PAS Tool Guide:
Developmentally Disabled Ages 6-11

Rate activities/behaviors as generally performed over the last year with *emphasis on current functioning*. If there are discrepancies in functioning, please describe when they happen and what causes them, if known.

Give credit for the highest level of skill which is performed at least 75% of the time.
Only give credit for **what the individual actually does**, not for what the individual "can do" or "might be able to do".

When a question groups many activities, rate the individual on his/her ability to complete the task as a whole.

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

If it is clearly evident that a customer is in need of more assistance than is received, the assessor may take that into consideration in scoring. This should be done conservatively as it may be difficult to determine the exact amount of assistance needed (e.g., only verbal assistance, not hands on assistance may be needed to attain a generally acceptable level of hygiene). **Justification for this need must be documented in the comments and/or summary. Do they have a history of falls with injuries? Script for therapy? How long does it take to complete the task(s)?**

***NOTE: Do NOT score PAS Areas in the field.**
Write down comments and observations ONLY. Be objective and professional.

ROLLING AND SITTING: The Customer's ability to roll and sit independently.

"Sitting with support" may include either the physical support of another person or other types of support such as pillows or a specially made chair.
Indicate only one answer that best describes the highest level of skill attained.

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

Things to Consider: How long does the client sit? What support is provided, if any? What happens without that support? Describe what happens at least 75% of the time.

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

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

Things to Consider: If client stands alone, is it steadily or not? Include length of time standing. Describe the support provided, if any. What happens without that support? Describe what happens at least 75% of the time.

AMBULATION - Use of special assistive devices (e.g., canes, walkers, braces) does **not** affect rating. So, if they use a cane and walk well with it and no one's help, they could still score a 0.

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

Things to Consider: If client walks alone, is it steadily or not? Include distance walked, and on which terrains. Describe the support provided, if any. What happens without that support? If client does not walk at all, include the reason why not. Describe what happens at least 75% of the time.

CLIMBING STAIRS OR RAMPS - Rate use of ramps if the client uses a wheelchair or another walking device that is not used on stairs (i.e. a walker or cane).

0. Moves up and down stairs or ramps **without** need for handrail
1. Moves up and down stairs or ramps with handrail **independently**

2. Moves up and down stairs or ramps with *physical assistance*
3. Does **not** move up or down stairs or ramps

Things to Consider: If client walks up and down stairs – does he/she use the handrail or not? OR: Does client use a wheelchair or other device (walker, cane, etc.) **on a ramp instead? If yes, please explain what devices are used.** Also, if devices are used, is the client independent going up and down ramp with the devices?
If needing help from someone else, what does that assistance look like? Who does it? How often? In what situations/locations does the caregiver help?
Describe what happens at least 75% of the time when device is used and when it's not used.

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WHEELCHAIR MOBILITY - Wheelchair may be motorized or manual. **Do not score client's ability to transfer to the wheelchair.** If a wheelchair is **not** used, indicate "0".

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

Things to Consider: If client uses a wheelchair – report if it is manual or motorized, or both. Does client propel self? How often? In what situations/locations?

OR if client has help: How often? Describe support provided, if any: what's being done, and when it is provided. If he/she has different kinds of help, describe the different scenarios.

Describe what happens and score based on what happens at least 75% of the time.
If both types of wheelchairs are used, score according to the chair used the majority of the time, and include that specifically in the comment (which is used most, and how often).

DRESSING - Putting on and removing **regular** articles of clothing, (e.g., skirt, blouse, shirt, pants, dress, shorts, socks and shoes, underwear/diapers/briefs).

The use of adaptive clothing (elastic waist pants, Velcro shoes or non-button shirts) does not disqualify the customer from being considered *independent*. So, if they do not receive any assistance with putting on or taking off these items, they could still score a 0.

This does NOT include braces, nor does it reflect the individual's ability to match colors or choose clothing appropriate for the weather. Do **NOT** include care of clothing.

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

Things to Consider: What does client do for him/herself? Does client dress AND undress self? How often? In what situations?
OR if client has help: How often? Describe support provided, if any: what's being done, and when it is provided. If he/she has different kinds of help, describe the different scenarios.

Be as specific as possible (i.e. mom fastens buttons and zippers every time every day)**. Include who does what tasks. Who puts on and/or remove diapers/briefs? Include that here. Describe what happens and score based on what happens at least 75% of the time for each task (shirt, shoes, socks, pants, etc.).**

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PERSONAL HYGIENE –

Those tasks involved in basic grooming, include only:

Brushing teeth, washing face and hands, combing/brushing hair, use of deodorant, nail care.

