



**COLORADO MEDICAID PEDIATRIC & PERSONAL CARE COMBINED ASSESSMENT TOOL**

The Combined Tool is designed to capture each Medicaid client’s individual skilled or Personal Care hour needs. This tool is to be completed by the provider **with** the client and/or their guardian or parent(s).

**Instructions on filling out the combined tool:**

This tool can be filled out as an auto complete PDF form or printed & completed by hand:

- If you use the auto fill PDF form, the totals will add up automatically
- If you print the tools and complete by hand you must add each section’s points up manually
- Each question is to be answered considering the **average needs** of the client (not based on a specific time the task was completed for the client)
- Select **only one** answer for each factor question, either Skilled Care **OR** Personal Care
- Answer all questions

**Definitions:**

- Age appropriate - a term used to identify when a task is something that a healthy child of the same age could complete. The Department uses [Iowa Ages & Stages](#) to identify age appropriate benchmarks
- Independent - defined in this assessment as a client not needing any assistance with a task
- Department Trained Provider - all individuals completing the combined tool are required to complete the Department of Health Care Policy and Financing’s “Combined Tool Series” training. Agencies are to keep a copy of all certificates in the event of a CDPHE audit

**Required Documentation**

Please submit the following documents with the Prior Authorization Request (PAR):

|   |
|---|
| Provider Orders and/or relevant documentation to PAR  |
| 485 – Home Health Certification Plan of Care (documenting the client’s need for each individual task) |
| Federal Coding Guidelines   |
| Home Equipment  |
| Medication List, complete and active medications  |
| Braden Scale (if necessary)   |

**IMPORTANT!**

The **Skilled Care** sections of this assessment may **ONLY** be completed by a DORA Licensed Provider.

The **Personal Care** sections of this assessment may **ONLY** be completed by a Home Care Provider or a Department Trained Provider (see Definitions).



**COLORADO MEDICAID PEDIATRIC & PERSONAL CARE COMBINED ASSESSMENT TOOL**

**Section I - Please complete for all clients**

**Client Information**

Client Name \_\_\_\_\_ Medicaid Number \_\_\_\_\_

Client Address \_\_\_\_\_

Birth-date \_\_\_\_\_ Gender Male Female

**Provider Information**

Provider Name \_\_\_\_\_

Provider Address \_\_\_\_\_

Provider Telephone Number \_\_\_\_\_ Provider ID \_\_\_\_\_

Printed name of person completing assessment \_\_\_\_\_

Signature of person completing assessment \_\_\_\_\_

Date Assessment Completed \_\_\_\_\_

**Discipline of Person Completing This Tool:**

Registered Nurse (RN)

Physical Therapist (PT)

Occupational Therapist (OT)

Other qualified provider Please identify \_\_\_\_\_

Homemaker

Personal Care Provider/Worker (PCP/W)

Other Home Care provider Please identify \_\_\_\_\_

**Clinical Record Items**

**Request is for:**

PERSONAL CARE SERVICES only

Certified Nursing Assistant (CNA) Services

RN or Licensed Practical Nurse (LPN) Services

**Current Payment Sources (mark all that apply):**

Medicaid (traditional fee-for-service)

Medicaid (Health Maintenance Organization (HMO)/Managed Care)

Title programs (e.g., Title III, V, or XX)

Other government (e.g., Tricare, VA, etc.)

Private insurance

Private HMO/Managed Care



**COLORADO MEDICAID PEDIATRIC & PERSONAL CARE COMBINED ASSESSMENT TOOL**

**Section I continued - Please complete for all clients**

**This assessment is being completed for the following reason:**

- New Prior Authorization Request (PAR)
- PAR revision request to a current, approved PAR

**Patient History and Diagnosis**

Please list all Principal and Secondary Diagnosis Codes with Descriptions  
(Include appropriate surgeries and procedures directly related to the client’s skilled or personal care needs)

| Diagnosis Code | Description |
|----------------|-------------|
|                |             |
|                |             |
|                |             |
|                |             |
|                |             |
|                |             |
|                |             |
|                |             |
|                |             |

**List equipment currently in use by/for client at their home:**

| Equipment Name | Client use description |
|----------------|------------------------|
|                |                        |
|                |                        |
|                |                        |
|                |                        |
|                |                        |
|                |                        |
|                |                        |
|                |                        |
|                |                        |

**Please check any services client is currently receiving:**

Home Health Name of Agency \_\_\_\_\_

Private Duty Nursing Name of Agency \_\_\_\_\_

Home Care Allowance

Waiver Services Please list below:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



**COLORADO MEDICAID PEDIATRIC & PERSONAL CARE COMBINED ASSESSMENT TOOL**

**DO NOT FORGET!**

If you or your agency **does not** provide a specific Skilled Care or Personal Care task, you may **not** score that task on this tool.

**Section II - Please complete for all clients**

**1. Ambulation/Locomotion Task**

**Skilled Care ONLY**

**Client Factors:**

- unable to assist
- unable to direct care or hands on assistance is required
- unable to maintain balance, bear weight or has not been deemed independent with assistive devices ordered by a qualified provider

**Note:**

- Assistive devices include, but are not limited to: wheelchairs, splints, braces, standers, and/or walkers

**Client requires assistance with mobility/ambulation (with or without assistive devices and/or wheelchair):**

|                                   |                                    |
|-----------------------------------|------------------------------------|
| This task is a Personal Care task |                                    |
| 0                                 | Independent and/or age appropriate |
| 3                                 | 50% or less of the time            |
| 6                                 | Greater than 50% of the time       |

**Personal Care ONLY**

**Client Factors:**

- able to balance and bear weight reliably
- independent with an assistive device
- assisting another care provider, caregiver or unpaid family caregiver who is competent in providing the skilled aspect of care
- able to ambulate, age appropriate

**Note:**

- Assistive devices include, but are not limited to: wheelchairs, splints, braces, standers, and/or walkers

**Client requires assistance with mobility/ambulation (with or without assistive devices and/or wheelchair):**

|                                  |                                    |
|----------------------------------|------------------------------------|
| This task is a Skilled Care task |                                    |
| 0                                | Independent and/or age appropriate |
| 1                                | 50% or less of the time            |
| 2                                | Greater than 50% of the time       |



**Skilled Care** task points from **THIS** page \_\_\_\_\_

**Personal Care** task points from **THIS** page \_\_\_\_\_

**Skilled Care** task points **RUNNING TOTAL** \_\_\_\_\_

**Personal Care** task points **RUNNING TOTAL** \_\_\_\_\_



**COLORADO MEDICAID PEDIATRIC & PERSONAL CARE COMBINED ASSESSMENT TOOL**

**Section II - Please complete for all clients**

**2. Bathing/Showering Task**

**Skilled Care ONLY**

**Client Factors:**

- an open wound(s), stoma(s), broken skin and/or active chronic skin disorder(s)
- is unable to maintain balance or to bear weight reliably due to fragility of illness, injury or disability, history of falls
- temporary lack of mobility due to surgery or other exacerbation of illness, injury or disability

