West Virginia Department of Health and Human Resources
Children with Disabilities Community Services Program (CDCSP)
Acute Care Hospital OR Nursing Facility
Level of Care Evaluation

I. DEMOGRAPHIC INFORMATION (COMPLETED BY PARENT OR GUARDIAN)

1. Individual's Full Name (Last, first, middle)	2. Sex F □ M □	3. Medicaid Member □ Yes (give number) □ No	4. Medicare Number □ Yes (give number) □ No
5. Address (including Street/Box, City, State and Zip)			
6. Private Insurance __ Yes (give information including policy number)__No			

7. County	8. Social Security No.	9. Birth date (M/D/YY)	10. Age	11. Phone Number

12. Parent/Guardian Name:	13. Address (if different from above)

14. Current living arrangements, including formal and informal support (i.e., family, friends, other services)

_____

_____

15. Name and Address of Provider, if applicable:

16. Medicaid Waiver Wait List A. __ Yes B. ___ No

17. Has the option of Medicaid Waiver been explained to the applicant? __ Yes ___ No

18. For the purpose of determining my need for appropriate services, I authorize the release of any medical information by the physician to the Department of Health and Human Resources or its Representative.

_____/_____/_____

Signature – Parent or Legal Guardian for Applicant/Member Relationship Date

Name of Person completing the form: _____

Telephone No. of person completing form: _____

Name of Applicant/Member: _____ Date: _____

II. MEDICAL ASSESSMENT

DIAGNOSIS:	
Primary Diagnosis:	**Secondary Diagnosis:**

NORMAL VITAL SIGNS FOR THE INDIVIDUAL:					
a. Height	**b. Weight**	**c. Blood Pressure**	**d. Temperature**	**3. Pulse**	**f. Respiratory Rate**

PHYSICAL EXAMINATION:
RESULTS: v-Normal NC=Not completed (explain) N/A = Not applicable X=Abnormal (explain)

AREA	RESULTS	EXPLANATION
Eyes/Vision		
Nose		
Throat		
Mouth		
Swallowing		
Lymph Nodes		
Thyroid		
Heart		
Lungs		
Breast		
Abdomen		
Extremities		
Spine		
Genitalia		
Rectal		
Prostrate (Males)		
Bi-Manual Vaginal		
Vision		
Dental		
Hearing		
NEUROLOGICAL		
Alertness		

Coherence		
Attention Span		
Speech		
Coordination		
Gait		
Muscle Tone		
Reflexes		

AREAS REQUIRING SPECIAL CARE	
RESULTS: v=within developmental limits	**AD=Age appropriate Dependent X=Problems Requiring Special Care (explain below)**

AREA	**RESULTS**	**PLEASE PROVIDE A DESCRIPTIVE – SPECIFIC EXPLANATION**
Grooming/Hygiene		
Dressing		
Bathing		
Toileting		
Eating/Feeding		
Simple Meal Preparation		
Communication (refers to the age appropriate ability to communicate by any means whether verbal, nonverbal-gestures, or with assistive devices)		
Mobility – Motor Skills – refers to the age appropriate ability to move one's person from one place to another with or without mechanical aids		
Self Direction – refers to the age appropriate ability to make choices and initiate activities, the ability to choose an active life style or remain passive, and the ability to engage in or demonstrate an interest in preferred activities.		
Household Skills (cleaning, laundry, dishes, etc.)		

Health and Safety		

CURRENT TREATMENT		
	EXAMPLES	**PLEASE PROVIDE A DESCRIPTIVE-SPECIFIC EXPLANATION OF TREATMENT**
Nutrition	**Tube feeding, N/G tube, IV use, Medications, Special diets, etc.**	
Bowel	**Colostomy**	
Urogenital	**Dialysis in the home, Ostomy, Catheterization**	
Cardiopulmonary	**CPAP/Bi-PAP, CP Monitor, Home Vent, Tracheostomy, Inhalation Therapy, Continuous Oxygen, Suctioning**	
Integument System	**Sterile dressing, decubiti, bedridden, special skin care**	
Neurological Status	**Seizures, Paralysis**	
Other		

