

NC DMA Community Alternatives Program for Children (CAP/C)
Family-Centered Assessment

Date: _____ Name _____ MID: _____

Red Font = Required Information **Blue Font = Information required if applicable to the recipient**
 highlighted areas to be completed by Registered Nurse
 "This font means that you ask this question of the family member and record their response."

Assessment Type: Initial, Medicaid application deadline date __ - __ - ____
 CNR, due date __ - __ - ____ Other, _____

FACE SHEET

First Name _____ Middle Name _____ Last Name _____ Suffix -SELECT-

Preferred Name/Nickname _____

Comments: _____

None
Jr.
III
IV

Medicaid ID No. ____ - ____ - ____ base X-ref **County of Residence** _____
 Medicaid ID No. ____ - ____ - ____ base X-ref **County of Medicaid** _____

Comments: _____

Gender -SELECT- _____ **Date of Birth** ____ - ____ - ____ **Age** ____ years **Race** -SELECT- _____ **Ethnicity** -SELECT- _____

Comments: _____

male
female

Physical Address
Street Address 1 _____
 Street Address 2 _____
 Apt # _____
City _____
State _____
Zip Code _____ - _____

White
 African American
 American Indian/Alaskan Native
 Asian American
 Hawaiian/Pacific Islander
 Unknown
 Prefer not to report

same as physical address
 Hispanic
 Non-Hispanic
 Unknown
 Prefer not to report

Home phone (____) ____ - ____ Cell phone (____) ____ - ____ Work phone (____) ____ - ____

must have either home or cell phone Email _____ @ _____

Comments: _____

PRIMARY CAREGIVER **Name** _____

Relationship to recipient -SELECT- _____

Role relative to recipient -SELECT- _____

Home phone (____) ____ - ____

Cell phone (____) ____ - ____

Work phone (____) ____ - ____

Email _____

Legal guardian
 Informal caregiver not in household
 Informal caregiver not in household, visitation
 Informal caregiver not in household, joint custody
 Power of attorney – healthcare
 Power of attorney – financial
 Representative payee
 Foster parent
 Other, please specify _____

mother
 father
 brother
 sister
 grandfather
 specify
 grandmother
 spouse
 other relative
 friend
 professional
 other, please

Agency _____
Address _____ same as physical address

PO Box 1 _____

PO Box 2 _____

City _____, North Carolina

Zip Code _____

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Date: _____ Name _____ MID: _____
 Phone (____) ____-____ ext. _____ Fax (____) ____-____ E-mail _____@_____
 If the nurse performing the assessment is not the Case Manager:
 Name: _____ Agency: _____ Phone (____) ____-____ ext. _____ Fax (____) ____-____ E-mail _____@_____
 Comments: _____

COORDINATING CARE PHYSICIAN/PRIMARY CARE PROVIDER None
 Name _____
 Name of Practice _____ Specialty _____
 Physical Address _____ Mailing address same as street address
 Street Address 1 _____ Street/PO Box 1 _____
 Street Address 2 _____ Street/PO Box 2 _____
 City _____ State _____ State _____
 Zip Code _____
 Office Phone (____) ____-____ none (____) ____-____
 Comments: _____

CONTACT RESTRICTIONS Applicable Not Applicable
 Full Name _____ Relationship to recipient -SELECT-, _____
 Physical Description of Person _____
 Nature of Conflict _____ Source of Information _____ Information verified by legal papers? -SELECT-, _____
 Comments: _____

EMERGENCY CONTACT INFORMATION
 Name _____ Relationship to recipient _____
 Home (____) ____-____ Work (____) ____-____ ext. _____ Cell _____
 Name _____
 Not Applicable Attendant level
 Personal Care level Nurse level
 Pediatric Nurse Aide level
 when the power goes out. _____
 if the caregiver is ill and unable to care for the child. _____
 to immediately leave their home in the event of an emergency, where would they go?
 yes
 no
 unknown
 MAD
 MAD pending
 MAB
 MAB pending
 IAS
 IAS pending
 HSF
 HSF pending
 N/A – initial
 SC
 HC
 Medicaid eligible without CAP? -SELECT- CAP Medicaid type -SELECT- CAP Indicator Code -SELECT-
 Deductible/Spend-down Information _____ CAPC Level of In-Home Care -SELECT- CAP Effective Date _____
 Comments: _____

PAYER SOURCES - THIRD PARTY
 Jan Feb Mar Apr May Jun
 Jul Aug Sep Oct Nov Dec
 Company/Policy # _____ Subscriber Name _____ Group Number _____
 No
 Yes, (specify) _____ E-mail _____ Phone (____) ____-____ ext. _____ Fax (____) ____-____
 Payor secondary tertiary other, please specify: _____
 Coverage Dates/ Insurance Year Dates -SELECT- through -SELECT-
 Required physician assignment? -SELECT-, Required pharmacy assignment? -SELECT-,
 Nursing Services: number of visits _____ and/or days and hours _____
 reimbursement rate _____ deductible _____ copay _____ limit _____ comments _____

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DME/Supplies: deductible _____ copay _____ limit _____ comments _____
Therapies: number of visits _____ reimbursement rate _____ deductible _____ copay _____ limit _____ comments _____
Other: _____: reimbursement rate _____ deductible _____ copay _____ limit _____ comments _____
Comments: _____

CHILD'S PHYSICAL HEALTH AND CARE NEEDS

This information in this section was collected by (check all that apply):

direct physical assessment observation of child interview of caregivers medical record review.

CURRENT DIAGNOSES	
DIAGNOSIS	DESCRIBE HOW THIS DIAGNOSIS CURRENTLY AFFECTS THE CHILD'S FUNCTIONING OR CARE NEEDS
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
"Do you feel that you have and understand enough information about your child's diagnoses?" <input type="checkbox"/> Yes <input type="checkbox"/> No,	
"Is there information you would like to know?" <input type="checkbox"/> I don't know <input type="checkbox"/> No <input type="checkbox"/> Yes, _____	
Comments: _____	

MEDICAL HISTORY		
EVENT/PROCEDURE	DESCRIBE HOW THIS EVENT/PROCEDURE CURRENTLY AFFECTS THE CHILD'S FUNCTIONING OR CARE NEEDS	DATE
_____	_____	_____
_____	_____	_____
_____	_____	_____
Comments: _____		

RESOURCE UTILIZATION
"Are you comfortable in monitoring your child's health and in knowing when to bring him/her to the doctor?" <input type="checkbox"/> Yes <input type="checkbox"/> Most of the time, _____ <input type="checkbox"/> Some of the time, _____ <input type="checkbox"/> No, _____
Does the recipient regularly visit a primary care physician for routine and preventative health care needs? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does the recipient/family use the emergency room when the need could be met by a visit to their physician? <input type="checkbox"/> Yes <input type="checkbox"/> No
Has the recipient had any preventable, unplanned hospitalizations? <input type="checkbox"/> Yes <input type="checkbox"/> No
Number of hospitalizations in the past year: _____
Number of those hospitalizations that were related to the primary diagnosis: _____
Number of those hospitalizations that were unplanned: _____
Comments: _____

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 Street Address 1 _____ Street/PO Box 1 _____
 Street Address 2 _____ Street/PO Box 2 _____
 City _____ State _____ City _____ State _____
 Zip Code _____ - _____ Zip Code _____ - _____

Office Phone () - - ext. _____ Fax () - - _____ After Hours Phone () - - _____

The last appointment with this doctor was ____ / ____ / ____ for illness routine check.

"Are you satisfied with this provider's services?" Yes No: _____

Skin Condition

<input type="checkbox"/> warm	<input type="checkbox"/> diaphoretic	<input type="checkbox"/> petechiae	<input type="checkbox"/> blisters
<input type="checkbox"/> dry	<input type="checkbox"/> excess dryness	<input type="checkbox"/> cuts/tears/abrasions	<input type="checkbox"/> burns, degree _____
<input type="checkbox"/> cool	<input type="checkbox"/> rash	<input type="checkbox"/> decubitus, stage _____	<input type="checkbox"/> other, _____
<input type="checkbox"/> clammy	<input type="checkbox"/> bruising		

Skin Color

<input type="checkbox"/> normal	<input type="checkbox"/> pale	<input type="checkbox"/> perioral cyanosis	<input type="checkbox"/> other, _____
<input type="checkbox"/> pink	<input type="checkbox"/> jaundice	<input type="checkbox"/> acrocyanosis	
<input type="checkbox"/> red	<input type="checkbox"/> mottled	<input type="checkbox"/> cyanotic	

Skin Turgor good poor

Skin Sensitivity

diminished sensitivity to hot and cold diminished sensitivity to pain and pressure
 none of the above

Describe abnormal findings and how they are treated _____

Wound (for trach and GT sites, see respiratory and nutrition sections)

Not Applicable Applicable Location _____

<input type="checkbox"/> within normal limits	<input type="checkbox"/> redness	<input type="checkbox"/> warmth	<input type="checkbox"/> tenderness
	<input type="checkbox"/> drainage	<input type="checkbox"/> breakdown	<input type="checkbox"/> other, _____

Care/Dressing: sterile non-sterile _____
 Is the care/dressing effective? Yes No, change in treatment plan needed: _____

Wound (for trach and GT sites, see respiratory and nutrition sections)

Not Applicable Applicable Location _____

<input type="checkbox"/> within normal limits	<input type="checkbox"/> redness	<input type="checkbox"/> warmth	<input type="checkbox"/> tenderness
	<input type="checkbox"/> drainage	<input type="checkbox"/> breakdown	<input type="checkbox"/> other, _____

Care/Dressing: sterile non-sterile _____
 Is the care/dressing effective? Yes No, change in treatment plan needed: _____

Skin-Related Assistive Devices

pressure relieving devices for bed pressure relieving devices for chair
 other, _____ none

Comments: _____

NEUROLOGICAL

Neurologist/Neurosurgeon Name _____ Name of Practice _____ No neurologist/neurosurgeon
 Physical Address _____ Mailing address same as physical address
 Street Address 1 _____ Street/PO Box 1 _____
 Street Address 2 _____ Street/PO Box 2 _____
 City _____ State _____ City _____ State _____
 Zip Code _____ - _____ Zip Code _____ - _____

Office Phone () - - ext. _____ Fax () - - _____ After Hours Phone () - - _____

The last appointment with this doctor was ____ / ____ / ____ for yes no intermittently routine check.

