



## Level of Care Tool For The MFTD Waiver

Date of Notice: 

Case Number: \_\_\_\_\_

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

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

Address 1: \_\_\_\_\_

Address 2: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ ZIP \_\_\_\_\_

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

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

City, State, ZIP \_\_\_\_\_

Phone: \_\_\_\_\_

TTY: \_\_\_\_\_

Fax: \_\_\_\_\_

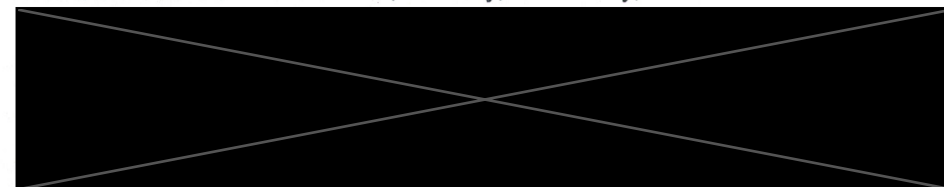
Child's Name: \_\_\_\_\_ DSCC ID: \_\_\_\_\_ Care Coordinator: \_\_\_\_\_

Primary Diagnosis: \_\_\_\_\_

Date of Initial LOC: \_\_\_\_\_ Date of Current LOC: \_\_\_\_\_ Date of Previous LOC: \_\_\_\_\_

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

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



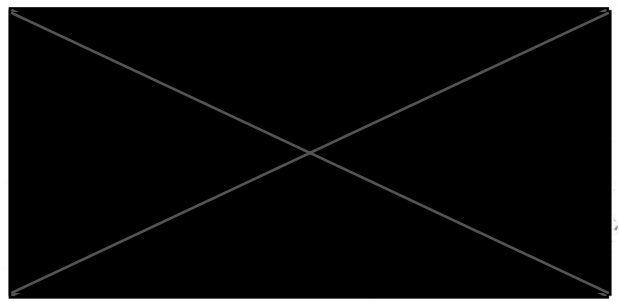




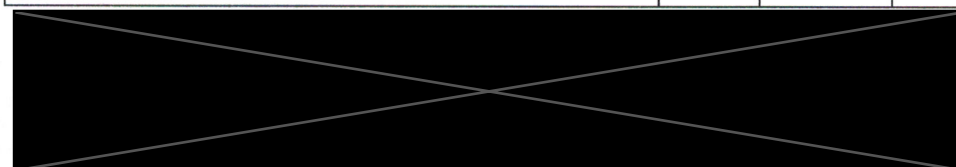
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2. CARE NEEDS	Points	Previous	Current	#	Freq.*	Justification
<b>A. Suctioning:</b> Child can do? Yes <input type="radio"/> Child can do? No <input type="radio"/>						
Daily	3					
<b>B. Tracheotomy Care:</b> Child can do? Yes <input type="radio"/>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



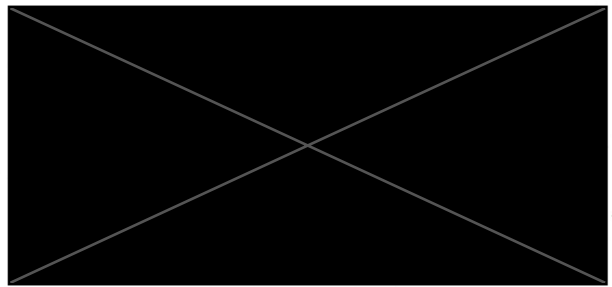




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2. CARE NEEDS	Points	Previous	Current	#	Freq.*	Justification
Less than 3 times per day	2					
N. Hospitalization/ER Visits/Emergency Hours	5					
SUBTOTAL CARE NEEDS				If Care Needs or Technology Needs Score is 0, client is not eligible for MFTD Waiver.		
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 ☐

