STAR Kids Screening and Assessment – Core

Section A. Identification Information

1. Date of Assessment Conducted with the Individual/LAR
   Month / Day / Year
2. Reason for Assessment

   Options are:

   - Initial
   - Re-assessment
   - Significant change in condition re-assessment
   - Minor correction to recent assessment
   - Major correction to recent assessment
3. Legal Name (First, Middle, Last and Suffix)
4. Gender (Male, Female, Unknown)
5. Birthdate

   Month / Day / Year

6. Ethnicity and Race

   Options are:

   - Hispanic or Latino
   - American Indian or Alaska Native
   - Asian
   - Black or African American
   - Native Hawaiian or other Pacific Islander
   - White
   - Other (space to report)
   - Prefer not to identify

7. Participants in Assessment

   Name

   Relationship to Individual

8. Individual's Profile

   A. A little about myself:

   B. What people like and admire about me:

   C. What's important TO me:

   D. What others need to know and do to support me:

   E. What the people are like that support me best:

   F. How I like to spend my day:

9. People important to me

   Name:

   Relationship:

   Important because:

10. Preferred Language – Indicate both the individual's and LAR's preferred written and spoken language for day-to-day communication.

    Options are:

    - English
    - Spanish
    - American Sign Language
    - Other (specify):

11. Qualified Interpreter Needed

    A. Individual

       Options are:

       - No
       - Yes

    B. Primary Caregiver / Guardian / LAR

       Options are:

       - No
       - Yes

12. Interpreter Information

    A. Name of interpreter

13. Individual Numeric Identifiers

    A. Social Security Number

    B. Medicare Number (if applicable)

    C. Medicaid Number

14. Individual / LAR Phone Number

    A. Primary

    B. Alternate

15. Individual / LAR Address of Current Residence

    Street

    City

16. Individual / LAR Postal / Zip Code of Current Residence

17. Individual / LAR Email Address
    A. Primary
    B. Alternate
18. Preferred Method of Contact
    A. Phone

       Options are:
       - No
       - Yes

    B. Email

       Options are:
       - No
       - Yes

    C. Mail

       Options are:
       - No
       - Yes

    D. Other (specify)

       Options are:
       - No
       - Yes

19. Since The Last Assessment, The Individual's Living Situation Has Changed?

    Options are:
    - No
    - Yes

20. Current Residence (specify yes or no for the following options)

A. Own home or apartment

Options are:

- Alone (includes person living alone who receives in-home services)
- With family
- With spouse/partner
- With non-relative/roommates

B. Someone else's home or apartment

Options are:

- Family
- Foster family
- Non-relative/roommate
- Certified or licensed group home

C. Group residential living

Options are:

- Residential treatment center (RTC)
- HCS waiver host home

D. Institution

Options are:

- Nursing home
- Intermediate care facility for individuals with intellectual disability or related conditions (ICF/IID)

E. Other living arrangements

Options are:

- College or school housing
- No permanent residence (for example, homeless shelter, emergency shelter)
- Other – specify

21. Does the caregiver indicate imminent need for out of home placement?

    Options are:

    - No
    - Yes

22. Prefers to live – only for individuals age 15 and older (specify yes or no for the following options)

    A. Own home or apartment

       Options are:

       - Alone (includes person living alone who receives in-home services)
       - With family
       - With spouse/partner
       - With non-relative/roommates

    B. Someone else's home or apartment

       Options are:

       - Family
       - Foster family
       - Non-relative/roommate
       - Certified or licensed group home

    C. Group residential living

       Options are:

       - Residential treatment center (RTC)
       - HCS waiver host home

    D. Institution

       Options are:

       - Nursing home
       - Intermediate care facility for individuals with intellectual disability or related conditions (ICF/IID)

E. Other living arrangements

Options are:

- College or school housing
- No permanent residence (for example, homeless shelter, emergency shelter)
- Other – specify

23. Does Individual want more information about community living?

Options are:

- No
- Yes
- NA

24. What is the primary caregiver's / guardian's / LAR's preference for living arrangements for this individual?

(Only for individuals age 15 and older)

Specify yes or no for the following options.

Option are:

- Not applicable (if no primary caregiver/guardian/LAR)
- Stay at current residence
- Move to own home / apartment (includes living with spouse / family)
- Assisted living facility (ALF)
- Adult foster care home
- HCS host home
- No consensus among multiple parties
- Move to a certified or licensed group home
- Move to a nursing home or other institutional setting (ICF/IID, SSLC, RTC)
- Move to someone else's home

25. Does the primary caregiver / Guardian/ LAR want more information about community living?

    (Only for individuals age 15 and older)

    Options are:

    - No
    - Yes
    - NA

26. Physician Information

    A. Does the individual have a physician that meets their medical needs?

       Options are:

       - No
       - Yes

    B. Name of Physician:

       First / Middle initial / Last

    C. Length of time individual has been in care of this physician

       Options are:

       - 12 months or less
       - Greater than 12 months

    D. Date of last visit with physician

       Month / Year

    E. NPI / API

    F. License number

    G. License state

    H. Specialty

    I. Physician contact information

       Address, City, State, Zip Code, Phone Number, Fax Number

27. Guardian / LAR

    A. Name of guardian / LAR

       First / Middle Initial / Last / Suffix

28. Legal responsibilities / guardianship

    Options are:

    - Both parents are legal guardians
    - Mother is legal guardian, but not father
    - Father is legal guardian, but not mother
    - Neither parent but relative(s) or non-relatives is legal guardian
    - Child Protection agency is legal guardian (e.g., CPS)
    - Individual is responsible for self

29. Does individual have healthcare needs not covered by current funding sources?

    Options are:

    - No
    - Yes

    If yes, please specify in the space provided.

30. Individual receives services through the following:

    A. Personal care services (PCS)

       Options are:

       - Receives
       - On interest list
       - Does not receive
       - Does not receive, would like to be on program/interest list

    B. Community First Choice (CFC)

       Options are:

       - Receives
       - On interest list
       - Does not receive
       - Does not receive, would like to be on program/interest list

C. Community Living Assistance Support Services (CLASS)

Options are:

- Receives
- On interest list
- Does not receive
- Does not receive, would like to be on program/interest list

D. Home and Community-based services (HCS)

Options are:

- Receives
- On interest list
- Does not receive
- Does not receive, would like to be on program/interest list

E. Deaf Blind and Multiple Disabilities (DBMD)

Options are:

- Receives
- On interest list
- Does not receive
- Does not receive, would like to be on program/interest list

F. Texas Home Living (TxHmL)

Options are:

- Receives
- On interest list
- Does not receive
- Does not receive, would like to be on program/interest list

G. Youth Empowerment Services (YES)

Options are:

- Receives
- On interest list
- Does not receive
- Does not receive, would like to be on program/interest list

H. Medically Dependent Children Program (MDCP)

Options are:

- Receives
- On interest list
- Does not receive
- Does not receive, would like to be on program/interest list

31. Is there anything else that would be helpful to know about the individual for this section (Section A: Identification Information)?

Section B. Primary Caregivers

1. Key primary caregivers

A. Relationship or primary caregiver(s) to individual

Options are:

- Parent
- Grandparent
- Sibling
- Spouse/significant other
- Other relative
- Foster parent
- Friend or neighbor
- Other (specify in space provided)
- Not applicable

B. Preferred gender of primary caregiver(s)

Options are:

- Male
- Female

C. Age of primary caregiver(s)

D. Primary caregiver(s) live(s) with individual

Options are:

- No
- Yes, less than 6 months
- Yes, more than 6 months

2. Primary caregiver(s) status / challenges

A. In school full-time

Options are:

- No
- Yes
- NA

B. In school part-time

Options are:

- No
- Yes
- NA

C. Working full-time

Options are:

- No
- Yes
- NA

D. Working part-time

Options are:

- No
- Yes
- NA

E. Sleep interrupted throughout the night because of caregiving related to individuals' condition

Options are:

- No
- Yes
- NA

F. Because of limitations or disabilities, primary caregiver unable to assist with some ADL or IADL

If yes, please specify.

Options are:

- No
- Yes
- NA

G. Other (specify in space provided)

Options are:

- No
- Yes
- NA

3. People living in your home

   Record number of children and individuals as two-digit number (e.g., 03) in each box, if none record "00"

   A. Number of other individuals in the household

   B. Number of other individuals with special needs (other than individual being assessed)

   C. Number of other individuals receiving Medicaid home care services (other than individual being assessed)

      Indicate number for each of the following:

      - Nursing services
      - Therapy services
      - Personal Care Services / CFC

4. Ability of primary caregiver to provide care is expected to decrease within next 90 days

   Options are:

   - No
   - Yes

5. Alternate plan for caregiving

   Individual or primary caregiver(s) has plans for alternative future support of living arrangements, if required (e.g., if current informal caregiver may no longer be able to provide support)

   Options are:

   - Alternative plans not considered OR not required
   - Alternative plans not made, but under consideration
   - Alternative plans made

6. Individual's social relationships / strengths in last 30 days
   A. Participates in activities / hobbies that they enjoy

      Options are:

      - Never / rarely
      - Sometimes
      - Usually
      - Almost always
      - Always
      - Unable to determine

   B. Is flexible about changes in daily routine

      Options are:

      - Never / rarely
      - Sometimes
      - Usually
      - Almost always
      - Always
      - Unable to determine

   C. Is cooperative in living situation

      Options are:

      - Never / rarely
      - Sometimes
      - Usually
      - Almost always
      - Always
      - Unable to determine

D. Positive towards household members

Options are:

- Never / rarely
- Sometimes
- Usually
- Almost always
- Always
- Unable to determine

E. Positive towards peers

Options are:

- Never / rarely
- Sometimes
- Usually
- Almost always
- Always
- Unable to determine

7. Is there anything else that would be helpful to know about the individual for this section (Section B: Primary Caregivers)?

Section C. School and Work

1. Type of current school or day program

A. Day care

Options are:

- No
- Yes

B. Head start or pre-kindergarten

Options are:

- No
- Yes

C. Kindergarten, elementary, middle or high school

Options are:

- No
- Yes

D. Homebound (through school system)

Options are:

- No
- Yes

E. Homebound (not through school system)

Options are:

- No
- Yes

F. Alternative school

Options are:

- No
- Yes

G. Vocational or technical/day program

Options are:

- No
- Yes

H. Day activity and health services (DAHS)

Options are:

- No
- Yes

I. College or Junior College

Options are:

- No
- Yes

J. Other (specify):

Options are:

- No
- Yes

K. Not applicable

Options are:

- No
- Yes

The information in item C.2-C.4 is confidential. The individual / LAR is not required to respond to these in order to qualify for services.