MEDICATION(S) INDIVIDUAL IS CURRENTLY BEING PRESCRIBED				
Medication	**Dosage/Route**	**Frequency**	**Reason Prescribed**	**Diagnosis**

III. HOSPITAL LEVEL OF CARE ASSESSMENT (only required for Hospital Level of Care)

Skilled Assessment (ONLY REQUIRED FOR HOSPITAL LEVEL OF CARE) (See Section IV)		
The individual requires acute care services that must be performed by, or under, the supervision of professional or technical personnel and directed by a physician.	**Yes __ (explain) No ___**	
The individual requires specialized professional training and monitoring beyond those ordinarily expected of parents.	**Yes __ (explain) No ___**	
Individual has a history of recurrent emergency room visits for acute episodes over the last year AND/OR history of recurrent hospitalizations over the last year	**Yes__(explain) No __**	
Individual has had ongoing visits with specialists in an effort to prevent an acute episode	**Yes__ (explain) No __**	
The individual's medical conditions is not stabilized, requiring frequent interventions	**Yes __ (explain) No __**	
Individual has had a history in the past year of a need to frequently stabilize in an inpatient setting using medication, surgery, and/or other procedures	**Yes__ (explain) No __**	
The individual requires rehabilitative services (therapies), wound care, and other intense nursing care of a chronic nature that is medically necessary and must be performed by, or under the supervision of professional or technical personnel.	**Yes __(explain) No__**	
The individual requires specialized professional training and monitoring beyond the capability of, and those ordinarily expected of parents.	**Yes__ (explain) No __**	
The individual's medical condition is stabilized.	**Yes __(explain) No__**	
The individual's care is ordered and delegated by the physician to an RN or LPN and/or RN or LPN oversight according to a plan to treatment with short and long term goals.	**Yes__(explain) No__**	
The individual's medical care can be managed in a setting that is less than an acute care setting.	**Yes__(explain) No ___**	

Name of Applicant/Member: _____ Date: _____

IV. PHYSICIAN RECOMMENDATION (recommendation by physician necessary)

Recommendation for the following level of Care for the Children with Disabilities Community Services Program **(only one can be checked**).

_____**Acute Care Hospital**: A child with a high need for medical services and/or nursing services who is at risk of hospitalization in an acute care hospital setting. Inpatient services are defined as services ordinarily furnished in a hospital for care and treatment of inpatients and are furnished under the direction of a physician. Hospital level of care is appropriate for individuals who continuously require the type of care ordinarily provided in a hospital, and who, without these services, would require frequent hospitalizations. This level of care is highly skilled and provided by professional in amounts not normally available in a skilled nursing facility but available in a hospital.

-OR-

_____**Nursing Facility (NF):** A child with a high need for medical services and/or nursing services who is at risk of hospitalization or placement in nursing facility. Nursing facility services are services that are needed on a daily basis that must be provided on an inpatient basis and that ordered by and provided under the direction of a physician. Nursing level of care is appropriate for individuals who do not require acute hospital care, but, on a regular basis, require licensed nursing service, or other health-related services ordinarily provided in an institution. With respect to an individual who has a mental illness or mental retardation, nursing facility level of care services are usually inappropriate unless that individual's mental health needs are secondary to needs associated with a more acute physical disorder.

I RECOMMEND THAT THIS INDIVIDUAL'S DEVELOPMENTAL DISABILITY, MEDICAL CONDITION AND/OR RELATED HEALTH NEEDS ARE AS DOCUMENTED ABOVE AND HE/SHE REQUIRES THE LEVEL OF CARE PROVIDED IN ONE OF THE ABOVE CHECKED FACILITIES.	
Physician's Signature (MD/DO) Physician's License Number Date this Assessment Completed	TYPE OF PRINT Physician's name/address below:

DISCLAIMER: Approval of this form does not guarantee eligibility for payment under the State Medicaid Plan.

NOTE: Information gathered from this form may be utilized for statistical/data collection.