"Are you satisfied with this provider's services?" yes no intermittently

Is the child alert? -SELECT-

Is the child oriented to person, as appropriate for age? -SELECT-

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Is the child oriented to place, as appropriate for age? -SELECT-
 Is the child oriented to time, as appropriate for age? -SELECT-
 Does the child have functional short-term memory? -SELECT-
 Does the child have functional long-term memory? -SELECT-
 Describe the child's cognitive skills for daily decision making. -SELECT-
Seizures Applicable Not applicable
 Describe before the seizure (pre-ictal) no ability to interact
 yes no intermittently unable to assess
 not applicable due to age
 independent – decisions consistent and reasonable
 modified independence – difficulty with new situations
 moderately impaired – difficulty with most situations
 severely impaired – rarely or never makes decisions
 Describe what happens during the seizure.
 loss of muscle tone (atonic, drop or fall seizure)
 repetitive jerking movements (clonic) grand mal (tonic-clonic)
 single jerking movement (myoclonic, involuntary dropping or throwing things) eye deviation
 automatisms (for example, fidgeting, lip smacking) other, _____
 Describe what happens after the seizure (post-ictal). nothing fatigue, sleeping, exhausted
 headache nausea confusion memory loss difficulty talking sensitivity to stimuli
 other, _____
 How long do the seizures last? -SELECT- How often do they occur? -SELECT-
 Do they tend to happen at certain times or associated with certain events? no
 flickering or flashing light menstrual cycle certain foods or lack of foods
 change in dose of seizure medication mental processes
 how long the seizure? nothing observation, safety
 primary oxygen administration PRN medications
 longer than 10 minutes during seizures, how often is it used? -SELECT-
 If used, when was the last time it was used? -SELECT-
Thermoregulation Disorder variable fever _____
 Symptoms: variable fever _____
 How is it managed? medications checks environment
 medications
Sleep Disorder difficulty sleeping sleep apnea
 sleeps too much insomnia sleep apnea
 days/nights mixed up teeth grinding REM behavior other
 How is it managed? unmanaged sleep hygiene scheduled medication
 respiratory support (BiPAP, CPAP) other, _____
 Bedtime routine: _____
 Comments: _____

yes
no
intermittently

yes
no
intermittently
unable to assess

not applicable due to age
independent – decisions consistent and reasonable
modified independence – difficulty with new situations
moderately impaired – difficulty with most situations
severely impaired – rarely or never makes decisions

more than once per day
once per day
2-6 times per week
weekly
2-3 times per month
monthly
every 2-3 months
every 4-6 months
every 6-12 months
less often than every 12 months

less than one minute
1-4 minutes
5 minutes
6-9 minutes
10 minutes
longer than 10 minutes

not applicable
with every seizure
with most seizures
with few seizures
other, please specify

not applicable
within the last week
within the last month
within the last three months
within the last six months
within the last year
longer than one year ago

SENSORY AND COMMUNICATION

OPHTHALMOLOGIST/OPTOMETRIST Name _____ Name of Practice _____ No eye doctor

Physical Address _____ Mailing address same as physical address
 Street Address 1 _____ Street/PO Box 1 _____
 Street Address 2 _____ Street/PO Box 2 _____
 City _____ State _____ City _____ State _____

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Zip Code _____ - _____		Zip Code _____ - _____	
Office Phone () _____ - _____ ext. _____		Fax () _____ - _____	
After Hours Phone () _____ - _____			
The last appointment with this doctor was ____ / ____ / ____ for <input type="checkbox"/> illness <input type="checkbox"/> routine check.			
"Are you satisfied with this provider's services?" <input type="checkbox"/> Yes <input type="checkbox"/> No: _____			
AUDIOLOGIST Name _____		Name of Practice _____ <input type="checkbox"/> No audiologist	
Physical Address		Mailing address <input type="checkbox"/> same as physical address	
Street Address 1 _____		Street/PO Box 1 _____	
Street Address 2 _____		Street/PO Box 2 _____	
City _____ State _____		City _____ State _____	
Zip Code _____ - _____		Zip Code _____ - _____	
Office Phone () _____ - _____ ext. _____		Fax () _____ - _____	
After Hours Phone () _____ - _____			
The last appointment with this doctor was ____ / ____ / ____ for <input type="checkbox"/> illness <input type="checkbox"/> routine check.			
"Are you satisfied with this provider's services?" <input type="checkbox"/> Yes <input type="checkbox"/> No: _____			
EAR/NOSE/THROAT Physician Name _____		Name of Practice _____ <input type="checkbox"/> No ENT doctor	
Physical Address		Mailing address <input type="checkbox"/> same as physical address	
Street Address 1 _____		Street/PO Box 1 _____	
Street Address 2 _____		Street/PO Box 2 _____	
City _____ State _____		City _____ State _____	
Zip Code _____ - _____		Zip Code _____ - _____	
Office Phone () _____ - _____ ext. _____		Fax () _____ - _____	
After Hours Phone () _____ - _____			
The last appointment with this doctor was ____ / ____ / ____ for <input type="checkbox"/> illness <input type="checkbox"/> routine check.			
"Are you satisfied with this provider's services?" <input type="checkbox"/> Yes <input type="checkbox"/> No: _____			
Visual Acuity: <input type="checkbox"/> No or Minimal Impairment <input type="checkbox"/> Moderate Impairment <input type="checkbox"/> Severe Impairment			
List Assistive Devices <input type="checkbox"/> none <input type="checkbox"/> glasses <input type="checkbox"/> contact lenses <input type="checkbox"/> magnifying device <input type="checkbox"/> eye patch <input type="checkbox"/> large print			
<input type="checkbox"/> Braille <input type="checkbox"/> text to speech readers <input type="checkbox"/> talking devices <input type="checkbox"/> other, _____			
Are the assistive devices used? -SELECT- If sometimes or less, why? -SELECT- _____			
Other management/treatment: <input type="checkbox"/> none <input type="checkbox"/> visual instruction <input type="checkbox"/> under services _____ Morehead School <input type="checkbox"/> other, _____			
Visual Instructor/Therapist Name _____		Name of Practice/Agency _____ <input type="checkbox"/> Therapist	
Physical Address		Mailing address _____	
Street Address 1 _____		Street/PO Box 1 _____	
Street Address 2 _____		Street/PO Box 2 _____	
City _____ State _____		City _____ State _____	
Zip Code _____ - _____		Zip Code _____ - _____	
Office Phone () _____ - _____ ext. _____		Fax () _____ - _____	
After Hours Phone () _____ - _____			
How often seen? _____			
What needs to be done between sessions? _____			
"Are you satisfied with this provider's services?" <input type="checkbox"/> Yes <input type="checkbox"/> No: _____			
Speech Ability: <input type="checkbox"/> No or Minimal Impairment <input type="checkbox"/> Moderate Impairment <input type="checkbox"/> Severe Impairment			
List Assistive Devices <input type="checkbox"/> none <input type="checkbox"/> writing messages <input type="checkbox"/> American Sign Language <input type="checkbox"/> signs/gestures/sounds			
<input type="checkbox"/> electronic larynx <input type="checkbox"/> speech amplifier <input type="checkbox"/> communication board <input type="checkbox"/> other, _____			
Are the assistive devices used? -SELECT- If sometimes or less, why? -SELECT- _____			
Other management/treatment: <input type="checkbox"/> none <input type="checkbox"/> speech therapy <input type="checkbox"/> occupational therapy <input type="checkbox"/> other, _____			
Speech Therapist Name _____		Name of Practice/Agency _____ <input type="checkbox"/> No ST	
Physical Address		Mailing address _____	
Street Address 1 _____		Street/PO Box 1 _____	
Street Address 2 _____		Street/PO Box 2 _____	
City _____ State _____		City _____ State _____	
Zip Code _____ - _____		Zip Code _____ - _____	
Office Phone () _____ - _____ ext. _____		Fax () _____ - _____	
After Hours Phone () _____ - _____			

not applicable
yes
usually
sometimes
not usually
no

damaged, doesn't work
uncomfortable/doesn't fit
other, please specify

not applicable
yes
usually
sometimes
not usually
no

damaged, doesn't work
uncomfortable/doesn't fit
other, please specify

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How often seen? _____

What needs to be done between sessions? _____

"Are you satisfied with this provider's services?" Yes No: _____

Hearing Ability: No or Minimal Impairment Moderate Impairment Severe Impairment

List Assistive Devices none hearing aids hearing system listening system text telephone

computerized speech recognition alerting device other, _____

Are the assistive devices used? -SELECT- If sometimes or less, why? -SELECT-, _____

Other management/treatment: _____

Overall Communication: No or Minimal Impairment Moderate Impairment Severe Impairment

What are the signs of communication? speaking writing sign language

communication device behaviors other, _____

How often does the child like something? _____

How often does the child dislike something? _____

Important to know how the child communicates: _____

Important to know how we should communicate with your child: _____

When this is happening	and the child does this	we think it means this	and we should do this
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Primary language spoken in household: -SELECT-

Is an interpreter needed? No Yes, who provide? _____

Comments: _____

PAIN Not Applicable Not Applicable

HOSPICE OR PALLIATIVE CARE PROVIDER Name _____ No provider

LOCATION chest back abdomen extremities incision or wound

general

PROVIDER _____

PALLIATIVE _____

QUALITY burning throbbing aching

pressure other, _____

RADIATING _____

STRENGTH Mild Pain, 1-3, Severe Pain; 7-10 FLACC scale

Moderate Pain, 4-6 unable to assess numerical, visual analog other, _____

TIMING Frequency -SELECT-, _____ Duration -SELECT-, _____ Pattern: -SELECT-, _____

TREATMENT

Pharmacological None Yes - Scheduled Yes - As needed

Non-Pharmacological Interventions

none parents present distraction massage rocking/hugging

hypnosis guided imagery use of heat/cold other, _____

Comments: _____

MUSCULOSKELETAL

ORTHOPEDIST Name _____ **Name of Practice** _____ no orthopedist

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Physical Address	Mailing address <input type="checkbox"/> same as physical address
Street Address 1 _____	Street/PO Box 1 _____
Street Address 2 _____	Street/PO Box 2 _____
City _____ State _____	City _____ State _____
Zip Code _____ - _____	Zip Code _____ - _____

Office Phone () - ext. _____ | Fax () - _____ | After Hours Phone () - _____

The last appointment with this doctor was ____ / ____ / ____ for illness routine check.