**Task Includes:**

- getting in and out of tub/shower

**Task Excludes:**

- grooming tasks: washing face, hands, and shampooing hair

**Client requires bathing assistance:**

|   |   |
|---|---|
|   | This task is a Personal Care task                                 |
| 0 | None, is independent, can be verbally cued, or is age appropriate |
| 2 | 50% or less of the time   |
| 4 | Greater than 50% of the time                                      |

**Personal Care ONLY**

**Client Factors:**

- has unbroken skin
- is independent with assistive devices

**Task Includes:**

- getting in and out of tub/shower

**Task Excludes:**

- grooming tasks: washing face, hands, and shampooing hair

**Client requires bathing assistance:**

|   |   |
|---|---|
|   | This task is a Skilled Care task                                  |
| 0 | None, is independent, can be verbally cued, or is age appropriate |
| 1 | 50% or less of the time   |
| 2 | Greater than 50% of the time                                      |



|   |       |  |       |
|---|-------|--|-------|
| <b>Skilled Care</b> task points from <b>THIS</b> page | _____ | <b>Personal Care</b> task points from <b>THIS</b> page | _____ |
| <b>Skilled Care</b> task points <b>RUNNING TOTAL</b>  | _____ | <b>Personal Care</b> task points <b>RUNNING TOTAL</b>  | _____ |



**COLORADO MEDICAID PEDIATRIC & PERSONAL CARE COMBINED ASSESSMENT TOOL**

**Section II - Please complete for all clients**

**3. Dressing Task(s):**

**Skilled Care ONLY**

**Client Factors:**

- is unable to assist or direct care
- experiences a temporary lack of mobility due to surgery or other exacerbation of illness, injury or disability
- has qualified provider ordered placement of braces or splints
- has qualified provider ordered application of anti-embolic or pressure stockings

**Note:**

- Application of splints, braces and anti-embolic or pressure stockings includes - putting them on and taking them off as 1 application daily

**Provider ordered braces, splints, and/or anti-embolic pressure stocking applications:**

|                                   |   |
|-----------------------------------|---|
| This task is a Personal Care task |   |
| 0                                 | None, is independent, can be verbally cued, or is age appropriate |
| 1                                 | Daily   |
| 2                                 | Greater than once per day   |

**Client requires dressing assistance:**

|                                   |   |
|-----------------------------------|---|
| This task is a Personal Care task |   |
| 0                                 | None, is independent, can be verbally cued, or is age appropriate |
| 1                                 | 50% or less of the time   |
| 2                                 | Greater than 50% of the time                                      |

**Personal Care ONLY**

**Client Factors:**

- requires assistance with ordinary clothing and application of braces, splints, and/or support stockings that do not require a qualified providers orders
- A PCW may assist another care provider, caregiver or family member who is competent in providing this aspect of care-

**Note:**

- Application of stockings includes - putting them on and taking them off as 1 application daily

**OR** **Non-provider ordered braces, splints, and/or stockings:**

|                                  |   |
|----------------------------------|---|
| This task is a Skilled Care task |   |
| 0                                | None, is independent, can be verbally cued, or is age appropriate |
| 1                                | Daily   |
| 2                                | Greater than once per day   |

**Client requires dressing assistance:**

|                                  |   |
|----------------------------------|---|
| This task is a Skilled Care task |   |
| 0                                | None, is independent, can be verbally cued, or is age appropriate |
| 1                                | 50% or less of the time   |
| 2                                | Greater than 50% of the time                                      |

|   |  |
|---|--|
| <b>Skilled Care</b> task points from <b>THIS</b> page _____ | <b>Personal Care</b> task points from <b>THIS</b> page _____ |
| <b>Skilled Care</b> task points <b>RUNNING TOTAL</b> _____  | <b>Personal Care</b> task points <b>RUNNING TOTAL</b> _____  |



**COLORADO MEDICAID PEDIATRIC & PERSONAL CARE COMBINED ASSESSMENT TOOL**

**Section II - Please complete for all clients**

**4. Meal Preparation Task**

**Skilled Care ONLY**

**Client Factors:**

- requires a diet with RN oversight to administer correctly
- requires meals that must have a modified consistency (thickened liquids, etc.) are considered skilled CNA tasks. There must be a documented decline in condition and/or on-going need documented in the client's record

**Meal is modified consistency requiring RN oversight:**

(CNA must have RN oversight to perform task)

|   |                                   |  |
|---|-----------------------------------|--|
|   | This task is a Personal Care task |  |
| 0 | Not applicable                    |  |
| 2 | Applicable                        |  |

**Personal Care ONLY**

**Client Factors:**

- All meal preparation is an unskilled task, except as defined in the Factors that Make Task Skilled portion of this section



**Client requires meal preparation assistance:**

|   |                                  |  |
|---|----------------------------------|--|
|   | This task is a Skilled Care task |  |
| 0 | None                             |  |
| 1 | 100% of the time or less         |  |

**Skilled Care** task points from **THIS** page \_\_\_\_\_

**Personal Care** task points from **THIS** page \_\_\_\_\_

**Skilled Care** task points **RUNNING TOTAL** \_\_\_\_\_

**Personal Care** task points **RUNNING TOTAL** \_\_\_\_\_



**COLORADO MEDICAID PEDIATRIC & PERSONAL CARE COMBINED ASSESSMENT TOOL**

**Section II - Please complete for all clients**

**5. Feeding Task(s):**

**Skilled Care ONLY**

**Client Factors:**

- unable to communicate verbally, non-verbally or by any other means
- is unable to be positioned upright
- is on a modified texture diet
- has a physiological or neurogenic chewing and/or swallowing problem
- has a structural issue, such as, but not limited to a cleft palate, or a documented swallowing issue(s)
- has a history of aspirating food
- is on mechanical ventilations
- is on a required syringe and/or G/J-tube feeding

**Note:**

- CNA may provide oral suctioning and must be deemed competent by home health agency to administer feedings via tube or syringe

**Personal Care ONLY**

**Client Factors:**

- independently chew and swallow without difficulty
- can be positioned upright
- can eat or be fed with adaptive utensils

**Client requires feeding assistance:**

| This task is a Personal Care task |  |
|-----------------------------------|--|
| 0                                 | None, is independent with chewing and swallowing without difficulty, does not eat by mouth or is age appropriate |
| 2                                 | 50% or less of the time  |
| 4                                 | Greater than 50% of the time   |



**Client requires feeding assistance:**

| This task is a Skilled Care task |  |
|----------------------------------|--|
| 0                                | None, is independent with chewing and swallowing without difficulty, does not eat by mouth or is age appropriate |
| 1                                | 50% or less of the time  |
| 2                                | Greater than 50% of the time   |

**Enteral G/J tube feedings task time - including pump set up, discontinuation and/or administering bolus feeds:**

(CNA must have RN oversight per DORA to perform)

| Agency does not provide - (DO NOT SCORE) |                           |
|--|---------------------------|
| 0  | None                      |
| 2  | 1 hour or less a day      |
| 4  | Greater than 1 hour a day |

