		
e.	Hepatitis	☐ A ☐ C ☐ H		
8. Cardiovascular				
a.	CHF	☐ A ☐ C ☐ H		
b.	Hypertension	☐ A ☐ C ☐ H		
c.	Congenital Anomalies of Heart	☐ A ☐ C ☐ H		
d.	Cardiac Murmurs	☐ A ☐ C ☐ H		
e.	Rheumatic Heart Disease	☐ A ☐ C ☐ H		
9. Musculoskeletal				
a.	Arthritis	☐ A ☐ C ☐ H		
b.	Fracture	☐ A ☐ C ☐ H		
c.	Contracture	☐ A ☐ C ☐ H		
d.	Anomalies of Spine (Kyphoscoliosis, Scoliosis, Lordosis)	☐ A ☐ C ☐ H		
e.	Paralysis	☐ A ☐ C ☐ H		
10. Respiratory				
a.	Asthma	☐ A ☐ C ☐ H		
b.	Bronchitis	☐ A ☐ C ☐ H		
c.	Pneumonia	☐ A ☐ C ☐ H		
d.	Respiratory Distress Syndrome	☐ A ☐ C ☐ H		
e.	Bronchopulmonary Dysplasia	☐ A ☐ C ☐ H		
f.	Cystic Fibrosis	☐ A ☐ C ☐ H		
g.	Reactive Airway Disease	☐ A ☐ C ☐ H		

h.	Tracheomalacia	☐ A ☐ C ☐ H		
i.	Congenital Pulmonary Problems	☐ A ☐ C ☐ H		
11. Genitourinary				
a.	Urinary Tract Infection	☐ A ☐ C ☐ H		
12. Gastrointestinal				
a.	Constipation	☐ A ☐ C ☐ H		
b.	Ulcers	☐ A ☐ C ☐ H		
c.	Hernia	☐ A ☐ C ☐ H		
d.	Esophagitis	☐ A ☐ C ☐ H		
e.	Gastroesophageal Reflux	☐ A ☐ C ☐ H		
13. EENT				
a.	Blindness	☐ A ☐ C ☐ H		
b.	Cataract	☐ A ☐ C ☐ H		
c.	Hearing Deficit	☐ A ☐ C ☐ H		
d.	Ear Infection	☐ A ☐ C ☐ H		
e.	Disorders of Eye Movements (Exotropia, Strabismus, Nystagmus)	☐ A ☐ C ☐ H		
f.	Glaucoma	☐ A ☐ C ☐ H		
14. Metabolic				
a.	Hypothyroidism	☐ A ☐ C ☐ H		
b.	Hyperthyroidism	☐ A ☐ C ☐ H		
c.	Diabetes Mellitus	☐ A ☐ C ☐ H		
d.	Pituitary Problem	☐ A ☐ C ☐ H		
15. Skin Conditions				
a.	Decubitus	☐ A ☐ C ☐ H		
b.	Acne	☐ A ☐ C ☐ H		
16. Psychiatric				
a.	Major Depression	☐ A ☐ C ☐ H		
b.	Bipolar Disorder	☐ A ☐ C ☐ H		
c.	Schizophrenia	☐ A ☐ C ☐ H		

Customer Name

Person ID

d.	Behavioral Disorders	☐ A ☐ C ☐ H		
e.	Conduct Disorder	☐ A ☐ C ☐ H		
f.	Alcohol Abuse	☐ A ☐ C ☐ H		
g.	Drug Abuse	☐ A ☐ C ☐ H		

17. Other Diagnoses									Diagnosis
ICD-10	a.							☐ A ☐ C ☐ H	
ICD-10	b.							☐ A ☐ C ☐ H	
ICD-10	c.							☐ A ☐ C ☐ H	
ICD-10	d.							☐ A ☐ C ☐ H	
ICD-10	e.							☐ A ☐ C ☐ H	

	Category	**Condition**	**Diagnosis**
MAJOR DIAGNOSES			

Comments:	

Customer Name Person ID

B. MEDICATIONS/TREATMENTS
(Include PRN medications/treatments received in last thirty (30) days and any other current medications/treatments). **Include dosage, frequency, duration, route, form for each medication and average use of major PRN medications.**

	MEDICATIONS/TREATMENTS/COMMENTS	RX	OTC
1.		☐	☐
2.		☐	☐
3.		☐	☐
4.		☐	☐
5.		☐	☐
6.		☐	☐
7.		☐	☐
8.		☐	☐
9.		☐	☐
10.		☐	☐
11.		☐	☐
12.		☐	☐
13.		☐	☐
14.		☐	☐
15.		☐	☐
16.		☐	☐
17.		☐	☐
18.		☐	☐
19.		☐	☐
20.		☐	☐

