The Commonwealth of Massachusetts

Executive Office of Health and Human Services

Department of Public Health

250 Washington Street, Boston, MA 02108-4619

KATHLEEN E. WALSH

Secretary

DR. ROBERT GOLDSTEIN Commissioner

**Tel: 617-624-6000**

**www.mass.gov/dph**

MAURA T. HEALEY

Governor

KIMBERLEY DRISCOLL

Lieutenant Governor

**Medical Review Team**

**Application for Certification for Short Term Stay**

**In a Pediatric Skilled Nursing Facility**

Thank you for your request for an application for a short-term stay in a pediatric nursing facility. All required forms are enclosed.

Each section of the application must be completed with current complete information. Incomplete application packets will be returned.

Once a completed application is received, the case will be scheduled for review by designated members of the Medical Review Team (MRT) The MRT meeting will be scheduled within a week of the date on which the application is received. If long term residential care is subsequently requested, an updated case review will then be conducted by all MRT members to determine if the child meets the long-term care criteria.

Please 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 or Stefanie Hall

Phone: 781-223-2731 Phone: 617-645-3856

katja.gerhardt@mass.gov Stefanie.A.Hall@mass.gov

**APPLICATION FOR SHORT TERM STAY**

**IN A PEDIATRIC SKILLED NURSING FACILITY**

# APPLICATION PACKET

This MRT application packet must be completed and submitted in its entirety. The full packet will be used to establish eligibility for short-term care in a pediatric nursing facility. Incomplete packets will be returned.

## APPLICATION PACKET CHECKLIST

\_\_\_\_Parent/Guardian Consent Form

\_\_\_\_Reason for seeking short term stay

\_\_\_\_Anticipated length of stay

\_\_\_\_Application for Short Term care

\_\_\_\_Comprehensive Medical Summary and supporting documents

\_\_\_\_Comprehensive Social Summary

\_\_\_\_Comprehensive Developmental/Functional Summary stating a developmental age

\_\_\_\_IFSP for individuals younger than 3 years of age

\_\_\_\_IEP for individuals 3 years of age or older

Child’s Name Date

**MEDICAL REVIEW TEAM**

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

**PARENT/GUARDIAN CONSENT FORM
FOR SHORT TERM STAY IN A**

**PEDIATRIC NURSING FACILITY**

I understand that the attached application constitutes a request for my child to stay in a Massachusetts pediatric nursing home for a period not to exceed 90 days in a year. I also understand that the Medical Review Team (MRT), convened by the Massachusetts Department of Public Health, is mandated to certify an individual’s eligibility for short term nursing home placement for individuals under twenty-two (22) years of age.

I consent to have the MRT obtain and review my child’s medical, social, developmental and educational records. 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 or professionals who will be involved in determining my child’s eligibility for a pediatric nursing home.

I have read and understand the above information and consent to the review of information on my child. I also understand that findings of the MRT will be in effect for one year from the date of review and that updated information on my child will need to be submitted and reviewed again if nursing home admission is sought beyond the certification dates. If placement beyond 90 days per year is requested, I understand that this will require review by the full Medical Review Team.

Child’s Name (print) Date of Birth

Parent/Guardian’s Signature Date

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

Referral Source Name (print) Date

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

Referral Source Signature

**APPLICATION FOR A SHORT TERM STAY**

**IN A PEDIATRIC SKILLED NURSING FACILITY**

Massachusetts Department of Public Health

Bureau of Family Health and Nutrition

Division for Children and Youth with Special Health Needs

**MRT DATA REQUIREMENTS:**

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

REASON FOR APPLICATION:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

1. Parent(s) or Primary Caregiver(s) Name(s), Address and Phone number:

Telephone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

1. Referred by:

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

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

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

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

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

## 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.

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

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

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

**MEDICAL CARE:**

**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**.

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|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Physicians’ Names | Specialty | Frequency 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**­­­­­­­­­­­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 \_\_\_\_\_

1. 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)

1. Communication (Check highest level)

##### Expressive Receptive

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

 \_\_\_Speaks in sentences for age

 \_\_\_Speaks phrases/words \_\_\_Understands language readily

 \_\_\_Some sounds with meaning \_\_\_Limited understanding

 \_\_\_Communicates non-verbally \_\_\_Responds to verbal cue

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

 highest level)

 **Bladder Bowel**

 \_\_\_Complete independent \_\_\_Completely Independent

 \_\_\_Time voiding \_\_\_ Needs some assistance

 \_\_\_ Little/no control \_\_\_ Little/no control

 \_\_\_Catheter/bag \_\_\_ Bag

1. 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.

1. Mobility/Locomotion (Check all that apply)

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

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

\_\_\_Ambulates w/assistance \_\_\_Sits with assistance

\_\_\_Ambulates w/assertive \_\_\_Stands independently

 device \_\_\_Stands with assistance

\_\_\_Independent in wheel \_\_\_Rolls over

 chair \_\_\_Totally dependent

\_\_\_Needs assistance in wheel chair

\_\_\_Independent in transfers

1. 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)

1. Therapy Services

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

**Educational Programming**

A detailed summary of any applicable educational program (through an early intervention report (IFSP), Individualized Education Plan (IEP) or a Ch. 688 Transition Plan (ITP) must be included in the application packet. These summaries should include the name of the program or school in which the child is enrolled, a contact person and their name and telephone number.

If the child is not participating in an educational program please explain

Has the school system made any arrangements for providing educational services to the child during the short-term stay?

**SUPPORT SERVICES**

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

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

**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

**Outline for Comprehensive Social Summary**

The social summary should 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 short term stay at a pediatric nursing home.
2. Anticipated length of stay.
3. Primary language spoken at home and access to interpreter services
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.
5. 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.
6. Summary and recommendations for child’s current and future care based on

family’s intermediate and long range goals. Summarize the reasons for requesting short term residential care at this time.

**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.