NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

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

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

CHILD'S NAME (*LAST, FIRST, MI,):*		
DATE OF BIRTH: / /	SEX: ☐ Male ☐ Female	MEDICAID CIN #:

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

1. ADMINISTRATIVE DATA

If child could not be cared for at home he/she would require:
☐ Skilled Nursing Facility ☐ Hospital

COUNTY OF RESIDENCE:	DIAGNOSIS: ☐ Primary ☐ Other

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

FAMILY STRUCTURE: (INVOLVEMENT, LIMITATIONS, ETC.)

MEDICAL TREATMENTS *(Check all which apply):*

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

2. FUNCTIONING

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

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

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

	YES	NO	COMMENTS
a. Daily intravenous medication or nutritional supplement	☐	☐	
b. Requires constant observation for:	☐	☐	
c. Physical, occupational or speech therapy.	☐	☐	

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

TITLE OF PERSON COMPLETING FORM:	DATE COMPLETED: / /

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

DATE LEVEL OF CARE APPROVED / EFFECTIVE: / /		

ADDITIONAL COMMENTS ABOUT CHILD:

Original – Health Care Integration Agency;

Copy – Local Department of Social Services, Case Planning Agency