Comments:	

Customer Name Person ID

C. SERVICES AND TREATMENTS
(Mark appropriate answers) Provide explanation when (N) is circled

			Frequency of Service			
1. Injections/IV	Receives	Needs	Cont.	Daily	Wkly.	Monthly
a. Intravenous Infusion Therapy	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
b. Intramuscular/Subcutaneous Injections	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M

Comments:	

2. Medications/Monitoring	Receives	Needs	Cont.	Daily	Wkly.	Monthly
a. Drug Regulation	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
b. Drug Administration	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M

Comments:	

3. Dressings	Receives	Needs	Cont.	Daily	Wkly.	Monthly
a. Decubitus Care	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
b. Wound Care	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
c. Non-Bladder/Bowel Ostomy Care	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M

Comments:	

4. Feedings	Receives	Needs	Cont.	Daily	Wkly.	Monthly
a. Parenteral Feedings/TPN	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
b. Tube Feedings	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M

Comments:	

5. Bladder/Bowel	Receives	Needs	Cont.	Daily	Wkly.	Monthly

Customer Name Person ID

a. Catheter Care	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
b. Ostomy Care	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
c. Bowel Dilatation	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M

Comments:	

				Frequency of Service		
6. Respiratory	Receives	Needs	Cont.	Daily	Wkly.	Monthly
a. Suctioning	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
b. Oxygen	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
c. SVN	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
d. Ventilator	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
e. Trach Care	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
f. Postural Drainage	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
g. Apnea Monitor	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M

Comments:	

7. Therapies	Receives	Needs	Cont.	Daily	Wkly.	Monthly
a. Physical Therapy	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
b. Occupational Therapy	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
c. Speech Therapy	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
d. Respiratory Therapy	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
e. Alcohol/Drug Treatment	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
f. Vocational Rehabilitation	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M

Customer Name Person ID

g. Individual/Group Therapy	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
h. Behavioral Modification Program	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M

Comments:	

8. Rehabilitative Nursing	Receives	Needs	Cont.	Daily	Wkly.	Monthly
a. Teaching/Training Program	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
b. Bowel/Bladder Retraining	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
c. Turning & Positioning	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
d. Range of Motion	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
e. Other Rehab Nursing (specify)	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M

Comments:	

9. Other	Receives	Needs	Cont.	Daily	Wkly.	Monthly
a. Peritoneal Dialysis	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
b. Hemodialysis	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
c. Chemotherapy/Radiation	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
d. Restraints	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
e. Fluid Intake/Output	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
f. Other (specify)	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M

Comments:	

Customer Name Person ID

D. MEDICAL STABILITY

1. Record the number of acute hospitalizations that occurred over the past year	
2. Currently requires direct care staff or caregiver **trained in special health care procedures** (e.g., ostomy care, positioning, adaptive devices, G-tube feedings, SVN, seizure precautions [if current seizure activity], diabetic monitoring)	☐ YES ☐ NO
3. Currently **requires special diet** planned by dietitian, nutritionist, or nurse (e.g., high fiber, low calorie, low sodium, pureed)	☐ YES ☐ NO

Comments:	

Customer Name

Person ID

E. SENSORY FUNCTIONS
(mark appropriate answers)

Impairment	Unable to Assess/ No Impairment	Minimum Impairment	Moderate Impairment	Severe Impairment
1. **Hearing** Ability to perceive sounds	☐ 0	☐ 1	☐ 2	☐ 3
2. **Vision** Ability to perceive objects visually	☐ 0	☐ 1	☐ 2	☐ 3

Comments:	

Customer Name

Person ID

F. SUMMARY EVALUATION

PCP: and other informants names for Personal Contacts entries

ELIGIBILITY REVIEW REQUESTED?	☐ Yes ☐ No	DATE	

Signature	Title	Date
Signature and Title	Title	Date

Completion Time (minutes)		Travel Time (minutes)	

PreAdmission Screening Tool

Developmentally Disabled/Physically Disabled 12+

Case Information			
AHCCCS ID		Medicare Part D	☐ Yes ☐ No
Person/App ID:			
Type of PAS	☐ Initial ☐ Reassessment ☐ Posthumous		
PSE Name			
PSE Phone			

