The Commonwealth of Massachusetts

Executive Office of Health and Human Services

Department of Public Health

Northeast Regional Health Office, Saunders Building

Tewksbury Hospital, 365 East Street, Tewksbury, MA 01876

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Lieutenant Governor

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**Tel: 617-624-6000**

**www.mass.gov**

Medical Review Team

Application for Certification

Pediatric Skilled Nursing Facility

For Long Term Care

(Residential Placement)

Thank you for your recent request for the certification application. Enclosed are the necessary forms.

Each section of the application packet **must** be completed with current and comprehensive information. Incomplete application packets will be returned to the referral source. As indicated in the application, **contact with the local DDS representative is required** to ensure that all available resources and supports have been explored with the family prior to consideration of certification for a pediatric nursing home placement. It is also suggested that **the local school special education director be included in the discussion** about long term placement options.

After the completed application is received, the case will be scheduled for a Medical Review Team meeting. Meetings are held on the first and third weeks of each month. Parents/guardians and/or primary caretakers may attend the meeting. We will call to confirm a meeting time and to learn who will be attending the meeting.

Please direct questions or mail applications to:

 Denise Guilbeault, LICSW

Medical Review Team Coordinator

Mass. Dept. of Public Health

Northeast Regional Health Office

Tewksbury Hospital

365 East Street

Tewksbury, MA 01876

978-851-7261 x4022

Revised: 3/16

### APPLICATION FOR RESIDENTIAL SERVICES

**PEDIATRIC SKILLED NURSING FACILITY**

**APPLICATION PACKET**

**The MRT application packet must be completed and submitted in its entirety. The full packet will be used to establish an individual’s eligibility for care in a pediatric skilled nursing facility. Any information may be included. Incomplete packets will be returned.**

APPLICATION PACKET CHECKLIST

\_\_\_\_ Parent/Guardian Consent Form

\_\_\_\_\_ Completed Report of alternative options considered

\_\_\_\_\_ Contact established with local Department of Developmental Services office

\_\_\_\_\_ Application for Residential Services for Pediatric Skilled Nursing Facility

\_\_\_\_\_ Current Chapter 766 Evaluation Report and Individualized Educational Plan

 (IFSP) for individuals younger than 3 years of age

 (IEP) for individuals 3 years of age or older

**In completing the following three summaries, please use the outlines at the end of the packet.**

\_\_\_\_\_ Comprehensive Medical Summary

\_\_\_\_\_ Comprehensive Social Summary

\_\_\_\_\_ Comprehensive Developmental/Functional Summary

This application is made by:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature

FOR INTERNAL USE:

Date initially received:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date complete packet received:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of MRT review:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MRT Decision: \_\_\_ Certified \_\_\_Deferred \_\_\_Not Certified

Date of Notification of Decision:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL REVIEW TEAM**

# PARENT/GUARDIAN CONSENT FORM

**FOR RESIDENTIAL PLACEMENT IN**

**PEDIATRIC SKILLED NURSING FACILITIES**

I understand that the Massachusetts Department of Public Health (Department) through the Medical Review Team (MRT) is mandated to certify an individual’s eligibility for nursing home placement for individuals under twenty-two (22) years of age. The MRT is an interagency, multidisciplinary professional team composed of staff representatives from the Department of Public Health’s Bureau of Family Health and Nutrition, the Department of Elementary and Secondary Education, the Division of Medical Assistance (Medicaid), the Massachusetts Commission for the Blind, the Department of Developmental Services and the Department of Children and Families. In addition there are three professional consultants to assist the MRT in the review of the application. These consultants include a physician, a nurse, and a social worker.

By giving my permission for this assessment, I consent to have the MRT obtain and review existing medical, social, developmental and educational records and information submitted. I understand that my child’s care needs may be assessed by the MRT for consideration of less restrictive alternative care. I understand that all information received by the MRT will be kept confidential. I further understand that the MRT packet will be forwarded only to those facilities, programs or professionals who will be involved in planning and/or implementing a care plan specific to my child’s needs.

I have read and understand the above and consent to the review of assessment information for my child by the Medical Review Team in order to determine eligibility in a pediatric nursing facility. I understand that this consent is in effect for six months.

