



**INSTRUCTIONS FOR COMPLETION**

An *INCOMPLETE* or *INCORRECT* Assessment will be returned and may result in a delay of the prior authorization for PCA services.

1. Print legibly.
2. Prior to submitting this *Assessment* valid Vermont Medicaid must be in place for the child.
3. This *Assessment* must be completed by a Medicaid provider or an employee of the Department of Health, Children with Special Health Needs (CSHN) program or Family, Infant & Toddler Project (FITP).
4. Complete the sections:
  - Section I:** GENERAL INFORMATION - general referral, medical, and assessment information.
  - Section II:** ACTIVITIES OF DAILY LIVING
  - Section III:** BEHAVIOR AND COGNITION INFORMATION
  - Section IV:** HOME ENVIRONMENT INFORMATION – complete in the presence of the parent/guardian.
  - Section V:** OTHER HEALTH INFORMATION - must be updated annually and when requesting a change in services.
5. Review this *Assessment* with the parent/guardian.
6. Both the assessor and the parent/guardian must sign the acknowledgement section.
7. Retain a copy of this *Assessment* for your own records.
8. Return this original *Assessment* and a current *Care Plan* or outline of personal care to:

**Children's Personal Care Services**  
**Division of Disability & Aging Services**  
 Department of DAIL  
 103 South Main Street  
 Waterbury, VT 05671  
 Fax: 802-241-4224

\*Department rules at M740-M740.7 authorize the Department of PATH to approve fewer hours than the hours requested based on this application/assessment.

**ASSESSMENT INFORMATION**

Initial Assessment       Re-Assessment

Date \_\_\_/\_\_\_/\_\_\_ Provider Number \_\_\_\_\_  
 Agency Name \_\_\_\_\_  
 Daytime Phone ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_  
 Name of Person Completing this Assessment \_\_\_\_\_

**REFERRAL INFORMATION**

Disability/DX \_\_\_\_\_  
 Number of PCS hours per week requested\* \_\_\_\_\_

**CLIENT**

Name \_\_\_\_\_  
 Medicaid ID # \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_/\_\_\_/\_\_\_ Age \_\_\_\_\_

**PARENT/GUARDIAN**

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Daytime Phone ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_  
 Mailing Address (if different) \_\_\_\_\_

Referred by (Agency/Doctor/School) \_\_\_\_\_

Daytime Phone ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_  
 Reason for Referral \_\_\_\_\_

**MEDICAL INFORMATION**

**PRIMARY DOCTOR**

Name \_\_\_\_\_  
 Mailing Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Daytime Phone ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

**SPECIALTY DOCTOR**

Name \_\_\_\_\_  
 Mailing Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Daytime Phone ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_



**I. GENERAL INFORMATION**

**LOCATION OF THIS INTERVIEW?**

- Home
- Hospital
- Other \_\_\_\_\_

**WHO WAS PRESENT FOR THIS INTERVIEW?**

*(Check All That Apply)*

- Child
- Parent/Guardian
- Other \_\_\_\_\_

**DID SOMEONE ANSWER OR HELP ANSWER QUESTIONS FOR THE CHILD?**

- No
- Yes

Helper's Name \_\_\_\_\_

Relationship to the Child \_\_\_\_\_

**II. ACTIVITIES OF DAILY LIVING (ADL)**

*Circle the number that, in your professional judgment, describes the child's ability to perform each ADL at his/her age level and then give a brief comment to support your selection.*

**1. DRESSING & UNDESSING - UPPER BODY**

Includes undergarments, pullovers, front-opening shirts and blouses, managing buttons, zippers, and snaps.

- 0 Able to dress upper body independently by getting clothes out of closet or drawers, putting them on, and removing them (may include use of dressing aids or assistive devices) **or** not applicable due to age.
- 1 Able to dress upper body with supervision or reminding (includes retrieving clothes from closet or drawers and laying them out for child, handing the child article(s) of clothing).
- 2 Dependent upon human assistance to dress upper body **some** but not all of the time.
- 3 Dependent upon human assistance to dress upper body **most** but not all of the time.
- 4 Complete physical assistance is necessary each time.

**COMMENTS** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**2. DRESSING & UNDESSING - LOWER BODY**

Includes undergarments, slacks, socks, and shoes.