I. INTAKE INFORMATION

Customer Information			
PAS Date		PAS Time	
Customer Name:			
Age			
Birthdate			
Gender	☐ Male ☐ Female		
Location at time of Assessment			
Telephone Number			

DD Status:	☐ Not DD ☐ Potential DD ☐ DD in NF ☐ DD

Prior Quarter:	Month 1:		Month 2:		Month 3:	

Authorized Representative	
Name	
Telephone Number	

Physical Measurements	
Height	Feet Inches
Weight	lbs.
Birth Weight (DD 0-5)	lbs.
Gestational Age (DD 0-5)	

Additional Information			
1.	Is customer currently hospitalized or in an intensive rehabilitation facility?	☐ YES	☐ NO

I. Intake Information

PreAdmission Screening
Developmentally Disabled /Physically Disabled
12+

Customer Name

Person ID

2.	If in an acute care facility, is discharge imminent (within 7 days)?	☐ YES	☐ NO
	Projected discharge date:		
3.	Ventilator Dependent?	☐ YES	☐ NO
4.	Number of Emergency Room visits in last 6 months(EPD)		
5.	Number of Hospitalizations in last 6 months(last year for DD 0-5)		
6.	Number of Falls in last 90 days(EPD)		

Personal Contacts					
Contact #1					
Name					
Relationship					
Address					
City		State		Zip Code	
Phone Number(s)					
Contact #2					
Name					
Relationship					
Address					
City		State		Zip Code	
Phone Number(s)					
Contact #3					
Name					
Relationship					
Address					
City		State		Zip Code	
Phone Number(s)					
Contact #4					
Name					
Relationship					
Address					
City		State		Zip Code	

I. Intake Information

PreAdmission Screening
Developmentally Disabled /Physically Disabled
12+

Customer Name

Person ID

Phone Number(s)	

Customer Name Person ID

II. FUNCTIONAL ASSESSMENT

A. MOTOR/INDEPENDENT LIVING SKILLS DOMAIN (CONSIDER ONE YEAR)

Rate activities/behaviors as generally performed over the last year with emphasis on current functioning.

Give credit for the highest level of a skill which is **performed at least 75 percent of the time**. Only give credit for what the individual actually does, not for what the individual "can do" or "might be able to do." When a question groups many activities, rate the individual on his/her ability to complete the task as a whole.

HAND USE

If individual has one hand or use of one hand only, rate better hand.

☐ 0	Uses fingers independently of each other
☐ 1	Uses thumbs and fingers of hand(s) in opposition
☐ 2	Uses raking motion or grasps with hand(s)
☐ 3	No functional use of hand(s)

Comments:	

AMBULATION

Use of special assistive devices (e.g., canes, walkers, braces) should not affect rating.

☐ 0	Walks well alone for normal distances and on all terrains
☐ 1	Walks well alone for a short distance (10 - 20 feet); balances well; distance limitation may be due to terrain.
☐ 2	Walks unsteadily alone for a short distance (10 - 20 feet)
☐ 3	Walks only with physical assistance from others
☐ 4	Does not walk

Comments:	

WHEELCHAIR MOBILITY

Wheelchair may be motorized or manual.

☐ 0	Wheelchair is not used or moves wheelchair independently
☐ 1	Moves wheelchair independently, but with some difficulty (may move wheelchair with some bumping and/or difficulty in steering)

Customer Name | Person ID

☐ 2	Individual needs some, but not total assistance, in moving wheelchair
☐ 3	Needs total assistance for moving wheelchair

Comments:	

TRANSFER

Degree of human assistance necessary on a consistent basis for transfer, such as assistance in getting into wheelchair, getting on and off toilet, into and out of bed, in and out of shower/tub. Rate these items ONLY with regard to the need for human intervention, NOT with regard to the need for assistive devices. Ability to transfer in and out of a vehicle is not rated.

☐ 0	No problem in this area; does transfer self independently but may require use of assistive devices
☐ 1	Needs hands-on physical guidance, but does not have to be physically lifted, OR needs supervision with more than half of transferring activities
☐ 2	Needs to be physically lifted or moved, but can participate physically
☐ 3	Must be totally transferred by one or more persons OR is bedfast

Comments:	

EATING/DRINKING

Rate tasks involved in eating food and/or drinking beverages served.