If the customer performs the tasks at varying levels of independence, indicate the answer that best describes the customer's overall ability in personal hygiene and explain in comments.

0. Completes the task independently
1. Able to complete the task with **verbal** prompts, cue by touch, materials setup, or other modifications
2. Requires hands-on assistance to initiate/complete the task (e.g., put toothpaste on toothbrush Or hands-on assistance to comb hair)
   ****Include in the comment what the client does.***
3. This task must be done for the individual but individual DOES physically participate.
   ****Include in the comment HOW the client participates.***
4. Requires total hands-on assistance and does not physically participate
   ****Include in the comment the reason (if known) why the client does not participate.***

Things to Consider: What does client do for him/herself? How often does client do it? Is it done by client every time the task is done?

OR if client has help: Describe the support provided – how often? Who does it? And when is it provided? Be as specific as possible (i.e. mom brushes client's teeth in the morning every day; client brushes his teeth every night with set-up of toothpaste done by mom)**. Include who does which tasks, or what parts of the tasks, and why (if known).**

Describe what happens and score based on what happens at least 75% of the time for each task

The comment for this area should include each task (oral care, hair care, washing hands, washing face outside the shower, putting on deodorant, and nail care) and who does it, the frequency it is done and by whom each time, and anything else helpful (such as sensory issues, etc.).

When a group of many tasks are included in one scoring area, rate the customer on the ability to complete each of the tasks.

For example, a customer who needs hands-on help for brushing teeth, but only verbal prompts or no assistance for combing hair or washing face and hands should be scored a "2" on Personal Hygiene (requires hands-on assistance to initiate/complete the task).

Another example: Mother will put toothpaste on the toothbrush for Client daily. Client will brush his teeth with mom's cues to do so, and mom will re-brush for adequate hygiene as Client will only brush the front teeth. Mother keeps Client's hair cut very short and does not have to comb it. Mother cues Client to wash his hands with soap and rinse well. Mother states that she will re-wash Client's face and hands for adequate hygiene daily. Sal is not using deodorant at this time. This would be scored as a 3.

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BATHING OR SHOWERING – Taking a bath, shower, sponge bath, or bed bath.

This includes drawing the bath water, washing, rinsing and drying all parts of the body, and shampooing hair.

The ability to wash face and hands when not bathing should be rated under <u>Personal Hygiene</u> instead.

The ability to *<u>transfer</u>* into the tub or shower is <u>not</u> rated here.

0. Completes the task independently
1. Requires verbal prompts for washing and drying **or** help with drawing water, checking temperature
2. Requires **extensive** verbal prompts **or** limited/occasional hands-on assistance to complete task (e.g. shampooing only) *****Include in the comment HOW the client participates.***
3. Requires hands-on assistance during **entire** bathing process but can physically participate. *****Include in the comment HOW the client participates.***

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

*****Include in the comment the reason client does not participate, if known (medical condition limiting their physical ability, behavioral issue/resistiveness, etc.).***

<u>Things to Consider:</u> Report in comment if client takes a shower or bath or bed bath, etc. What does client do for him/herself? How often does client do it? Is it done by client <u>every</u> time the task is done?

OR if client has help: Describe the support provided – how often? Who does it? And when is it provided? Be as specific as possible (i.e. mom washes client's hair in the bathtub every time client bathes, which is every other day. Client washes his body with set-up and cues throughout bathing process or he won't do it)**.**

Describe what happens, and score based on what happens at least 75% of the time for each task (drawing water, using soap and washing body, shampooing hair, rinsing body/hair, drying body parts)**.**

Comment should include each task: who does it, frequency it is done and by whom each time, and anything else helpful.

If the customer/rep indicates the customer requires verbal prompts, what does that look like? How "extensive" are they? (i.e. Mom provides one reminder to take a shower and wash well versus she provides step by step instructions throughout the entire bathing process).

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TOILETING – Involves initiating and caring for bodily functions involving bowel and bladder control.

NOTE: Do **NOT** rate ability to wash hands after toileting, **or** the ability to transfer on/off the toilet.

0. Completes the task independently
1. Able to complete the task with **verbal** prompts, cue by touch, materials setup, or other modifications
2. Can indicate the need for toileting, but requires **hands-on** assistance to complete/perform the task (e.g., help with fasteners, toilet paper, flushing the toilet)

3. Does **not** indicate the need for toileting, but usually avoids accidents through a toileting schedule (e.g., periodic tripping by caregiver) and requires hands-on assistance to complete/perform the task.
4. Does **not** perform **nor** indicate the need for toileting **and** requires total caregiver intervention.