 Child’s Name (print) Date of Birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/ Guardian’s Signature Date

I have explained the contents of this form to the parent/guardian. To the best of my knowledge he/she understands the material.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referral Source Name (print) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referral Source Signature

 **CONSIDERATION OF ALTERNATIVES**

1. **The Parents or referral source MUST demonstrate that alternative community-based services or programs have been explored and found unavailable or inappropriate for the child prior to certification, as the first step in the application for nursing home placement. Please identify all individuals contacted relative to each category and state their responses. Use reverse side of the paper if needed.**

**(Examples are: home nursing, PCA, DDS out of home respite, residential school program, medical foster home through DCF, etc.)**

|  |  |  |  |
| --- | --- | --- | --- |
|  Agency/Service Type |  Contacted |  Name of Contact | Outcome of Contact |
|  |  Yes |  No |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

1. **Alternative services have been explained to the family but the family will not consider any alternative community-based service or program because:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Massachusetts Department of Public Health

Bureau of Family Health and Nutrition

Division of Perinatal, Early Childhood and Special Health Needs

 **APPLICATION FOR RESIDENTIAL SERVICES**

 **PEDIATRIC SKILLED NURSING FACILITY**

Each portion of this form **must** be completed.

**IDENTIFYING DATA**:

1. Child's Name:

2. Child's Birth Date \_\_\_/\_\_\_/\_\_\_/ Sex: \_\_M \_\_F

3. Child’s Health Insurance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 If Masshealth, does the child have Kaleigh Mulligan? \_\_\_Yes \_\_\_No \_\_\_ Don’t Know

4. Parent(s)/Primary Caregiver(s) Name(s), Address and Phone

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Telephone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Parent’s Primary Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Diagnosis(es): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. Referred by:

 Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Title/Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_

 Hospital/Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL CARE PROVIDERS:**

A medical summary provided by a primary care, specialty or attending physician written within the last 2 months must be included.

The summary must include the information described in the outline attached to this packet. Please use the other side of the page when additional space is needed.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Physicians’ Names |  Specialty | Freq. of visits |  Location | Date of last visit |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**NURSING PROCEDURES/TREATMENTS**:

If your child receives **nursing services** please include the last monthly summary. Indicate the relevant frequency of the following procedures.

1. Respiratory/cardiac care

 No special procedure\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Ventilator\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Tracheostomy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Requires O2\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of last use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_Provide O2 Log: \_\_\_\_\_\_\_

 Chest physical therapy/ postural drainage \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Deep Upper Airway Suctioning \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Monitors (Specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Other monitoring equipment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Feeding Programs

 No specific program\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Hyperalimentation (IV feedings) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Difficult oral feedings\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Gavage/tube (G, G-J, NG)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Specialized diet\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Special positioning/equipment: (describe:) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Bowel and Bladder Care

 Bladder catheterization: indwelling or intermittent\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Suppositories/enemas\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Ostomy care\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Other (list) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Other Nursing Procedures and Skilled Assessments

 VP shunt \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Seizure Disorder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_Date of last seizure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Provide seizure log: \_\_\_\_\_\_

 Seizure intervention \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Special skin care including ostomy and wound site care \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Turning/positioning \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Medications: (List all medications, dosage, administration techniques)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 No medications\_\_\_\_\_\_\_\_\_\_\_\_

**ATTENTION:**

**IF PRN IS INDICATED ON ANY LINE, PLEASE LIST DATE LAST GIVEN OR PERFORMED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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**DEVELOPMENTAL/FUNCTIONAL STATUS**:

In addition to this checklist, a **comprehensive developmental/functional summary,** based on an evaluation performed within the year, must be included. The summary must include the information described in the outline attached to this packet.

1. Cognitive Function (Check highest level)

 No delay\_\_\_\_\_

 Slight/mild delay\_\_\_\_\_

 Severe delay\_\_\_\_\_

 Profound delay\_\_\_\_\_

 Unable to assess\_\_\_\_\_

2. Behavioral/Social (Check all that apply)

 No difficulties\_\_\_\_\_

 Does not interact with others\_\_\_\_\_

 Acts out against self\_\_\_\_\_

 Acts out against others\_\_\_\_\_

 Sleep difficulties\_\_\_\_\_

 Self-stimulatory behavior\_\_\_\_\_

 Hyperactivity\_\_\_\_

 Other (describe)\_\_\_\_\_

3. Communication (Check highest level)

 **Expressive** **Receptive**

 \_\_\_\_Communication is age appropriate \_\_\_Understanding is appropriate for age