2. Current special education

Options are:

- No
- Yes

If yes, indicate each environment where special education services are provided (more than one may apply)

Options for each of the following are:

- No
- Yes

A. General education

B. Resource room

C. Self-contained room

D. Special school

E. Home-based

F. Other (specify):

3. Individual has individualized education plan (IEP)

   Options are:

   - No (if no, skip to #5)
   - Yes

4. Individual or primary caregiver / guardian / LAR consents to share IEP with assessor and those involved with individual's care

   Options are:

   - No
   - Yes

5. Services currently provided at school or day program in the last 30 days (or since last assessment if individual has not been in school or day program in last 30 days

   A. Personal care services

      Options are:

      - No
      - Yes
      - N/A

   B. Habilitation

      Options are:

      - No
      - Yes
      - N/A

   C. Occupational therapy

      Options are:

      - No
      - Yes
      - N/A

D. Physical therapy

Options are:

- No
- Yes
- N/A

E. Speech therapy

Options are:

- No
- Yes
- N/A

F. Orientation and mobility specialist

Options are:

- No
- Yes
- N/A

G. Behavioral intervention plan (BIP)

Options are:

- No
- Yes
- N/A

H. Intensive behavioral intervention (IBI) or applied behavioral analysis (ABA)

Options are:

- No
- Yes
- N/A

I. Nursing services

Options are:

- No
- Yes
- N/A

J. Vision therapy

Options are:

- No
- Yes
- N/A

K. Audiology services

Options are:

- No
- Yes
- N/A

L. Other (specify):

Options are:

- No
- Yes
- N/A

6. Transition planning needed

   Only for individuals age 15 and older

   From one program o other (educational or vocational or age-specific)

   Options are:

   - No
   - Yes

   If yes, please specify in space provided.

7. Current employment status or volunteer work

   Only for individuals age 14 and older

   Options are:

   - Employed full-time
   - Employed part-time
   - Volunteer work
   - Interested in seeking employment
   - Not employed
   - Not applicable

8. Employment interest

   Only for individuals age 14 and older

   Options are:

   - Interested in new job
   - Not interested in new job
   - Not applicable

9. Type of employment or volunteer work

   Only for individuals age 14 and older

   A. Attends pre-vocational day/work activity program

      Options are:

      - No
      - Yes

B. Attends sheltered workshop

Options are:

- No
- Yes

C. Has paid job in the community

Options are:

- No
- Yes

D. Works at home

Options are:

- No
- Yes

E. Does volunteer work

Options are:

- No
- Yes

F. Other (specify):

Options are:

- No
- Yes

10. Need for assistance to work

Only for individuals age 14 and older

Options are:

- Independent (with assistive devices if uses them)
- Needs help weekly or less
- Needs help every day but does not need the continuous presence of another person
- Needs the continuous presence of another person
- Not applicable

11. Is there anything else that would be helpful to know about the individual for this section (Section C: School and Work)?

Section D. Diagnoses and Healthcare Utilization

1. Diagnosis type (record diagnoses and ICD codes and the month/year of the diagnosis)

   For each diagnosis, specify one of the following options:

   - Active medical, cognitive, or behavioral treatment, no exacerbation past 30 days
   - Active medical, cognitive, or behavioral treatment, acute exacerbation past 30 days
   - Inactive (but monitored)

2. List of all medications

   *List all active prescriptions, and any over the counter vitamins, supplements or medications taken in the **LAST 30 DAYS.***

   List all medications that the individual received during the last 30 days. Include scheduled medications that are used regularly, but less than weekly.

   Individual or LAR reports no active prescriptions, and no over the counter vitamins, supplements or medications taken in the LAST 30 DAYS.

   Options are:

   - No
   - Yes

   For each drug record the following information in the table provided:

   A. Name

   B. Dose- A number such as 0.5, 5, 150, 300. [Note: Never write a zero by itself after a decimal point (X mg). Always use a zero before a decimal point (example: 0.X mg).] Enter the med on more than one line to indicate if taking different doses, and add a comment in column D_2h "other information”

C. Unit – code using the following list:

- gtts (Drops)
- gm (Gram)
- L (Liters)
- Tab (Tablet)
- mcg (Microgram)
- mEq (Milli-equivalent)
- mg (Milligram)
- ml (Milliliter)
- oz (Ounce)
- Puffs
- % (Percent)
- Units
- Other (explain in column C)

D. Route of administration – code using the following list:

- PO (By mouth / orally)
- SL (Sublingual)
- IM (Intramuscular)
- IV (Intravenous)
- SQ (Subcutaneous)
- PR (Rectum)
- TOP (Topical)
- IH (Inhalation)
- NAS (Nasal)
- ET (Enteral Tube)
- TD (Transdermal)
- EYE (Eye)
- Other (route not listed, explain in column H)
- EAR (ear)
- VAG (Vaginally)

E. Frequency – code the number of times per day, week, or month the medication is administered using the following list:

- QH (Every hour)
- Q2H (Every 2 hours)
- Q3H (Every 3 hours)
- Q4H (Every 4 hours)
- Q6H (Every 6 hours)
- Q8H (Every 8 hours)
- QD (daily)
- HS (at bedtime)
- BID (2 times daily)
- TID (3 times daily)
- QID (4 times daily)
- QOD (Every other day)
- Q3D (Every 3 days)
- Weekly
- 2W (2 times weekly)
- PRN
- Monthly (Once per month)
- Other (explain in column h)

F. Stability - Indicate whether the medication is Stable (S), New in the last 30 days (N), dose has been adjusted (last 14 days), (A)

G. #PRN - If a medication is PRN, record the number of times the PRN medication was given over the past 30 days. If medication is NOT PRN, leave blank.

H. Other information - Provide any additional information about the medication (if OTHER is coded in unit, route, or Freq, use this field to explain).

I. Medication certification: individual / LAR certify the medication information listed in the table provided are correct.

   Options are:

   - No
   - Yes

3. Resists medications

   Options are:

   - No
   - Yes

   If yes, please specify in the space provided.

4. Does the individual receive medications via an enteral (feeding) tube?

   Options are:

   - No
   - Yes

5. Does the individual receive medications via injections (shots) in a location that is not a medical facility?

   Options are:

   - No
   - Yes

6. Does the individual receive infusions in a location that is not a medical facility?

   Options are:

   - No
   - Yes

7. Has a physician / medical professional diagnosed the individual with a condition that indicates there is a state of unconsciousness, persistent vegetative state or is in a coma?

   Options are:

   - No
   - Yes

8. Caregiver, individual or others are concerned about individual's developmental status or decline from baseline?

   A. Related to motor skills (i.e. sitting, walking, range of motion, balance, running, jumping)

      Options are:

      - No
      - Yes

   B. Related to communication (i.e. talking, understanding)

      Options are:

      - No
      - Yes

   C. Related to learning or academic skills (i.e. coloring, reading, writing, math)

      Options are:

      - No
      - Yes

   D. Related to self-care (i.e. dressing, bathing, personal hygiene, toileting)

      Options are:

      - No
      - Yes

   E. Related to social/emotional skill

      Options are:

      - No
      - Yes

9. Further assessment is needed to determine if individual is eligible / should be referred for ECI services

   Only for individuals under 36 months.

   If individual is under 36 months old and there are any developmental concerns, they may need further assessment for ECI services.

   Options are:

   - Currently receives ECI services.
   - No further assessment is needed.
   - Yes, further assessment is needed.

   If individual receives ECI services, answer questions below using the following options:

   Options are:

   - No
   - Yes
   - N/A

   A. Occupational therapy

   B. Physical therapy

   C. Speech therapy

   D. Vision services

   E. Behavioral intervention (BI)

   F. Nursing services

   G. Audiology services

   H. Nutrition / dietary

   I. Counseling

   J. Family education

   K. Psychological services

   L. Specialized skills training

   M. Social work services

   N. Case management (service coordination)

   O. Other (specify):

10. Documented severity of intellectual disability

    Options are:

    - No intellectual disabilities suspected
    - Borderline
    - Mild
    - Moderate
    - Severe
    - Profound
    - Suspected but severity not documented

11. Documented related condition

    Options are:

    - No related condition suspected
    - Diagnosed related condition (s)
    - Suspected but not diagnosed

12. Surgeries

    If more than 25 surgeries document in question D. 25

    Options are:

    - No (go to D.13)
    - Yes

    Document each surgery and year in table provided.

13. Allergies

    Options are:

    - No (if no, skip to D_14)
    - Yes (if yes, please complete table)

    In the table provided, document type, what individual is allergic to, reaction, and current treatment and notes.

    For type of allergy, options are:

    A. Environmental allergy

    B. Food allergy

    C. Medication allergy

14. Prenatal history / prematurity (only ask during initial assessment)

    A. Premature birth

       Options are:

       - No
       - Yes
       - Unknown

    B. Birth weight <1500 g (3 pounds 5 ounces)

       Options are:

       - No
       - Yes
       - Unknown

    C. Maternal health problems during pregnancy (e.g., preeclampsia, toxemia, substance abuse, gestational diabetes)

       Options are:

       - No
       - Yes
       - Unknown

15. Prevention

    A. Complete physical examination up-to-date

       Options are:

       - No
       - Yes
       - Unknown

    B. Dental exam up-to-date

       Options are:

       - No
       - Yes
       - Unknown

C. Eye screening up-to-date

Options are:

- No
- Yes
- Unknown

D. Hearing screening up-to-date

Options are:

- No
- Yes
- Unknown

E. Influenza vaccine up-to-date

Options are:

- No
- Yes
- Unknown

F. Immunizations up-to-date

Options are:

- No
- Yes
- Unknown

G. Autism screening performed (if applicable)

Options are:

- No
- Yes
- Unknown

H. Additional information, if necessary: (specify in space provided)

Options are:

- No
- Yes
- Unknown

16. Gynecological history (only for individuals age 10 or older)

A. Last menstrual period (specify date)

a. Regular

Options are:

- No
- Yes
- N/A

b. Irregular

Options are:

- No
- Yes
- N/A

c. N/A

Options are:

- No
- Yes
- N/A

B. Have you ever been pregnant, or do you have plans of being pregnant? (Only for individuals age 13 and older)

Options are:

- No
- Yes
- N/A

C. Additional information, if necessary:

17. Hospital use, emergency room use, physician visit, nursing home stay

Code for numbers of times during the LAST YEAR (or since last assessment if LESS THEN A YEAR AGO). Record all 9's if unknown.