"Are you satisfied with this provider's services?" Yes No: _____

OCCUPATIONAL THERAPIST Name _____ Name of Practice/Agency _____ No OT

Physical Address	Mailing address <input type="checkbox"/> same as physical address
Street Address 1 _____	Street/PO Box 1 _____
Street Address 2 _____	Street/PO Box 2 _____
City _____ State _____	City _____ State _____
Zip Code _____ - _____	Zip Code _____ - _____

Office Phone () - ext. _____ | Fax () - _____ | After Hours Phone () - _____

How often seen? _____

What needs to be done between sessions? _____

"Are you satisfied with this provider's services?" Yes No: _____

PHYSICAL THERAPIST Name _____ Name of Practice/Agency _____ No PT

Physical Address	Mailing address <input type="checkbox"/> same as physical address
Street Address 1 _____	Street/PO Box 1 _____
Street Address 2 _____	Street/PO Box 2 _____
City _____ State _____	City _____ State _____
Zip Code _____ - _____	Zip Code _____ - _____

Office Phone () - ext. _____ | Fax () - _____ | After Hours Phone () - _____

How often seen? _____

What needs to be done between sessions? _____

"Are you satisfied with this provider's services?" Yes No: _____

Ambulatory Status

Independent Person-assisted

Device-assist, please specify _____ wheels self other person who _____

Related to: unsteady gait more than 10 _____

Fall Frequency fell in last 30 days 2-6 months fracture in last six months

Non-ambulatory/mobile (rolls, sits, scooters, crutches, etc.)

Non-ambulatory/non-mobile; position _____, recommend _____

Fall Risk Applicable Not Applicable _____

Total number of falls in last 6 months -SELECT- _____

Foot control light _____ other, _____

_____ type: _____ schedule of use: _____

_____ n, location: _____

Tone -SELECT- Location -SELECT- _____

Strength

Normal, location: -SELECT-, _____

Mild weakness, location: -SELECT-, _____

Moderate weakness, location: -SELECT-, _____

Paresis/ weakness, severe location: -SELECT-, _____

Paralysis, location: -SELECT-, _____

Range of Motion

1 6
2 7
3 8
4 9
5 10
more than 10

throughout
left sided
right sided
upper body
lower body
other, please specify

throughout
left sided
right sided
upper body
lower body
other, please specify

rigid/high
normal
flaccid/low

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neck	<input type="checkbox"/> normal	<input type="checkbox"/> limited _____	spine	<input type="checkbox"/> normal	<input type="checkbox"/> limited _____
shoulders	<input type="checkbox"/> normal	<input type="checkbox"/> limited _____	elbows	<input type="checkbox"/> normal	<input type="checkbox"/> limited _____
wrist	<input type="checkbox"/> normal	<input type="checkbox"/> limited _____	feet	<input type="checkbox"/> normal	<input type="checkbox"/> limited _____
hips	<input type="checkbox"/> normal	<input type="checkbox"/> limited _____			
ankles	<input type="checkbox"/> normal	<input type="checkbox"/> limited _____			

Balance standing-SELECT _____
Musculoskeletal Endurance
 Within normal limits Minimal limitation

maintains position as required
 unsteady, but able to rebalance without
 assistance
 needs partial physical support to
 maintain balance
 can not attempt without extensive
 assistance

ACTIVITIES OF DAILY LIVING

Bathing/Grooming
 Bathing means the ability to wash the entire body (excludes grooming, washing hands and face only and bathing r/t incontinence care) in the shower, tub, or with a sponge or bed bath for the purpose of maintaining adequate hygiene. This includes getting in and out of the tub or shower, turning faucets on and off, regulating water temperature, wetting, soaping, and rinsing skin, shampooing hair, drying body, applying lotion to skin, and routine catheter care. Bathing includes all transfers related to bathing. Grooming means the ability to attend to personal hygiene needs, i.e; washing face or hands, combing or brushing hair, shaving, nail care, applying deodorant, and oral care.

- Age appropriate
- Able to bathe self in shower or tub, with or without an assistive device.
- Able to groom self, with or without the use of assistive devices or adapted methods.
- Able to bathe self in shower or tub, but requires the presence of another person for supervision or cueing. Able to groom self, but requires the presence of another person for supervision or cueing
- Needs physical assistance to set up bathing and grooming supplies, but then can bathe and groom self with or without supervision or cueing.
- Able to bathe in shower, tub, or bed with partial physical assistance from another person. Needs partial physical assistance for grooming
- Unable to effectively participate in bathing and is totally bathed by another person. Depends entirely upon another person for grooming.

- hand-held shower
- bath/shower chair
- transfer device
- long-handled brush
- long-handled comb
- other, _____

If child is not age appropriate/independent with activity, is the functional deficit due to :
 physical limitations
 cognitive or behavioral limitations
 both

Procedures/Products/Toys _____

Dressing
 Dressing means the ability to dress and undress (with or without an assistive device) as necessary. This includes fine motor coordination for buttons and zippers. Difficulty with buttons or zippers in the back does not constitute a functional deficit.

- Age appropriate
 - Able to dress self independently.
 - Able to dress self but requires the presence of another person for supervision or cueing.
 - Able to dress self if clothing is laid out or handed to him/her
 - Needs partial physical assistance from another person.
 - Dependent entirely upon another person.
- PROSTHETICS, BRACES, SPLINTS**
- Age appropriate
 - Able to apply/remove equipment

- Assistive devices used for dressing:
- button hook
 - zipper pull
 - dress stick
 - sock aid
 - long handled shoe horn
 - elastic shoe laces
 - Velcro
 - other, _____

If child is not age appropriate/independent with activity, is the functional deficit due to :
 physical limitations

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	<p>independently <input type="checkbox"/> Able to apply/remove equipment but requires the presence of another person for supervision or cueing <input type="checkbox"/> Able to apply/remove equipment if set up <input type="checkbox"/> Needs partial physical assistance from another person. <input type="checkbox"/> Dependent entirely upon another person.</p>	<p><input type="checkbox"/> cognitive or behavioral limitations <input type="checkbox"/> both</p> <p>List the type(s) of prosthetic, splint, or brace _____</p> <p>If child is not age appropriate/independent with activity, is the functional deficit due to : <input type="checkbox"/> physical limitations <input type="checkbox"/> cognitive or behavioral limitations <input type="checkbox"/> both</p>
<p>Mobility, Bed Mobility, Transfer Mobility means the child's ability to move between locations in his/her living environment, including the kitchen, living area, bathroom, and sleeping area. It does not include basements, attics, or other areas of the house which do not need to be accessed on a daily basis. Mobility is determined with or without the use of assistive devices such as wheelchairs, walkers, canes, crutches, and scooters. Bed mobility is defined as movement within a bed for repositioning. Moving side to side, or up and down in a bed, or lifting part of the body up from the bed, or getting from supine to sitting are all considered bed mobility. Transfers involve getting in/out of the bed are not considered part of bed mobility. Bed mobility aids are devices that assist in the performance of bed mobility. Devices that lift an individual off the bed (lifts) or that move them from the bed to another surface (transfer devices) are not considered bed mobility devices. Transfer means the physical ability to move between surfaces (e.g., from bed/chair to wheelchair or walker), the ability to get in and out of bed or usual sleeping place, and the ability to use assistive devices for transfers. Transfer excludes transfers related to bathing and toileting.</p>	<p><input type="checkbox"/> Age appropriate <input type="checkbox"/> Able to ambulate, move self in bed, and transfer self with or without an assistive device <input type="checkbox"/> Able to ambulate, move self in bed, and transfer self with or without an assistive device, but requires the presence of another person for supervision or cueing <input type="checkbox"/> Able to ambulate, move self in bed, and transfer with the physical assistance of another person, but can participate (e.g., can stand and bear weight) <input type="checkbox"/> Needs complete physical help from another person, unable to participate (e.g. unable to stand and pivot or unable to bear weight) <input type="checkbox"/> Needs help from another person with the use of a mechanical device (e.g., Hoyer lift) when transferring</p>	<p>Assistive devices used: <input type="checkbox"/> none <input type="checkbox"/> hoyer lift <input type="checkbox"/> ceiling system <input type="checkbox"/> side rail <input type="checkbox"/> trapeze <input type="checkbox"/> non-skid surface <input type="checkbox"/> safety railing <input type="checkbox"/> cane <input type="checkbox"/> crutches <input type="checkbox"/> walker <input type="checkbox"/> adaptive stroller <input type="checkbox"/> scooter <input type="checkbox"/> manual wheelchair <input type="checkbox"/> power wheelchair <input type="checkbox"/> other, _____</p> <p>If child is not age appropriate/independent with activity, is the functional deficit due to : <input type="checkbox"/> physical limitations <input type="checkbox"/> cognitive or behavioral limitations <input type="checkbox"/> both</p>
<p>Does performance of ADLs match ability? <input type="checkbox"/> Yes <input type="checkbox"/> No, please describe _____</p>		
<p>Comments: _____</p>		

CARDIAC-RESPIRATORY

CARDIOLOGIST Name _____ Name of Practice _____

No cardiologist

NC DMA Community Alternatives Program for Children (CAP/C)
Family-Centered Assessment

Date: _____ Name _____ MID: _____

Physical Address	Mailing address <input type="checkbox"/> same as physical address
Street Address 1 _____	Street/PO Box 1 _____
Street Address 2 _____	Street/PO Box 2 _____
City _____ State _____	City _____ State _____
Zip Code _____ - _____	Zip Code _____ - _____

Office Phone () - - ext. _____ Fax () - - _____ After Hours Phone () - - _____

The last appointment with this doctor was ____ / ____ / ____ for illness routine check