**Skilled Care** task points from **THIS** page \_\_\_\_\_

**Personal Care** task points from **THIS** page \_\_\_\_\_

**Skilled Care** task points **RUNNING TOTAL** \_\_\_\_\_

**Personal Care** task points **RUNNING TOTAL** \_\_\_\_\_



**COLORADO MEDICAID PEDIATRIC & PERSONAL CARE COMBINED ASSESSMENT TOOL**

**Section II - Please complete for all clients**

**6. Hygiene - Hair Care/Grooming Task**

**Skilled Care ONLY**

**Client Factors:**

- is unable to complete independently
- has open wound(s) or stoma(s) on their head
- requires shampoo/conditioner prescribed by qualified provider and dispensed by a pharmacy

**Note:**

- Hygiene/grooming may be completed during a bath/shower
- Styling of hair is not a skilled task

**Client requires hair care assistance:**

|                                   |                                    |
|-----------------------------------|------------------------------------|
| This task is a Personal Care task |                                    |
| 0                                 | Independent and/or age appropriate |
| 1                                 | 100% of the time or less           |

**Personal Care ONLY**

**Client Factors:**

- styling of hair with non-provider ordered hair products, to include drying, combing and styling

**Note:**

- Active and chronic skin issues such as dandruff and cradle cap do not make this task skilled



**Client requires grooming assistance:**

|                                  |                                    |
|----------------------------------|------------------------------------|
| This task is a Skilled Care task |                                    |
| 0                                | Independent and/or age appropriate |
| 1                                | 100% of the time or less           |

**7. Hygiene - Mouth Care Task**

**Client Factors:**

- is unconscious
- has difficulty swallowing
- is considered a choking or aspiration risk
- has decreased oral sensitivity or hypersensitivity
- is on medications that increase the risk of bleeding, injury or medical disease of the mouth
- requires shampoo/conditioner prescribed by qualified provider and dispensed by a pharmacy

**Note:**

- CNA may provide oral suctioning

**Client requires mouth care assistance:**

|                                   |                                    |
|-----------------------------------|------------------------------------|
| This task is a Personal Care task |                                    |
| 0                                 | Independent and/or age appropriate |
| 1                                 | 100% of the time or less           |



**Client Factors:**

- Basic oral hygiene and/or denture care

**Note:**

- The presence of gingivitis, receding gums, cavities and other general dental problems do not make mouth care skilled

**Client requires mouth care assistance:**

|                                  |                                    |
|----------------------------------|------------------------------------|
| This task is a Skilled Care task |                                    |
| 0                                | Independent and/or age appropriate |
| 1                                | 100% of the time or less           |

**Skilled Care** task points from **THIS** page \_\_\_\_\_

**Personal Care** task points from **THIS** page \_\_\_\_\_

**Skilled Care** task points **RUNNING TOTAL** \_\_\_\_\_

**Personal Care** task points **RUNNING TOTAL** \_\_\_\_\_



**COLORADO MEDICAID PEDIATRIC & PERSONAL CARE COMBINED ASSESSMENT TOOL**

**Section II - Please complete for all clients**

**8. Hygiene - Nail Care Task**

**Skilled Care ONLY**

**Client Factors:**

- has peripheral circulatory problems
- loss of sensation in hands
- is a bleeding risk
- is at high risk for injury secondary to nail care

**Note:**

- Any of the above tasks must be completed by a CNA who has been deemed competent by home care agency in nail care for this population

**Client requires nail care assistance:**

|                                   |                                    |
|-----------------------------------|------------------------------------|
| This task is a Personal Care task |                                    |
| 0                                 | Independent and/or age appropriate |
| 1                                 | 100% of the time or less           |



**Personal Care ONLY**

**Client Factors:**

- soaking of nails
- pushing back of cuticles without utensils
- filing of nails

**Note:**

- Personal care shall not include nail trimming

**Client requires nail care assistance:**

|                                  |                                    |
|----------------------------------|------------------------------------|
| This task is a Skilled Care task |                                    |
| 0                                | Independent and/or age appropriate |
| 1                                | 100% of the time or less           |

**9. Hygiene - Shaving Task**

**Client Factors:**

- has peripheral circulatory problems
- has loss of sensation
- is a bleeding risk
- has broken skin and/or has a chronic active skin condition (at/near the shaving site)

**Client requires shaving assistance:**

|                                   |                                    |
|-----------------------------------|------------------------------------|
| This task is a Personal Care task |                                    |
| 0                                 | Independent and/or age appropriate |
| 1                                 | 100% of the time or less           |



**Client Factors:**

- requires assistance with an electric or safety razor

**Client requires shaving assistance:**

|                                  |                                    |
|----------------------------------|------------------------------------|
| This task is a Skilled Care task |                                    |
| 0                                | Independent and/or age appropriate |
| 1                                | 100% of the time or less           |

**Skilled Care** task points from **THIS** page \_\_\_\_\_

**Personal Care** task points from **THIS** page \_\_\_\_\_

**Skilled Care** task points **RUNNING TOTAL** \_\_\_\_\_

**Personal Care** task points **RUNNING TOTAL** \_\_\_\_\_



**COLORADO MEDICAID PEDIATRIC & PERSONAL CARE COMBINED ASSESSMENT TOOL**

**Section II - Please complete for all clients**

**10. Hygiene - Skin Care Task(s)**

**Skilled Care ONLY**

**Client Factors:**

- requires skin care prescribed by a qualified provider
- requires a skin care product(s) dispensed by a pharmacy
- has broken skin, a wound(s) or an active skin disorder
- has a G/J tube or stoma
- is unable to apply skin product independently due to a client record documented decline in condition or ongoing need

**Task Includes:**

- Includes application of a qualified provider prescribed skin product

**Client has a provider prescribed skin product and requires assistance:**

|   |  |
|---|--|
| 0 | No assistance  |
| 1 | Application at a minimum once per day, to G/J tube, stoma, or broken skin or area defined by ordering provider |

**Client has a non-provider prescribed skin product and requires assistance:**

|                                   |  |
|-----------------------------------|--|
| This task is a Personal Care task |  |
| 0                                 | No assistance  |
| 1                                 | Application at a minimum once per day, to G/J tube, stoma, or broken skin or area defined by ordering provider |



**Personal Care ONLY**

**Client Factors:**

- has unbroken skin
- has no chronic skin problems active
- requires preventative rather than therapeutic skin care, including the application of non-medicated, non-provider ordered skin products

**Client requires assistance with non-prescribed skin products:**

|                                  |  |
|----------------------------------|--|
| This task is a Skilled Care task |  |
| 0                                | No assistance, is independent or age appropriate |
| 1                                | 50% of the time or less                          |
| 2                                | Greater than 50% of the time                     |

|   |       |  |       |
|---|-------|--|-------|
| <b>Skilled Care</b> task points from <b>THIS</b> page | _____ | <b>Personal Care</b> task points from <b>THIS</b> page | _____ |
| <b>Skilled Care</b> task points <b>RUNNING TOTAL</b>  | _____ | <b>Personal Care</b> task points <b>RUNNING TOTAL</b>  | _____ |



