State of Illinois
Department of Healthcare and Family Services

[redacted]

Level of Care Tool For The MFTD Waiver

Date of Notice: [redacted]

Case Number: _____

First Name: _____
Last Name: _____
Address 1: _____
Address 2: _____
City: _____
State: _____ ZIP _____

Office Name: _____
Office Address: _____
City, State, ZIP _____
Phone: _____
TTY: _____
Fax: _____

Child's Name: _____ DSCC ID: _____ Care Coordinator: _____

Primary Diagnosis: _____

Date of Initial LOC: _____ Date of Current LOC: _____ Date of Previous LOC: _____

1. TECHNOLOGY NEEDS	Points	Previous	Current	#	Freq.*	Justification
A. Ventilator Support						
Dependent (16 or more hrs/day)	50					
Intermittent (less than 16 hrs/day)	45					
B. CPAP, BIPAP, NON-INVASIVE VENTILATOR						
Via tracheotomy (non-ventilator)	45					
Via mask, pneumo-belt or sip and puff ventilator	35					
C. Tracheotomy	43					
D. Nasal Stents	20					
E. Oxygen Therapy						
Continuous, unstable (12 or more hrs/day)	35					
Intermittent - based on O2 sats (less than 12 hrs/day)	20					
Continuous, stable (6 or more continuous hrs/day)	15					
F. IV Infusion	40					
G. NG Tube						
Continuous (6 or more continuous hrs/day)	40					
Bolus	25					
H. G-Tube and/or J-Tube						
Continuous feeding with reflux (6+ continuous hrs/day)	35					
Continuous feeding (6+ continuous hrs/day)	15					
Bolus feeding with reflux	10					
Bolus feeding	5					
I. Peritoneal Dialysis	35					
SUBTOTAL TECHNOLOGY				If score for technology is 0,client is not eligible for MFTD waiver.		

***FREQUENCE KEY:** **H** = hour, **D** = daily, **W** = weekly, **O** = other

[redacted]

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2. CARE NEEDS	Points	Previous	Current	#	Freq.*	Justification
A. Suctioning: Child can do? Yes ◯ Child can do? No ◯						
Daily	3					
B. Tracheotomy Care: Child can do? Yes ◯ Child can do? No ◯	5					
C. Vital Signs Instability	3					
D. Special Treatments:						
4 or more times per day	8					
3 times per day	6					
2 times per day	4					
Once per day	2					
E. Medication:						
Complex (7 or more routine medications)	8					
Moderate (3-6 routine medications)	4					
Simple (1-2 routine medications)	2					
F. IV/Total Parenteral Nutrition						
Continuous (16 or more continuous hrs/day)	8					
8-15 hours per day	6					
4-7 hours per day	4					
Less than 4 hours per day	2					
G. NG/GT Feeding						
Continuous (6 or more continuous hrs/day)	5					
Every 2 hours	4					
Every 3 hours	3					
Every 4 or more hours	2					
H. Aspiration Precautions with NG/GT Feeding	2					
I. Specialized I/O Monitoring	5					
J. Intermittent Catheterization: Child can do? Yes ◯ Child can do? No ◯	4					
K. Seizure Precautions Required	1					
L. Seizures Requiring Intervention						
Daily	3					
Less than daily but more than once per month	2					
Less frequently than once per month	1					
M. Dressings, Sterile						
3 times per day or more	3					

[redacted]

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2. CARE NEEDS	Points	Previous	Current	#	Freq.*	Justification
Less than 3 times per day	2					
N. Hospitalization/ER Visits/Emergency Hours	5					
SUBTOTAL CARE NEEDS				If Care Needs or Technology Needs Score is 0, client is not eligible for MFTD Waiver.		
SUBTOTAL TECHNOLOGY NEEDS						
TOTAL LOC SCORE				If total score is less than 50, client is not eligible for MFTD Waiver.		
Care Coordinator's Initials _____						

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3. HISTORY OF HOSPITAL/ EMERGENCY ROOM VISITS AND EMERGENCY HOURS

A. Number of hospital admissions in the last 12 months _____

When and why?

B. Number of emergency room visits in the last 12 months _____

When and why?

C. Number of times emergency hours provided to prevent hospitalization in the last 12 months _____

D. Has the child ever lived in the home? Yes ☐ No ☐

[redacted]