"Are you satisfied with this provider's services?" Yes No: _____

PULMONOLOGIST Name _____ Name of Practice _____ No pulmonologist

Physical Address	Mailing address <input type="checkbox"/> same as physical address
Street Address 1 _____	Street/PO Box 1 _____
Street Address 2 _____	Street/PO Box 2 _____
City _____ State _____	City _____ State _____
Zip Code _____ - _____	Zip Code _____ - _____

Office Phone () - - ext. _____ Fax () - - _____ After Hours Phone () - - _____

The last appointment with this doctor was ____ / ____ / ____ for illness routine check

"Are you satisfied with this provider's services?" Yes No: _____

"Does anyone in your household use tobacco?" -SELECT- _____

Respiratory	<input type="checkbox"/> normotensive <input type="checkbox"/> hypotensive <input type="checkbox"/> hypertensive <input type="checkbox"/> other, please describe _____	<input type="checkbox"/> no <input type="checkbox"/> yes, interested in quitting <input type="checkbox"/> yes, not interested in quitting <input type="checkbox"/> not disclosed	<input type="checkbox"/> Q 2 H <input type="checkbox"/> Q 4 H <input type="checkbox"/> Q 6 H <input type="checkbox"/> Q 8 H <input type="checkbox"/> Q 12 H <input type="checkbox"/> once daily <input type="checkbox"/> less than once daily <input type="checkbox"/> other, please specify _____
--------------------	---	---	---

Pulse	<input type="checkbox"/> regular <input type="checkbox"/> normal rate	<input type="checkbox"/> bradycardia <input type="checkbox"/> tachycardia	<input type="checkbox"/> irregular <input type="checkbox"/> other _____
--------------	--	--	--

Blood Pressure -SELECT- _____ actual reported

Nebulizer/Met _____ Not Applicable

_____ Acute Illness/Exacerbation -SELECT- _____

_____ -SELECT- _____

most frequently during _____

spring _____ seasonal disc

Chest Physiotherapy _____ Not Applicable

Method -SELECT- _____

Frequency QD BID TID QID

after neb treatment prior to start

PN, describe indication and frequency _____

Applicable: _____

Pulse Ox _____ Not Applicable

Used _____

Frequency of and reason for _____

Apnea Monitor _____ Not Applicable

Settings _____ When Used _____

Frequency of and reason for valid alarms _____

Equipment care _____

normotensive
hypotensive
hypertensive
other, please describe

no
yes, interested in quitting
yes, not interested in quitting
not disclosed

Q 2 H
Q 4 H
Q 6 H
Q 8 H
Q 12 H
once daily
less than once daily
other, please specify

more than once per day
once per day once per month
4-6 days per week less than monthly
1-3 days per week rarely if ever
2-3 times per month other, please specify

manual
percussor
vest
other, please specify

more than monthly
monthly
every 2-3 months
every 4-6 months
every 7-12 months
rarely if ever
other, please specify

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Date: _____ Name _____ MID: _____

Cardiac Monitor	<input type="checkbox"/> Applicable <input type="checkbox"/> Not Applicable Settings _____ When Used _____ Frequency of and reason for valid alarms _____ Equipment care _____														
Oxygen	<input type="checkbox"/> Applicable <input type="checkbox"/> Not Applicable Route <input type="checkbox"/> blow-by <input type="checkbox"/> mask <input type="checkbox"/> BiPAP <input type="checkbox"/> other, _____ <input type="checkbox"/> nasal cannula <input type="checkbox"/> trach <input type="checkbox"/> CPAP Amount: _____ <input type="checkbox"/> continuous, stable rate <input type="checkbox"/> continuous, requires rate adjustments; frequency: _____ <input type="checkbox"/> PRN; indication: _____, actual frequency of use _____ When Used _____ Equipment care _____														
Suctioning	<input type="checkbox"/> Applicable <input type="checkbox"/> Not Applicable <input type="checkbox"/> oropharyngeal; indication _____, actual frequency _____ <input type="checkbox"/> nasal; indication _____, actual frequency _____ <input type="checkbox"/> nasotracheal; indication _____, actual frequency _____ <input type="checkbox"/> tracheal; see below Is there an order for how deep to suction? <input type="checkbox"/> no <input type="checkbox"/> yes, to _____ Equipment care _____														
Trach	<input type="checkbox"/> Applicable <input type="checkbox"/> Not Applicable Type _____ Size _____ Is there a smaller, back-up trach available? <input type="checkbox"/> Yes <input type="checkbox"/> No Site: <input type="checkbox"/> within normal limits <input type="checkbox"/> redness <input type="checkbox"/> drainage <input type="checkbox"/> warmth <input type="checkbox"/> rash <input type="checkbox"/> skin breakdown <input type="checkbox"/> other, _____ Care/dressing procedure _____ and frequency _____ Actual Frequency of Suctioning _____ <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:30%;">Trach Mask</td> <td style="width:30%;"><input type="checkbox"/> Not Applicable</td> <td style="width:40%;"><input type="checkbox"/> Applicable; Frequency _____</td> </tr> <tr> <td>Thermovent</td> <td><input type="checkbox"/> Not Applicable</td> <td><input type="checkbox"/> Applicable; Frequency _____</td> </tr> <tr> <td>Passy-Muir</td> <td><input type="checkbox"/> Not Applicable</td> <td><input type="checkbox"/> Applicable; Frequency _____</td> </tr> <tr> <td>Trach Cap</td> <td><input type="checkbox"/> Not Applicable</td> <td><input type="checkbox"/> Applicable; Frequency _____</td> </tr> </table>			Trach Mask	<input type="checkbox"/> Not Applicable	<input type="checkbox"/> Applicable; Frequency _____	Thermovent	<input type="checkbox"/> Not Applicable	<input type="checkbox"/> Applicable; Frequency _____	Passy-Muir	<input type="checkbox"/> Not Applicable	<input type="checkbox"/> Applicable; Frequency _____	Trach Cap	<input type="checkbox"/> Not Applicable	<input type="checkbox"/> Applicable; Frequency _____
Trach Mask	<input type="checkbox"/> Not Applicable	<input type="checkbox"/> Applicable; Frequency _____													
Thermovent	<input type="checkbox"/> Not Applicable	<input type="checkbox"/> Applicable; Frequency _____													
Passy-Muir	<input type="checkbox"/> Not Applicable	<input type="checkbox"/> Applicable; Frequency _____													
Trach Cap	<input type="checkbox"/> Not Applicable	<input type="checkbox"/> Applicable; Frequency _____													
CPAP, BiPAP	<input type="checkbox"/> Applicable <input type="checkbox"/> Not Applicable Indication _____ Frequency of Use _____ Frequency of Use _____ other, please specify _____														
Ventilator	<input type="checkbox"/> Applicable <input type="checkbox"/> Not Applicable type _____ Rate _____ PIP _____ FiO2 _____ PEEP/CPAP _____ Pressure Limit _____ Sensitivity _____ Flow _____ Frequency: <input type="checkbox"/> continuous <input type="checkbox"/> during sleep <input type="checkbox"/> other: _____ <input type="checkbox"/> being weaned Number of hours per day used: _____ Equipment care _____ Is a back-up battery, second ventilator, or other back-up available? <input type="checkbox"/> yes <input type="checkbox"/> no														
Cardio/Respiratory Endurance -SELECT-, _____															
Comments: _____															

within normal limits
fatigues with exertion
easily fatigued
unable to participate in ADLs
other, please specify

NC DMA Community Alternatives Program for Children (CAP/C)
Family-Centered Assessment

Date: _____ Name _____ MID: _____

NUTRITION		
GASTROENTEROLOGIST Name _____ Name of Practice _____		<input type="checkbox"/> No gastroenterologist
Physical Address	Mailing address <input type="checkbox"/> same as physical address	
Street Address 1 _____	Street/PO Box 1 _____	
Street Address 2 _____	Street/PO Box 2 _____	
City _____ State _____	City _____ State _____	
Zip Code _____ - _____	Zip Code _____ - _____	
Office Phone () _____ - _____ ext. _____	Fax () _____ - _____	After Hours Phone () _____ - _____
The last appointment with this doctor was ____ / ____ / ____ for <input type="checkbox"/> illness <input type="checkbox"/> routine check		
"Are you satisfied with this provider's services?" <input type="checkbox"/> Yes <input type="checkbox"/> No: _____		
DENTIST/ORAL SURGEON Name _____ Name of Practice _____		<input type="checkbox"/> No dentist/oral surgeon
Physical Address	Mailing address <input type="checkbox"/> same as physical address	
Street Address 1 _____	Street/PO Box 1 _____	
Street Address 2 _____	Street/PO Box 2 _____	
City _____ State _____	City _____ State _____	
Zip Code _____ - _____	Zip Code _____ - _____	
Office Phone () _____ - _____ ext. _____	Fax () _____ - _____	After Hours Phone () _____ - _____
The last appointment with this doctor was ____ / ____ / ____ for <input type="checkbox"/> illness <input type="checkbox"/> routine check		
"Are you satisfied with this provider's services?" <input type="checkbox"/> Yes <input type="checkbox"/> No: _____		
DIETICIAN Name _____ Name of Practice _____		<input type="checkbox"/> No dietician
Physical Address	Mailing address <input type="checkbox"/> same as physical address	
Street Address 1 _____	Street/PO Box 1 _____	
Street Address 2 _____	Street/PO Box 2 _____	
City _____ State _____	City _____ State _____	
Zip Code _____ - _____	Zip Code _____ - _____	
Office Phone () _____ - _____ ext. _____	Fax () _____ - _____	After Hours Phone () _____ - _____
The last appointment with this doctor was ____ / ____ / ____ for <input type="checkbox"/> illness <input type="checkbox"/> routine check		
"Are you satisfied with this provider's services?" <input type="checkbox"/> Yes <input type="checkbox"/> No: _____		
SPEECH/FEEDING THERAPIST Name _____ Name of Practice/Agency _____		<input type="checkbox"/> No therapist
Physical Address	Mailing address <input type="checkbox"/> same as physical address	
Street Address 1 _____	Street/PO Box 1 _____	
Street Address 2 _____	Street/PO Box 2 _____	
City _____ State _____	City _____ State _____	
Zip Code _____ - _____	Zip Code _____ - _____	
Office Phone () _____ - _____ ext. _____	Fax () _____ - _____	After Hours Phone () _____ - _____
How often seen? _____		
What needs to be done between sessions? _____		
"Are you satisfied with this provider's services?" <input type="checkbox"/> Yes <input type="checkbox"/> No: _____		
"Do you feel that there is enough food in your home for you and your family?"		
<input type="checkbox"/> Usually <input type="checkbox"/> Sometimes <input type="checkbox"/> Not Usually		
If you answered 'sometimes' or 'not usually',		
"Do you ever run out of food?" <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, "What do you do when you run out of food?" _____		
"Have you applied for food stamps?" <input type="checkbox"/> Yes <input type="checkbox"/> No		
If no, "Would you like information about for food stamps?" <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I would like to think about it.		
"Would you like information about other community resources where food can be obtained?" <input type="checkbox"/> Yes <input type="checkbox"/> No		