A. Inpatient acute hospital admission planned (non-psychiatric)

B. Inpatient acute hospital admission unplanned (non-psychiatric)

C. Emergency room visit (with no inpatient admission)

D. Urgent care

E. Physician visit routine follow-up (or authorized assistant or practitioner)

F. Physician visit urgent need (or authorized assistant or practitioner)

G. Nursing home stay

H. Additional information, if necessary:

18. Time since last hospital admission

Code for most recent instance in last year.

Options are:

- No hospitalization within last year
- 6 to 12 months ago
- 1 to 5 months ago
- 8 to 30 days ago
- In the last 7 days
- Now in the hospital
- Unknown

19. Any planned hospitalization or surgeries (in-patient or out-patient) scheduled in the next 90 days?

If yes, specify type and date in the space provided.

Options are:

- No (go to D. 20)
- Yes

20. Individual currently uses or has a need for assistive devices / DME

If individual does not use assistive devices/ DME code "0"

Options are:

- Individual does not use DME/assistive devices
- Assistive device/DME is available and adequate
- Referral in place for assistive device/DME
- Referral needed to assess for unmet assistive device/DME need
- Reassessment needed to assess for device/DME need due to change in age or condition

If individual uses or has a need for DME/assistive device, specify the type(s) in space provided.

21. Individual uses disposable care supplies (e.g., formula, wipes, tips, dressings, etc.)

Options are:

- No
- Yes

If yes, please specify in space provided.

22. Individual has a medical emergency plan?

Options are:

- The individual does not have a condition or diagnosis that requires an emergency plan.
- Individual has a condition or diagnosis that requires an emergency plan and a plan is in place.
- Individual has a condition or diagnosis that requires an emergency plan and a plan is not in place.

  Specify additional information, if necessary.

23. Emergency contact

Specify name

Specify phone number of contact

24. Care transition planning

For individuals 15 and older.

A. Has the Individual's doctor or healthcare provider discussed having the individual see doctors or other healthcare providers who treat adults?

Options are:

- No
- Yes

a. If no, would discussions about transition care to adult providers have been helpful?

Options are:

- No
- Yes

B. Has the Individual's doctor or other healthcare provider discussed the individual's healthcare needs as they become an adult?

Options are:

- No
- Yes

a. If no, would discussions about transition care to adult providers have been helpful?

Options are:

- No
- Yes

C. Has anyone discussed how to obtain or maintain some form of health insurance coverage as the individual becomes and adult?

   Options are:

   - No
   - Yes

   a. If no, would discussions about transition care to adult providers have been helpful?

      Options are:

      - No
      - Yes

D. How often do the individual's doctors or healthcare providers encourage him or her to take responsibility for their healthcare needs (i.e., taking medications, understanding their health and medications, following medical advice)?

   Options are:

   - Never
   - Rarely
   - Occasionally
   - Frequently
   - Very frequently

25. Is There Anything Else That Would Be Helpful To Know About The Individual For This Section (Section D: Diagnoses and Healthcare Utilization)?

Section E. Strengths and Challenges in Performing Daily Tasks

(Note: questions in this section should be considered in the context of age appropriateness)

1. Cognitive skills for daily decision making

   Making decisions regarding tasks of daily life that are age appropriate-e.g., when to get up or have meals, which clothes to wear or activities to do

   Options are:

   - Independent – Decisions consistent, reasonable and safe
   - Modified independence – Some difficulty in new situations only
   - Moderately impaired – Decisions consistently poor or unsafe; cues/supervision required
   - Severely impaired – Never or rarely makes decisions
   - Unable to assess

2. Making self understood (expression)

   Expressing information content- both verbal and non-verbal (however able; with communication device, if normally used)

   Options are:

   - Understood – Expresses self without difficulty
   - Usually understood – Difficulty finding words or finishing thoughts AND prompting usually required
   - Sometimes understood – Ability is limited to making concrete requests
   - Rarely or never understood
   - Unable to assess

3. Ability to understand others (comprehension)

   Understanding verbal information content (however able; with hearing appliance, if normally used)

   Options are:

   - Understands – Clear Comprehension
   - Usually understands – Misses some part/intent of message BUT comprehends most of the conversation
   - Sometimes understands – Responds adequately to simple, direct communication only
   - Rarely or never understands
   - Unable to assess

4. Periodic disordered thinking or awareness

   (*Note: Accurate assessment requires conversations with family or others who have direct knowledge of the individual's behavior over this time)*

   A. Easily distracted – e.g., episodes of difficulty paying attention; gets sidetracked

      Options are:

      - Not present
      - Present, consistent with usual functioning
      - Present, appears different from usual (e.g., new onset or worsening; different from a few weeks ago)

   B. Episodes of disorganized speech - e.g., speech is nonsensical, irrelevant, or rambling from subject to subject; loses train of thought

      Options are:

      - Not present
      - Present, consistent with usual functioning
      - Present, appears different from usual (e.g., new onset or worsening; different from a few weeks ago)

C. Mental function varies over course of day - e.g., sometimes better, sometimes worse

Options are:

- Not present
- Present, consistent with usual functioning
- Present, appears different from usual (e.g., new onset or worsening; different from a few weeks ago)

5. Acute Change In Mental Status From Individual's Usual Functioning (e.g., restlessness, lethargy, difficult to arouse, altered environmental perception)

   Options are:

   - No
   - Yes

6. Change In Decision-Making Compared To 90 Days Ago (or since last assessment if less than 90 days ago)

   Options are:

   - Improved
   - No change
   - Declined
   - Uncertain

7. Is There Anything Else That Would Be Helpful To Know About The Individual For This Section (Section E: Strengths and Challenges in Performing Daily Tasks)?

Section F. Nutritional and Sleep Status / Concerns

1. Height / Weight and BMI

   Record (a.) height in inches or centimeters and (b.) weight in pounds or kilograms. Base weight on most recent measure known. If height, weight or BMI is unknown, enter "9" in the boxes provided.

   A. Height (in.) (specify in space provided) OR Height (cm.) (specify in space provided)

   B. Weight (lbs.) (specify in space provided) OR Weight (kg.) (specify in space provided)

   C. BMI (specify in space provided)

   D. Date of height / weight / BMI measurements

      Options are:

      - Within last 30 days
      - Within last 90 but not last 30 days
      - Within last year but not last 90 days
      - Greater than last year
      - Unknown

2. Are there any concerns about individual's weight gain / loss in last 6 months?

   Options are:

   - No
   - Yes

   If yes, please specify in space provided.

3. Mode of nutritional intake

   A. Normal – swallow all typical foods

      Options are:

      - No
      - Yes

B. Modified independent - independent oral intake using safe swallow strategies with set up alone. Need for modification may be unknown.

   Options are:

   - No
   - Yes

C. Modified supervision - modified diet AND cueing and supervision for safety is required

   Options are:

   - No
   - Yes

D. Requires diet modification to swallow solid food - mechanical diet (e.g., pureed, minced) or only able to digest specific foods

   Options are:

   - No
   - Yes

E. Requires modifications to swallow liquids – e.g., thickened liquids

   Options are:

   - No
   - Yes

F. Enteral feeding – nasogastric, percutaneous endoscopic gastrostomy (PEG) tube or G-button, j-tube

   Options are:

   - No
   - Yes

G. Parenteral feeding - includes all types of parenteral feeding, such as total parenteral nutrition (TPN)

   Options are:

   - No
   - Yes

4. Dietary requirements
    A. Individual requires special diet (e.g., gluten-free)

        Options are:

        - No
        - Yes

        If yes, please specify in space provided.

    B. Special ordered diet is new or has been changed since last assessment

        Options are:

        - No
        - Yes

    C. Additional electrolyte drink / formula / protein shake / juice given between meals

        Options are:

        - No
        - Yes

5. Sleep patterns (the look back period for this question is 7 days)
    A. Based on the following information, individual typically receives the recommended amount of sleep daily (including naps)

        a. 0-2 months old: 12-18 hours of sleep
        b. 3-11 months old: 14-15 hours of sleep
        c. 12-35 months old: 12-14 hours of sleep
        d. 3-4 years old: 11-13 hours of sleep
        e. 5-10 years old: 10-11 hours of sleep
        f. 11-17 years old: 8.5-9.5 hours of sleep
        g. 18-21 years old: 7-9 hours of sleep

        Options are:

        - No problem
        - Too little sleep
        - Too much sleep

B. Average number of times individual wakes up during the night

C. Average number of days in week individual wakes up during the night without returning to sleep

D. Barriers to individual sleeping

Code each item (more than one may apply)

Options for each of the following items are:

- No
- Yes

a. Individual needs care (e.g., medication, repositioning) during the night

b. Individual wakes for toileting or incontinence needs

c. Individual has difficulty sleeping through night because of disease / condition or pain

d. Other (specify)

E. Individual falls asleep at inappropriate times

Options are:

- No
- Yes

6. Is there anything else that would be helpful to know about the individual for this section (Section F: Nutritional and sleep status/concerns)?

Section G. Current Treatment and Procedures

1. Treatments in last 30 days

   Code yes if the treatment was provided in any setting. Include treatments provided by licensed and unlicensed caregivers

   Options for each of the following items are:

   - No
   - Yes

   A. Chemotherapy

   B. Dialysis

   C. IV medication

   D. Oxygen therapy

   E. Radiation

   F. Tracheal and/or naso-pharyngeal suctioning

   G. Oral suctioning

   H. Tracheostomy care

   I. Transfusion

   J. Ventilator

   K. Wound care / Skin care

   L. Nebulizer

   M. Urinary catheter care-insertion or maintenance

   N. Continuous positive airway pressure (CPAP) or Bilevel positive airway pressure (BiPAP)

   O. Chest percussive therapy (vest or manual)

   P. Active medication adjustment /titration /monitoring

   Q. IPPB (Intermittent Positive Pressure Breathing)

   R. Seizure interventions (includes routine seizure medications)

   S. Ostomy / Stoma care

   T. Intrapulmonary Percussive Ventilators (IPV)

   U. Mechanical Insufflation-Exsufflation Device (e.g. CoughAssist)

V. Other (specify)

2. Care provided by any formal agency or service provider in the last 30 days.

   Types of services and supports provided in the last 30 days. These occurred once or more in this time frame.