- 0 Able to dress lower body independently by getting clothes out of closet or drawers, putting them on, and removing them (may include use of dressing aids or assistive devices) **or** not applicable due to age.
- 1 Able to dress lower body with supervision or reminding (includes retrieving clothes from closet or drawers and laying them out for child, handing the child article(s) of clothing).
- 2 Dependent upon human assistance to dress lower body **some** but not all of the time.
- 3 Dependent upon human assistance to dress lower body **most** but not all of the time.
- 4 Complete physical assistance is necessary each time.

**COMMENTS** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**3. BATHING**

Refers to the child's ability to bathe or shower. Bathing and showering means running the water, getting in and out of the tub or shower and washing all parts of the body including shampooing hair.

- 0 Able to bathe self independently (may include use of aids or assistive devices) **or** not applicable due to age.
- 1 Able to bathe self with supervision or reminding (may include placement of assistive devices or aids).
- 2 Dependent upon human assistance to bathe **some** but not all of the time.
- 3 Dependent upon human assistance to bathe **most** but not all of the time.
- 4 Complete physical assistance is necessary each time.

**COMMENTS** \_\_\_\_\_  
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\_\_\_\_\_  
\_\_\_\_\_



**4. GROOMING (PERSONAL HYGIENE)**

Refers to the child's ability to tend to personal hygiene needs (e.g. washing face and hands, hair care, shaving or makeup, teeth care, fingernail and toenail care).

- 0 Able to groom self independently **or** not applicable due to age.
- 1 Able to groom self with supervision or reminding (may include use of aids or assistive devices). Includes providing a washing basin and grooming articles.
- 2 Dependent upon human assistance to groom self **some** but not all of the time.
- 3 Dependent upon human assistance to groom self **most** but not all of the time.
- 4 Complete physical assistance is necessary each time.

**COMMENTS** \_\_\_\_\_  
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\_\_\_\_\_  
\_\_\_\_\_

**5. TOILET USE**

Refers to how well the child can manage using the toilet, bedpan, or urinal. Includes adjusting clothing, getting on and off the toilet, cleaning oneself, changing pad, managing ostomy or catheter.

- 0 Able to use toilet independently or does not use toilet (see item 6 and 7) **or** not applicable due to age.
- 1 Able to use toilet with supervision and reminding (may include handing the child a bedpan or placing articles necessary for changing ostomy within reach).
- 2 Dependent upon human assistance to use toilet **some** but not all of the time.
- 3 Dependent upon human assistance to use toilet **most** but not all of the time.
- 4 Complete physical assistance is necessary each time.

**COMMENTS** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**6. CONTINENCE – BLADDER**

Refers to child's ability to control bladder functions.

- 0 Never incontinent **or** not applicable due to age.
- 1 Incontinent once a week or less.
- 2 Incontinent more than once a week but not daily.
- 3 Incontinent daily but still has some control.
- 4 Has no bladder control . Wears diapers . Has catheter . (*Please Specify*)

**COMMENTS** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**7. CONTINENCE – BOWEL**

Refers to child's ability to control bowel functions.

- 0 Never incontinent **or** not applicable due to age.
- 1 Incontinent once a week or less.
- 2 Incontinent more than once a week but not daily.
- 3 Incontinent daily but still has some control.
- 4 Has no bowel control . Wears diapers . Has ostomy . (*Please Specify*)

**COMMENTS** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**8. ADAPTIVE DEVICES**

Refers to child's ability to manage putting on and removing braces, splints, and other assistive devices. List the devices other than wheelchairs (see item 10 for wheelchairs).

- 1 Able to perform activity independently . Not applicable . Not applicable due to age .
- 2 Able to perform activity with supervision or reminding.
- 3 Able to manage adaptive devices with human assistance **some** but not all of the time.
- 4 Able to manage adaptive devices with human assistance **most** but not all of the time.
- 5 Complete physical assistance is necessary each time.

**COMMENTS** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**9. TRANSFERRING**

Refers to all of the child's physical ability (e.g., bed to chair) **except** tub (see item 3) and toilet (see item 5).

- 0 Able to transfer independently with or without use of an assistive device **or** not applicable due to age.
- 1 Able to transfer with supervision or reminding. Includes giving the person a transfer board or locking the wheels on a wheelchair.
- 2 Able to transfer with minimal human assistance related to age, size, or ability of the child.
- 3 Requires extensive human assistance to transfer self independently but is able to bear weight and pivot during the transfer process.
- 4 Complete physical assistance is necessary each time.