**COLORADO MEDICAID PEDIATRIC & PERSONAL CARE COMBINED ASSESSMENT TOOL**

**Section II - Please complete for all clients**

**11. Mobility - Positioning Task**

**Skilled Care ONLY**

**Client Factors:**

- is not age appropriate
- is unable to communicate
- is not independent due to fragility or exacerbation of illness, injury or disability
- is not independent due to surgical procedure

**Note:**

- Positioning may include adjusting the client’s alignment or posture in a bed, wheelchair, other furniture, assistive devices and/or Durable Medical Equipment that has been ordered by a qualified ordering provider
- This excludes positioning that is completed in conjunction with other activities of daily living

**Client requires positioning assistance:**

|   |                                   |
|---|-----------------------------------|
|   | This task is a Personal Care task |
| 0 | Independent, age appropriate      |
| 2 | 50% or less of the time           |
| 4 | Greater than 50% of the time      |

**Personal Care ONLY**

**Client Factors:**

- is age appropriate
- is able to communicate when position needs to be changed, verbally or non-verbally or by other methods of communication identified in the client’s plan of care (for example: an alphabet or picture board that they point to identify the character or picture)
- skilled skin care with positions is not needed

**Note:**

- Positioning may include alignment in a bed, wheelchair, or other furniture



**Client requires positioning assistance:**

|   |                                  |
|---|----------------------------------|
|   | This task is a Skilled Care task |
| 0 | Independent, age appropriate     |
| 1 | 50% of less of the time          |
| 2 | Greater than 50% of the time     |

|   |       |  |       |
|---|-------|--|-------|
| <b>Skilled Care</b> task points from <b>THIS</b> page | _____ | <b>Personal Care</b> task points from <b>THIS</b> page | _____ |
| <b>Skilled Care</b> task points <b>RUNNING TOTAL</b>  | _____ | <b>Personal Care</b> task points <b>RUNNING TOTAL</b>  | _____ |



**COLORADO MEDICAID PEDIATRIC & PERSONAL CARE COMBINED ASSESSMENT TOOL**

**Section II - Please complete for all clients**

**12. Mobility - Transfer Task**

**Skilled Care ONLY**

**Client Factors:**

- is not age appropriate
- is unable to communicate
- is not independent due to fragility or exacerbation of illness, injury or disability,
- is not independent due to surgical procedure
- lacks the strength and stability to stand and/or bear weight reliably
- is not independent in the use of assistive devices and/or ordered Durable Medical Equipment that is ordered by a qualified provider
- requires a mechanical lift for safe transfers

**Note:**

- Use of a mechanical lift requires CNA competency in the clients lift

**Personal Care ONLY**

**Client Factors:**

- has sufficient balance and strength to reliably stand, pivot and assist in transferring themselves
- requires assistance in transferring and is able to direct the transfer and assist the providers
- is age appropriate

**Note:**

- Adaptive and safety equipment may be used in transfers, provided that the client and **Personal Care Worker (PCW)** are fully trained in the use of the equipment and the client, client’s family member or guardian can direct the transfer step by step or a PCW is deemed competent in the specific transfer technique for the client
- Adaptive equipment may include, but is not limited to, wheel chairs, tub seats and grab bars
- Gait belts may be used in a transfer as a safety device for a PCW as long as the worker has been properly trained in its use

**Client requires assistance:**

|   |                                   |
|---|-----------------------------------|
|   | This task is a Personal Care task |
| 0 | Independent                       |
| 3 | 50% or less than the time         |
| 6 | Greater than 50% of the time      |



**Client requires assistance:**

|   |                                  |
|---|----------------------------------|
|   | This task is a Skilled Care task |
| 0 | Independent                      |
| 3 | 50% or less than the time        |
| 6 | Greater than 50% of the time     |

|   |       |  |       |
|---|-------|--|-------|
| <b>Skilled Care</b> task points from <b>THIS</b> page | _____ | <b>Personal Care</b> task points from <b>THIS</b> page | _____ |
| <b>Skilled Care</b> task points <b>RUNNING TOTAL</b>  | _____ | <b>Personal Care</b> task points <b>RUNNING TOTAL</b>  | _____ |



**COLORADO MEDICAID PEDIATRIC & PERSONAL CARE COMBINED ASSESSMENT TOOL**

**Section II - Please complete for all clients**

**13. Protective Oversight**

**Skilled Care ONLY**

**Task Factors:**

Not Applicable to the **Skilled Care** Benefit

**Personal Care ONLY**

**Includes:**

monitoring a client to reduce or minimize the likelihood of injury or harm due to the nature of the client's injury, illness or disability

**Note:**

A Personal Care Worker may provide this task only when:

- Providing protective oversight as stand-by assistance with any other Personal Care Task
- Trained in appropriate intervention and redirection techniques if the client requires protective oversight to prevent wandering or dangerous or destructive behaviors

**Special Considerations:**

- Protective Oversight may only be provided during the completion of other Personal Care Tasks listed in this rule
- The need for Protective Oversight is indicated by significant impairment in behavior, memory, or cognition

**Skilled Care** task points from **THIS** page \_\_\_\_\_

**Personal Care** task points from **THIS** page \_\_\_\_\_

**Skilled Care** task points **RUNNING TOTAL** \_\_\_\_\_

**Personal Care** task points **RUNNING TOTAL** \_\_\_\_\_



**COLORADO MEDICAID PEDIATRIC & PERSONAL CARE COMBINED ASSESSMENT TOOL**

**Section II - Please complete for all clients**

**14. Toileting - Bladder Care Task(s):**

**Skilled Care ONLY**

**Client Factors:**

- is unable to assist or direct care
- is not age appropriate
- has broken skin
- has healed skin which had a break down documented less than 60 days ago
- has been assessed with a high and on-going risk for skin breakdown and/or requires skilled skin care for toileting (requires client record documentation)

**Client requires assistance with urinary hygiene:**

Includes diaper changes and perineal care associated with diaper changes

|                                   |                              |
|-----------------------------------|------------------------------|
| This task is a Personal Care task |                              |
| 0                                 | Independent                  |
| 1                                 | 50% or less of the time      |
| 3                                 | Greater than 50% of the time |

**Personal Care ONLY**

**Client Factors:**

- requires assist to and from the bathroom
- requires bedpan and/or commode, to include pericare
- requires changing of clothing, pads of any kind used for the care of incontinence, to include pericare
- has all prior broken skin completely healed



**Client requires assistance with urinary hygiene:**

Includes diaper changes and perineal care associated with diaper changes

|                                  |                              |
|----------------------------------|------------------------------|
| This task is a Skilled Care task |                              |
| 0                                | Independent                  |
| 1                                | 50% or less of the time      |
| 2                                | Greater than 50% of the time |

|   |       |  |       |
|---|-------|--|-------|
| <b>Skilled Care</b> task points from <b>THIS</b> page | _____ | <b>Personal Care</b> task points from <b>THIS</b> page | _____ |
| <b>Skilled Care</b> task points <b>RUNNING TOTAL</b>  | _____ | <b>Personal Care</b> task points <b>RUNNING TOTAL</b>  | _____ |