   Options for each of the following items are:

   - No
   - Yes

   A. Personal care services / attendant care / home health aide / Habilitation

   B. Nursing services

   C. Medical transportation program

   D. Homemaking services

   E. Meals

   F. Respiratory therapy

   G. Physical therapy

   H. Occupational therapy

   I. Speech-language pathology or audiology services

   J. Palliative care program

   K. Hospice

   L. Prescribed Pediatric Extended Care Center (PPECC)

   M. Other (specify)

3. Pain control – adequacy of current therapeutic regimen to control pain

   [note: use G.4 to comment on additional information]

   Options are:

   - No issue of pain
   - Pain intensity acceptable to individual; no treatment regime or change in regimen required
   - Controlled adequately by therapeutic regimen
   - Controlled when the therapeutic regimen followed, but not always followed
   - Therapeutic regimen followed, but pain control not adequate
   - No therapeutic regimen being followed for pain; pain not adequately controlled

4. Is there anything else that would be helpful to know about the individual for this section (Section G: Current Treatment and Procedures)?

Section H. Mental Health and Behavioral Health Concerns

1. Observed mental health symptoms

   Options for each of the following items are:

   - No
   - Yes

   A. Persistent anger with self or others**-** easily annoyed; anger at care received

   B. Pattern of irritability- marked increase in being short-tempered or upset more than expected

   C. Pattern of defiance- active, persistent refusal to comply with reasonable requests (e.g., active refusal to complete chores, actively disobeys rules)

   D. Pressured speech or racing thoughts- rapid speech, rapid transition from topic to topic

   E. Compulsive behavior- e.g., hand washing, repetitive checking of room, counting, hoarding

F. Impulsive- e.g., running into traffic, takes risky actions without thinking, difficulty taking turns, interrupts

G. Easily distracted- e.g., episodes of difficulty paying attention, gets sidetracked

H. Flat or blunted affect- indifference, non-responsiveness, hard to get to smile, etc.

I. Episodes of panic- cascade of symptoms of fear, anxiety, or loss of control

J. Hallucinations (auditory or visual)- false sensory perceptions in the absence of external stimuli

K. Delusions- fixed false beliefs (e.g., grandiose, paranoid, somatic, excluding beliefs specific to individual's culture or religion)

2. Observed behaviors

Options for each of the following items are:

- No
- Yes

A. Wandering/elopement – attempts to or exits/leaves home/school, etc. at inappropriate times, without notice/permission, seemingly oblivious to needs for safety when moving

B. Resists care- e.g., taking medications/injections, ADL assistance, eating

C. Verbally abusive/argumentative- e.g., others were threatened, cursed at

D. Physically abusive – e.g., shoves, scratches, pinches, bites others

E. Bullying others – e.g., pattern of repeated oppression or victimization of others

F. Repetitive behavior that interferes with normal activities – e.g., finger flicking, rocking, spinning objects

G. Destructive behavior towards properties - e.g., throwing or breaking objects, turning over beds or tables, vandalism

H. Fire-setting or preoccupation with fire - e.g., playing with matches or lighters unsupervised, deliberate fire setting

I. Sexual behavior - sexual behavior that has an impact on social relationships or interferes with everyday functioning (e.g., excessive masturbation, masturbation in public, excessive touching or physical contact (of others)

J. Cruelty to animals - deliberate physical injury to or torture of animals (excludes behaviors that are consistent with cultural norms)

K. Injury to self/Others

L. Suicide/Homicide attempt

M. Suicidal/Homicidal Ideations

N. Pica- craving and chewing substances that have no nutritional value

3. Any medications to assist with behavioral health issues (e.g., anti-anxiety, anti-depressant, sedative, hypnotic, anti-psychotic or anti-convulsive)?

   Options are:

   - No
   - Yes

4. Urgent mental / behavioral health service use in the last 6 months

   Because of mental or behavioral problem, admission to inpatient treatment facility, trip to ER or unscheduled visit to health professional.

   Options are:

   - No occurrence
   - Occurred

5. Formal care or treatment received in last 30 days

   Options for each of the following items are:

   - Not needed
   - Needed and received
   - Needed and not received

   A. Psychiatric facility admission (or psychiatric unit of acute care hospital)

   B. Visit to Psychiatrist, Psychologist, licensed mental health professional or developmental specialist

   C. Substance abuse program

   D. Targeted case management

If individual needed but did not receive a service, specify the reason in space provided.

6. Individual has behavior inappropriate to situation that respond to caregiver intervention

   Options are:

   - No
   - Yes

   If no, skip to H.7. If yes, code each item.

   A. Individual can be redirected

   B. Individual responds to verbal reinforcement

   C. Individual responds to rewards

   D. Other (specify)

7. Lifestyle

   Code for last 30 days, unless otherwise specified.

   A. Uses any tobacco or vaping

      Options are:

      - No
      - Yes

   B. Alcohol- highest number of drinks in any "single sitting" in LAST 14 DAYS

      Options are:

      - None
      - 1
      - 2-4
      - 5 or more

   C. Uses illegal drugs or misuses prescription medication

      Options are:

      - No
      - Yes

D. Engages in risky sexual behavior

Options are:

- No
- Yes

8. Is there anything else that would be helpful to know about the individual for this section (Section H: Mental Health and Behavioral Health Concerns)?

Section I. Cognition and Executive Functioning

(code items for last 30 days unless otherwise specified)

1. Memory / recall ability

   Only for individuals age 4 and older. Code for recall of what was learned or known.

   A. Short-term memory OK- Seems/appears to recall after 5 minutes

   Options are:

   - Yes, memory ok
   - Memory problem
   - Unable to assess

   B. Long-term memory OK- Seems/appears able to recall more distant past (e.g., individuals activities last week or special events)

   Options are:

   - Yes, memory ok
   - Memory problem
   - Unable to assess

   C. Procedural memory OK**-** Can perform all or almost all steps in a multitask sequence without cue

   Options are:

   - Yes, memory ok
   - Memory problem
   - Unable to assess

D. Situational memory OK**-** Both: recognizes caregivers' names/faces frequently. Encountered AND knows location of places regularly visited (bedroom, bathroom, classroom)

Options are:

- Yes, memory ok
- Memory problem
- Unable to assess

2. Is there anything else that would be helpful to know about the individual for this section (Section I: Cognition and Executive Functioning)?

Section J. Hearing and Vision

(code items for last 30 days unless otherwise specified)

2. Hearing

Ability to hear (with hearing appliance, if normally used)

Options are:

- Adequate – No difficulty in normal conversation, social interaction, listening to TV
- Minimal / moderate difficulty – Problem hearing normal conversation, requires quiet setting to hear well OR difficulty in some environments
- Severe difficulty – Difficulty in all situations (e.g., speaker has to talk loudly or speak very slowly; or individual reports that all speech is mumbled)
- No hearing

2. Ability to see near or far in adequate light

Ability to see near or far in adequate light (with glasses or with other visual appliances, if normally used)

Options are:

- Adequate – Saw fine detail, including fine detail in pictures, regular print in books
- Some impairment – Limited vision; was able to see large print or numbers in books; identify large objects in pictures

- Highly impaired – vision or saw only light, colors, or shapes; eyes do not appear to follow objects
- Cortical blindness – No vision, did not see light, colors, or shapes; and eyes do not appear to follow objects. *(physician diagnosed)*

3. Is there anything else that would be helpful to know about the individual for this section (Section J: Hearing and Vision)?

Section K. Functional Status

(code items for last 30 days unless otherwise specified)

1. Instrumental activities of daily living (IADLs) self-performance

   Code for effect based on whether or not illness or condition (including behavioral health or IDD) affects the performance of task. Use the following options for effect:

   - Individual's condition does not affect the performance of the task by the individual or caregiver (i.e., time it takes to do task or the number of persons needed to do task)
   - Individual's condition affects the performance of the task by the individual or caregiver (regularly takes longer to perform OR two-person assistance regularly provided/needed)

   Code for individual’s current level of performance in routine activities around the home or in the community. Use the following options to indicate the individual’s current level of performance:

   - Independent - Set-up help, cueing/redirection, or hands-on assistance never provided OR provided no more than 1 or 2 times
   - Set-up help only - Set-up help provided>or equal to 3 times
   - Cueing/Redirection - Standby assistance, encouragement, cueing, redirection provided > or equal to 3 times
   - Limited assistance - Individual highly involved in activity; received help on some occasions (at least 3 times)
   - Extensive assistance - Individual received help throughout task most of the time, or full performance by others some, but not all, of the time
   - Total dependence - Full performance by others during entire period

- Activity did not occur - During entire period

For each of the following items, select a response for both effect and performance indicated above.

A. Meal preparation – Preparing meals and snacks; assembling ingredients; cutting, chopping, grinding or pureeing food; setting out food and utensils; serving food; preparing and pouring a predetermined amount of liquid nutrition; cleaning the feeding tube; cleaning area after meal; washing dishes.

B. Medication assistance or administration – Assisting with oral medications that are normally self-administered

C. Telephone use or other communication – making or receiving telephone calls; managing and setting up communication devices.

D. Escort or assistance with transportation services – making transportation arrangements for medical and other appointments; accompanying the individual to a healthcare appointment to assist with needed ADLs.

E. Laundry – doing laundry; gathering, sorting, washing, drying, folding, and putting away personal laundry, bedding, and towels; removing bedding to be washed and remaking the bed; using a laundry facility.

F. Light housework – Performing light housework such as cleaning and putting away dishes; wiping countertops; dusting; sweeping, vacuuming or mopping; changing linens and making bed; cleaning bathroom; taking out trash.

G. Grocery and household shopping – Shopping for grocery and household items; preparing a shopping list; putting food and household items away; picking up medication and supplies.

H. Money management – Managing day-to-day finances; paying bills/balancing checkbook; making deposits or withdrawals; assisting in preparing and adhering to a budget.

2. Activities of daily living (ADLs) self-performance

Consider all episodes of care.

Code for EFFECT based on whether or not illness or condition (including behavioral health or IDD) affects the performance of tasks. Use the following options for effect:

- Individual's condition does not affect the performance of the tasks (i.e., time it takes to do tasks or the number of persons needed to do task)
- Individual's condition affects the performance of the task (because of child's condition, task regularly takes longer to perform OR two-person assistance regularly provided/needed)

Code for individual's current level of performance in routine activities around the home or in the community. Use the following options to indicate the individual's current level of performance:

- No help/independent - No set-up help, redirection/cueing, hands-on assistance OR some type of help provided only 1 or 2 times
- Set-up help only - Set-up help provided > or equal 3 times
- Cueing/Redirection - Standby assistance, encouragement, cueing, redirection provided > equal 3 times
- Limited assistance - Individual highly involved in activity; received physical/hands-on help (e.g., guided maneuvering of limbs) that is non-weight bearing > equal 3 times
- Extensive assistance - While individual performed part of activity, help of the following type(s) was provided 3 or more times: Weight-bearing support; Full caregiver performance during part (but not all) of 30-day period
- Total dependence - Full caregiver performance of activity during entire 30-day period (e.g., each time activity occurred)
- Activity did not occur during entire period

For each of the following items, select a response for both effect and performance indicated above.