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 Family-Centered Assessment

Date: _____ Name _____ MID: _____

I would like to think about it.

inches centimeters is or less objective estimated New pounds/ounces kilograms grams Rarely objective estimated

If not always usually, "What support does your child or family need to be able to follow the child's prescribed diet?" _____

Height _____ -SELECT- -SELECT- Weight _____ -SELECT- -SELECT-
 Current Percentile _____ Last Year Percentile _____ Weight change in last year _____ -SELECT- -SELECT-
 Last Year Percentile _____

Is the above within the Feeding Difficulties? planned or expected
 unplanned or unexpected

Oral Feeding

inflamed gum

pudding/spoon consistency
 honey consistency
 nectar consistency
 other, please specify

salt restricted, _____ milligrams per day
 carbohydrate restricted, _____ grams per day
 protein restricted, _____ grams per day
 fat restricted, _____ grams per day
 thickened liquids, -SELECT-, _____

vegetarian, -SELECT-, _____
 diabetic
 other, _____

low cholesterol
 supplemental formula

Name _____ Amount _____ Frequency _____
 If PRN, actual frequency of use _____
 Amount per can _____ cc Calories per can _____

The child receives -SELECT- of his/her nutrition this way.

fruitarian
 vegan
 lacto-vegetarian
 lacto-ovo vegetarian
 pollo vegetarian
 pescatarian
 macrobiotic
 flexitarian
 other, please specify

all
 most
 some
 little
 almost none

"our child like?" _____
 "our child dislike?" _____

Ability to eat and drink using adaptive utensils. This also includes the ability to cut, chew, and swallow food. Eating does not include meal preparation. Eating does not include tube feedings or intravenous feedings.

Age appropriate
 Able to feed self, with or without the use of assistive devices or adapted methods.
 Able to feed self, but requires the presence of another person for supervision or cueing
 Able to feed self after set-up (example, cutting food)
 Recent documented history of choking/aspiration or potential for choking/aspiration
 Needs partial physical

List assistive devices used

adaptive dishes
 adaptive utensils
 Haberman feeder
 feeder seat
 cheek support
 chin support
 hand over hand support
 other, _____

NC DMA Community Alternatives Program for Children (CAP/C)
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Date: _____

Name _____

MID: _____

		feeding from another person <input type="checkbox"/> Needs total feeding from another person	
Enteral Feeding	<input type="checkbox"/> Applicable <input type="checkbox"/> Not Applicable		
	Tube Type -SELECT-, _____ Brand -SELECT-, _____		BARD Mic-Key other, please specify
	Frequency _____ <input type="checkbox"/> at home <input type="checkbox"/> by physician		
	NG (nasogastric) JT (jejunostomy) OG (orogastric) GJ (gastrostomy-jejunostomy) GT (gastrostomy) DT (duodenal tube) low profile GT other, please specify		not used meds/flushes only venting only supplemental feeding flushes only all feeding other, please specify
Site: _____ <input type="checkbox"/> other, _____			breakdown
	Tube is used for -SELECT-, _____		
	Q2H twice/day 18 hrs/day 6 hrs/day Q4H three times/day 16 hrs/day 4 hrs/day Q6H four times/day 14 hrs/day other, Q8H five times/day 12 hrs/day please Q12H 24 hrs/day 10 hrs/day describe Q24H 20 hrs/day 8 hrs/day		continuous, gravity continuous, feeding pump bolus, gravity bolus, feeding pump other, please specify
	The child receives -SELECT-, _____ <input type="checkbox"/> Applicable <input type="checkbox"/> Not Applicable		all most some little almost none
Parenteral Feeding	Type of Access -SELECT-, _____ Location of Access -SELECT-, _____		neck chest antecubital femoral other, please specifv
	Broviac/Hickman Infus-a-Port/Port-a-Cath PICC line other, please specify		
	_____ hours per _____ cc/hr for _____		all most some little almost none
Testing	blood glucose tests <input type="checkbox"/> Applicable		
	Site -SELECT-, _____ Frequency _____		yes no sometimes other, please specify
	target range _____ child do own testing? -SELECT-, _____		
	urinary _____ <input type="checkbox"/> Not Applicable		
	Frequency _____ <input type="checkbox"/> when sick <input type="checkbox"/> other, _____		
	Other _____		
Comments: _____			

ELIMINATION

NC DM... Children (CAP/C)

not age appropriate; child under 3
totally continent
incontinent during sleep only
occasional daytime accidents
occasional night-time accidents
totally incontinent
other, please specify

MID:

no urologist or nephrologist

Physical Address: Street Address 1, Street Address 2, City, Zip Code
Mailing Address: Mailing address same as physical address, Street/PO Box 1, Street/PO Box 2, City, State, Zip Code

Office Phone () - ext. Fax () -
The last appointment with this doctor was / /
"Are you satisfied with this provider's services?" Yes

indwelling intermittent
suprapubic condom catheter
only for dilation of vesicostomy

Bladder Contenance -SELECT-,
Method Commode Diaper, type, amount per day Colostomy
 Catheter, type -SELECT-, size

Bowel Contenance -SELECT-
Method Commode Diaper, Bowel Regimen, please describe Colostomy, Bag Type, St

not age appropriate; child under 3
totally continent
incontinent during sleep only
occasional daytime accidents
occasional night-time accidents
totally incontinent
colostomy
other, please specify

Functional Ability
Elimination A
Elimination off ine
of assistiv
a to toilet sen
if nce care with or without the
a sistive devices, but requires the
in of another person for
 sion or cueing.
 eeds partial physical assistance for
 eting or incontinence
 Needs complete physical help from
another person

not applicable, child continent
not applicable; child under 2
years of age
expect normal toilet training
expect delayed/prolonged
toilet training
child does not have ability to
be toilet-trained
other, please specify

- commode
- ostomy
- intermittent catheterization
- indwelling catheter
- diaper/disposable undergarment
- incontinence undergarment, reusable
- disposable liner for reusable incontinence undergarment
- chux
- other, _____

Toilet Training -SELECT-, Diaper change procedure _____
Catheter and/or Ostomy care procedure: _____
Comments: _____

CHILD'S MENTAL HEALTH AND CARE NEEDS

PSYCHIATRIST/COUNSELOR Name _____ Name of Practice _____ no psychiatrist/counselor
Physical Address: Street Address 1, Street Address 2, City, State, Zip Code
Mailing Address: Mailing address same as physical address, Street/PO Box 1, Street/PO Box 2, City, State, Zip Code
Office Phone () - ext. Fax () - After Hours Phone () -
The last appointment with this doctor was / / for illness routine check

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Date: _____ Name _____ MID: _____

"Are you satisfied with this provider's services?" Yes No: _____

MOOD

- Dysphoric: Unpleasant mood; sadness, anxiety, irritability
- Elevated: Exaggerated sense of well being, euphoria, elation
- Euthymic: Mood in the normal range
- Expansive: lack of restraint in expressing feelings; frequently with an over evaluation of one's significance or importance
- Irritable: Easily annoyed and provoked to anger

AFFECT

- Broad: normal range of emotion
- Constricted/Restricted: mild restriction in the range or intensity of expressions of feeling
- Blunted: a more severe restriction than constricted/restricted
- Flat: the absence of any exhibition of emotions
- Inappropriate: display of emotion out of context for the situation
- Labile: emotional instability, dramatic mood swings

BEHAVIOR

How does the child usually behave toward persons outside the household/immediate family?
 cooperative passive argumentative suspicious hostile bites hits verbally abusive
 holds breath cries wanders other, _____

Self-abusive or repetitive behaviors:

- none head banging rocking hitting oneself biting or
- pulling hair other, _____

"Has there been a recent change in the child's behavior?" No Yes

Comments:

all care some medical care
 non-medical ADL supports
 non-medical IADL supports
 other non-medical care supports
 companionship/socialization
 financial/legal
 other, please specify

INFORMAL SUPPORTS

P	yes	relationship and contact information)
	no, but seeking employment	to the recipient/family? -SELECT-, _____
	no, not seeking employment	provide the above care?
	other, please specify	
		Afternoon (12N-4P)
		evening (4P-12N)
		weekend
		availability
		schedule
		never or rarely
		sometimes
		a lot
		other, please specify
		yes, and my commute time is...
		no, but I am available during work hours
		no, and I can be available during work hours
		other, please specify
		very flexible
		somewhat flexible
		not flexible
		other, please specify
		Employment -SELECT-, _____
		Is this work outside of the home? -SELECT-, _____
		type of work: _____
		Are the hours flexible? -SELECT-, _____
		under 18 years
		18-64 years
		65 years and older
		Prefer not to answer
		abilities? -SELECT-, _____
		Does this person have any medical conditions that affect their ability to provide care?
		frequently
		occasionally
		rarely
		never
		other, please specify
		yes no unsure
		prefer not to answer
		other, please specify
		Age _____ or -SELECT-, _____

yes no on a wait list
needs a referral prefer not to answer
other, please specify

yes no unsure
other, please specify

Date: _____ Name: _____ MID: _____
care? -SELECT-, _____ Is this person a service recipient as well? -SELECT-, _____
Is this person's physical or mental health affected by care giving burden? -SELECT-, _____
Comments: _____

Other household members and regular informal support persons

Name _____ Relationship to recipient -SELECT-, _____ Role relative to recipient -SELECT-, _____
Street Address _____ Mailing Address same as street address
Street _____ Street _____
City _____, NC Zip Code _____
Phone (work) (____) _____-_____
Email _____@_____
What is this person's restriction? _____
What is this person's role relative to recipient/family? -SELECT-, _____

	Morning (7A-12N)	Afternoon (12N-6P)	Evening (6P-11P)	Overnight (11P-7A)
work schedule	work	available for care	work	available for care

- mother
- father
- brother
- sister
- grandfather
- specify
- grandmother
- spouse
- other relative
- friend
- professional
- other, please
- legal guardian
- informal caregiver not in household
- informal caregiver not in household, visitation
- informal caregiver not in household, joint custody
- power of attorney – healthcare
- power of attorney – financial
- representative payee
- foster parent
- other, please specify

Employment status: _____ Are these workers? _____
Are there on-call responsibilities? -SELECT-, _____
Do the recipient's care needs hamper obtaining or maintaining employment?
If employed and requesting in-home nurse, nurse aide, or attendant coverage of work hours, submit verification of employment.