☐ 0	Completes the task independently
☐ 1	Able to complete the task with verbal prompts, cue by touch, materials setup, or other modifications (e.g., plate guard, built-up spoon, cutting of food)
☐ 2	Requires hands-on assistance to initiate/complete the task (e.g., place utensils in hand, hand-over-hand scooping, or other assistance)
☐ 3	Does not perform this task even when assisted; is fed
☐ 4	Individual is tube fed

Comments:	

Customer Name

Person ID

DRESSING

Putting on and removing regular articles of clothing, (e.g., skirt, blouse, shirt, pants, dress, shorts, socks and shoes, underwear). This does NOT include braces, nor does it reflect the individual's ability to match colors or choose clothing appropriate for the weather. Do NOT include care of clothing.

☐ 0	Completes the task independently
☐ 1	Able to complete the task with verbal prompts, cue by touch, materials setup, or other modifications (e.g., laying-out of clothes)
☐ 2	Requires hands-on assistance to initiate/complete the task (e.g., help with fasteners)
☐ 3	Is not able to actively perform any part of this task but can physically participate
☐ 4	Requires total hands-on assistance and does not physically participate

Comments:	

PERSONAL HYGIENE

Those tasks involved in basic grooming, including hair care, brushing teeth, washing face and hands, shaving, nail care, menses care and use of deodorant.

☐ 0	Completes the task independently
☐ 1	Able to complete the task with verbal prompts, cue by touch, materials setup, or other modifications
☐ 2	Requires hands-on assistance to initiate/complete the task (e.g., put toothpaste on toothbrush or hands on assistance to comb hair).
☐ 3	This task must be done for the individual but individual can physically participate
☐ 4	Requires total hands-on assistance and does not physically participate

Comments:	

BATHING OR SHOWERING

Washing body (e.g., bath, shower, sponge bath, or bed bath) includes shampooing hair

☐ 0	Completes the task independently
☐ 1	Requires verbal prompts for washing and drying or help with drawing water, checking temperature
☐ 2	Requires extensive verbal prompts or limited/occasional hands-on assistance to complete task (e.g.

	shampooing.)
☐ 3	Requires hands-on assistance during entire bathing process but can physically participate
☐ 4	Requires total hands on assistance and does not physically participate

Comments:	

FOOD PREPARATION

Preparation of simple meals, such as sandwiches, cold cereal, frozen dinners, eggs. Rate the item independent of the heating sources used (e.g., microwave, regular oven, stove top – may use only the microwave and still be independent).

☐ 0	Completes the task independently
☐ 1	Able to complete the task with verbal prompts, cue by touch, materials setup, or other modifications
☐ 2	Requires hands-on assistance to initiate/complete the task
☐ 3	Does not perform this task, even when assisted; the task must be done for the person

Comments:	

COMMUNITY MOBILITY

Movement around the neighborhood or community, including accessing buildings, stores, and restaurants, and using any mode of transportation, such as walking, wheelchair, cars, buses, taxis, bicycles.

☐ 0	Moves about the neighborhood or community independently without assistance
☐ 1	Moves about the neighborhood or community independently for a complex trip (several stops, unfamiliar places, bus transfers) with instructions and/or directions
☐ 2	Moves about the neighborhood or community independently for a simple direct trip and/or familiar locations with instructions and/or directions
☐ 3	Moves about the neighborhood or community with some physical assistance and/or occasional accompaniment
☐ 4	Moves about the neighborhood or community only with accompaniment

Comments:	

Customer Name

Person ID

TOILETING

Involves initiating and caring for those bodily functions involving bowel and bladder control. NOTE: Do NOT rate ability to wash hands after toileting or the ability to transfer on and off the toilet.

☐	0	Completes the task independently
☐	1	Able to complete the task with verbal prompts, cue by touch, materials setup, or other modifications
☐	2	Can indicate the need for toileting, but requires hands-on assist to complete/perform the task (e.g., help with fasteners, toilet paper, flushing the toilet)
☐	3	Does not indicate the need for toileting, but usually avoids accidents through a toileting schedule (e.g., periodic tripping by caregiver) and requires hands-on assist to complete/perform the task
☐	4	Does not perform nor indicate the need for toileting and requires total caregiver intervention

Comments:	

If bladder accidents occur, how frequently? Times per ☐ Day ☐ Month ☐ Year

Customer Name

Person ID

B. COMMUNICATION/COGNITIVE DOMAIN

EXPRESSIVE VERBAL COMMUNICATION

Ability to communicate thoughts verbally with words or sounds.