- Locomotion or Mobility- Moving between locations; walking or using a wheelchair, walker, or other mobility equipment.
- Positioning- Positioning body while in a chair, bed or other piece of furniture or equipment; changing and adjusting positions; moving to or from a sitting position; turning side-to-side; assisting the client to sit upright.
- Eating- Using utensils or special or adaptive eating devices; clean up after task is completed.

- Transferring- Moving from one surface to another with or without a sliding board; moving from bed, chair, wheelchair, or vehicle to a new position; moving the client with lift devices.
- Toileting- Some or all parts of toileting; using commode, bedpan, urinal, toilet chair; transferring on and off, cleansing, changing diapers, pad, incontinence supplies; adjusting clothing; clean up after task is completed.
- Dressing- Any or all parts of getting dressed; putting on, fastening, and taking off all items of clothing; donning and removing shoes or prostheses; choosing and laying out weather appropriate clothing.
- Personal hygiene- Some or all parts of personal hygiene; routine hair care; oral care; ear care; shaving; applying makeup; managing feminine hygiene; washing and drying face, hands, perineum; basic nail care; applying deodorant; routine skin care; clean up after task is completed.
- Bathing- Any or all parts of bathing; selecting appropriate water temperature and flow speed, turning water on and off; laying out and putting away supplies; transferring in and out of bathtub or shower; washing and drying hair and body; clean up after task is completed.

3. Individual needs cueing / redirection during ADLs or IADLs due to a mental, behavior or developmental problem / condition

   Options are:

   - No
   - Yes

4. Primary mode of locomotion

   Options are:

   - Crawling/Scooting
   - Walking, no assistive device
   - Walking, uses assistive device-e.g., cane, walker, crutch, pushing wheelchair
   - Wheelchair, scooter
   - Bedbound

5. Change in functional abilities as compared to 90 days ago, or since last assessment if less than 90 days ago

   Options are:

   - Improved
   - No Change
   - Declined
   - Uncertain

6. Is there anything else that would be helpful to know about the individual for this section (Section K. Functional Status)?

Section L. Continence

1. Bladder continence

   Only for individuals age 4 and older.

   Code for individual's control of urinary bladder function with appliances or programs, if used.

   Options are:

   - Continent - Complete control; DOES NOT USE any type of catheter or other urinary collection device
   - Complete control with appliance or program - over last 7 days
   - Infrequently incontinent - Not incontinent over last 7 days, but does have incontinent episodes
   - Occasionally incontinent - Less than daily
   - Frequently incontinent - Daily, but some control present
   - Incontinent - No control present
   - Nighttime Incontinence ONLY in LAST 7 DAYS
   - Did not occur - No urine output from bladder in last 7 days (referral needed)

2. Bowel continence

   Only for individuals age 4 and older

   Code for individual's control of bowel movement with appliances or programs, if used.

   Options are:

- Continent - Complete control; DOES NOT USE any type of appliance of program
- Control with appliance or program - over last 7 days
- Infrequently incontinent - Not incontinent over last 7 days, but does have incontinent episodes
- Occasionally incontinent - Less than daily
- Frequently incontinent - Daily, but some control present
- Incontinent - No control present
- Nighttime Incontinence ONLY in LAST 7 DAYS
- Did not occur - No bowel movement in last 7 days (further assessment needed)

3. Is there anything else that would be helpful to know about the individual for this section (Section L: Continence)?

Section M. Habilitation Needs

(code items for the last 30 days unless otherwise specified)

1. Are you interested in the CFC benefit?

   Options are:

   - No
   - Yes

2. Goals / desired outcomes for habilitation
3. Individual has preferred learning style

   A. Visual

      Options are:

      - No
      - Yes

   B. Aural

      Options are:

      - No
      - Yes

C. Verbal

Options are:

- No
- Yes

D. Physical

Options are:

- No
- Yes

E. Solitary

Options are:

- No
- Yes

F. Social

Options are:

- No
- Yes

G. Logical

Options are:

- No
- Yes

H. Unable to determine

Options are:

- No
- Yes

4. Skill acquisition and training activities related to attendant care needs

   Individual requires training to acquire, enhance, or maintain the skills needed to perform the following ADLS or IADLs. If yes, note individual's preferences for learning to do tasks. Refer to IADL and ADL definitions in items K.1 and K.2 if needed.

   A. Meal preparation

      Options are:

      - No
      - Yes

   B. Medication assistance or administration

      Options are:

      - No
      - Yes

   C. Telephone use or other communication

      Options are:

      - No
      - Yes

   D. Escort or assistance with transportation

      Options are:

      - No
      - Yes

   E. Laundry

      Options are:

      - No
      - Yes

   F. Light housework

      Options are:

      - No
      - Yes

G. Grocery or household shopping

Options are:

- No
- Yes

H. Money management

Options are:

- No
- Yes

I. Locomotion or mobility

Options are:

- No
- Yes

J. Positioning

Options are:

- No
- Yes

K. Eating

Options are:

- No
- Yes

L. Transferring

Options are:

- No
- Yes

M. Toileting

Options are:

- No
- Yes

N. Dressing

Options are:

- No
- Yes

O. Personal hygiene

Options are:

- No
- Yes

P. Bathing

Options are:

- No
- Yes

5. Additional habilitation needs

Individual requires training to acquire, enhance or maintain the following skills. If yes, note individual's preferences for learning to do tasks and their desired goal.

A. Community integration

Options are:

- No
- Yes

B. Use of DME / assistive devices

Options are:

- No
- Yes

C. Personal decision-making

Options are:

- No
- Yes

D. Communication

Options are:

- No
- Yes

E. Increase positive social encounters and engagement in preferred activities

Options are:

- No
- Yes

F. Socialization / relationship development

Options are:

- No
- Yes

G. Accessing leisure and recreation activities

Options are:

- No
- Yes

H. Use of community resources

Options are:

- No
- Yes

I. Other (specify)

Options are:

- No
- Yes

J. Other (specify)

Options are:

- No
- Yes

Texas STAR Kids Screening and Assessment – NCAM

(Code items for last 30 days unless otherwise specified)

Section N. Complex Conditions and Nursing Care

Neurological

1. Individual has seizure disorder

   Options are:

   - No (if no, skip to N.2)
   - Yes

   A. Presence of seizures new since last assessment

      Options are:

      - No
      - Yes (code yes, if seizures is a new diagnosis since last assessment)

   B. Average number of seizures

      Options are:

      - No seizures
      - Less than 1 seizure per week
      - 1-6 seizures per week
      - 1 seizure per day
      - 2-5 seizures per day
      - 6-12 seizures per day
      - More than 12 seizures per day

C. Typical level of seizure intervention

Options are:

- Mild- stable with or without routine seizure medications
- Moderate- rescue medications or other intervention (as listed in item f) required during seizure
- Severe- rescue medications and additional interventions required during a seizure

D. Type of seizures in the last 30 days

Code all that apply

a. Generalized

Options are:

- No
- Yes

b. Focal / partial

Options are:

- No
- Yes

c. Other (specify)

Options are:

- No
- Yes

d. Date of last seizure (month / year)

e. Frequency of interventions

(1) Ambu-bag

Options are:

- Never used
- Less than 4 times a month
- 1-6 times a week
- Daily
- More than 2 times per day

(2) Rescue breaths

Options are:

- Never used
- Less than 4 times a month
- 1-6 times a week
- Daily
- More than 2 times per day

(3) Suctioning

Options are:

- Never used
- Less than 4 times a month
- 1-6 times a week
- Daily
- More than 2 times per day

(4) Oxygen

Options are:

- Never used
- Less than 4 times a month
- 1-6 times a week
- Daily
- More than 2 times per day

(5) Rescue medication

Options are:

- Never used
- Less than 4 times a month
- 1-6 times a week
- Daily
- More than 2 times per day

(6) Vagal nerve stimulator (VNS)

Options are:

- Never used
- Less than 4 times a month
- 1-6 times a week
- Daily
- More than 2 times per day

(7) Deep brain stimulation (DBS)
Never used

Options are:

- Less than 4 times a month
- 1-6 times a week
- Daily
- More than 2 times per day

2. New or revised ventricular shunts within last 30 days

   Options are:

   - No
   - Yes

3. Nursing services related to neurological care

   In-home treatments and programs received or scheduled in the **LAST 7 DAYS**

   Use these codes for the following items unless otherwise specified:

   A. Neurological assessment frequency greater than once per shift (reflexes, Glascow Coma Scale, pupillary reaction, etc.)

      Do not code interventions already coded in N.1f

   B. Other (specify):

   C. Additional neurological information, if necessary:

Airway Management

1. Individual uses physician ordered apnea monitor

   Options are:

   - No (if no, skip to N.5)
   - Yes

   A. Used:

      Options are:

      - 1-6 hours per day
      - 7-12 hours per day
      - 13-23 hours per day
      - Continuous
      - PRN (If PRN, specify date of last use, frequency of PRN use and reason why)

   B. Individual uses an apnea monitor during sleep

      Options are:

      - No
      - Yes

2. Individual uses a physician ordered pulse oximeter

   Options are:

   - No (if no, skip to N.6)
   - Yes

   A. Used:

      Options are:

      - 1-6 hours per day
      - 7-12 hours per day
      - 13-23 hours per day
      - Continuous
      - PRN (If PRN, specify date of last use, frequency of PRN use and reason why)

3. Individual uses a physician ordered Bi-PAP or CPAP

   If a Multifunction Ventilator (or other mechanical ventilation device) is being used for Bi-PAP or CPAP code here

   Options are:

   - No (if no, skip to N.7)
   - yes

   A. Used:

      Options are:

      - 1-6 hours per day
      - 7-12 hours per day
      - 13-23 hours per day
      - Continuous
      - PRN (If PRN, specify date of last use, frequency of PRN use and reason why)

4. Individual has tracheostomy

   Options are:

   - No (if no, skip to N.8)
   - Yes

   A. New or revised within last 30 days

      Options are:

      - No
      - Yes

   B. Tracheostomy size needed (specify size)

   C. Tracheostomy is

      Options are:

      - Cuffed
      - Uncuffed

D. Speaking valve

Options are:

- No
- Yes

E. Appearance of site in the last 30 days

a. Site is red

Options are:

- Not present
- Present

b. Site has signs of drainage

Options are:

- Not present
- Present

c. Site shows excoriation

Options are:

- Not present
- Present

d. Shows other problems

Options are:

- Not present
- Present

If "present" please specify in space provided.