Age _____ or -SELECT- Does this person have physical or mental medical conditions that affect their ability to provide care? -SELECT-, _____
Is this person's physical or mental health affected by care giving burden? -SELECT-, _____
Comments: _____

If there are additional informal support persons, please indicate them on page A.

CHANGES IN HOUSEHOLD COMPOSITION

"Caring for a special needs child can be stressful. Major changes in household composition (birth, death, marriage, divorce, older siblings moving out, other family members moving in, return to workforce, or leaving workforce...?" -SELECT-, _____
cause additional stress for your household recently

Comments: _____

FAMILY DYNAMICS

Briefly describe the relationships and interactions between the client, household members, and immediate family members. Note, for instance, whether the adults appear to have a supportive relationship or hostility; whether the siblings interact with the client or are feeling jealous of the client's attention. _____

Comments: _____

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 Family-Centered Assessment

Date: _____ Name _____ MID: _____

SUPPORT NEEDS

"Do you feel that you have family members or acquaintances in the area that you can call on for...
 ...providing medical care for your child? -SELECT-
 ...providing that medical care for your child overnight, or for a weekend? ? -SELECT-
 ...help with non-medical support such as siblings, errands, housework? ? -SELECT-
 ...emotional support for the family/someone you confide in?" ? -SELECT-

"Are you acquainted with other families of _____ needs children similar to yours?" -SELECT-

"How would you describe your support needs?"
 We are well supported, we have all the support we need
 We have some support, but we need more
 We have no one to support us in this way
 We don't need or want this type of support
 Not disclosed

Comments: _____

FAMILY HEALTH

"Do you and your family all have a doctor for your own health care needs?" Yes No
 "Are you/they able to get to the doctor when ill?" Yes No
 "Are you/they able to go to the doctor for routine preventive exams?" Yes No
 If 'no' to any of these questions, "What support do you/they need in order to receive medical care?" _____
 "Does anyone in the house abuse alcohol or drugs (prescription or illegal)?" Unsure No Yes: - Would you like information or support? Yes No I would like to think about it.
 "Is anyone in the house ever verbally threatened or abused?" No Yes

Comments: _____

FAMILY RESOURCES FOR DAILY LIVING

TRANSPORTATION

"Do you have any problems with transportation?" No Yes: _____
 "Do you have a family car that is operable and insured?" Yes No
 If no,
 "How do you usually get to appointments at the doctors office, social services, etc?" _____
 "How does your child get to school or daycare?" _____
 "Is there anyone who might be able to drive you to appointments?" No Yes: Name Contact Info _____
 Availability _____
 If yes,
 "Does it have room for your child's medical equipment/wheelchair/assistive device?" Yes No: _____
 "Do you have use of it during the day?" Yes No Sometimes
 If no or sometimes, please explain _____

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 Family-Centered Assessment

Date: _____ Name _____ MID: _____
 "Do you have a child car seat that meets the needs of your child?" Yes No: _____ Not Applicable
 Comments: _____

HOUSING		
Living Arrangement - <u>SELECT</u>		
Street Address: _____		
"Is your child living there?" <input type="checkbox"/> Yes <input type="checkbox"/> No. "Is the home able to meet your family's needs?" _____		
<input type="checkbox"/> with parent(s) <input type="checkbox"/> with other relative(s) <input type="checkbox"/> with others, private residence <input type="checkbox"/> group home or other congregate living facility		
<input type="checkbox"/> Indicate how the child accesses all areas of the house and how the child accesses the house in an emergency, such as a fire. _____ <input type="checkbox"/> multiple levels. If the child has limited mobility, please indicate how the child accesses all areas of the house. _____ <input type="checkbox"/> other, _____		
	Safe	Needs attention
Exterior access Can the child/family enter and exit the home safely, especially in an emergency? For immobile clients, is the access adequate for someone to get the client out of the home, i.e. ramps or door width?	<input type="checkbox"/>	<input type="checkbox"/>
Interior access Does the child/family have safe access to all essential areas within the home? For example, can a wheelchair bound client get through all needed doorways? Are there areas contributing to frequent falls? Are there necessary safety rails or grab bars? Is there enough room for all of the necessary medical equipment, i.e. ramps or door width?	<input type="checkbox"/>	<input type="checkbox"/>
Heating Is the heating adequate to maintain the living area at a comfortable temperature? Does the source of the heat appear safe and reliable? Do special precautions need to be taken during extreme weather, such as alertness to freezing lines or overheating of appliances?	<input type="checkbox"/>	<input type="checkbox"/>
Cooling Is there a method to adequately cool the environment? Does it appear to be safe?	<input type="checkbox"/>	<input type="checkbox"/>
Cleanliness of home Is the environment relatively neat and clean? Are there piles of litter that could attract/hide pests? Is there clutter that could make it difficult for the client to walk? Are there obvious unsanitary conditions?	<input type="checkbox"/>	<input type="checkbox"/>
Trash disposal Is there a sanitary way to dispose of garbage and trash? Is it being used?	<input type="checkbox"/>	<input type="checkbox"/>
Clean water source Is there an adequate, reliable source of clean water to use for bathing and cooking? Are there potential problems in very cold or dry weather that need to be recognized?	<input type="checkbox"/>	<input type="checkbox"/>
Hot water Is there a safe and reliable source of hot water, whatever the means obtained (water heater, boiling on stove, or other means)?	<input type="checkbox"/>	<input type="checkbox"/>
Body waste disposal If there is indoor plumbing, are there indications that it is not functional? Is the method of disposal sanitary and accessible?	<input type="checkbox"/>	<input type="checkbox"/>
Laundry Is there an adequate and sanitary method to clean clothes and bed linen?	<input type="checkbox"/>	<input type="checkbox"/>

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Cooking appliance Is there a safe and adequate method to prepare food? Does the appliance present any particular hazards?	<input type="checkbox"/>	<input type="checkbox"/>
Refrigerator Is there a functioning refrigerator in the home? If not, is there another means of keeping foods as well as medications that may require refrigeration?	<input type="checkbox"/>	<input type="checkbox"/>
Lighting Is there adequate lighting for the client and caregivers to function? Does it appear safe?	<input type="checkbox"/>	<input type="checkbox"/>
Other electrical Are there obvious signs of electrical hazards, such as bare wires? Does the wiring appear adequate to support any life sustaining equipment in the home? If life sustaining equipment is used, has the power company been notified?	<input type="checkbox"/>	<input type="checkbox"/>
Structural integrity Does the home appear to be in good repair? Are there holes in the roof or floors? Are there unsafe steps? Is it drafty? Does rain come in through the windows, roof, or doorways? Can the floor support equipment used by the client? Are windows or doors broken?	<input type="checkbox"/>	<input type="checkbox"/>
Telephone Is there a phone? Is it accessible to the client and/or caregivers? If there is not a phone in the home, is there one in the immediate area?	<input type="checkbox"/>	<input type="checkbox"/>
Pest/vermin control Are there any signs of infestation of any types of pests or vermin rats, mice, snakes, bugs, or other creatures? Are past infestations under control? Are there active measures to control infestations that may be likely?	<input type="checkbox"/>	<input type="checkbox"/>
Fire safety Are there obvious fire hazards in the home, such as piles of newspaper, frayed electrical cords, faulty heating appliances, or unsafe storage of flammables? Are there working smoke detectors? Are local fire officials aware of a bedfast or wheelchair bound client? Are there safe exits in the event of a fire?	<input type="checkbox"/>	<input type="checkbox"/>
Security Are there obvious security hazards? Are there functioning and seemingly adequate locks?	<input type="checkbox"/>	<input type="checkbox"/>
Comments: _____		
If the child receives CAP/C services in more than one household, please complete for each additional household (Assessment Appendix B).		

