NEW YORK STATE

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 OPM140.

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

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

(DSS-4362)

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

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

	YES	NO	COMMENTS
a. Daily intravenous medication or nutritional supplement			
b. Requires constant observation for:_____			
c. Physical occupational or speech therapy			

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.