F. Tracheal suctioning in a 24-hour day

Options are:

- Once a day or less frequently than daily
- 2-5 times a day
- 6-11 times a day
- 12 or more times a day

G. Additional information on tracheostomy if necessary (specify)

5. Individual uses a physician ordered supplemental oxygen

Options are:

- No (if no, skip to N.9)
- Yes

A. Used:

Options are:

- Intermittently
- Continuously
- PRN (if PRN, specify date of last use, frequency of PRN and reason why)

B. Oxygen has to be titrated

Options are:

- No
- Yes

C. Oxygen administered via

Options are:

- Nasal Cannula
- Mask
- Tracheostomy

D. Additional information about supplemental oxygen, if necessary (specify).

6. Individual uses ventilator

   Options are:

   - No (if no, skip to N.10)
   - Yes

   A. Used

      Options are:

      - Intermittently
      - Continuously
      - PRN (if PRN, specify date of last use and reason why)

   B. Additional information on ventilators, if necessary (specify).

7. Physician ordered nursing services related to airway management care

   In-home treatments and programs received or scheduled in the LAST 7 DAYS

   Use these codes unless otherwise specified for each of the following items:

   - No
   - Yes

   A. Apnea monitor

   B. Pulse oximeter

   C. Naso-pharyngeal suctioning

   D. Tracheal suctioning

   E. Bi-Pap or C-Pap

   F. Chest vest

   G. Percussor

   H. Manual chest physical therapy (CPT)

   I. Tracheostomy care

   J. Nebulizer

   K. Aspiration precaution

   L. Intrapulmonary percussive ventilators (IPV)

   M. Mechanical insufflation-exsufflation device (e.g., CoughAssist)

N. Oxygen

O. Intermittent positive pressure breathing (IPPB)

P. Ventilator

Q. Other (specify)

R. Other (specify)

Nutritional

1. Enteral feeding (e.g., NG/G tube / J tube)

   Options are:

   - No (if no, skip to N.12)
   - Yes (If yes, answer the following questions.)

   A. Frequency of enteral feedings

      Options are:

      - Not used
      - Less frequently than or equal to every 4 hours
      - More frequently then every 4 hours
      - Continuously

      a. Via bolus

         Options are:

         - No
         - Yes

      b. Via drip

         Options are:

         - No
         - Yes

      c. Via pump

         Options are:

         - No
         - Yes

B. Tube specifications
   - Diameter (FR)
   - Length (cm)

C. Tube site care

   Options are:
   - Needed daily
   - Needed bid
   - Needed every 8 hours

D. Appearance of tube site

   a. Tube site is red

      Options are:
      - No
      - Yes

   b. Tube site has signs of drainage

      Options are:
      - No
      - Yes

   c. Tube site shows other problems

      Options are:
      - No
      - Yes (if yes, please specify)

E. Concerns with feeding

Options are:

- Never
- Rarely
- Often
- After each feeding (if this option is indicated, please answer each of the following items with these options: no, yes)
  - Because of feeding, experiences irritability
  - Because of feeding, experiences distension
  - Because of feeding, experiences vomiting

a. Feeding over night

Options are:

- No
- Yes

F. Additional information on tube feedings, if necessary

2. Signs and symptoms of possible swallowing disorder

A. Loss of liquids/solids from mouth when eating or drinking

Options are:

- Never
- Rarely
- Often
- After each feeding
- NPO

B. Holding food in mouth-cheeks/residual food in mouth during or after meals

   Options are:

   - Never
   - Rarely
   - Often
   - After each feeding
   - NPO

C. Coughing or choking during meals or when swallowing medications

   Options are:

   - Never
   - Rarely
   - Often
   - After each feeding
   - NPO

D. Complaints of difficulty or pain when swallowing

   Options are:

   - Never
   - Rarely
   - Often
   - After each feeding
   - NPO

E. Other (specify)

   Options are:

   - Never
   - Rarely
   - Often
   - After each feeding
   - NPO

3. Nursing services related to nutrition

   *In-home treatments and programs received or scheduled in the **last 7 days.***

   Use the following codes for items 'a' through 'f' unless otherwise specified:

   - No
   - Yes

   A. Parental / IV feeding

   B. Feeding tube (e.g., NG/G tube / J tube)

   C. Reflux precautions

   D. Other (specify)

   E. Other (specify)

   F. Additional information on nutrition, if necessary

Medication

1. Individual receives medication via IV (in-home)

   Options are:

   - No (if no, skip to N.15)
   - Yes

   A. Method of IV access

      Options are:

      - Peripheral
      - Peripherally inserted central catheter (PICC)
      - Broviac/Hickman central line
      - Groshong central line
      - Central line port
      - Other (specify)

   B. Appearance of IV site

      Options are:

      - No
      - Yes

a. IV site is red

Options are:

- No
- Yes

b. IV site has signs of drainage

Options are:

- No
- Yes

c. Signs of swelling

Options are:

- No
- Yes

d. Signs of infiltration

Options are:

- No
- Yes

e. Signs of extravasation

Options are:

- No
- Yes

f. Signs of infection

Options are:

- No
- Yes

g. Other problem(s) (specify)

Options are:

- No
- Yes

C. Frequency of IV site care

Options are:

- Weekly
- Twice a week
- Three times a week
- Other (specify)

2. Nursing services related to medication care / administration

In-home treatments and programs received or scheduled in the last 7 days.

A. IV medication

B. Injectable medication

C. Medication by enteral tube

D. Lab draw

E. Finger stick

F. Complex medication administration and/or RX < q2h intervals

G. Medication requiring post-administration monitoring (e.g., vital signs, notating effects on condition, etc.)

H. Other (specify)

I. Other (specify)

J. Additional information on medication, if necessary.

Elimination

1. Individual has constipation

Options are:

- No (if no, skip to item N.17)
- Yes

A. Average bowel movement frequency

Options are:

- 1 to 3 days
- 4 to 7 days
- More than 7 days

B. High fiber diet (may include fiber supplement)

Options are:

- No
- Yes

C. Number of medications taken for constipation (oral stool softener, laxative, suppositories, etc.)

Options are:

- None
- One
- Two or more

D. Enemas used

Options are:

- None
- 1 to 2 times per month
- Weekly or more often

E. History of dis-impaction

Options are:

- None
- One to two times per month
- Weekly or more often

2. Individual has urinary catheter

   Options are:

   - No (If no, skip to item N.18)
   - Yes

   A. Type of catheter

      Options are:

      - Indwelling (Foley)
      - Intermittent
      - External
      - Suprapubic Catheter

3. Physician ordered nursing services related to elimination care

   In-home treatments and programs received or scheduled in the last 7 days.

   A. Urinary toileting program

      Options are:

      - No
      - Yes

   B. Bowel continence program

      Options are:

      - No
      - Yes

   C. Digital stimulation

      Options are:

      - No
      - Yes

   D. Home dialysis

      Options are:

      - No
      - Yes

E. Ostomy (specify)

Options are:

- No
- Yes

F. Other (specify)

Options are:

- No
- Yes

G. Additional information on elimination, if necessary (specify)

Options are:

- No
- Yes

Integumentary

1. Individual's skin status

A. Current skin color

Options are:

- Pink/WNL
- Pale
- Jaundice
- Cyanotic

B. Current skin condition

a. Warm

Options are:

- No
- Yes

b. Hot

Options are:

- No
- Yes

c. Cool

Options are:

- No
- Yes

d. Cold

Options are:

- No
- Yes

e. Dry

Options are:

- No
- Yes

f. Diaphoretic

Options are:

- No
- Yes

C. Current number of pressure injuries at each stage

a. Stage l: any area of persistent skin redness

b. Stage ll: partial loss of skin layers

c. Stage lll: deep craters in the skin

d. Stage IV: breaks in skin exposing muscle or bone

e. Unstageable (e.g., slough and/or eschar predominant)

D. Pressure injury site or additional information (specify)

E. Prior pressure injury(s) in last 30 days

Options are:

- No
- Yes

F. Total number of venous and arterial injuries currently present

G. Other skin problems currently present

a. Open lesions other than injuries, rashes, cuts (e.g., cancer lesion)

Options are:

- No
- Yes

b. Surgical wound(s)

Options are:

- No
- Yes

c. Burn(s) (second or third degree) (if yes, please specify)

Options are:

- No
- Yes

2. Nursing services related to integumentary care

In-home treatments and programs received or scheduled in the last 7 days.

A. Pressure reducing device for chair

Options are:

- No
- Yes

B. Pressure reducing device for bed

Options are:

- No
- Yes

C. Turning/repositioning program

Options are:

- No
- Yes

D. Nutrition or hydration intervention to manage skin problems

Options are:

- No
- Yes

E. Pressure injury care

Options are:

- No
- Yes

F. Surgical wound care

Options are:

- No
- Yes

G. Application of nonsurgical dressings (with or without topical medications) other than to feet

Options are:

- No
- Yes

H. Application of ointments/medications other than to feet

Options are:

- No
- Yes

I. Skin treatment every four hours or more often

Options are:

- No
- Yes

J. Other (specify)

Options are:

- No
- Yes

K. Other (specify)

Options are:

- No
- Yes

L. Additional information on integumentary if necessary (specify)

Options are:

- No
- Yes

Other nursing services

3. Other nursing services

In-home treatments and programs received or scheduled in the last 7 days.

Specify other nursing services.

Texas STAR Kids Screening and Assessment – MDCP Module

(Use last 7 days as time reference unless otherwise specified)

Section O. MDCP Related Items

(Use last 7 days as time reference unless otherwise specified)

1. Reason for assessment

Options are:

- Initial
- Re-Assessment
- Significant change in condition re-assessment
- Minor correction to recent assessment
- Major correction to recent assessment

Cognitive patterns

2. Individual has no discernable consciousness, is in a persistent vegetative state, or is in a coma

   Options are:

   - No
   - Yes (if yes, skip to 0.15)

3. Making self understood (expression)

   Expressing information content – both verbal and non-verbal (however able; with communication device, if normally used) Enter "-" dash if unable to assess.

   Options are:

   - Understood – Express self without difficulty
   - Usually Understood – Difficulty finding words or finishing throughs AND prompting usually required
   - Sometimes Understood – Ability is limited to making concrete requests
   - Rarely or Never Understood

4. Individual us under 7 years, at least 7 but rarely / never understood, or unable to be assessed (expression)

   Options are:

   - No
   - Yes (if yes, skip to 0.9)

5. Repetition of three works by individual (BIMS)

   Ask individual: "I am going to say three words for you to repeat. Please repeat the words after I have said all three. The words are sock, blue and bed. Now tell me the three words. Enter a "-" dash if unable to assess. Enter the number of words repeated after first attempt.