☐ 0	Carries on a complex or detailed conversation
☐ 1	Carries on a simple brief conversation, such as talking about everyday events (e.g., the clothes you are wearing)
☐ 2	Uses simple two-word phrases (e.g., “I go,” “give me”)
☐ 3	Uses a few simple words and associates words with appropriate objects, such as names of common objects and activities
☐ 4	Uses no words, but does use a personal language or guttural sounds to communicate very basic concepts
☐ 5	Makes no sounds which are for communication; may babble, cry or laugh

Comments:	

CLARITY OF COMMUNICATION

Ability to speak in a recognizable language or use a formal symbolic substitute, such as American Sign Language or alternate communication system. If has more than one form of communication, score on what is best understood.

☐ 0	Uses speech in a normal manner intelligible to an unfamiliar listener; no special effort is required to understand this individual
☐ 1	Speech understood by strangers with some difficulty; unfamiliar individuals can understand, but due to the lack of clarity, not all of the words are understood and the listener must pay close attention in order to understand
☐ 2	Uses a non-speech communication system that is understood by an unfamiliar listener (e.g., writing, communication board/device, gestures, or pointing)
☐ 3	Speech or other communication system understood only by either those who know the person well or who are trained in the alternate communication system
☐ 4	Does not communicate using a recognizable language or formal symbolic substitutions

Comments:	

Customer Name

Person ID

ASSOCIATING TIME WITH EVENTS AND ACTIONS

Indicate person's sense of time. Note: does NOT have to tell time.

☐	0	Associates events with specific time (e.g., the concert starts at 7:45)
☐	1	Associates regular events with specific hour (e.g., dinner is at six, work starts at eight, bedtime is at ten)
☐	2	Associates regular events with morning, noon, or night (e.g., daily or weekly events, such as we go to school in the morning or I go to bed at night); does not understand time but knows the sequence of daily events
☐	3	Does not associate events and actions with time

Comments:	

REMEMBERING INSTRUCTIONS AND DEMONSTRATIONS

Can recall examples of instructions or demonstrations on how to complete a specific task as demonstrated and/or verbally directed. Comments **MUST include examples of tasks assessed.**

☐	0	Displays memory of instructions or demonstrations without prompting if they are given once
☐	1	Displays memory of instructions or demonstrations if they are given once and if prompted to recall
☐	2	Displays memory of instructions or demonstrations if they are repeated three or more times and if prompted to recall
☐	3	Displays no or extremely limited (rare or very incomplete) memory of instructions or demonstrations

Comments:	

Customer Name

Person ID

C BEHAVIORAL DOMAIN

ALL BEHAVIORS IN THIS SECTION SCORED ABOVE A ZERO MUST BE DESCRIBED IN COMMENTS AND THE INTERVENTION SPECIFIED.

AGGRESSION

Physical attacks on others, including throwing objects, punching, biting, pushing, pinching, pulling hair, scratching. Do NOT include self-injurious behaviors, threatening or property destruction.

☐ 0	Problem does not occur or occurs at a level not requiring intervention
☐ 1	Minor problem; occasional aggression which requires some additional supervision in a few situations and/or verbal redirection
☐ 2	Moderate problem; frequent aggression that requires close supervision and/or physical redirection
☐ 3	Serious problem; constant aggression that requires close supervision and/or constant verbal or physical interruption.
☐ 4	Extremely Urgent problem; has had episode(s) causing injury in the last year, requires close supervision and physical interruption

Comments:	

VERBAL OR PHYSICAL THREATENING

Threatens to do harm to self, others or objects. Do NOT include actual acts of physical aggression or self-injury.

☐ 0	Problem does not occur or occurs at a level not requiring intervention
☐ 1	Minor problem; makes occasional threats which are not taken seriously and do not frighten others nor result in aggression from others; requires some additional supervision and/or verbal redirection
☐ 2	Moderate problem; makes frequent threats that sometimes cause fear and/or aggression from others; requires close supervision and physical redirection
☐ 3	Serious problem; makes constant threats that sometimes cause fear and/or aggression from others; requires close supervision and/or constant verbal or physical interruption
☐ 4	Extremely Urgent problem; has had serious incident(s) in the last year; incidents always generate fear and/or are likely to result in aggression from others; requires close supervision and physical interruption.

Comments:	

Customer Name

Person ID

SELF-INJURIOUS BEHAVIOR

Biting, scratching, putting inappropriate objects into ear, mouth, or nose, repeatedly picking at skin, head slapping or banging.

