

DEPARTMENT OF SOCIAL SERVICES

40 NORTH PEARL STREET, ALBANY, NEW YORK 12243-0001

MARY JO BANE
Commissioner



(518) 474-9475

LOCAL COMMISSIONERS MEMORANDUM

DSS-4037EL (Rev. 9/89)

Transmittal No: 92 LCM-113

Date: July 27, 1992

Division: Medical Assistance

TO: Local District Commissioners

SUBJECT: Pediatric Patient Review Instrument for Use in the Care at Home Medicaid Model Waivers Authorized under Social Services Law 366.6

ATTACHMENTS: Pediatric Patient Review Instrument
(available on-line)

The New York State Department of Social Services, Division of Medical Assistance, has received approval from the Federal Health Care Financing Administration (HCFA), to implement the use of the Pediatric Patient Review Instrument (PPRI), Form DSS-4362, in the Care at Home I and II Medicaid Model Waiver Programs.

This form must be completed by a nurse, licensed by the New York State Department of Education.

The PPRI is designed to specifically address the level of care issues unique to infants and children; it will replace the DMS-1 and the PRI currently used in the Care at Home I and the Care at Home II Programs respectively.

The PPRI (see attachment) will be in effect as of August 1, 1992.

When the forms are returned from the printer, we will send a supply to each county. Please photocopy the attached form for now.

Any questions concerning the use of the PPRI should be addressed to Ms. Janice Tricarico at 1-800-342-3715 ext. 4-9785, User ID 0PM140.

Jo-Ann A. Costantino
Deputy Commissioner
Division of Medical Assistance

NYS DEPARTMENT OF SOCIAL SERVICES
PEDIATRIC PATIENT REVIEW INSTRUMENT
for Care At Home Waiver Program

Date: _____

I. ADMINISTRATIVE DATA

Patient Name: _____

Birthdate: _____

Sex: Male Female

If child could not be cared for at home he/she would require:

SNF: _____ Hosp.: _____ Other: _____ level of care

County of Residence: _____

Diagnosis:

Primary: _____

Other: _____

Brief description of child's illness: (including age of on-set)

Family Structure (involvement, limitations, etc.)

MEDICAL TREATMENTS: (check all which apply)

Yes No

Yes No

<u>Trach Care</u> <u>Suctioning</u> Oral/nasal Trach. <u>Oxygen</u> Daily Intermittently <u>Ventilator</u> Continuous Intermittent <u>Feeding</u> By mouth Nasal gastric feeding Parenteral (IV) Gastric Tube			<u>Total Parenteral Nutrition (TPN)</u> <u>Home Dialysis</u> <u>Monitoring device(s):</u> - oximeter - apnea - cardiac <u>Shunt Care</u> VP VA Shunt has functioned without a problem for last 6 months		
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Other:

FUNCTIONING

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

DEVELOPMENTAL DOMAIN;	SUSPECTED PROBLEM/ ASSESSMENT PENDING	MODERATE PROBLEM	SEVERE PROBLEM	NOT APPLICABLE/ AGE INAPPROP./ DON'T KNOW
a. Gross motor	1	2	3	0
b. Fine motor	1	2	3	0
c. Receptive communication	1	2	3	0
d. Expressive communication	1	2	3	0
e. Self-care				
Toileting	1	2	3	0
Personal hygiene	1	2	3	0
Grooming	1	2	3	0
Eating	1	2	3	0
Bathing	1	2	3	0
Dressing	1	2	3	0
f. Vision	1	2	3	0
g. Hearing	1	2	3	0

MOBILITY

Yes No

Comments

<p><u>Mobility</u> a) Child is age appropriate b) If child is not age appropriate cont.: Requires assistance of another human to ambulate <u>Ambulate</u> Requires device to ambulate: - wheelchair - walker - prosthesis</p>			
<p><u>Respiratory Care:</u> Postural drainage Inhalation therapy <u>Wound Care</u> Sterile Unsterile <u>Catheter Care</u> <u>Seizures</u> Intervention daily 1 x mo. 1 x in past 3 mos. 1 x in past year <u>Ostomy</u> <u>Orthotics</u> <u>Ongoing medication by</u> NG G-tube <u>Mental Status</u> Alert Lethargic Stuperous Comatose Agitated</p>			

- a. Daily intravenous medication or nutritional supplement
- b. Requires constant observation for: _____
- c. Physical occupational or speech therapy

YES	NO	COMMENTS

FORM COMPLETION DATE: _____

FORM COMPLETED BY: _____ R.N.

TITLE OF PERSON COMPLETING FORM: _____

ADDITIONAL COMMENTS ABOUT CHILD:

If you have any questions about completing this form, please call Janice Tricarico at New York State Department of Social Services (518) 474-9785.