FINANCES
<p>"Do you have enough money to pay the bills?" <input type="checkbox"/> Yes <input type="checkbox"/> No _____</p> <p>"Do you ever run out of money before the end of the month?" <input type="checkbox"/> No <input type="checkbox"/> Yes: _____</p> <p>"Do you want help planning the monthly budget?" <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I would like to think about it</p> <p>"Will you be able to pay for your own and your child's health care?" <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I am not sure.</p> <p>"Are there <u>needed</u> items or services that the child does without each month due to lack of funds?" <input type="checkbox"/> No <input type="checkbox"/> Yes:</p>
Comments: _____

FORMAL SUPPORT SYSTEMS NOT PREVIOUSLY LISTED

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PEDIATRICIAN OR FAMILY PHYSICIAN
see facesheet
The last appointment with this doctor was ___/___/___ for <input type="checkbox"/> illness <input type="checkbox"/> routine check.
"Are you satisfied with this provider's services?" <input type="checkbox"/> Yes <input type="checkbox"/> No: _____
Comment: _____

DEVELOPMENTAL/REHAB PHYSICIAN Name _____ Name of Practice _____ <input type="checkbox"/> No dvlpt/rehab physician
Physical Address _____ Mailing address <input type="checkbox"/> same as physical address
Street Address 1 _____ Street/PO Box 1 _____
Street Address 2 _____ Street/PO Box 2 _____
City _____ State _____ City _____ State _____
Zip Code _____ - _____ Zip Code _____ - _____
Office Phone () _____ - _____ ext. _____ Fax () _____ - _____ After Hours Phone () _____ - _____
The last appointment with this doctor was ___/___/___ for <input type="checkbox"/> illness <input type="checkbox"/> routine check
"Are you satisfied with this provider's services?" <input type="checkbox"/> Yes <input type="checkbox"/> No: _____
Comments: _____

EARLY INTERVENTION SERVICES <input type="checkbox"/> Not Applicable
CDSA Name _____ Child Service Coordinator Name/Title _____
Physical Address _____ Mailing address <input type="checkbox"/> same as physical address
Street Address 1 _____ Street/PO Box 1 _____
Street Address 2 _____ Street/PO Box 2 _____
City _____ State _____ City _____ State _____
Zip Code _____ - _____ Zip Code _____ - _____
Office Phone () _____ - _____ ext. _____ Fax () _____ - _____ Email _____ @ _____
Services Provided:
<input type="checkbox"/> assistive technology <input type="checkbox"/> medical services <input type="checkbox"/> psychological services <input type="checkbox"/> audiology <input type="checkbox"/> multidisciplinary evaluation <input type="checkbox"/> respite <input type="checkbox"/> early identification and screening <input type="checkbox"/> nursing services <input type="checkbox"/> social work services <input type="checkbox"/> health services <input type="checkbox"/> nutritional therapy <input type="checkbox"/> vision services <input type="checkbox"/> family counseling and therapy <input type="checkbox"/> occupational therapy <input type="checkbox"/> special instruction (CBRS) <input type="checkbox"/> physical therapy <input type="checkbox"/> transportation <input type="checkbox"/> speech-language therapy <input type="checkbox"/> child service coordination <input type="checkbox"/> other, _____
"Are you satisfied with this provider's services?" <input type="checkbox"/> Yes <input type="checkbox"/> No: _____
Comment: _____

DAY CARE OR PRESCHOOL <input type="checkbox"/> Not Applicable
Name _____ Contact Person Name/Title _____
Physical Address _____ Mailing address <input type="checkbox"/> same as physical address
Street Address 1 _____ Street/PO Box 1 _____
Street Address 2 _____ Street/PO Box 2 _____
City _____ State _____ City _____ State _____
Zip Code _____ - _____ Zip Code _____ - _____
Office Phone () _____ - _____ ext. _____ Fax () _____ - _____ Email _____ @ _____
Rating/Licensure <input type="checkbox"/> 1 star <input type="checkbox"/> 2 star <input type="checkbox"/> 3 star <input type="checkbox"/> 4 star
Type of Service _____

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Date: _____ Name _____ MID: _____
 5 star notice of compliance public preschool standard developmental medically fragile
 "Are you satisfied with this provider's services?" Yes No: _____
 Comment: _____

SCHOOL Not Applicable

School Name _____ Contact Person Name/Title _____

Physical Address Street Address 1 _____ Street Address 2 _____ City _____ State _____ Zip Code _____ - _____ Office Phone (____) _____ - _____ ext. _____	Mailing address <input type="checkbox"/> same as physical address Street/PO Box 1 _____ Street/PO Box 2 _____ City _____ State _____ Zip Code _____ - _____ Fax (____) _____ - _____ Email _____@_____
--	---

Type of School Calendar
 traditional modified traditional year-round modified year-round extended school year

School Plan of Care None IHP IEP 504

Describe Services and Frequency of Services Provided _____

"Are you satisfied with this provider's services?" Yes No: _____

If nurse or nurse aide services are provided in the school, submit the 'Documentation of Payer Source for CAP/C Children Receiving Nurse or Nurse Aide Services in the School and Justification for CAP/C Payment of Those Services if Applicable' to document need and payer source.

Comment: _____

PROVIDER AGENCIES Not Applicable

Agency Name _____ Contact Person Name/Title _____

Agency Type
 home health home care behavioral/mental health hospice other, _____
 Durable Medical Equipment home infusion independent practitioner

Service Type
 RN/LPN scheduled Nurse Aide scheduled
 RN/LPN visits Nurse Aide visits
 RN/LPN respite Nurse Aide respite institutional respite
 physical therapy occupational therapy speech therapy
 respiratory therapy other, _____
 hospice home infusion therapy
 supplies durable medical equipment
 community support services developmental therapy services

Service Location
 home school community outpatient facility drop-ship other, _____

Service Frequency _____

Physical Address Street Address 1 _____ Street Address 2 _____ City _____ State _____ Zip Code _____ - _____ Office Phone (____) _____ - _____ ext. _____	Mailing address <input type="checkbox"/> same as physical address Street/PO Box 1 _____ Street/PO Box 2 _____ City _____ State _____ Zip Code _____ - _____ Fax (____) _____ - _____ Email _____@_____
--	---

"Are you satisfied with this provider's services?" Yes No: _____

Comment: _____

If there are additional providers, please complete Assessment Appendix C.

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Family-Centered Assessment

Date: _____ Name _____ MID: _____

OTHER PLANNING CONSIDERATIONS

SAFETY AND WELFARE

Do any concerns exist regarding the child's health, safety, or well-being? No Yes, please describe: _____

Comments: _____

THINGS TO KNOW ABOUT THE CHILD

"Activity/Hobby Interests

- school employment
 internet/social networking sports/sporting events games/cards music/videos exercises
 walking reading/writing spiritual/religious activities gardening TV/movies
 crafts, arts social activities, gatherings talking, phoning, texting videogames other, _____
 none"

"Special toy/blanket/pacifier _____

Other favorite toys _____

Favorite things to do _____

Dislikes _____

Fears _____

Skills and gifts _____

What people like about him or her" _____

Other: _____

Comments: _____

CHILD'S CONCERNS AND GOALS

- The child can't answer these questions due to his/her age.
 The child can't answer these questions due to his/her medical condition.

"Do you have any concern about your care?" No Yes: _____

"What help do you need to resolve these concerns?" _____

"What is important TO you?" _____ "What is important FOR you?" _____

"What is working best in your life right now?" _____ "What isn't working in your life right now?" _____

"What are your goals for the next year?" _____

"What are your hopes and dreams for the future?" _____

"What strengths (talents, traits) do you have to help you meet these goals?" _____

"What help do you need to meet these goals?" _____

Comments: _____

FAMILY'S CONCERNS AND GOALS

"Do you have any concern about your child's/family's care?" No Yes: _____

"What help do you need to resolve these concerns?" _____

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"What is important TO your family?" _____ "What is important FOR your family?" _____

"What is working best in your family's life right now?" _____

"What isn't working in your family's life right now?" _____

"What are your family's goals for the next year?" _____

"What are your hopes and dreams for your family's future?" _____

"What strengths (talents, traits) does your family have to help you meet these goals?" _____

"What help does your family need to meet these goals?" _____

Comments: _____

CONCERNS AND GOALS OF OTHER RELATIVES OF THE CHILD

Name _____ relationship _____

"Do you have any concerns about the child's health or medical care?" No Yes: _____

"What help do you believe the child needs?" _____

"What is working best in your family's life right now?" _____

"What isn't working in your family's life right now?" _____

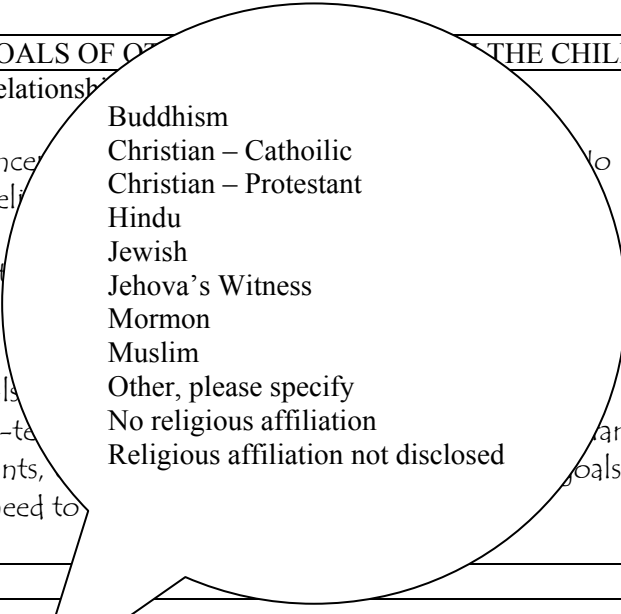
"What are your goals for the child's future?" _____

"What are your long-term hopes and dreams for your family's future?" _____

"What strengths (talents, traits) does your family have to help you meet these goals?" _____

"What help do they need to meet these goals?" _____

Comments: _____



RELIGIOUS/CULTURAL/PERSONAL VALUES AFFECTING CHILD'S CARE

Religious Affiliation -SELECT-, _____

"Is there any religious or cultural belief that goes against your/your family's religious or personal values?" No Yes: _____

"What help do you believe the child needs?" _____

"What are your goals for the child's future?" _____

"What are your long-term hopes and dreams for your family's future?" _____

"What strengths (talents, traits) does your family have to help you meet these goals?" _____

"What help do they need to meet these goals?" _____

Comments: _____

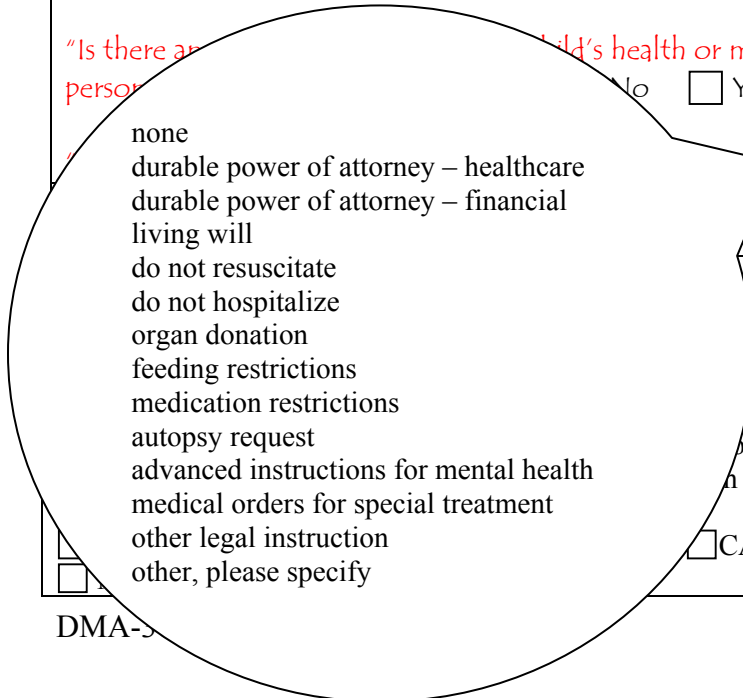
Not Applicable

_____ school college

_____ services workforce

CAP-DA (CAP for Disabled Adults)