☐ 0	Problem does not occur or occurs at a level not requiring intervention
☐ 1	Minor problem; occasional incidents which require some additional supervision in a few situations and/or occasional verbal redirection
☐ 2	Moderate problem; frequent incidents that require close supervision and/or physical redirection
☐ 3	Serious problem; constant incidents; requires close supervision and/or verbal or physical interruption
☐ 4	Extremely Urgent problem; has had episode(s) causing serious injury requiring immediate medical attention in the last year, requires close supervision and physical interruption

Comments:	

RESISTIVENESS/REBELLIOUSNESS

Inappropriately stubborn and or uncooperative, including passive or active obstinate behaviors. Do NOT include difficulties with auditory processing or reasonable expressions of self-advocacy. Do NOT include verbal threatening or acts of physical aggression to self or others.

☐ 0	Problem does not occur or occurs at a level not requiring intervention
☐ 1	Minor problem; occurs occasionally and requires occasional attention, prompting and/or verbal redirection for cooperation
☐ 2	Moderate problem; occurs frequently and requires frequent attention, prompting and/or physical redirection for cooperation
☐ 3	Serious problem; occurs constantly and requires constant attention, prompting and/or physical redirection for cooperation

Comments:	

Customer Name

Person ID

III. MEDICAL ASSESSMENT

A. MEDICAL CONDITIONS

A = Acute, C = Chronic, H = History (Check appropriate answers)

		A, C, H	Comments	Major Dx
Neurological/Congenital/Developmental Conditions				
1. Cerebral Palsy				
a.	Diplegia	☐ A ☐ C ☐ H		
b.	Hemiplegia	☐ A ☐ C ☐ H		
c.	Quadriplegia	☐ A ☐ C ☐ H		
d.	Paraplegia	☐ A ☐ C ☐ H		
e.	Unspecified Cerebral Palsy	☐ A ☐ C ☐ H		
2. Epilepsy/Seizure Disorder **NOTE:** Indicate **DATE of LAST Seizure** and **FREQUENCY of *EACH TYPE*** of Seizure in Comments.				
a.	Generalized non-convulsive (absence, petit mal, minor, akinetic, atonic.)	☐ A ☐ C ☐ H		
b.	Generalized convulsive (clonic, myoclonic, tonic, tonic-clonic, grand mal, major)	☐ A ☐ C ☐ H		
c.	Unspecified (complex partial, psychomotor, temporal lobe, simple partial, Jacksonian, epilepsia partialis, continual	☐ A ☐ C ☐ H		
3. Mental Intellectual/Cognitive Disability				
a.	Mild Intellectual/Cognitive Disability	☐ A ☐ C ☐ H		
b.	Moderate Intellectual/Cognitive Disability	☐ A ☐ C ☐ H		
c.	Severe Intellectual/Cognitive Disability	☐ A ☐ C ☐ H		
d.	Profound	☐ A ☐ C ☐ H		

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	Intellectual/Cognitive Disability			
e.	Unspecified Intellectual/Cognitive Disability	☐ A ☐ C ☐ H		
f.	Borderline Intelligence	☐ A ☐ C ☐ H		
4. Autism				
a.	Autism	☐ A ☐ C ☐ H		
b.	Pervasive Developmental Disorder	☐ A ☐ C ☐ H		
c.	Autistic-Like Behaviors	☐ A ☐ C ☐ H		
5. Attention Deficit Disorder (ADD)				
a.	ADD with Hyperactivity	☐ A ☐ C ☐ H		
b.	ADD without Hyperactivity	☐ A ☐ C ☐ H		
6. Other Neurological / Congenital / Developmental Conditions				
a.	Prematurity	☐ A ☐ C ☐ H		
b.	Fetal Alcohol Syndrome	☐ A ☐ C ☐ H		
c.	Developmental Delays	☐ A ☐ C ☐ H		
d.	Hydrocephaly	☐ A ☐ C ☐ H		
e.	Macrocephaly	☐ A ☐ C ☐ H		
f.	Microcephaly	☐ A ☐ C ☐ H		
g.	Meningitis	☐ A ☐ C ☐ H		
h.	Encephalopathy	☐ A ☐ C ☐ H		
i.	Spina Bifida	☐ A ☐ C ☐ H		
j.	Genetic Anomalies	☐ A ☐ C ☐ H		
k.	Down's Syndrome	☐ A ☐ C ☐ H		
l.	Congenital Anomalies	☐ A ☐ C ☐ H		
m.	Near Drowning	☐ A ☐ C ☐ H		
n.	Head Trauma	☐ A ☐ C ☐ H		
o.	Dementia (Organic Brain Syndrome)	☐ A ☐ C ☐ H		

