MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SPECIAL HEALTH CARE NEEDS
MEDICALLY FRAGILE ADULT WAIVER

# LEVEL OF CARE DETERMINATION

| PARTICIPANT NAME | DCN | SSN | DATE OF BIRTH |
|---|---|---|---|
| | | | |

PROGNOSIS

☐ Temporary (Duration: _____months) ☐ Indefinite

DIAGNOSIS

Primary:_____

_____

_____

Secondary: _____

_____

_____

SUBSTANTIAL FUNCTIONAL LIMITATION IN 3 OR MORE OF THE FOLLOWING

☐ Self-care
☐ Understanding and use of language
☐ Learning
☐ Mobility
☐ Self-direction
☐ Capacity for independent living

| DATE OF ONSET OF CONDITION OR ACCIDENT | DOES THE INDIVIDUAL REQUIRE CARE AT THE ICF/MR LEVEL? ☐ Yes ☐ No |
|---|---|

| SUMMARY OF POINTS (See Section IV on the Client Assessment Form) | ✓ | MEDICAL CRITERIA | ✓ |
|---|---|---|---|
| Monitoring | | Unusual support to maintain vital functions (oxygen, respiratory therapy, total parenteral nutrition, gastrostomy/NG feeding). | |
| Medication | | | |
| Treatment | | Continuous maintenance attention (positioning, feeding, cleaning, bathing, changing linens and/or diapers). | |
| Restorative Services | | | |
| Rehabilitation | | Continual monitoring for skin breakdown and infections due to incontinence of bowel and/or bladder. | |
| Personal Care | | | |
| Behavior/Mental Condition | | Private Duty Nursing for at least 4 consecutive hours per day. | |
| Mobility | | Continuous drug therapy | |
| Dietary | | Seizure intervention (continuous or grand mal) | |
| TOTAL | 0 | | |

Participants must score a total of 21 points or greater. Participants of the Medically Fragile Adult Waiver also must meet at least three of the medical criteria.

PERIOD OF ELIGIBILITY From: To:

| SERVICE COORDINATOR'S SIGNATURE | DATE |
|---|---|
| | |