 \_\_\_\_Speaks in sentences \_\_\_Understands language readily

 \_\_\_\_Speaks phrases/words \_\_\_Limited understanding

 \_\_\_\_Some sounds with meaning \_\_\_Responds to verbal cues

 \_\_\_\_Communicates non-verbally \_\_\_Responds to visual cues

 \_\_\_\_Sign language \_\_\_No response

 \_\_\_\_Communication board \_\_\_Unable to assess

 \_\_\_\_Computer

 \_\_\_\_Other (describe)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_Some sounds without meaning

 \_\_\_\_No communication

 \_\_\_\_Unable to assess

4. Self Care Skills (Check highest level)

 Independent/Age Needs Totally

 Appropriate Assistance Dependent

 a. Feeding \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

 b.. Dressing \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

 c. Personal Hygiene (teeth, hands, face) \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

 d. Bathing \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

 e. Toileting (Indicate the highest level) \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

  **Bladder** **Bowel**

 \_\_\_\_\_\_Completely independent \_\_\_Completely independent

 \_\_\_\_\_\_Time voidings \_\_\_\_Needs some assistance

 \_\_\_\_\_\_Little/no control \_\_\_\_Little/no control

 \_\_\_\_\_\_Catheter/bag \_\_\_\_Bag

5. Arm/Hand Use (Indicate the highest level)

  **Right:** \_\_\_full use \_\_\_partial use \_\_\_little/no control \_\_\_no use

  **Left:** \_\_\_\_full use \_\_\_partial use \_\_\_little/no control \_\_\_no use

 Please indicate hand dominance/preference or that both hands are used equally well:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Mobility/Locomotion (Check all that apply)

 \_\_\_\_Appropriate for age \_\_\_\_ Needs assistance with transfers

 \_\_\_\_Ambulates \_\_\_\_Sits independently

 \_\_\_\_Ambulates with assistance \_\_\_\_ Sits with assistance

 \_\_\_\_Ambulates with assistive device \_\_\_\_ Stands independently

 \_\_\_\_Independent in wheelchair \_\_\_\_ Stands with assistance

 \_\_\_\_Needs assistance in wheelchair \_\_\_\_ Rolls Over

 \_\_\_\_Independent in transfers \_\_\_\_ Totally dependent

7. Equipment use

Indicate all necessary equipment, with (**R) Rented or (O) Owned**.

 \_\_\_\_\_\_No special equipment \_\_\_\_\_Dressing aids

 \_\_\_\_\_\_Wheelchair (power, manual) \_\_\_\_\_Seating system other than wheelchair

 \_\_\_\_\_\_Walker/crutches/cane \_\_\_\_\_ Braces/casts/special shoes

 \_\_\_\_\_\_Hearing aids \_\_\_\_\_Communication devices

 \_\_\_\_\_\_Glasses/contact lens \_\_\_\_\_Other (describe)

8. Therapy Services

|  |  |  |
| --- | --- | --- |
| SERVICES | FREQUENCY | LOCATION |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**EDUCATIONAL PROGRAMMING**

A detailed summary of the educational program through an early intervention report (IFSP), Individualized Education Plan (IEP) or a Ch. 688 Transition Plan (ITP) must be included.

1. Early Intervention Program \_\_\_\_\_Yes \_\_\_\_\_No

 Name of Program\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Contact Person\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Telephone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Service Provided:

 \_\_\_\_\_in home \_\_\_\_\_ hours per day \_\_\_\_\_days per week

 \_\_\_\_\_center-based \_\_\_\_\_hours per day \_\_\_\_\_days per week

2. Special Education Services through Chapter 766 \_\_\_\_\_Yes \_\_\_\_\_No

 a. Responsible School District\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 School District Liaison\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Telephone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 b. Type of Program

 \_\_\_\_\_\_In district \_\_\_\_ Ch. 766 Residential School

 \_\_\_\_\_\_Collaborative \_\_\_\_\_Home-based

 \_\_\_\_\_\_Ch. 766 Day School

 c. Individualized Education Plan attached

 \_\_\_\_Yes

 \_\_\_\_No (Please explain)

3. Other Educational Programming (describe)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Please list therapy/medical services being provided at school

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5. If an educational program is not being offered, please explain.