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Other Medical Conditions				
7. Hematologic				
a.	Anemia	☐ A ☐ C ☐ H		
b.	HIV Positive	☐ A ☐ C ☐ H		
c.	AIDS	☐ A ☐ C ☐ H		
d.	Leukemia	☐ A ☐ C ☐ H		
e.	Hepatitis	☐ A ☐ C ☐ H		
8. Cardiovascular				
a.	CHF	☐ A ☐ C ☐ H		
b.	Hypertension	☐ A ☐ C ☐ H		
c.	Congenital Anomalies of Heart	☐ A ☐ C ☐ H		
d.	Cardiac Murmurs	☐ A ☐ C ☐ H		
e.	Rheumatic Heart Disease	☐ A ☐ C ☐ H		
9. Musculoskeletal				
a.	Arthritis	☐ A ☐ C ☐ H		
b.	Fracture	☐ A ☐ C ☐ H		
c.	Contracture	☐ A ☐ C ☐ H		
d.	Anomalies of Spine (Kyphoscoliosis, Scoliosis, Lordosis)	☐ A ☐ C ☐ H		
e.	Paralysis	☐ A ☐ C ☐ H		
10. Respiratory				
a.	Asthma	☐ A ☐ C ☐ H		
b.	Bronchitis	☐ A ☐ C ☐ H		
c.	Pneumonia	☐ A ☐ C ☐ H		
d.	Respiratory Distress Syndrome	☐ A ☐ C ☐ H		
e.	Bronchopulmonary Dysplasia	☐ A ☐ C ☐ H		
f.	Cystic Fibrosis	☐ A ☐ C ☐ H		
g.	Reactive Airway Disease	☐ A ☐ C ☐ H		

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h.	Tracheomalacia	☐ A ☐ C ☐ H		
i.	Congenital Pulmonary Problems	☐ A ☐ C ☐ H		
11. Genitourinary				
a.	Urinary Tract Infection	☐ A ☐ C ☐ H		
12. Gastrointestinal				
a.	Constipation	☐ A ☐ C ☐ H		
b.	Ulcers	☐ A ☐ C ☐ H		
c.	Hernia	☐ A ☐ C ☐ H		
d.	Esophagitis	☐ A ☐ C ☐ H		
e.	Gastroesophageal Reflux	☐ A ☐ C ☐ H		
13. EENT				
a.	Blindness	☐ A ☐ C ☐ H		
b.	Cataract	☐ A ☐ C ☐ H		
c.	Hearing Deficit	☐ A ☐ C ☐ H		
d.	Ear Infection	☐ A ☐ C ☐ H		
e.	Disorders of Eye Movements (Exotropia, Strabismus, Nystagmus)	☐ A ☐ C ☐ H		
f.	Glaucoma	☐ A ☐ C ☐ H		
14. Metabolic				
a.	Hypothyroidism	☐ A ☐ C ☐ H		
b.	Hyperthyroidism	☐ A ☐ C ☐ H		
c.	Diabetes Mellitus	☐ A ☐ C ☐ H		
d.	Pituitary Problem	☐ A ☐ C ☐ H		
15. Skin Conditions				
a.	Decubitus	☐ A ☐ C ☐ H		
b.	Acne	☐ A ☐ C ☐ H		
16. Psychiatric				
a.	Major Depression	☐ A ☐ C ☐ H		
b.	Bipolar Disorder	☐ A ☐ C ☐ H		
c.	Schizophrenia	☐ A ☐ C ☐ H		

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d.	Behavioral Disorders	☐ A ☐ C ☐ H		
e.	Conduct Disorder	☐ A ☐ C ☐ H		
f.	Alcohol Abuse	☐ A ☐ C ☐ H		
g.	Drug Abuse	☐ A ☐ C ☐ H		

17. Other Diagnoses									Diagnosis
ICD-10	a.							☐ A ☐ C ☐ H	
ICD-10	b.							☐ A ☐ C ☐ H	
ICD-10	c.							☐ A ☐ C ☐ H	
ICD-10	d.							☐ A ☐ C ☐ H	
ICD-10	e.							☐ A ☐ C ☐ H	

	Category	**Condition**	**Diagnosis**
MAJOR DIAGNOSES			

Comments:	

Customer Name

Person ID

B. MEDICATIONS/TREATMENTS

(Include PRN medications/treatments received in last thirty (30) days and any other current medications/treatments). Include dosage, frequency, duration, route, form for each medication.

