The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
250 Washington Street, Boston, MA 02108-4619

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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 request 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:

Medical Review Team (MRT)
MA Department of Public Health
250 Washington St, 5th Floor
Boston, MA 02108
Fax: 1-857-323-8323

Contact:

Dr. Katja Gerhardt
Phone: 781-223-2731
katja.gerhardt@mass.gov

or

Stefanie Hall
Phone: 617-645-3856
Stefanie.A.Hall@mass.gov

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 Program
(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, MassHealth, the Massachusetts Commission for the Blind, the Department of Developmental Services and the Department of Children and Families. In addition, the MRT includes representatives from different professions as a physician, a nurse, a parent representative, 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/ Legal 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/legal guardian 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 community-based program/ service/ agency and state their responses. Use reverse side of the paper if needed.**

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

Agency/Service Type	Contacted (Yes/No)	Name of Contact	Outcome of Contact

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

_____
_____
_____
_____
_____

PEDIATRIC SKILLED NURSING FACILITY

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

IDENTIFYING DATA:

1. Individual's Name:
2. Individual's Birth Date ___/___/___ Sex: ___M ___F___Other: _____
3. Individual's Health Insurance:_____
   - o If MassHealth, does the child have Kaileigh Mulligan? ___Yes ___No ___Unknown
4. Parent(s)/Primary Caregiver(s) Name(s), Address and Phone

   _____

   _____

   Email: _____

   Telephone: _____ Cell Phone: _____
5. Diagnosis(es): _____

   _____

   _____
6. Referred by:
   Name: _____

   Title/Position: _____

   Hospital/Agency: _____

   Address: _____

   _____

   Telephone:_____

7. MDPH Race, Ethnicity, and Language-Preference

Introduction: In order to guarantee that all clients receive the highest quality of care and to ensure the best services possible, we are collecting data on race and ethnicity. Could you please select the category or categories that best describes your background?

7a. Is the applicant Hispanic/Latinx? Latinx is a gender-neutral term to refer to a Latino/Latina person

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

7b. What is the applicant's ethnicity? (You can specify one or more). Ethnicity represents the applicant's ethnic origin or descent, heritage, or nationality or the place of birth of the applicant or their ancestors.

- ☐ African (specify country_____)
- ☐ African American
- ☐ Albanian
- ☐ American
- ☐ Armenian
- ☐ Brazilian
- ☐ Cambodian/Khmer
- ☐ Canadian
- ☐ Cape Verdean
- ☐ Caribbean Islander (specify_____)
- ☐ Chinese
- ☐ Colombian
- ☐ Cuban
- ☐ Dominican
- ☐ English
- ☐ Filipino
- ☐ French
- ☐ German
- ☐ Greek
- ☐ Guatemalan
- ☐ Haitian
- ☐ Honduran
- ☐ Indian /Asian Indian (from/family from India)*
- ☐ Irish
- ☐ Italian
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Mexican, Mexican American, Chicano
- ☐ Middle Eastern (specify_____)
- ☐ Native American
- ☐ Polish
- ☐ Portuguese
- ☐ Puerto Rican
- ☐ Russian
- ☐ Salvadoran
- ☐ Scottish
- ☐ Swedish
- ☐ Ukrainian
- ☐ Vietnamese
- ☐ Other not named above (specify_____)
- ☐ Unknown
- ☐ Do not know
- ☐ Prefer not to answer

7c. What is the applicant's race? (You can specify one or more)

- ☐ American Indian/Alaska Native (specify tribal nation_____)
- ☐ Asian
- ☐ Black
- ☐ Native Hawaiian or Other Pacific Islander (specify_____)
- ☐ White
- ☐ Other (specify_____)
- ☐ Do not know
- ☐ Prefer not to answer

7d. What language does the applicant/parent/legal guardian prefer to communicate in about health? (You can specify one or more)