Things to Consider: Does client indicate the need to use the restroom to void bowel/bladder? Is client on a tripping schedule? Is it effective?
Does client do it all independently? OR does client have help? Describe the help provided, if any – and also include how often, who does it, and when it is provided.
Be as specific as possible (i.e. Client uses restroom independently daily when he needs to void, and only requires reminders to flush, daily.)**. Describe what happens at least 75% of the time.**

LEVEL OF BLADDER CONTROL – Rate typical/usual control level.

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

Things to Consider: Include how often client has a bladder accident, if any. Are they during the day or at night? How often does each happen? Describe what happens at least 75% of the time. Be as specific as possible. Do NOT rate temporary occurrences due to acute illness or medication. **Comments should indicate if accidents occur during day or at night, or both.**

ORIENTATION TO FAMILIAR SETTINGS FAMILIAR TO INDIVIDUAL -

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

Things to Consider: Where is client familiar with settings? (home, school, church, etc.)
If he/she needs prompting: include Where, When, Why (is it a safety issue or is he/she really disoriented), and who helps him/her.

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Or does client have <u>hands-on</u> help? Describe the support provided, if any – how often? Who does it? And when is it provided? Be as specific as possible. Describe what happens at least 75% of the time, and where.

EXPRESSIVE VERBAL COMMUNICATION - Ability to communicate thoughts **verbally with words or sounds.**

0. Carries on a complex or detailed conversation
   ****Helpful to include an example of what client talks about at least 75% of the time.**
1. Carries on a simple brief conversation, such as talking about everyday events (e.g., the clothes you are wearing)
   **** Helpful to include an example of what client talks about at least 75% of the time.**
2. Uses simple two-word phrases (e.g., "I go," "give me")
   **** Helpful to include an example of phrases used (2-3words)**
3. Uses a few simple words and associates them with appropriate objects, such as names of common objects and activities
   **** Helpful to include an example of words used (i.e. only knows "ball", "dog", "cup", "eat")**
4. Uses no words, but uses a personal language or guttural sounds to communicate very basic concepts
   **** Helpful to include an example of what client does to communicate <u>with sounds</u>**
5. Makes **<u>no sounds</u>** which are for communication; may babble, cry or laugh

<u>Things to Consider:</u> What happens 75% of the time? Provide examples to illustrate and support score. What does applicant typically say or what sounds does he/she make? Include your observations of the customer's communication ability during the PAS interview also.

CLARITY OF COMMUNICATION - Ability to **speak in a recognizable language** <u>or</u> use a formal symbolic substitute, such as American Sign Language **or alternate communication system**.

If client has more than one form of communication, score on what is <u>best</u> understood.

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

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<u>Things to Consider:</u> What does customer use at least 75% of the time (spoken language, pointing, sign language, writing, etc.)?
And who understands client – are they familiar with him/her or not?
Provide examples of both to illustrate and support the score. Include your observations of the customer's communication ability during the PAS interview also.

<u>BEHAVIORS</u>:

In selecting the best answers for children in this age group, the assessor must try to view the child's behavior in the context of the reasonable expectation of a child this age. For example, sibling teasing or arguing that does not escalate to serious threats or acts of aggression may be considered normal in a child within this age group.

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

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

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

The following definitions should be applied when answering questions related to behavior:
"Physical Interruption" requires immediate physical (hands-on) interaction to stop the behavior.
"Occasional" less than weekly; **"Frequent"** weekly to every other day.
"Constant" at least once a day.

If there are any differences noted between the ACE program and the PAS Manual, staff should follow the guidance provided in the PAS Manual first.

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AGGRESSION –

Physical attacks on PEOPLE, including throwing objects, punching, biting, pushing, pinching, pulling hair, and/or scratching.

Do NOT include self-injurious behaviors, threatening, or only property destruction.

Destruction of property alone, or abuse of animals is not rated, but should be described in the PAS Summary section.