_____ other, please specify _____



NC DMA Community Alternatives Program for Children (CAP/C)
Family-Centered Assessment

Date: _____ Name _____ MID: _____

CAP-MR/DD (CAP for Persons with Mental Retardation/Developmental Disability)
 Community Support Services Developmental Therapy Services Hospice
 Home Health Home Infusion Services
 to
 home facility
 daycare early intervention services preschool
 elementary school middle school high school college
 special education services mainstream education services workforce
 pediatrician adult physician
 CAP/C Medicaid Personal Care Services CAP-DA (CAP for Disabled Adults)
 Medicaid Private Duty Nursing
 CAP-MR/DD (CAP for Persons with Mental Retardation/Developmental Disability)
 Community Support Services Developmental Therapy Services Hospice Home Health
 Home Infusion Services
 on or about ____/____/____.

The good things about this transition are _____.

The things about this transition I am concerned about are: _____.

"My child generally copes with transitions well with difficulty".
If with difficulty, "What would help your child cope effectively?" _____

My family generally copes with transitions well with difficulty.
If with difficulty, "What would help your family cope effectively?" _____

Comments: _____

OTHER PLANS OF CARE

None IEP IHP 504 IFSP CMS-485 therapy plan of care
 advance directive custody/guardianship/visitation other, _____

Plan(s) of care attached OR please describe what the plan includes _____ (disregard for school plan described in school section)

Comments: _____

SERVICES

If you are new to the CAP/C program:
"What services, if any, is your child currently receiving?"

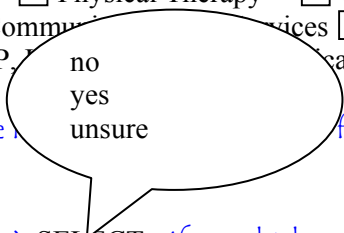
None Skilled Nursing Visits Private Duty Nursing
 Nurse Aide/Personal Care Services Physical Therapy Occupational Therapy Speech Therapy
 Hospice CAP-MR/DD Community Support Services Developmental Therapy Services
 Early Intervention Services IEP, _____ Medicaid or waiver program in another state WIC
 other: _____

"What is it about these services that are _____ family's needs?" _____

"How will having CAP/C help?" _____

Are you on the wait list for any services? -SELECT- If so, which service(s)? _____ since when? _____

If you are already receiving CAP/C services:
"Is the current plan of care meeting your child's/family's needs?" Yes No, _____



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Date: _____ Name _____ MID: _____

If no, "What changes need to be made to meet your child's/family's needs?" _____

Comments: _____

STAFF NEEDS

We would like for our child to have Nurses/Nurse Aides/Attendants with the following professional qualifications or personal characteristics: _____

Comments: _____

yes
no
other, please specify

TRAINING NEEDS

"Are you comfortable with performing all the kinds of care and procedures that your child needs?" **-SELECT-**, _____

"Are you comfortable in the use, care, and storage of your child's medical equipment?" **-SELECT-**, _____

Comments: _____

ADDITIONAL INFORMATION

Use the space below to expand on any of the previous sections or to provide any additional information you or the family feel is important.

There is no additional information.

There is additional information: _____

NC DMA - Community Alternatives Program for Children (CAP/C)
Letter of Understanding and Freedom of Choice

By signing this form, I, as the primary caregiver (parent or legally responsible party) for _____,
MID # _____ acknowledge my understanding of the CAP/C policies stated below.

1. I have a choice between A) placing my child in a nursing home or hospital and B) receiving in-home care for my child through CAP/C services. I have chosen for my child to receive CAP/C services.
2. I understand that I have the freedom to choose from among any enrolled Medicaid provider(s) to provide care or services for my child.
3. I understand that the following people may not be the paid CAP/C providers for the recipient: the recipient's parent, stepparent, foster parent, custodial parent, or adoptive parent; the recipient's grandparents; the recipient's siblings; the recipient's spouse; anyone who has legal responsibility for the recipient; and anyone who lives in the same household as the recipient.
4. I understand that the recipient may not receive CAP/C services in the home of any caregiver paid to provide those services.
5. My child, the recipient, must require skilled nursing care equivalent to care received in an institutional setting to be eligible for this program.
6. CAP/C is designed to supplement, not replace, the formal and informal services already available to my child.
7. As the primary caregiver, I will actively participate in planning for my child's care, and will comply with the mutually agreed upon Plan of Care and will provide or make arrangements for needed care to be provided to my child during the planned and unplanned absences of the CAP/C provided nurses or nurse aides.
8. The amount, frequency, or type of services my child receives may change over time based on changes in the care needs of my child or in the availability of his or her supports. It is my responsibility to notify my Case Manager of these changes.
9. CAP/C services will be terminated when my child meets any of the following criteria:
 - The recipient's Medicaid is terminated.
 - The recipient's physician does not recommend CAP/C participation.
 - The recipient's physician does not recommend nursing facility level of care.
 - Nursing facility level of care is not approved.
 - The recipient is admitted to a facility for 30 or more calendar days (including admission to inpatient facilities, including but not limited to a hospital, nursing facility, or rehabilitation facility).
 - The recipient moves out of his/her primary residence to a hospital, nursing facility, or adult care home for long-term care.
 - The CAP/C case manager has been unable to establish contact with the recipient and/or his/her parent or legally responsible party for more than 60 days.
 - The recipient fails to qualify for program participation based on medical needs; that is, the recipient does not require CAP/C services to remain safely at home.
 - The recipient does not need and use at least one waiver service besides case management and respite each quarter.
 - The recipient's health, safety, and well-being cannot be reasonably assured with services provided within program limits.
 - The recipient's 21st birthday. The last day of CAP/C services must be on or before the last day the recipient is 20 years old.
 - The recipient, recipient's parent, or legally responsible party does not participate in development of or sign the recipient's plan of care.
 - Case management services are not available.
10. If a waiver service is denied, reduced, or terminated, I will be notified in writing and be told how to appeal the denial if applicable.
11. Decisions made by my child's physician or home care provider agency cannot be appealed to DMA.
12. The providers may have certain requirements regarding my participation in my child's treatment and enrollment with their agency.
13. The Case Manager is responsible for coordinating the assessment, plan of care, and monitoring CAP/C services to ensure that my child's needs are met within program guidelines. I understand that I must maintain communication with my Case Manager by returning telephone calls, being available for home visits, and informing him/her of
 - Changes in my child's condition
 - Change in availability of caregivers
 - Hospitalizations, emergency room visits, and physician appointments
 - Absences from the county
 - New equipment or supplies
14. The Division of Medical Assistance has sole approval authority over the plan of care. My Case Manager is unable to approve or deny any services or supplies.

I have been given a copy of or provided access to the CAP/C Parent Handbook
(<http://www.ncdhhs.gov/dma/capc/capcparenthandbook.pdf>.)

NC DMA Community Alternatives Program for Children (CAP/C)
Family-Centered Assessment

Date: _____

Name: _____

MID: _____

CERTIFICATION

Each of the people/agencies checked below has been involved in the assessment and/or in the development of the plan of care. An individual who certifies a material and false statement in this assessment will be subject to investigation for Medicaid fraud and will be referred to the appropriate professional licensing agency for investigation.

	Signature, Title	Date	Participated by...
<input type="checkbox"/> primary caregiver Name: _____			
<input type="checkbox"/> primary caregiver Name: _____			
<input type="checkbox"/> other caregiver Name: _____			<input type="checkbox"/> interview <input type="checkbox"/> record review
<input type="checkbox"/> legal guardian (if not primary caregiver) Name: _____			<input type="checkbox"/> interview <input type="checkbox"/> record review
<input type="checkbox"/> CAP/C case manager Name: _____	If Case Manager is RN, sign only once		
<input type="checkbox"/> RN Name: _____			non-highlighted sections completed, if any: _____
<input type="checkbox"/> coordinating care physician Name: _____			<input type="checkbox"/> interview <input type="checkbox"/> record review
<input type="checkbox"/> other physician Name: _____			<input type="checkbox"/> interview <input type="checkbox"/> record review
<input type="checkbox"/> physical therapist Name: _____			<input type="checkbox"/> interview <input type="checkbox"/> record review
<input type="checkbox"/> occupational therapist Name: _____			<input type="checkbox"/> interview <input type="checkbox"/> record review
<input type="checkbox"/> speech therapist Name: _____			<input type="checkbox"/> interview <input type="checkbox"/> record review
<input type="checkbox"/> medically fragile daycare Name: _____			<input type="checkbox"/> interview <input type="checkbox"/> record review
<input type="checkbox"/> CDSA Name: _____			<input type="checkbox"/> interview <input type="checkbox"/> record review
<input type="checkbox"/> school Name: _____			<input type="checkbox"/> interview <input type="checkbox"/> record review
<input type="checkbox"/> provider agency Name: _____			<input type="checkbox"/> interview <input type="checkbox"/> record review
<input type="checkbox"/> provider agency Name: _____			<input type="checkbox"/> interview <input type="checkbox"/> record review
<input type="checkbox"/> other Name: _____			<input type="checkbox"/> interview <input type="checkbox"/> record review
<input type="checkbox"/> other Name: _____			<input type="checkbox"/> interview <input type="checkbox"/> record review

The caregivers/legally responsible person should review this assessment and receive a copy of it for inclusion in their CAP/C Parent Handbook.