**COLORADO MEDICAID PEDIATRIC & PERSONAL CARE COMBINED ASSESSMENT TOOL**

**Section II - Please complete for all clients**

**15. Toileting - Bowel Care Task(s):**

**Skilled Care ONLY**

**Client Factors:**

- is unable to assist or direct care
- is not age appropriate
- has broken skin
- has been assessed with a high and on-going risk for skin breakdown and/or requires skilled skin care for toileting (requires client record documentation)

**The frequency of bowel movements for the Client is on average:**

|                                   |                       |
|-----------------------------------|-----------------------|
| This task is a Personal Care task |                       |
| 0                                 | 2 or less per day     |
| 1                                 | 3-4 times a day       |
| 2                                 | 5 or more times a day |

**Client requires assistance with bowel hygiene:**

|                                   |                              |
|-----------------------------------|------------------------------|
| This task is a Personal Care task |                              |
| 0                                 | None or is independent       |
| 2                                 | 50% or less of the time      |
| 4                                 | Greater than 50% of the time |

**Personal Care ONLY**

**Client Factors:**

- requires assistance to and from the bathroom
- requires bedpan and/or commode, to include pericare
- requires changing of clothing, pads of any kind used for the care of incontinence, to include pericare
- has all prior broken skin completely healed

**The frequency of bowel movements for the Client is on average:**

|                                  |                       |
|----------------------------------|-----------------------|
| This task is a Skilled Care task |                       |
| 0                                | 2 or less per day     |
| 1                                | 3-4 times a day       |
| 2                                | 5 or more times a day |

**Client requires assistance with bowel hygiene:**

|                                  |                              |
|----------------------------------|------------------------------|
| This task is a Skilled Care task |                              |
| 0                                | None or is independent       |
| 2                                | 50% or less of the time      |
| 4                                | Greater than 50% of the time |



|   |       |  |       |
|---|-------|--|-------|
| <b>Skilled Care</b> task points from <b>THIS</b> page | _____ | <b>Personal Care</b> task points from <b>THIS</b> page | _____ |
| <b>Skilled Care</b> task points <b>RUNNING TOTAL</b>  | _____ | <b>Personal Care</b> task points <b>RUNNING TOTAL</b>  | _____ |



**COLORADO MEDICAID PEDIATRIC & PERSONAL CARE COMBINED ASSESSMENT TOOL**

**Section II - Please complete for all clients**

**16. Toileting - Bowel Program Task(s)**

**Skilled Care ONLY**

**Client Factors:**

- requires over the counter suppositories and/or enemas
- requires recording or reporting of output to a nurse

**Client requires assistance with bowel elimination/ostomy:**

|                                   |                         |
|-----------------------------------|-------------------------|
| This task is a Personal Care task |                         |
| 0                                 | Does not have an ostomy |
| 1                                 | Has an ostomy           |

**Bowel Program :**

Client has a bowel program ordered by a qualified provider and needs:

|   |                                 |
|---|---------------------------------|
| 0 | As needed, prn                  |
| 1 | Interventions weekly            |
| 4 | Interventions ordered every day |

**Personal Care ONLY**

**Client Factors:**

- requires ostomy bag and/or urinary collection devices emptied and no output is recorded or reported

**Note:**

- Does not include digital stimulation, insertion of suppositories or enemas



**Client requires assistance with bowel elimination/ostomy:**

|                                  |   |
|----------------------------------|---|
| This task is a Skilled Care task |   |
| 0                                | Does not have an ostomy                 |
| 1                                | Has an ostomy & no outputs are recorded |

**Bowel Program:**

Please refer to **Bowel Elimination – Ostomy** above

|   |  |
|---|--|
| <b>Skilled Care</b> task points from <b>THIS</b> page _____ | <b>Personal Care</b> task points from <b>THIS</b> page _____ |
| <b>Skilled Care</b> task points <b>RUNNING TOTAL</b> _____  | <b>Personal Care</b> task points <b>RUNNING TOTAL</b> _____  |



**COLORADO MEDICAID PEDIATRIC & PERSONAL CARE COMBINED ASSESSMENT TOOL**

**Section II - Please complete for all clients**

**17. Toileting - Catheter Care Task(s)**

**Skilled Care ONLY**

**Client Factors:**

- requires emptying of urinary collection devices, such as catheter bags, with a need for observation or reporting to a nurse
- requires insertion and/or removal of catheters, and/or care of catheters
- requires changing from a leg to a bed bag and/or cleaning of tubing and bags
- requires their indwelling catheter tubing to be opened for any reason, and they are unable to do it independently

**Catheter Care**

Client requires catheter to be emptied

|                                   |                                      |
|-----------------------------------|--------------------------------------|
| This task is a Personal Care task |                                      |
| 0                                 | Independent                          |
| 1                                 | No output recorded or reported       |
| 3                                 | Output must be recorded and reported |

**Personal Care ONLY**

**Client Factors:**

- requires emptying of urinary collection devices, such as catheter bags, when there is no need for observation or reporting to a nurse
- pericare if the client has an indwelling catheter



**Catheter Care**

Client requires catheter to be emptied

|                                  |   |
|----------------------------------|---|
| This task is a Skilled Care task |   |
| 0                                | Independent   |
| 0                                | Without recording or reporting output and/or breaking the tubing seal |
| 1                                | Greater than 50% of the time  |

**Menses**

**Client Factors:**

Client requires assistance with menses:

|                                   |   |
|-----------------------------------|---|
| This task is a Personal Care task |   |
| 0                                 | Is male and/or does not have menses (naturally or with medication intervention) |
| 0                                 | Independent or requires 50% or less of the time                                 |
| 1                                 | Greater than 50% of the time  |



**Client Factors:**

Client requires assistance with menses:

|                                  |   |
|----------------------------------|---|
| This task is a Skilled Care task |   |
| 0                                | Is male and/or does not have menses (naturally or with medication intervention) |
| 0                                | Independent or requires 50% or less of the time                                 |
| 1                                | Greater than 50% of the time  |

**Skilled Care** task points from **THIS** page \_\_\_\_\_

**Personal Care** task points from **THIS** page \_\_\_\_\_

**Skilled Care** task points **RUNNING TOTAL** \_\_\_\_\_

**Personal Care** task points **RUNNING TOTAL** \_\_\_\_\_



**COLORADO MEDICAID PEDIATRIC & PERSONAL CARE COMBINED ASSESSMENT TOOL**

**Section II - Please complete for all clients**

**18. Medication Task - Medication Reminder**

**Skilled Care ONLY**

**NO Task Factors unless:**

Department of Regulatory Agency (DORA) approved CNA- MED certification is valid Then CNA may:

- ask client if they have taken medications
- replace oxygen tubing and set to ordered flow rate (SEE Respiratory care section)
- client is unable to complete task due to their age