**COMMENTS** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**10. MOBILITY - AMBULATION/LOCOMOTION**

Refers to the child's ability to move between locations from a standing position or to use a wheelchair once in a seated position on a variety of surfaces. Includes power wheelchairs.

- 0 Able to ambulate independently or without a wheelchair or other assistive devices **or** not applicable due to age.
- 1 Requires human supervision or assistance to negotiate stairs or steps of uneven surface (may include handing child a walker or cane, unlocking the brakes on a wheelchair, or adjusting foot pedals to facilitate foot motion while wheeling).
- 2 Dependent on supervision or assistance from another person to walk or wheel **some** but not all of the time (occasionally needs someone to push a wheelchair).
- 3 Dependent on supervision or assistance from another person to walk or wheel **most** but not all of the time.
- 4 Unable to ambulate or self-propel wheelchair.

**COMMENTS** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**11. BED MOBILITY**

Refers only to the child's ability to reposition in bed.

- 0 Able to perform activity independently (may include use of aids or assistive devices) **or** not applicable due to age.
- 1 Can perform activity with supervision or reminding (may include placement of assistive device or aid).
- 2 Human assistance is required **some** but not all of the time.
- 3 Human assistance is required **most** but not all of the time.
- 4 Complete physical assistance is necessary each time.

**COMMENTS** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**12. EATING/FEEDING**

Refers to the process of eating, chewing and swallowing meals and snacks not preparing food to be eaten.

- 0 Able to feed self independently (includes using straws and special utensils) **or** not applicable due to age.
- 1 Able to feed self independently with meal set-up and supervision or cueing.
- 2 Able to feed self with physical assistance during **some** but not all of a meal.
- 3 Able to feed self but requires physical assistance throughout **most** of the meal.
- 4 Unable to feed self. Must be assisted throughout a meal or eating does not occur (G. Tube or TPN, etc.).

**COMMENTS** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**13. PREPARING LIGHT MEALS**

Refers to opening containers, cutting meat, and meal set-up (e.g. breakfast-cereal or toast; lunch-soup or sandwich; able to reheat in microwave or stovetop).

- 0 Able to independently plan, prepare, and clean up after meals for self **or** is physically, cognitively, and mentally able to prepare meals on a regular basis but has not routinely performed meal preparation in the past **or** not applicable due to age.
- 1 Able to prepare simple meals with supervision and cueing.
- 2 Able to prepare simple meals with assistance and supervision **some** but not all of the time.
- 3 Able to prepare simple meals with assistance and supervision **most** but not all of the time.
- 4 Unable to prepare simple meals due to severe physical or cognitive limitations or set-up G-tube, TPN, etc.).

**COMMENTS** \_\_\_\_\_  
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\_\_\_\_\_  
\_\_\_\_\_

**14. COMMUNICATION**

- 0 Communication/language skills are appropriate to this child's developmental level.
- 1 Speech is not developed to age appropriate level. Can communicate with people familiar to the child.
- 2 Requires assistive devices: picture boards, amplification device, hearing aid or alternative method (e.g. signing). Sometimes becomes frustrated with inability to communicate effectively.
- 3 Speech is often not intelligible. Often becomes frustrated with inability to communicate effectively.
- 4 Is non-communicative **or** communicates only with eyes, pointing, or grunting.

**COMMENTS** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**15. ABILITY TO USE TELEPHONE**

- 0 Able to dial and answer calls appropriately and as desired (may include the use of adaptive equipment, aids, and assistive devices) **or** not applicable due to age.
- 1 Able to answer the phone and carry on a normal conversation, but has difficulty with placing calls although is able to dial 9-1-1 if necessary.
- 2 Able to answer the phone only some of the time or able to carry on only a limited conversation.
- 3 Unable to answer phone but can listen if assisted with adaptive equipment or if phone is held for child.
- 4 Activity does not occur, child is non-communicative, or child has no phone.

**COMMENTS** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**16. LIGHT HOUSEKEEPING**

Refers to child's ability to do chores, clean own bedroom, playroom, or pick up after self.

- 0 Able to independently perform all housekeeping tasks **or** not applicable due to age.
- 1 Physically, cognitively and mentally able to perform tasks but has not routinely participated in housekeeping tasks in the past. (May require supervision , reminders )
- 2 Needs assistance from another person **some** of the time or with some tasks.
- 3 Needs assistance from another person **most** but not all of the time.
- 4 Unable to perform tasks at all due to severe physical and or cognitive limitations.