0. Problem does not occur or occurs at a level not requiring intervention
1. **Minor** problem; occasional aggression which requires some additional supervision in a few situations **and/or** verbal redirection
2. **Moderate** problem; frequent aggression that requires close supervision and/or frequent verbal or physical **redirection** **[*Physical redirection:** requires immediate removal of person/customer or change of environment such as sending them to their room or removing objects used to hurt someone**]**
3. **Serious** problem; constant aggression that requires close supervision and/or constant verbal or physical **interruption**
4. **Extremely Urgent** problem; has had episode(s) **causing injury in the last year**, requires close supervision and physical interruption

Things to Consider: What is being done and to whom? (Must be directed at a person/people). How often is it being done? What is the injury caused? (Cuts, scrapes, bruises, headaches, crying, ER visit, etc.)**? If there was an injury in the last year, what was done about it? When did it happen approximately? (An exact date is preferred).**
What is done to prevent or stop the attack(s)?

VERBAL OR PHYSICAL THREATENING - Threatens to do harm to self, others or objects.

***Do NOT Include actual acts of physical aggression or self-injury.**

0. Problem does not occur or occurs at a level not requiring intervention
1. **Minor** problem; makes occasional threats which are not taken seriously **and** do **not** frighten others **nor** result in aggression from others; requires some additional supervision **and/or** verbal redirection
2. **Moderate** problem; makes frequent threats that **sometimes** cause fear **and/or** aggression from others; requires close supervision and/or frequent verbal or physical redirection
3. **Serious** problem; makes constant threats that **sometimes** cause fear **and/or** aggression from others; requires close supervision **and/or** constant verbal **or** physical interruption

[Physical interruption: requires immediate physical (hands-on) interaction of the caregiver to stop the customer's behavior.**]**

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

Things to Consider: What is being threatened to be done and to whom/what?
How often is it being done? Are those who are threatened fearful of the one making the threats? How often? What is done to prevent or stop the threat(s)?

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SELF-INJURIOUS BEHAVIOR – **Repeated** behaviors that **cause injury**, and may include: biting, scratching, putting inappropriate objects in the ear, mouth or nose, repeatedly picking at skin, head slapping or head-banging.

0. Problem does not occur or occurs at a level not requiring intervention
1. **Minor** problem; occasional incidents which require some additional supervision in a few situations **and/or** occasional verbal redirection
2. **Moderate** problem; frequent incidents that require close supervision **and/or** frequent verbal or physical **redirection**
3. **Serious** problem; constant incidents; requires close supervision **and/or constant** verbal or physical **interruption [Physical interruption:** requires immediate physical (hands-on) interaction of the caregiver to stop the customer's behavior.**]**
4. **Extremely Urgent** problem; has had episode(s) causing **serious injury** requiring immediate **medical attention** in the **last year,** requires close supervision and physical interruption

Things to Consider: What is being done? (The actual behavior) **Is it repeated?**
How often is it being done?
What is the injury or result of the behavior? (Cuts, scrapes, bruises, headaches, ER visit, etc.)
If there was a serious injury in the last year, what was done about it (first aid? ER visit? etc.)
And when did the serious injury happen approximately? (An exact date is preferred)
What is done to prevent or stop the behavior(s)? How often? Does it work to stop/prevent it?

RUNNING OR WANDERING AWAY - Leaves situation or environment inappropriately without either notifying or receiving permission from appropriate individuals as would normally be expected.

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

Things to Consider: What is being done? (The actual behavior: crawling out window, walking away in the store/parking lot, leaving school alone without permission, etc.)
How often is it happening?
What is the result of the behavior? (Where does the client go? How long are they gone?)**?**
What is the safety issue, if any?
What is done to prevent or stop the behavior(s)? How often? Does it work to stop/prevent it?

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

0. Problem does not occur or occurs at a level not requiring intervention
1. **Minor** problem; occurs occasionally and requires occasional intervention
2. **Moderate** problem; occurs frequently and requires frequent intervention
3. **Serious** problem; occurs constantly and requires constant intervention

Things to Consider: **What is being done?** (The actual behavior)
How often is it happening?
What is the result of the behavior? (WHO is disrupted by it?? HOW??)
What is the safety issue, if any?
What is done to prevent or stop the behavior(s)? How often? Does it work to stop/prevent it?

IMPORTANT!!!

Please review all medical records as soon as they become available. If any discrepancies are noted between the caregiver/rep report and these records, the customer/rep should be contacted to clarify each discrepancy in detail so the assessor can determine how best to score.

If the customer has had recent previous PAS's, these should be reviewed prior to the PAS interview and any changes since the last PAS (if reasonably recent) **should be addressed and clarified with the customer/rep in order for the assessor to determine how best to score. The clarification(s) should be added to the summary or each individual comment area. If the customer/rep is contacted after the PAS interview for clarification, a dated addendum will need to be added to the summary also.**

Please be objective and professional.