**CNA DORA MED authority:**

(CNA may not administer medications unless they have a valid CNA-MED certification from DORA)

|   |  |  |
|---|--|--|
|   | This task is a Personal Care task                                  |  |
| 0 | No MED authority   |  |
| 2 | Has MED authority, 100% or less of the time client requires assist |  |

**Personal Care ONLY**

**Task Factors:**

- asking if medications were taken by client
- verbally prompting the client to take medications
- handing a marked medication reminder container to the client
- provide assistance opening the marked medication container if a client is unable

**Notes:**

- All medications in the client's marked medication reminder container must be preselected by the client, the client's unpaid family caregiver, a nurse, or a pharmacist and stored in a pre-filled medication reminder boxes which are marked as to the day and time of dosage
- preferably the container should also have the person identified who filled the medication reminder and the date and time it was filled



**Client requires medication assistance:**

|   |                                  |  |
|---|----------------------------------|--|
|   | This task is a Skilled Care task |  |
| 0 | None                             |  |
| 1 | 100% or less of the time         |  |

|   |       |  |       |
|---|-------|--|-------|
| <b>Skilled Care</b> task points from <b>THIS</b> page | _____ | <b>Personal Care</b> task points from <b>THIS</b> page | _____ |
| <b>Skilled Care</b> task points <b>RUNNING TOTAL</b>  | _____ | <b>Personal Care</b> task points <b>RUNNING TOTAL</b>  | _____ |



**COLORADO MEDICAID PEDIATRIC & PERSONAL CARE COMBINED ASSESSMENT TOOL**

**Section II - Please complete for all clients**

**19. Range of Motion (ROM) or Exercise Program Task:**

**Skilled Care ONLY**

**Task Factors:**

- Qualified provider prescribed ROM or exercise plan
- CNA with demonstrated competency can provide prescribed exercise and/or passive ROM services
- OT and PT includes active or passive ROM with or without equipment to improve development, muscle tone, or stretching

**Client has a combined daily ROM or exercise program:**

|   |   |
|---|---|
| 0 | Completes independently, age appropriate or requires reminding to complete task |
| 2 | 1 hour or less a day  |
| 4 | Greater than 1 hour a day   |

**Personal Care ONLY**

Not Applicable to the **Personal Care** Benefit

|   |       |  |       |
|---|-------|--|-------|
| <b>Skilled Care</b> task points from <b>THIS</b> page | _____ | <b>Personal Care</b> task points from <b>THIS</b> page | _____ |
| <b>Skilled Care</b> task points <b>RUNNING TOTAL</b>  | _____ | <b>Personal Care</b> task points <b>RUNNING TOTAL</b>  | _____ |



**COLORADO MEDICAID PEDIATRIC & PERSONAL CARE COMBINED ASSESSMENT TOOL**

**Section II - Please complete for all clients**

**20. Vital Sign Task(s)**

**Skilled Care ONLY**

**Task Factors:**

- Vital signs may be taken only as ordered by the client’s nurse and/or the Plan of Care (POC)
- Reporting of vital signs to the RN shall be timely to ensure client needs are met

**Note:**

- Any client interventions related to vital sign results shall be delegated by an RN according to the Colorado Nurse Practice Act

Vital signs, physician ordered:

**Client requires vital signs:**

|   |   |
|---|---|
| 0 | None  |
| 1 | POC includes vital signs and RN notification parameters |

**Vital signs, RN ordered:**

|   |  |
|---|--|
| 0 | None   |
| 1 | POC includes blood glucose test and/or pulse oximetry RN notification parameters |

**Personal Care ONLY**

**Task Factors:**

Not Applicable to the **Personal Care** Benefit

**STOP!**

**You have completed section II.**

**For Skilled care please continue to section III.**

**For Personal Care please skip to section VI. (page 31).**

**Skilled Care** task points from **THIS** page \_\_\_\_\_ **Personal Care** task points from **THIS** page \_\_\_\_\_

Section II **Skilled Care** task **TOTAL** points \_\_\_\_\_ Section II **Personal Care** task **TOTAL** points \_\_\_\_\_



**COLORADO MEDICAID PEDIATRIC & PERSONAL CARE COMBINED ASSESSMENT TOOL**

**Section III - CNA SERVICES ONLY: (to be completed for skilled care clients only)**

Respiratory Care to be provided by a CNA (following all DORA requirements)

**1. Chest Percussive Therapy (CPT), High Frequency Chest Wall Oscillation (HFCWO) vest or cough assist**

Client needs frequency:

|   |                   |
|---|-------------------|
| 0 | None              |
| 2 | 1-2 times a day   |
| 4 | 3 or more per day |

**2. Oxygen Therapy: to place oxygen on client and/or set at ordered flow rate**

Client needs assistance:

|   |                 |
|---|-----------------|
| 0 | None            |
| 1 | As needed (PRN) |

**3. Oral suctioning (or dental suction) to remove superficial oral secretions**

Client needs suctioning assistance:

|   |                                  |
|---|----------------------------------|
| 0 | None                             |
| 1 | PRN                              |
| 2 | Frequent or multiple times a day |

**STOP!**  
 You have completed section III.  
 For Skilled care please continue to section IV.

Section III CNA Services TOTAL points \_\_\_\_\_



**COLORADO MEDICAID PEDIATRIC & PERSONAL CARE COMBINED ASSESSMENT TOOL**

**Section IV - RN-LPN SERVICES ONLY: (to be completed for skilled care clients only)**

Medication Administration

**1. Intravenous (IV) Medication, to include flushes and pain medications**

Client requires IV medications infused:

|   |                              |
|---|------------------------------|
| 0 | None                         |
| 1 | As needed, PRN               |
| 2 | Monthly                      |
| 3 | More often than once a month |
| 4 | Weekly                       |
| 6 | Daily                        |
| 7 | Multiple times a day         |

**2. Intravascular Catheter Dressing Changes (to include clean or sterile dressings)**

Client requires dressing changes:

|   |                        |
|---|------------------------|
| 0 | None                   |
| 3 | Less often than weekly |
| 4 | Once a week            |
| 5 | Every three days       |

**3. Medications that must be administered by a RNL or LPN (other than respiratory or IV medications)**

Client requires assistance with medication administration:

|   |                      |
|---|----------------------|
| 0 | None                 |
| 1 | Occasionally         |
| 2 | Monthly              |
| 4 | Weekly               |
| 6 | Daily                |
| 7 | Multiple times a day |

**4. Pre-filled Medication Planner:**

Client relies on RN or LPN to fill a medication planner which is done:

|   |           |
|---|-----------|
| 0 | Never     |
| 2 | Monthly   |
| 3 | Bi-weekly |
| 4 | Weekly    |

**STOP!** Please record the **highest** number selected on this page, **NOT** the total amount \_\_\_\_\_



**COLORADO MEDICAID PEDIATRIC & PERSONAL CARE COMBINED ASSESSMENT TOOL**

**Section IV - RN-LPN SERVICES ONLY: (to be completed for skilled care clients only)**

Elimination Status

**5. Catheter Status**

**Client requires intermittent straight, indwelling, or suprapubic catheterization interventions:**

|   |                              |
|---|------------------------------|
| 0 | None                         |
| 1 | As needed, PRN               |
| 2 | At least monthly             |
| 4 | More often than once a month |
| 6 | Daily                        |
| 7 | Multiple times a day         |