**COMMENTS** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**III. BEHAVIOR & COGNITION INFORMATION**

*Circle the number that in your professional judgment, most accurately describes the child's behavior and cognition information distinct from the child's physical abilities assessed under the previous section.*

**17. SLEEP PATTERN**

- 0 Sleeps through the night uninterrupted (may get up to go to the bathroom, returns to sleep; may include use of sleep medication).
- 1 Sleeps noticeably more  or less  than "normal." *(Please Specify)*
- 2 Nightmares, disturbed sleep, or increased awakenings.
- 3 Up wandering for all or most of the night, inability to sleep.

**COMMENTS** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**18. WANDERING WITHOUT PURPOSE OR AWARENESS**

Circle appropriate number and check all applicable statements.

- 0 Does not wander or is chair-bound or bed-bound **or** not applicable due to age.
- 1 Wanders within residence but does not jeopardize health and safety  **or**
- 2 Wanders within residence, health and safety may be jeopardized  **and/or** wanders outside and health and safety may be jeopardized .
- 3 Has a consistent history of: leaving grounds , getting lost , being combative about returning . Requires a treatment plan that may include the use of psychotropic drugs for management and safety .

**COMMENTS** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**19. BEHAVIORIAL DEMANDS ON OTHERS**

- 0 Attitudes, habits, and emotional states do not limit the child's type of living arrangements or companions **or** not applicable due to age.
- 1 Attitudes, habits, and emotional states limit the child's type of living arrangements and companions.

- 2 Attitudes, disturbances, and emotional states create consistent difficulties that are not easily modifiable to manageable levels.
- 3 The child's behavior cannot be changed to reach the desired outcome through respite and in-home services, even if caregiver is trained. *(Please explain)*

**COMMENTS** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**20. DANGER TO SELF AND OTHERS**

- 0 Is not disruptive or aggressive **or** is not dangerous or capable of harming self or others **or** not applicable due to age.
- 1 Is sometimes disruptive or aggressive either physically or verbally or is sometimes extremely agitated or anxious even after proper evaluation and treatment.
- 2 Is frequently disruptive or aggressive or is frequently extremely agitated or anxious and professional judgment is required when to administer prescribed medication.
- 3 Is dangerous or physically abusive and even with proper evaluation and treatment may require physician's orders for appropriate intervention.

**COMMENTS** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**21. AWARENESS OF NEEDS/JUDGMENT**

- 0 Understands those needs that must be met to maintain self-care **or** not applicable due to age.
- 1 Sometimes has difficulty understanding those needs that must be met but will cooperate when given direction or explanation.
- 2 Frequently has difficulty understanding those needs that must be met, but will cooperate when given direction or explanation.
- 3 Does not understand those needs that must be met for self-care and will not cooperate even though given direction or explanation.

**COMMENTS** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**IV. HOME ENVIRONMENT**

*Provide the following information using your professional judgment and, where indicated, based on the caregiver's report. Briefly describe any instruction or action(s) taken.*

**22. ENVIRONMENTAL CHECKLIST**

- a. Dangerous stairs/floors  Yes  No
- b. Difficult to get to home entrance  Yes  No
- c. Difficult to get to bathroom/bedroom  Yes  No
- d. Major appliances/toilet not working  Yes  No
- e. Problems with heating/cooling system  Yes  No
- f. Problems getting water/hot water  Yes  No
- g. Difficult to keep home free from odor & pests  Yes  No
- h. Smoke alarm/fire extinguisher needed  Yes  No
- i. Poor lighting  Yes  No
- j. Electrical hazards  Yes  No
- k. Unsafe stove  Yes  No
- l. Loose/slippery rugs  Yes  No
- m. Inadequate locks for doors/windows  Yes  No
- n. Difficult to keep home clean/free of clutter  Yes  No
- o. Other Problems (*Please Specify*)  Yes  No

**COMMENTS** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**23. PRIMARY CAREGIVER**

Name \_\_\_\_\_  
Mailing Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Daytime Phone ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_  
Evening Phone ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_  
Relationship \_\_\_\_\_

- a. In an emergency (e.g., fire) Primary Caregiver reports that he/she would be unable to get child out of dwelling safely.  Yes  No

*Primary Caregiver reports giving the following care:*

- b. Personal care (e.g., bathing, dressing, using the toilet, getting in/out of bath, eating)  Yes  No
- c. Housekeeping (e.g., meal preparation, cleaning, laundry, trash removal)  Yes  No
- d. Transportation  Yes  No
- e. Shopping/errands  Yes  No
- f. Supervision  Yes  No
- g. Taking Medication  Yes  No
- h. Managing Money  Yes  No
- i. Other Care (*Please Specify*)  Yes  No

*Primary Caregiver reports that:*

- YES, there are factors that would make it difficult to provide care if services were not in place.
- NO, there are not any factors that would make it difficult to provide care if services were not in place.

