MEDICALLY FRAGILE LONG TERM CARE ASSESSMENT ABSTRACT

*Please Remember This Information is Confidential*

1. Type of Review (Check one): Initial ☐ Readmit ☐ Retrospective ☐ Reassessment ☐

| 2. Recipient's Name: Last First MI | 3. Person Completing Abstract: | | CM Provider # **D0676** |
|---|---|---|---|
| 4. MEDICAID NUMBER: | 5. Age: | 6. Date of Birth | 7. Gender: |
| **9 5 6** - - | | | M ☐ F ☐ |

***The information recorded on this abstract should reflect the recipient's overall condition.***

| **DIAGNOSIS / PROBLEMS** (*One per line*) | **18. DD / MR ASSESSMENT FACTORS** (Score -1- 5 for all Factors Below) | **SCORE** 1-5 |
|---|---|---|
| 8. | A. Sensorimotor Development | |
| 9. | 1. Mobility | |
| 10. | 2. Toileting | |
| 11. | 3. Hygiene | |
| **MEDICATION** *List up to four most important medications, method of administration and frequency:* | 4. Dressing | |
| 12. | B. Affective Development | |
| 13. | C. Speech & Language Development | |
| 14. | 1. Expressive | |
| 15. | 2. Receptive | |

| **16. MEDICAL FRAGILITY ASSESSMENT FACTORS** | **SCORE** 1-5 | | |
|---|---|---|---|
| A. Medication Administration | | D. Auditory Functioning | |
| B. Medical Care and Supervision | | E. Cognitive Development | |
| C. Nutrition and Feeding | | F. Social Development / Social Skills | |
| D. Respiratory | | 1. Interpersonal Skills | |
| E. Neurological | | 2. Social Participation | |
| F. Other Complex Medical/Skilled Care Treatments | | G. ADL/ Independent Skills | |
| G. Medical Impact Based on Ability for Self Care | | 1. Home Skills | |
| H. Family Support Issues | | 2. Community Skills | |
| | | H. Challenging Behaviors | |
| | | 1. Harmful Behavior | |
| | | 2. Disruptive Behavior | |
| | | 3. Socially Unacceptable/ Stereotypic Behavior | |
| | | 4. Uncooperative Behavior | |
| | | | |
| **17. TOTAL MF SCORE** | | **19. TOTAL DD / MR SCORE** | |

| *Level I = 8 - 18* | *Level II = 19 - 24* | *Level III = 25 - 31* | *Level IV = 32 - 40* |
|---|---|---|---|
| ☐ MF-I | ☐ MF-II | ☐ MF-III | ☐ MF IV Does not meet eligibility criteria |

| *Level I 17 - 32* | *Level II 33 - 54* | *Level III 55 - 71* | *Level IV 72 - 85* |
|---|---|---|---|
| ☐ DD/MR-I | ☐ DD/MR-II | ☐ DD/MR-III | ☐ DD/MR-IV Does not meet eligibility criteria |

***20. Physician's Statement: I have seen and evaluated this recipient and recommend the above MF and DD/MR Levels:***

| *Physician's Signature:* | Physician Name and Address: | Date: |
|---|---|---|
| | | |

FOR UR AGENCY USE ONLY:

| REVIEW INFORMATION: | 21. Level of Care: ☐ MFI ☐ MFII ☐ MFIII ☐ MFIV | 22. Level of Care: ☐ DD/ MRI ☐ DD/MRII ☐ DD/MR III ☐ DD/MRIV | 23. Effective Date: | 24. Days: | 25. Expiration Date: |
|---|---|---|---|---|---|

| 26. Review Decision: ☐ Approved ☐ Denied | 27. UR Agency Reviewer Signature: | 28. Review Date: |
|---|---|---|
| | | |