- ☐ Albanian
- ☐ American Sign language
- ☐ Amharic, Somali, or other Afro-Asiatic
- ☐ Arabic
- ☐ Armenian
- ☐ Cape Verdean Creole
- ☐ Chinese (specify dialect_____)
- ☐ English
- ☐ French
- ☐ German
- ☐ Greek
- ☐ Haitian Creole
- ☐ Hindi
- ☐ Italian
- ☐ Khmer
- ☐ Korean
- ☐ Polish
- ☐ Portuguese
- ☐ Russian
- ☐ Spanish
- ☐ Swahili or other Eastern or Southern African
- ☐ Vietnamese
- ☐ Yoruba, Twi, Igbo, or other Western African
- ☐ Other (specify_____)

7e. In what language does the applicant/legal guardian/parent prefer health-related written materials? (You can specify one or more)

- ☐ Albanian
- ☐ Amharic, Somali, or other Afro-Asiatic
- ☐ Arabic
- ☐ Armenian
- ☐ Cape Verdean Creole
- ☐ Chinese (specify dialect_____)
- ☐ English
- ☐ French
- ☐ German
- ☐ Greek
- ☐ Haitian Creole
- ☐ Hindi
- ☐ Italian
- ☐ Khmer
- ☐ Korean
- ☐ Polish
- ☐ Portuguese
- ☐ Russian
- ☐ Spanish
- ☐ Swahili or other Eastern or Southern African
- ☐ Vietnamese
- ☐ Yoruba, Twi, Igbo, or other Western African
- ☐ Other (specify_____)
- ☐ Large print
- ☐ Braille
- ☐ Needs assistance reading written material

MEDICAL CARE PROVIDERS:

A medical summary provided by a primary care, specialty or attending physician written within the last 3 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 the individual 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

_____

_____

DEVELOPMENTAL/FUNCTIONAL STATUS:

In addition to this checklist, a **comprehensive developmental/functional summary,** based on an evaluation performed within the last 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 Appropriate	Needs Assistance	Totally Dependent
a. Feeding	_____	_____	_____
b. Dressing	_____	_____	_____
c. Personal Hygiene (teeth, hands, face)	_____	_____	_____
d. Bathing	_____	_____	_____
e. Toileting (Indicate the highest level)	_____	_____	_____

Bladder
_____Completely independent
_____Time voidings
_____Little/no control
_____Catheter/bag

Bowel
___Completely independent
___Needs some assistance
____Little/no control
____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
____Ambulates
____Ambulates with assistance
____Ambulates with assistive device
____Independent in wheelchair
____Needs assistance in wheelchair
____Independent in transfers
____ Needs assistance with transfers
____ Sits independently
____ Sits with assistance
____ Stands independently
____ Stands with assistance
____ Rolls over
____ Totally dependent

7. Equipment usage

Indicate all necessary equipment, with (**R) Rented or (O) Owned**.
_____No special equipment
_____Wheelchair (power, manual)
_____Walker/crutches/cane
_____Hearing aids
_____Glasses/contact lens
_____Dressing aids
_____Seating system other than wheelchair
_____ Braces/casts/special shoes
_____Communication devices
_____Other (describe)

8. Therapy Services

SERVICES	FREQUENCY	LOCATION

EDUCATIONAL PROGRAMMING

A detailed summary of the educational program through an Early Intervention Family Service Plan (IFSP), Individualized Education Program (IEP) or a Chapter 688 Individual 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
   _____
   _____
   _____

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

6. Chapter 688 status _____
   _____
   _____

SUPPORT SERVICES

(Frequency = hours/day/week; Funding Source = DDS, DMH, DCF, MCB, MassHealth)

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

Individuals 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 individual'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 individual 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. Preference for written language.

3. Description of individual'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 individual and his/her family. Include names of caseworkers involved. Also include other services and supports which may be helpful to the individual and his/her family but are currently unavailable.

5. Description of the current relationship of the individual and his/her family with the referral source. Include frequency and quality of contact and plans for follow-up.

6. Summary of all community options explored, and all state agencies contacted. Indicate all available alternatives.

7. Summary and recommendations for individual'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

Individuals 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 individual'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, musculoskeletal, and nutritional/feeding issues should be addressed.

   More specifically, the health history will include:
   - Growth and physical development (including growth parameters)
   - Medications: schedule, dose, route of administration
   - Allergies
   - Immunizations
   - 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-V 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.

Outline for Comprehensive Medical Summary (continued)

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