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6. Chapter 688 status \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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## SUPPORT SERVICES

(frequency = hrs/day/week) (Funding Source= DDS, DMH, DCF, MCB, DMA)

|  |  |  |
| --- | --- | --- |
| SERVICES | FREQUENCY | FUNDING SOURCE |
| Nursing Services |  |  |
| Personal Care Attendant Services |  |  |
| Home Health Aide |  |  |
| Out-of-Home Respite |  |  |
| Counseling |  |  |
| Case Management |  |  |
| Day Care |  |  |
| Recreation/after school program |  |  |
| Other (list) |  |  |

**Outline for Comprehensive Developmental/Functional Summary**

Children referred for MRT review have usually had developmental summaries prepared either in conjunction with comprehensive medical evaluations or educational plan evaluations. If the developmental summary was written in the past year and includes the data listed below, a new summary need not be prepared.  **This summary should be prepared by the child’s developmental pediatrician, educational or developmental specialist and/or occupational, physical, speech/language therapists.**

The summary must include the following:

1. Description of developmental milestones achieved in the areas of cognition,

 gross/fine motor, self-help, social and expressive/receptive language skills.

2. Summary of most recent developmental evaluation, including progress reports,

 names of standardized tools for assessment, and focusing on gross/fine motor,

 expressive/receptive language skills, visual processing and visual/motor

 integration.

3. Description of all equipment used to enhance functioning and independence:

 communication boards, seating systems, adaptive utensils, etc..

4. Overview of functional status and approximate developmental age, including

 capacity for self-care, mobility, communication and verbal/visual

 comprehension, cognition, emotional/behavioral status. Please conclude with a

 statement of goals and recommendations for treatment.

**Outline for Comprehensive Social Summary**

The social summary is to be prepared by a social service professional who knows the child and his/her family and has visited the home. The summary should be prepared in consultation with the family and include the following information:

1. Reason for referral for MRT review.

2. Primary language spoken at home and access to interpreter services.

3. Description of child’s residence and neighborhood, including safety concerns,

 architectural barriers within and outside the home, access to transportation, etc..

4. Description of all community services, resources and/or state agencies which are

 providing services or support to the child and his/her family. Include names of

 caseworkers involved. Also include other services and supports which may be

 helpful to the child and his/her family but are currently unavailable.

1. Description of the current relationship of the child and his/her family with the

referral source. Include frequency and quality of contact, and plans for follow-up.

1. Summary of all community options explored and all state agencies contacted.

 Indicate all available alternatives.

7. Summary and recommendations for child’s current and future care based on

 family’s intermediate and long range goals. Summarize the reasons for

 requesting residential care at this time.

**Outline for Comprehensive Medical Summary**

Children referred for MRT review usually have had medical summaries prepared in conjunction with comprehensive medical evaluations in a hospital or clinic. If the summary was written in the past 2 months and includes the data listed below, a new summary need not be prepared. If a current summary does not exist it needs to be secured and submitted by the child’s primary medical care provider.

A summary **MUST** include the following:

1. Presenting problem(s)/diagnosis(es)

2. Prenatal, perinatal, and neonatal history

3. Health history including a complete description, by diagnoses or organ system

 involvement, of active or previously active problems. Include date of onset,

 Results of evaluation, functional implications and prognosis or date of

 resolution. Neurologic, musculo/skeletal and nutritional/feeding issues should be

 addressed.

More specifically, the health history will include:

1. Growth and physical development (including growth parameters)
2. Medications: schedule, dose, route of administration
3. Allergies
4. Immunizations
5. Hospitalizations/surgical procedures: please include discharge summaries from

 hospitalizations that have occurred during the last year

 - Significant trauma history

 - Nutritional status

 - Respiratory history and status

 - Bowel/bladder status

 - Skin condition

 - Cognitive/behavioral/developmental status

4. Psychiatric History: Please list DSM-IV diagnosis

5. Family Medical History: Special attention needs to be given to genetic issues

 and any additional special medical needs.

6. Physical Examination Report

7. Visual and hearing assessment/testing reports. When applicable please

 indicate if registered with the Massachusetts Commission for the Blind

8. Conclusion: summarizing diagnoses, etiology and prognosis and listing specific

 recommendations