**6. Catheter/Bladder Irrigation**

**Client requires bladder irrigation:**

|   |                              |
|---|------------------------------|
| 0 | None                         |
| 1 | As needed, PRN               |
| 2 | At least monthly             |
| 3 | More often than once a month |
| 4 | Weekly                       |

**7. Peritoneal dialysis managed by the DORA qualified nurse**

**Client requires Peritoneal Dialysis:**

|   |                              |
|---|------------------------------|
| 0 | None                         |
| 1 | As needed, PRN               |
| 2 | At least monthly             |
| 4 | More often than once a month |
| 6 | Daily                        |
| 7 | Multiple times a day         |

**8. Bowel Program (RN only)**

**Client requires bowel program completed:**

|   |                          |
|---|--------------------------|
| 0 | None                     |
| 1 | As needed, PRN           |
| 2 | At least monthly         |
| 4 | At least weekly          |
| 5 | More than one day a week |
| 6 | Daily                    |

**STOP!** Please record the **highest** number selected on this page, **NOT** the total amount \_\_\_\_\_



**COLORADO MEDICAID PEDIATRIC & PERSONAL CARE COMBINED ASSESSMENT TOOL**

**Section IV - RN-LPN SERVICES ONLY: (to be completed for skilled care clients only)**

**9. Enteral G/J Tube (RN only)**

Client requires feeding assistance:

|   |                              |
|---|------------------------------|
| 0 | None or delegated to a CNA   |
| 2 | At least monthly             |
| 3 | More often than once a month |
| 4 | At least weekly              |
| 6 | Daily                        |
| 7 | Multiple times a day         |

**10. Failure To Thrive (FTT)**

Client requires assistance/interventions related to FTT:

|   |                              |
|---|------------------------------|
| 0 | None                         |
| 2 | As needed, PRN               |
| 3 | At least once a month        |
| 4 | More often than once a month |
| 6 | Daily                        |
| 7 | Multiple times a day         |

**11. Airway/Tracheostomy Care (to include: tracheal, nasal, and/or oral pharyngeal suctioning)**

Client requires assistance with respiratory care (airway management or suctioning):

|   |                              |
|---|------------------------------|
| 0 | None                         |
| 1 | As needed, PRN               |
| 2 | Monthly                      |
| 3 | More often than once a month |
| 4 | At least weekly              |
| 6 | Daily                        |
| 7 | Multiple times a day         |

**12. Nebulizers (RN only)**

Client requires nebulizer treatments:

|   |                             |
|---|-----------------------------|
| 0 | None                        |
| 1 | As needed, PRN              |
| 4 | Weekly                      |
| 5 | More often than once a week |
| 6 | Daily                       |
| 7 | Multiple times a day        |

**STOP!** Please record the **highest** number selected on this page, **NOT** the total amount \_\_\_\_\_



**COLORADO MEDICAID PEDIATRIC & PERSONAL CARE COMBINED ASSESSMENT TOOL**

**Section IV - RN-LPN SERVICES ONLY: (to be completed for skilled care clients only)**

**13. Chest Physiotherapy (CPT), High Frequency Chest Wall Oscillation (HFCWO) vest or cough assist (RN only)**

Client requires CPT, HFCWO vest or cough assist treatments:

|   |                              |
|---|------------------------------|
| 0 | None                         |
| 1 | As needed, PRN               |
| 2 | Monthly                      |
| 3 | More often than once a month |
| 4 | Weekly                       |
| 5 | More often than once a week  |
| 6 | Daily                        |
| 7 | Multiple times a day         |

**14. BiPAP/CPAP administered (RN only):**

Client requires BiPAP/CPAP administered:

|   |                              |
|---|------------------------------|
| 0 | None                         |
| 1 | As needed, PRN               |
| 2 | Monthly                      |
| 3 | More often than once a month |
| 4 | Weekly                       |
| 5 | More often than once a week  |
| 6 | Daily                        |
| 7 | Multiple times a day         |

**15. Ventilator**

Client requires ventilator care:

|   |                              |
|---|------------------------------|
| 0 | None                         |
| 1 | As needed, PRN               |
| 2 | Monthly                      |
| 3 | More often than once a month |
| 4 | Weekly                       |
| 5 | More often than once a week  |
| 6 | Daily                        |
| 7 | Multiple times a day         |

**16. Wounds/Dressings**

Client requires dressing changes:

|   |                             |
|---|-----------------------------|
| 0 | None                        |
| 1 | As needed, PRN              |
| 4 | Weekly                      |
| 5 | More often than once a week |
| 7 | Multiple times a day        |

**STOP!** Please record the **highest** number selected on this page, **NOT** the total amount \_\_\_\_\_



**COLORADO MEDICAID PEDIATRIC & PERSONAL CARE COMBINED ASSESSMENT TOOL**

**Section IV - RN-LPN SERVICES ONLY: (to be completed for skilled care clients only)**

**17. Foot Care (RN only)**

Client has RN provided foot care:

|   |                        |
|---|------------------------|
| 0 | None                   |
| 1 | As needed, PRN         |
| 2 | At least monthly       |
| 3 | At least twice a month |
| 4 | At least weekly        |

**18. Routine Blood Draws:**

Client requires scheduled/routine blood draws:

|   |                        |
|---|------------------------|
| 0 | None                   |
| 2 | At least monthly       |
| 4 | More than once a month |
| 6 | Daily                  |
| 7 | Multiple times a day   |

**19. Telehealth Services:**

Client requires telehealth monitoring:

|   |                                |
|---|--------------------------------|
| 0 | None                           |
| 1 | As needed, PRN                 |
| 4 | Regular interventions required |

**STOP!**

**You have completed section IV.**

**For Skilled care please continue to section V.**

Please record the **highest** number selected on this page, **NOT** the total amount \_\_\_\_\_

Record the **highest** number selected for all of section IV, **NOT** the total amount \_\_\_\_\_



**COLORADO MEDICAID PEDIATRIC & PERSONAL CARE COMBINED ASSESSMENT TOOL**

**Section V - SKILLED CARE MODIFIERS A&B – to be filled out by an RN only**

**Modifier Section A:**

**Communication – Expressive:**

The ability of the client to express thoughts, feelings, and needs through their own means of communication.

**Client’s ability to function is affected:**

|   |   |
|---|---|
| 1 | ≤ 25% of the time or on a monthly basis |
| 2 | 26-74% of the time or on a weekly basis |
| 3 | ≥ 75% of the time or on a daily basis   |

**Communication – Receptive:**

The ability of the client to understand the communication of others in their own language.