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III. MEDICAL ASSESSMENT

"**Acute**" An active condition having a sudden onset, lasting a short time and requiring intervention. The condition may still be considered acute if the customer is in a convalescent stage of an acute illness.

"**Chronic**" A condition which is either always present or occurs periodically, or is marked by a long duration. If a customer is being treated for a condition over a long period, the condition would probably be considered chronic. For example, a seizure disorder that is controlled with medication would be considered chronic rather than historical.

"**History**" A condition which occurred in the past, may or may not have required treatment, but is not currently active. If possible, the approximate date of the condition should be noted for historical diagnoses. If the date is not available, then it must be documented in the comments approximately how long ago the condition occurred.

This section is used to record **only** the diagnoses and specific medical conditions that have a relationship to the customer's **current** developmental/ILS status, cognitive, mood and behavior status, medical treatments, skilled nursing care or risk of death.

The assessor should review each category of conditions listed to ensure that no **significant** diagnoses are omitted.

Comment fields are provided to clarify any diagnosis indicated.

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

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

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

The customer's DD qualifying diagnosis MUST always be indicated as a major diagnosis.

NOTE: It's helpful to include in the comment WHO made each diagnosis and WHEN.

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Neurological/Congenital/Developmental Conditions **A, C, H** **Comments**

1. Cerebral Palsy

a.	Diplegia	A C H	
b.	Hemiplegia	A C H	
c.	Quadriplegia	A C H	
d.	Paraplegia	A C H	
e.	Unspecified Cerebral Palsy	A C H	

2. Epilepsy/Seizure Disorder

NOTE: Indicate **DATE of LAST Seizure** and **FREQUENCY of *EACH TYPE*** of Seizure in Comments.

a	**Generalized non-convulsive** (absence, petit mal, minor, akinetic, atonic.)	A C H	
b.	**Generalized convulsive** (clonic, myoclonic, tonic, tonic-clonic, grand mal, major)	A C H	
c.	**Unspecified** (complex partial, psychomotor, temporal lobe, simple partial, Jacksonian, epilepsia partialis, continual	A C H	

3. Mental Retardation (Cannot be Acute)

a	Mild Mental Retardation	A C H	
b	Moderate Mental Retardation	A C H	
c	Severe Mental Retardation	A C H	
d	Profound Mental Retardation	A C H	
e	Unspecified Mental Retardation	A C H	
f.	Borderline Intelligence	A C H	

NOTE: ONLY ONE DIAGNOSIS IN THE CATEGORY OF MENTAL RETARDATION CAN BE INDICATED AS CHRONIC, AND NONE CAN BE INDICATED AS ACUTE.

III. MEDICAL ASSESSMENT

A. MEDICAL CONDITIONS (continued)

A, C, H **Comments**

4. Autism

a.	Autism	A C H	
b.	Pervasive Developmental Disorder	A C H	
c.	Autistic-Like Behaviors	A C H	

5. Attention Deficit Disorder (ADD)

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a.	ADD with Hyperactivity	A	C	H	
b.	ADD without Hyperactivity	A	C	H	

6. Other Neurological / Congenital / Developmental Conditions

a.	Prematurity	A	C	H	
b.	Fetal Alcohol Syndrome	A	C	H	
c.	Developmental Delays *(describe in comment)*	A	C	H	
d.	Hydrocephaly	A	C	H	
e.	Macrocephaly	A	C	H	
f.	Microcephaly	A	C	H	
g.	Meningitis	A	C	H	
h.	Encephalopathy	A	C	H	
i.	Spina Bifida	A	C	H	
j.	Genetic Anomalies	A	C	H	
k.	Down's Syndrome	A	C	H	
l.	Congenital Anomalies	A	C	H	
m.	Near Drowning	A	C	H	
n.	Head Trauma	A	C	H	
o.	Dementia (Organic Brain Syndrome)	A	C	H	

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Customer Name _____ Person ID _____

III. MEDICAL ASSESSMENT

A. MEDICAL CONDITIONS (continued)

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

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

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III. MEDICAL ASSESSMENT

A. MEDICAL CONDITIONS (continued)

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

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

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III. MEDICAL ASSESSMENT

A. MEDICAL CONDITIONS (continued)

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

	A, C, H	Comments
15. Skin Conditions		
a. Decubitus	A C H	
b. Acne	A C H	
16. Psychiatric		
a. Major Depression	A C H	
b. Bipolar Disorder	A C H	
c. Schizophrenia	A C H	
d. Behavioral Disorders	A C H	
e. Conduct Disorder	A C H	
f. Alcohol Abuse	A C H	
g. Drug Abuse	A C H	

	Category	Condition	Diagnosis
MAJOR DIAGNOSES			

Comments: _____

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III. MEDICAL ASSESSMENT

B. MEDICATIONS/TREATMENTS

(Include PRN medications/treatments received in last thirty (30) days and any other current medications/treatments).