	MEDICATIONS / TREATMENTS / COMMENTS	RX	OTC
1.		☐	☐
2.		☐	☐
3.		☐	☐
4.		☐	☐
5.		☐	☐
6.		☐	☐
7.		☐	☐
8.		☐	☐
9.		☐	☐
10.		☐	☐
11.		☐	☐
12.		☐	☐
13.		☐	☐
14.		☐	☐
15.		☐	☐
16.		☐	☐
17.		☐	☐
18.		☐	☐
19.		☐	☐
20.		☐	☐

Comments:	

Customer Name Person ID

C. SERVICES AND TREATMENTS
(Mark appropriate answers) Provide explanation when (N) is circled

			Frequency of Service			
1. Injections/IV	Receives	Needs	Cont.	Daily	Wkly.	Monthly
a. Intravenous Infusion Therapy	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
b. Intramuscular/Subcutaneous Injections	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M

Comments:	

2. Medications/Monitoring	Receives	Needs	Cont.	Daily	Wkly.	Monthly
a. Drug Regulation	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
b. Drug Administration	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M

Comments:	

3. Dressings	Receives	Needs	Cont.	Daily	Wkly.	Monthly
a. Decubitus Care	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
b. Wound Care	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
c. Non-Bladder/Bowel Ostomy Care	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M

Comments:	

4. Feedings	Receives	Needs	Cont.	Daily	Wkly.	Monthly
a. Parenteral Feedings/TPN	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
b. Tube Feedings	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M

Comments:	

5. Bladder/Bowel	Receives	Needs	Cont.	Daily	Wkly.	Monthly

Customer Name

Person ID

a. Catheter Care	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
b. Ostomy Care	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
c. Bowel Dilatation	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M

Comments:	

			Frequency of Service			
6. Respiratory	Receives	Needs	Cont.	Daily	Wkly.	Monthly
a. Suctioning	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
b. Oxygen	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
c. SVN	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
d. Ventilator	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
e. Trach Care	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
f. Postural Drainage	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
g. Apnea Monitor	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M

Comments:	

7. Therapies	Receives	Needs	Cont.	Daily	Wkly.	Monthly
a. Physical Therapy	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
b. Occupational Therapy	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
c. Speech Therapy	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
d. Respiratory Therapy	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
e. Alcohol/Drug Treatment	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
f. Vocational Rehabilitation	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M

Customer Name Person ID

g. Individual/Group Therapy	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
h. Behavioral Modification Program	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M

Comments:	

8. Rehabilitative Nursing	Receives	Needs	Cont.	Daily	Wkly.	Monthly
a. Teaching/Training Program	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
b. Bowel/Bladder Retraining	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
c. Turning & Positioning	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
d. Range of Motion	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
e. Other Rehab Nursing (specify)	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M

Comments:	

9. Other	Receives	Needs	Cont.	Daily	Wkly.	Monthly
a. Peritoneal Dialysis	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
b. Hemodialysis	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
c. Chemotherapy/Radiation	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
d. Restraints	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
e. Fluid Intake/Output	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
f. Other (specify)	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M

Comments:	

Customer Name

Person ID

D. MEDICAL STABILITY

1. Record the number of acute hospitalizations that occurred over the past year	
2. Currently requires direct care staff or caregiver **trained in special health care procedures** (e.g., ostomy care, positioning, adaptive devices, G-tube feedings, SVN, seizure precautions [if current seizure activity], diabetic monitoring)	☐ YES ☐ NO
3. Currently **requires special diet** planned by dietitian, nutritionist, or nurse (e.g., high fiber, low calorie, low sodium, pureed)	☐ YES ☐ NO

Comments:	

Customer Name

Person ID

E. SENSORY FUNCTIONS
(mark appropriate answers)

Impairment	Unable to Assess/ No Impairment	Minimum Impairment	Moderate Impairment	Severe Impairment
1. **Hearing** Ability to perceive sounds	☐ 0	☐ 1	☐ 2	☐ 3
2. **Vision** Ability to perceive objects visually	☐ 0	☐ 1	☐ 2	☐ 3

Comments:	

Customer Name

Person ID

F. SUMMARY EVALUATION

PCP: and other informants names for Personal Contacts entries

ELIGIBILITY REVIEW REQUESTED?	☐ Yes ☐ No	DATE	

Signature	Title	Date
Signature and Title	Title	Date

Completion Time (minutes)		Travel Time (minutes)	