*If YES, check the factors that might limit the Primary Caregiver:*

- j. Job  Yes  No
- k. Finances  Yes  No
- l. Family responsibilities  Yes  No
- m. Physical burden  Yes  No
- n. Emotional burden  Yes  No
- o. Caregiver's Mental Health  Yes  No
- p. Other Factors (*Please Specify*)  Yes  No

**COMMENTS** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**24. OTHER CAREGIVERS**

Name \_\_\_\_\_  
Daytime Phone ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_  
Evening Phone ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_  
Relationship \_\_\_\_\_  
Type of Care/Help Given \_\_\_\_\_

Name \_\_\_\_\_  
Daytime Phone ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_  
Evening Phone ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_  
Relationship \_\_\_\_\_  
Type of Care/Help Given \_\_\_\_\_



**V. OTHER HEALTH INFORMATION** *Complete this section annually or when requesting a change in services.*

**25. DESCRIBE THE CHILD'S MEDICAL HEALTH STATUS**

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**26. DESCRIBE THE CHILD'S EMOTIONAL, BEHAVIORIAL & PSYCHIATRIC STATUS**

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**27. DESCRIBE OTHER SPECIAL CIRCUMSTANCES**

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**28. DESCRIBE FREQUENCY & DURATION OF ANY SERVICES OR SUPPORTS WHICH THE CHILD OR FAMILY RECEIVE**

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**29. MEDICAID HI-TECH PROGRAM SERVICES**

Number of Nursing Hours per Week: Approved \_\_\_\_ Receiving \_\_\_\_  
Nursing Care Manager and/or Agency Name \_\_\_\_\_  
 Other Hi-Tech Program Services \_\_\_\_\_

**30. FAMILY, INFANT & TODDLER PROJECT SERVICES**

Service Coordinator Name \_\_\_\_\_  
Respite \_\_\_\_\_

**31. CHILDREN WITH SPECIAL HEALTH NEEDS SERVICES** (Department of Health)

Contact Name \_\_\_\_\_  
Respite \_\_\_\_\_  
Clinic(s) \_\_\_\_\_

**32. DEVELOPMENTAL SERVICES** (Department of Developmental & Mental Health Services)

Contact Name \_\_\_\_\_  
 Flexible Family Funding \_\_\_\_\_  
 Developmental Services Waiver \_\_\_\_\_

**33. CHILDREN'S MENTAL HEALTH SERVICES** (Department of Developmental & Mental Health Services)

Contact or Agency Name \_\_\_\_\_  
 Mental Health Respite/Specialized Rehabilitation Services \_\_\_\_\_  
 Mental Health Waiver \_\_\_\_\_  
 Intensive Family-based Services \_\_\_\_\_



**34. SCHOOL SERVICES**

Case Manager Name \_\_\_\_\_

*Child is in:*

- EEE \_\_\_\_ hours per day \_\_\_\_ days per week
- School \_\_\_\_ hours per day \_\_\_\_ days per week

*Child has an:*

- IEP in place
- Instructional Assistant (1:1 Aide) \_\_\_\_ hours per day \_\_\_\_ days per week

**35. OTHER SERVICES & SUPPORTS**

- Child Care Subsidy (Department of Social & Rehabilitative Services)
- SSI or DCHC ("Katie Beckett")
- SRS \_\_\_\_\_
- Other \_\_\_\_\_

**ASSESSOR ACKNOWLEDGEMENT**

*I acknowledge that I performed this Assessment in the presence of the child and the parent/guardian who has reviewed it with me and stated concurrence with my findings.*

\_\_\_\_\_  
Assessor Signature  
\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

**PARENT/GUARDIAN ACKNOWLEDGEMENT**

*I acknowledge this Assessment was performed with input from me and I am in agreement with this Assessment.*

\_\_\_\_\_  
Parent/Guardian Signature  
\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date