   Options are:

   - None
   - One
   - Two
   - Three

After the individual's first attempt, repeat the words using cues, ("sock, something to wear; blue, a color; bed, a piece of furniture"). You may repeat the words up to two more times.

6. Temporal orientation (orientation to year, month, and day) by individual (BIMS)

   Enter "-" dash if unable to assess

   A. Able to report correct year (Ask individual: "Please tell me what year it is right now")

      Options are:

      - Missed by greater than 5 years or no answer
      - Missed by 2 to 5 years
      - Missed by 1 year
      - Correct

   B. Able to report correct month (Ask individual: "What month are we in right now?")

      Options are:

      - Missed by greater than one month or no answer
      - Missed by 6 days to one month
      - Accurate within 5 days

   C. Able to report correct day of the week (Ask individual: "What day of the week is today?")

      Options are:

      - Incorrect or no answer
      - Correct

7. Recall by individual (BIMS) - Ask individual: "Let's go back to an earlier question. What were those three words I asked you to repeat? If unable to repeat a word, give a cue (something to wear, a color, a piece of furniture) for that word. Enter a "-" if unable to assess.

   A. Able to recall "sock"

      Options are:

      - No – could not recall
      - Yes, after cueing ("something to wear")
      - Yes, no cue required

   B. Able to recall "blue"

      Options are:

      - No – could not recall
      - Yes, after cueing ("a color")
      - Yes, no cue required

   C. Able to recall "bed"

      Options are:

      - No – could not recall
      - Yes, after cueing ("a piece of furniture")
      - Yes, no cue required

8. Summary score (BIMS)

   The sum of the scores for O.5-O.7. If the individual was unable to complete O.5-O.7 (i.e. 3 or more responses contain a "-" dash), record the score of 99, and proceed to O.9-O.10. Otherwise, record the sum as a number 00-15, and skip to O.11.

9. Short term memory (caregiver assessment)

   Ok – seems or appears to recall after five minutes. Enter "-" dash if unable to assess.

   Options are:

   - Yes, memory ok
   - Memory problems

10. Cognitive skills for daily decision making (caregiver assessment)

    Making decisions regarding tasks of daily life – e.g., when to get up or have meals, which clothes to wear or activities to do. Enter "-" dash if unable to assess.

    Options are:

    - Independent – decisions consistent, reasonable and safe
    - Modified Independence – Some difficulty in new situations only
    - Moderately Impaired – Decisions consistently poor or unsafe; cues/supervision required
    - Severely Impaired – Never or rarely makes decisions (skip to O.12 Caregiver assessment of individual mood (PHQ-9-OV))

Mood

11. Individual mood interview (PHQ-9)

    Say to individual: "Over the last 2 weeks, have you been bothered by any of the following problems?" If symptom is present, enter "1" (yes) in column 1 (provided in form).

    Then ask the individual: "About how often have you been bothered by this?" Read the individual the frequency choices. Indicate response in column 2 (provided in form).

    Use the following options for items "i" through "ix" below.

    A. Symptom presence

       Options are:

       - No (enter "0" in column 2)
       - Yes (enter "0-3" in column 2)
       - No response (enter dash "-" in column 2)

    B. Symptom frequency

       Options are:

       - Never or one day
       - 2 to 6 days (several days)
       - 7 to 11 days (half or more of the days)
       - 12 to 14 days (nearly every day)

a. Little interest or pleasure in doing things – does not exhibit pleasure at events that would normally be pleasurable (e.g., birthdays, parties, holidays)

b. Feeling down, depressed, or hopeless – e.g., furrowed brow, constant frowning

c. Trouble falling or staying asleep, or sleeping too much

d. Feeling tired or having little energy – lethargy; low energy; unusual fatigue; seems unusually worn out/tired

e. Poor appetite or overeating

f. Feeling bad about yourself – or that you are a failure or have let yourself or your family down

g. Trouble concentrating on things – problems thinking/concentrating; distractibility

h. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual

i. Thoughts that you would be better off dead or of hurting yourself in some way

Total severity score – the sum of all frequency responses in column 2. If the individual was unable to complete O.11 (i.e., 3 or more responses in column 2 contain a "-" dash), record a score of 99, and proceed to O.12. Otherwise, record the sum (00-27), and skip to O.13.

12. Caregiver assessment of individual mood (PHQ-9-OV)

Over the last 2 weeks, has the individual been bothered by any of the following problems. If symptom is present, enter "1" (yes) in column 1. Then move to column 2 and indicate symptom frequency in last 14 days. Do not complete if the individual mood interview was completed.

A. Symptom presence

Options are:

- No (enter "0" in column 2)
- Yes (enter "0-3" in column 2)

B. Symptom frequency

Options are:

- Never or one day
- 2 to 6 days (several days)
- 7 to 11 days (half or more days
- 12 to 14 days (nearly every day)

a. Little interest or pleasure in doing things – does not exhibit pleasure at events that would normally be pleasurable (e.g., birthdays, parties, holidays)

b. Feeling down, depressed, or hopeless – e.g., furrowed brow, constant frowning

c. Trouble falling or staying asleep, or sleeping too much

d. Feeling tired or having little energy – lethargy; low energy; unusual fatigue; seems unusually worn out/tired

e. Poor appetite or overeating

f. Feeling bad about yourself – or that you are a failure or have let yourself or your family down

g. Trouble concentrating on things – problems thinking/concentrating; distractibility

h. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual

i. Thoughts that you would be better off dead or of hurting yourself in some way

j. Being short-tempered, easily annoyed

Total severity score – the sum of all frequency responses in column 2. If the individual was unable to complete O.11 (i.e., 3 or more responses in column 2 contain a "-" dash), record a score of 99, and proceed to O.12. Otherwise, record the sum (00-30), and skip to O.13.

Behavior

1. Potential indicators of psychosis

   A. Hallucinations (auditory or visual) – False sensory perceptions in the absence of external stimuli

      Options are:

      - No
      - Yes

   B. Delusions – Fixed false beliefs (e.g., grandiose, paranoid, somatic, excluding beliefs specific to individual's culture or religion)

      Options are:

      - No
      - Yes

2. Behavior patterns in last 7 days

   Code for indicators observed, irrespective of the assumed cause.

   Options for items "a" through "e" are:

   - Not present
   - Behavior present 1 to 3 days
   - Behavior present 4 to 6 days, but less than daily
   - Behavior presents daily

   A. Physical abuse – shoves, scratches, pinches, bites others

   B. Verbal abuse – threatens, screams/curses at others

   C. Other behavioral symptoms not directed toward others – (e.g., pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily waste, or verbal/vocal symptoms like screaming, disruptive sounds)

   D. Rejection of care – reject evaluation or care (e.g., bloodwork, taking medications, ADL assistance) that is necessary to achieve the individual's goals for health and well-being. Do not include behaviors that have already been addressed (e.g., by discussion of care planning with the individual or family) and determined to be consistent with individual values, preferences, or goals.

E. Wandering/elopement – attempts to or exits/leaves home/school, etc., at inappropriate times without notice/permission

Functional status

Activities of Daily Living (ADLs)

Instructions for rule of 3:

- When an activity occurs three times a day at any one given level, code that level
- When an activity occurs three times at multiple levels, code the most dependent, exceptions are total dependence (4), activity must require full assist every time and did not occur (8), activity must not have occurred at all. Example, three times extensive assistance (3) and three times limited assistance (2), code extensive assistance (3).
- When an activity occurs at various levels, but not three times at any given level, apply the following:
  - When there is a combination of full caregiver performance and extensive assistance, code extensive assistance
  - When there is a combination of full caregiver performance, weight bearing assistance and/or non-weight bearing assistance, code limited assistance (2).

If none of the above are met, code supervision (1).

1. ADL self-performance

   Code for individual's performance not including set up. If the ADL activity occurred 3 or more times at various levels of assistance, code the most dependent – except for total dependence, which requires full caregiver performance every time.

   Refer to the following list of options for items "a" through "d".

   A. Activity occurred 3 or more times

      Options are:

      - Independent – no help or caregiver oversight at any time
      - Supervision – oversight, encouragement or cueing

- Limited assistance – individual highly involved in activity; caregiver provided guided maneuvering of limbs or other non-weight bearing assistance
- Extensive assistance – individual involved in activity, caregiver provided weight bearing support
- Total dependence – full caregiver performance every time during entire 7-day period

B. Activity occurred 2 or fewer times

Options are:

- Activity occurred only once or twice – activity did occur but only once or twice
- Activity did not occur – activity (or any part of the ADL) was not performed by individual or caregiver at all over the entire 7 day period

a. Bed mobility – How individual moves to and from lying positions, turns from side to side, and positions while in bed.

b. Transfers – How individual moves between surfaces, to/from bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)

c. Eating – How individual eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parental nutrition)

d. Toilet use – How individual uses the toilet room (or commode, bedpan, urinal), transfers on/off toilet, cleanses self after toilet use or incontinent episode(s), changes bed pad, manages ostomy or catheter, adjusts clothes

2. ADL support provided

Code for most support provided; code regardless of individual's self-performance classification

A. Bed mobility – How individual moves to and from lying positions, turns from side to side, and positions while in bed.

Options are:

- No setup or physical help from caregiver
- Setup help only
- One person physical assist

- Two or more persons physical assist
- ADL activity did not occur during entire period

B. Transfers – How individual moves between surfaces, to/from bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)

   Options are:

   - No setup or physical help from caregiver
   - Setup help only
   - One person physical assist
   - Two or more persons physical assist
   - ADL activity did not occur during entire period

C. Eating – How individual eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parental nutrition)

   Options are:

   - No setup or physical help from caregiver
   - Setup help only
   - One person physical assist
   - Two or more persons physical assist
   - ADL activity did not occur during entire period

D. Toilet use – How individual uses the toilet room (or commode, bedpan, urinal), transfers on/off toilet, cleanses self after toilet use or incontinent episode(s), changes bed pad, manages ostomy or catheter, adjusts clothes

   Options are:

   - No setup or physical help from caregiver
   - Setup help only
   - One person physical assist
   - Two or more persons physical assist
   - ADL activity did not occur during entire period

Bladder and Bowel

1. Urinary toileting program

   Current continence promotion program or trail – is individualized continence promotion program (e.g. scheduled toileting, prompted voiding, or bladder training) currently being used to manage the individual's urinary continence?

