

**REQUEST FOR TITLE XIX CARE LEVEL DETERMINATION
ADDENDUM FOR DEVELOPMENTALLY DISABLED CLIENT / RESIDENT**

Completion of this form is not mandatory; however, a resident's level of care, for Medicaid reimbursement, cannot be evaluated and determined without the information requested below. Collection of personal information will be used to determine the resident's level of care and for no other purpose.

Name - Client / Resident (Last, First, MI)		Social Security / MA Number	
Name - Provider	City	License Number	

PART A - To be Completed by Physician

- Attach a copy of the objectives and special procedures designed to meet the objectives of the plan of care.
- Portions of items 1 - 2 below may be deleted if attached in a signed narrative form.
- Item 3 does not need to be completed for recertification in a community waiver program.

1. Physician's Plan of Care

A. Course of Treatment (including medical/surgical procedures done and date)

B. Diagnoses (long term, admitting, and discharging)

2. Physician's Orders

Include specific orders for medications and treatments, diagnostic tests, activities, activity level, special diet, special treatments including social services, PT, OT, speech therapy. Specify frequency per week.

3. Treatment Goals and Prognosis

A. Short stay of _____ month(s) with rehabilitation leading to discharge to:

- Home Foster Home Group Home Nursing Facility ICF/MR Other (Specify.)

B. Long Term Care

C. Criteria for Determining a Need for Alternative Placement

I certify that this patient's medical conditions and related conditions are essentially as indicated above and that inpatient care is appropriate.

SIGNATURE - Physician	Name - Physician (Print or type.)	Date Signed	Telephone Number
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PART B SECTION DEFINITIONS

All sections of the worksheet must be completed using prior knowledge or direct observation/assessment of the client in order to support the determination that the resident is developmentally disabled and to give an accurate picture of the resident's current functional status. The six areas of major life activity measured by this worksheet are defined as follows:

- (1) **Self-care skills** refer to the effectiveness or degree with which individuals meet the standards of personal independence and social responsibility expected of their age and cultural group. Self-care skills include personal skills essential for privacy and independence including, but not limited to toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, and grooming. Independent living skills include, but are not limited to, such things as meal preparation, doing laundry, bed making, budgeting, and skills essential for one's safety in the community, such as watching for traffic before crossing streets.
- (2) **Understanding and use of language** refers to the development of both verbal and nonverbal and receptive and expressive communication skills.
- (3) **Learning** refers to the development of those processes by which information received by the senses is stored, recovered, and used. It includes the development of the processes and abilities involved in memory, reasoning, and problem solving.
- (4) **Self-direction** refers to the independent ability to engage in a direct course of thought or action; to engage in motivated, purposeful actions. For example, a client who can reliably and independently locate leisure time material and use them in a normative manner would be characterized as possessing a high degree of self-direction.
- (5) **Mobility** refers to the ability to move from one area to another area independently. The need for assistive devices does not indicate that the individual is non-mobile, but the assistive devices should be noted.
- (6) **Capacity for independent living** refers to the ability to provide for one's own custody. The capacity for independent living involves the degree to which there is a probability of physical impairment or injury to the resident or other individuals due to violent behavior or impaired judgement. The determination of an individual's capacity for independent living may (or may not) be affected by limitations in self-care skills, learning, and self-direction the individual may have.

PART B - To be Completed by the Facility or Person Familiar with Client/Resident**Attach a copy of the client/resident social history/narrative.**

Describe the resident's substantial functional limitations in the following areas.

1. Self-Care Skills

Indicate, for each of the following, the level of independence usually displayed by the client.

1 = Can complete task independently

4 = Needs complete physical assistance to complete task

2 = Can complete task given verbal reminders only

5 = Not applicable/unknown

3 = Can complete task given partial physical assistance

Also, place an * by any letter if the client needs assistance setting up the task.

- | | | |
|--|---|---|
| <input type="checkbox"/> A. Bathing self | <input type="checkbox"/> F. Grooming and personal hygiene | <input type="checkbox"/> K. Use of private or public transportation |
| <input type="checkbox"/> B. Dressing self | <input type="checkbox"/> G. Dental hygiene | <input type="checkbox"/> L. Household chores (e.g., wash dishes, make bed) |
| <input type="checkbox"/> C. Feeding self | <input type="checkbox"/> H. Food preparation | <input type="checkbox"/> M. Safety skills in the community (e.g., looking before crossing streets, ability to dial emergency phone numbers when appropriate.) |
| <input type="checkbox"/> D. Toileting self | <input type="checkbox"/> I. Laundry | |
| <input type="checkbox"/> E. Budgeting | <input type="checkbox"/> J. Grocery shopping | |

2. Understanding and Use of Language

Check all items that apply.