Include dosage, frequency, duration, route (by mouth, injection, etc.), form for each medication and average use of major PRN medications.

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

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III. MEDICAL ASSESSMENT
C. SERVICES AND TREATMENTS

If a Need is indicated, the assessor must explain in comments. The determination of need should be based on documentation, such as physician order, the recommendation of a therapist, or a clearly defined medical condition for which the service is routine treatment.

Indicate the frequency of services by selecting (C) for Continuously, (D) for Daily to several times daily, (W) for Weekly to 3 times a week (if more often than 3 times a week consider daily), and (M) for Monthly or greater.
An ongoing service or treatment which lasts several hours or more may be considered continuous (e.g., tube feeding or oxygen at night only).

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

Comments: _____

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

Comments: _____

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

Comments: _____

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

Comments: _____

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

Comments: _____

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III. MEDICAL ASSESSMENT

C. SERVICES AND TREATMENTS (continued)

(Circle appropriate answers) **Provide explanation when (N) is circled**.

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

Comments: _____

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

Comments: _____

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

Comments: _____

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

Comments: _____

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III. MEDICAL ASSESSMENT

D. MEDICAL STABILITY

1. The number of acute hospitalizations that occurred in the past year
Do not include birth *as a hospitalization for an infant unless the hospitalization continued due to the* ***child's*** *medical problems.* _____

2. Currently requires direct care staff or caregiver **trained in special health care procedures** (e.g., ostomy care, positioning, adaptive devices, G-tube feedings, SVN, seizure precautions [if current seizure activity], diabetic monitoring) ☐ YES ☐ NO

 Do include training for procedures that are intermittent but on-going (i.e. SVNs seasonally). **Make comments as to the procedure and who is trained.**

 Do not include personal care that would not require special training, such as routine help with ADLs or applying AFO's or a simple brace.

 Do not include training for a procedure that the customer has received in the past **but no longer routinely requires.**

3. Currently **requires special diet** planned by dietitian, nutritionist, or nurse ☐ YES ☐ NO
Indicate ***(Y)*** *yes for this item if the individual requires a special diet ordered by a physician, planned by a dietitian, nutritionist or nurse (e.g., high fiber, low calorie, low sodium, pureed) and* ***write in the type of diet in the comments section. This would include formula for tube feedings, but would*** *not* ***include formula for infants and young children who typically receive one of a variety of infant formulas by bottle or sippy cup.***

Comments: _____

E. SENSORY FUNCTIONS

(circle appropriate answers)

Hearing refers to the ability to receive sounds, and does **not** refer to the ability to comprehend mentally the meaning of sound.

****If an assistive device is used, hearing should be rated while using the device.**

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

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

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

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

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VISION -- refers to perceiving objects visually. In this section, the assessor will evaluate the customer's ability to see close objects and objects at a distance in adequate lighting, using any visual appliances (e.g., glasses, magnifying glass).

A medical condition or disease affecting the eye that does <u>not</u> affect the ability to <u>see</u> should <u>not</u> be considered in determining adequacy of sight.

0) Unable to Assess/No Impairment. There is no impairment or impairment is compensated by corrective lenses (e.g., can see newsprint, TV, medication labels) or unable to assess.
1) Minimum Impairment. Difficulty with focus at close (reading) range but can see large print and obstacles but not details. May be blind in one eye but has been able to compensate.
2) Moderate Impairment. Very poor focus at close range. Unable to see large print and/or field of vision is limited (tunnel vision or central vision loss).
3) Severe Impairment. May only see light, shapes, colors, or has no vision.

Comments: _____

III. MEDICAL ASSESSMENT
F. SUMMARY EVALUATION _____

Pre-Admission Screening
Developmentally Disabled
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Customer Name _____ Person ID _____

III. MEDICAL ASSESSMENT

F. SUMMARY EVALUATION (continued) _____

Physician Review requested? ☐ **Yes** ☐ **No** **Date Sent:** _____

Signature and Title _____ Date _____

Signature and Title _____ Date _____

Completion Time _____ (Minutes) Travel Time _____ (Minutes)