   Options are:

   - No
   - Yes

2. Bowel continence program

   Is an individualized continence program currently being used to manage the individual's bowel continence?

   Options are:

   - No
   - Yes

Diagnoses and Conditions

1. Problem conditions

   A. Fever

      Options are:

      - No
      - Yes

   B. Vomiting

      Options are:

      - No
      - Yes

   C. Dehydrated

      Options are:

      - No
      - Yes

D. Internal bleeding

Options are:

- No
- Yes

2. Active diseases / conditions

A. Aphasia

Options are:

- No
- Yes

B. Cerebral Palsy

Options are:

- No
- Yes

C. Diabetes Mellitus (e.g., diabetic retinopathy, nephropathy, and neuropathy)

Options are:

- No
- Yes

D. Hemiplegia or Hemiparesis

Options are:

- No
- Yes

E. Multiple Sclerosis

Options are:

- No
- Yes

F. Pneumonia/lower respiratory infection

Options are:

- No
- Yes

G. Quadriplegia

Options are:

- No
- Yes

H. Septicemia

Options are:

- No
- Yes

Skin Conditions

1. Current number of pressure injuries at each stage
   A. Stage I: any area of persistent redness
   B. Stage II: partial loss of skin layers
   C. Stage III: deep craters in the skin
   D. Stave IV: breaks in skin exposing muscle or bone
   E. Unstageable (e.g., slough and/or eschar predominant)
2. Total number of venous and arterial injuries present
3. Other skin problems
   A. Open lesion(s) other than injuries, rashes, cuts (e.g., cancer lesion)

   Options are:

   - No
   - Yes

   B. Surgical wound(s)

   Options are:

   - No
   - Yes

C. Burn(s) (second or third degree)

Options are:

- No
- Yes

4. Foot problems

A. Infection of the foot (e.g., cellulitis, purulent drainage)

Options are:

- No
- Yes

B. Diabetic foot injury(s)

Options are:

- No
- Yes

C. Other open lesion(s) on foot

Options are:

- No
- Yes

5. Skin and injury treatments

Options for items "a" through "i" are as follows:

- No
- Yes

A. Pressure reducing device for chair

B. Pressure reducing device for bed

C. Turning/repositioning program

D. Nutrition or hydration intervention to manage skin problems

E. Pressure injury care

F. Surgical wound care

G. Application of nonsurgical dressings (with or without topical medications) other than to feet

H. Applications of ointment/medications other than feet

I. Applications of dressing to feet (with or without topical medication)

Nutritional status

1. Nutritional approaches

   If yes to Question 26a or 26b, answer Question 26c and 26d. If no, proceed to Question O.27.

   A. Individual uses parenteral/IV feeding

      Options are:

      - No
      - Yes

   B. Individual uses feeding tube-nasogastric or abdominal (PEG or G-button)

      Options are:

      - No
      - Yes

   C. Proportion of total calories the individual receives through parenteral or tube feeding during the entire 7 days

      Options are:

      - 25 percent or less
      - 26 to 50 percent
      - 51 percent or more

   D. Average fluid intake per day by IV or tube feeding during the entire 7 days

      Options are:

      - 500 cc per day or less
      - 501 cc per day or more

2. Weight loss of 5 percent or more in last 30 days or 10 percent or more in last 180 days

   Options are:

   - No or unknown
   - Yes, on physician prescribed weight-loss program
   - Yes, not on physician prescribed weight-loss program

Physician Care

1. Number of days the physician (or authorized assistant or practitioner) examined the individual in last 14 days
2. Number of days the physician (or authorized assistant or practitioner) changed the individual's orders in last 14 days

   Special treatments, procedures, and programs

3. Record the number of days that injections of any type were received during the last 7 days
4. Formal treatments in last 14 days

   Types of service and supports provided in last 14 days. These occurred once or more in this time frame.

   Options for items "a" through "i" are as follows:

   - • No
   - • Yes

   A. Chemotherapy

   B. Radiation

   C. Oxygen Therapy

   D. Suctioning

   E. Tracheostomy care

   F. Ventilator

   G. IV medication

   H. Transfusion

   I. Dialysis

5. Restorative nursing program

Code the number of days each of the following programs was performed (for at least 15 minutes a day) in the last 7 calendar days (enter 0 if none or less than 15 minutes daily)

A. Range of motion (passive)

B. Range of motion (active)

C. Splint or brace assistance

D. Training/skill practice in bed mobility

E. Training/skill practice in transfer

F. Training/skill practice in walking

G. Training/skill practice in dressing and/or grooming

H. Training/skill practice in eating and/or swallowing

I. Training/skill practice in amputation/prosthesis care

J. Training/skill practice in communication

6. Speech-language pathology and audiology services

   A. Individual minutes – record the total number of minutes this therapy was administered individually in last 7 days

   B. Concurrent minutes – record the total number of minutes this therapy was administered to the individual concurrently with one other individual in the last 7 days

   C. Group minutes – record the total number of minutes this therapy was administered to the individual as part of a group of individuals in the last 7 days

      If sum of individual, concurrent and group minutes is zero, skip to O.34, occupational therapy.

   D. Days – record the number of days this therapy was administered for at least 15 minutes in the last 7 days

7. Occupational therapy

   A. Individual minutes – record the number of minutes this therapy was administered to the individual individually in last 7 days

   B. Concurrent minutes – record the total number of minutes this therapy was administered to the individual concurrently with one other individual in the last 7 days

C. Group minutes – record the total number of minutes this therapy was administered to the individual as part of a group of individuals in the last 7 days

   If sum of individual, concurrent and group minutes is zero, skip to O.35, physical therapy.

D. Days – record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days

8. Physical therapy

   A. Individual minutes – record the number of minutes this therapy was administered to the individual individually in last 7 days

   B. Concurrent minutes – Record the total number of minutes this therapy was administered to the individual concurrently with one other individual in the last 7 days

   C. Group minutes – record the number of minutes this therapy was administered to the individual as part of a group of individuals in the last 7 days

   D. If sum of individual, concurrent and group minutes is zero, skip to O.36, respiratory therapy.

   E. Days – record the number of days this therapy was administered for at least 15 minutes in the last 7 days

9. Respiratory therapy

   A. Days – record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days

Section P. Goals for Care

1. Individual's expressed goals of care (only for individuals age 7 and up)

   Record goals in box (provided on form) (list goals in order of priority) and primary goal in space beneath box.

2. Primary caregiver's expressed goals of care for individual

   Record goals in box (provided on form) (list goals in order of priority) and primary goal in space beneath box.

3. One or more expressed care goals met since last assessment

   Options are:

   - No
   - Yes
   - N/A (Initial Assessment)

4. Individual or individual's family has been contacted by an MCO service coordinator

   The service coordinator would assist the individual and their family in connecting, with appropriate, least-restrictive, community-based resources.

   Options are:

   - No
   - Yes

5. Individual service plan tailored specific needs is in place.

   Options are:

   - ISP is in place and tailored to specific needs
   - ISP is in place but not tailored to specific needs
   - No ISP in place
   - N/A (Initial Assessment)

Section Q. Assessment Summary

1. Individual or caregiver has urgent concerns

   Options are:

   - No
   - Yes (if yes, please specify in space provided.)

2. Individual receives services that are helpful

   Options are:

   - No
   - Yes (if yes, please specify in space provided.)

3. PCS needs

   Options are:

   - No
   - Yes

4. Habilitation needs

   Options are:

   - No
   - Yes

5. Nursing needs

   Options are:

   - No
   - Yes

MDCP and CFC Determinations

1. MN (CFC or MDCP) and MDCP RUG requirements

   A. MN determination needed?

      Options are:

      - No
      - Yes

   B. MDCP RUG calculation required?

      Options are:

      - No
      - Yes

ERS-Emergency Response Services

1. Does the individual require ERS?

   Options are:

   - No
   - Yes (if yes, please describe how the individual will benefit from ERS)

Support Management

includes how to select, manage, and dismiss attendants

1. Are you interested in receiving information about support management (how to select, manage, and dismiss attendants)?

   Options are:

   - No
   - Yes

2. Further assessment is needed

   Please use the following options for items "a" through "r":

   - No
   - Yes

   Code according to the instruction on the form.

   A. Behavioral health

   B. Assistive devices / DME

   C. Physical theraoy

   D. Occupational therapy

   E. Speech language pathology

   F. Respiratory therapy

   G. ECI

   H. Nutrition

   I. IDD

   J. Education

   K. Medical provider evaluation; i.e., longer than one year since office visit

   L. Blind services for children

   M. Deaf and hard of hearing services

   N. Employment services; e.g., supported employment, employment assistance, vocational rehabilitation

   O. Medical care supplies requested

   P. Medical emergency plan required

Q. ISP required

R. ISP update requested

3. Additional information / referrals recommended by assessor

Please use the following options for items "a" through "n":

- No
- Yes

A. MCO Disease Management

B. CFC Level of Care determination (LIDDA or LMHA)

C. Children with Special Healthcare Needs (CSHCN) Program

D. STAR+PLUS (for Individuals nearing age 21)

E. Waiver Interest List (MDCP, YES, CLASS, HCS, TxHmL, DBMD)

F. State Supported Living crisis diversion slot

G. PASRR crisis diversion slot

H. Medicaid Medical Transportation Program (MTP)

I. Blind Children's Program

J. Deaf and Hard of Hearing Services

K. Autism Program

L. Comprehensive Rehabilitation Services Program

M. Independent Living Services

N. Other Non-Medicaid Non-State Community Services (e.g., family or individual housing, community transportation, respite); specify

O. Additional information on further assessment needs or referrals recommended (specify)

Section R. Assessor Information

1. Name of assessor (first name / middle initial / last name / suffix)
   A. Licensure

      Options are:

      - RN
      - APRN
      - NP
      - LVN
      - LMSW
      - LCSW
      - LBSW
      - PA
      - Other (specify)

   B. Sections completed

      a. Core

         Options are:

         - No
         - Yes

      b. NCAM

         Options are:

         - No
         - Yes

      c. MDCP

         Options are:

         - No
         - Yes

2. Name of second assessor (if full assessment not able to be completed by first assessor)

   first name / middle initial / last name / suffix

A. Licensure

Options are:

- RN
- APRN
- NP
- LVN
- LMSW
- LCSW
- LBSW
- PA
- Other (specify)

B. Sections completed

a. Core

Options are:

- No
- Yes

b. NCAM

Options are:

- No
- Yes

c. MDCP

Options are:

- No
- Yes

3. Assessment submission date (Month / day / year)