- | | |
|---|---|
| <input type="checkbox"/> A. Can write | <input type="checkbox"/> G. Can verbally communicate |
| <input type="checkbox"/> B. Reads simple stories | <input type="checkbox"/> H. Uses sign language to communicate |
| <input type="checkbox"/> C. Reads newspaper and can relay facts of current events to others | <input type="checkbox"/> I. Uses communication board/other assistive device |
| <input type="checkbox"/> D. Understands verbal speech | <input type="checkbox"/> J. Can communicate basic needs through gesture |
| <input type="checkbox"/> E. Understands English | <input type="checkbox"/> K. Can carry on a conversation |
| <input type="checkbox"/> F. Understands language other than English (including sign language) | <input type="checkbox"/> L. Cannot communicate basic needs |

3. Learning

Indicate, **WITH A NUMBER**, how often the client performs the following skills/tasks.

1 = Never 2 = Rarely 3 = Sometimes 4 = Almost always or always 5 = Unknown

- A. Recognizes the end of an activity
- B. Requests assistance when necessary to complete a task
- C. Independently corrects errors during a familiar task
- D. Independently corrects errors during an unfamiliar task
- E. Correctly follows two or more step directives/requests
- F. Remembers directive or event for 24 hours
- G. Remembers directive or event for 7 days or more
- H. Discriminates objects by size/shape/color
- I. Understands cause and effect relationships (e.g., plans to repeat an action to obtain a particular result)
- J. Is able to determine another person's feelings and change their behavior accordingly
- K. Can learn to perform new discrete (with definite beginning and end) task within **1 week**
- L. Can learn to perform new discrete (with definite beginning and end) task within **1 month**

4. Self-Direction

Indicate, **WITH A NUMBER**, how often the client performs the following skills/tasks.

1 = Never 2 = Rarely 3 = Sometimes 4 = Almost always or always 5 = Unknown

- A. Makes requests to speak to or be with a specific person
- B. Makes menu selections
- C. Chooses own clothing to wear for the day
- D. Chooses item to purchase at a store
- E. Has prized possessions (e.g., family photos, toys, etc.)
- F. Chooses activities/materials
- G. Chooses radio station to listen to or TV programs to watch
- H. Plans/schedules appointments or leisure time

5. Mobility

Check the item **most** applicable to the client.

- A. Ambulatory (is able to walk unassisted)
- B. Non-ambulatory, mobile (can move from one place to another with assistive devices, such as crutches, wheelchair, walker, etc., or by crawling, seat scooting, etc.)

Specify the nature and degree of limitations in the client's ability to independently move about during the course of the day.

- C. Non-ambulatory, non-mobile (cannot move from one place to another).

Check all appliances or prosthesis that the client **CURRENTLY** uses or needs:

- | | |
|--|--|
| <input type="checkbox"/> 1. Cane | <input type="checkbox"/> 6. Dentures |
| <input type="checkbox"/> 2. Crutches | <input type="checkbox"/> 7. Eye Glasses/Contacts |
| <input type="checkbox"/> 3. Walker | <input type="checkbox"/> 8. Hearing Aid |
| <input type="checkbox"/> 4. Manual Wheelchair | <input type="checkbox"/> 9. Braces (Specify.) |
| <input type="checkbox"/> 5. Powered Wheelchair | <input type="checkbox"/> 10. Prosthesis (Specify.) |

6. Capacity for Independent Living

Indicate, **WITH A NUMBER**, how often the client performs the following skills/tasks.

1 = Never 2 = Rarely 3 = Sometimes 4 = Almost always or always 5 = Unknown

- ___ A. Chooses clothing that is appropriate for the weather
- ___ B. Recognizes and attends to signs/symptoms of illness
- ___ C. Can identify threatening acts or gestures from other
- ___ D. Will take action to protect himself from threatening acts or gestures
- ___ E. Effectively uses time to ensure that his basic needs are met
- ___ F. Independently manages finances to ensure basic necessities are met (e.g., food, clothing, shelter)

Describe the frequency and nature of routine nursing medical monitoring care or treatment that the resident needs.

Note specific psychiatric symptoms and challenging behaviors that the resident exhibits, along with the frequency, or a description of the severity or duration of the symptoms and behaviors.

Additional Comments

SIGNATURE - Person Completing This Form	Professional Title	Date Signed
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