**Client’s ability to function is affected:**

|   |   |
|---|---|
| 1 | ≤ 25% of the time or on a monthly basis |
| 2 | 26-74% of the time or on a weekly basis |
| 3 | ≥ 75% of the time or on a daily basis   |

**Levels of Cooperation:**

The client’s ability to cooperate or participate safely with daily activities. This includes identifying risks, acting in a safe manner, and/or displaying aggression towards self or others.

**Client’s ability to function is affected:**

|   |   |
|---|---|
| 1 | ≤ 25% of the time or on a monthly basis |
| 2 | 26-74% of the time or on a weekly basis |
| 3 | ≥ 75% of the time or on a daily basis   |

**Neuromuscular Status:**

Factors that impact the inability of the client to perform tasks on demand; this may include muscle weakness, paralysis, involuntary movements, amputated limbs and/or loss of limbs, contractures, spasticity, and/or motor conditions.

**Client’s ability to function is affected:**

|   |   |
|---|---|
| 1 | ≤ 25% of the time or on a monthly basis |
| 2 | 26-74% of the time or on a weekly basis |
| 3 | ≥ 75% of the time or on a daily basis   |

Skilled Tasks - Modifier A points TOTAL \_\_\_\_



**COLORADO MEDICAID PEDIATRIC & PERSONAL CARE COMBINED ASSESSMENT TOOL**

**Section V - SKILLED CARE MODIFIERS A&B – to be filled out by an RN only**

**Modifier Section B:**

**Airway Status:**

Client has documented airway patency issues impacting daily care.

**Client's ability to function is affected:**

|   |   |
|---|---|
| 1 | ≤ 25% of the time or on a monthly basis |
| 2 | 26-74% of the time or on a weekly basis |
| 3 | ≥ 75% of the time or on a daily basis   |

**Hearing:**

The impact of a client's auditory status in performing tasks on demand.

**Client's ability to function is affected:**

|   |   |
|---|---|
| 1 | ≤ 25% of the time or on a monthly basis |
| 2 | 26-74% of the time or on a weekly basis |
| 3 | ≥ 75% of the time or on a daily basis   |

**Pain:**

Client has a documented chronic condition directly impacting daily care.

**Client's ability to function is affected:**

|   |   |
|---|---|
| 1 | ≤ 25% of the time or on a monthly basis |
| 2 | 26-74% of the time or on a weekly basis |
| 3 | ≥ 75% of the time or on a daily basis   |

**Seizures:**

Client has documented seizures directly impacting daily care.

**Client's ability to function is affected:**

|   |   |
|---|---|
| 1 | ≤ 25% of the time or on a monthly basis |
| 2 | 26-74% of the time or on a weekly basis |
| 3 | ≥ 75% of the time or on a daily basis   |

**Vision:**

The impact of the client's visual status to perform tasks on demand.

**Client's ability to function is affected:**

|   |   |
|---|---|
| 1 | ≤ 25% of the time or on a monthly basis |
| 2 | 26-74% of the time or on a weekly basis |
| 3 | ≥ 75% of the time or on a daily basis   |

**Skilled Task Modifier B points from THIS page \_\_\_\_\_ Skilled Task Modifier B points RUNNING TOTAL \_\_\_\_\_**



**COLORADO MEDICAID PEDIATRIC & PERSONAL CARE COMBINED ASSESSMENT TOOL**

**Section V - SKILLED CARE MODIFIERS A&B – to be filled out by an RN only**

**Modifier Section B:**

**Skin:**

What is the client’s risk of developing pressure ulcers?

**Client’s Braden Score is:**

|   |                    |
|---|--------------------|
| 0 | Braden Score 19-23 |
| 1 | Braden Score 15-18 |
| 2 | Braden Score 13-14 |
| 3 | Braden Score 10-12 |
| 4 | Braden Score ≤9    |

**Weight:**

**Client’s most current weight in pounds (lbs):**

|   |             |
|---|-------------|
| 0 | ≤ 50 lbs    |
| 1 | 51-99 lbs   |
| 2 | 100-149 lbs |
| 3 | ≥ 150 lbs   |

**STOP!**

**You have completed section V.**

**For Skilled Care please skip to page 34 of this assessment.**

**Skilled Task Modifier B points from THIS page \_\_\_\_\_ Skilled Task Modifier B points TOTAL \_\_\_\_\_**



**COLORADO MEDICAID PEDIATRIC & PERSONAL CARE COMBINED ASSESSMENT TOOL**

**Section VI - PERSONAL CARE MODIFIERS A&B (to be filled out for personal care clients only and are patient or legal guardian responses)**

**Modifier Section A:**

**The client is currently receiving Skilled Care services (Do NOT complete this section)**

**The questions in section VI (Personal Care Modifiers) were answered by:**

The client reported

The legal guardian reported on behalf of the client

**Question 1:**

How often does your ability to express your thoughts, feelings and needs when talking (or using your hands) affect your caregiver’s ability to meet your needs?

|   |   |
|---|---|
| 0 | No Effect                               |
| 1 | ≤ 25% of the time or on a monthly basis |
| 2 | 26-74% of the time or on a weekly basis |
| 3 | ≥ 75% of the time or on a daily basis   |

**Question 2:**

When your caregiver is talking to you about your care, how often does your ability to understand what they are saying affect their ability to meet your needs?

|   |   |
|---|---|
| 0 | No Effect                               |
| 1 | ≤ 25% of the time or on a monthly basis |
| 2 | 26-74% of the time or on a weekly basis |
| 3 | ≥ 75% of the time or on a daily basis   |

**Question 3:**

How often does your ability to cooperate and communicate safely, affect your caregiver’s ability to meet your needs?

|   |   |
|---|---|
| 0 | No Effect                               |
| 1 | ≤ 25% of the time or on a monthly basis |
| 2 | 26-74% of the time or on a weekly basis |
| 3 | ≥ 75% of the time or on a daily basis   |

**Question 4:**

How often does your ability to control your muscles when you are trying to move your body, affect your caregiver’s ability to meet your needs?

|   |   |
|---|---|
| 0 | No Effect                               |
| 1 | ≤ 25% of the time or on a monthly basis |
| 2 | 26-74% of the time or on a weekly basis |
| 3 | ≥ 75% of the time or on a daily basis   |

**Personal Care Modifier A points TOTAL \_\_\_\_\_**



**COLORADO MEDICAID PEDIATRIC & PERSONAL CARE COMBINED ASSESSMENT TOOL**

**Section VI - PERSONAL CARE MODIFIERS A&B (to be filled out for personal care clients only and are patient or legal guardian responses)**

**Modifier Section B:**

**Question 5:**

How often does your ability to breathe when doing activities, affect your caregiver’s ability to meet your needs?

|   |   |
|---|---|
| 0 | No Effect                               |
| 1 | ≤ 25% of the time or on a monthly basis |
| 2 | 26-74% of the time or on a weekly basis |
| 3 | ≥ 75% of the time or on a daily basis   |

**Question 6:**

How often does your ability to hear what people say to you, affect your caregiver’s ability to meet your needs?

|   |   |
|---|---|
| 0 | No Effect                               |
| 1 | ≤ 25% of the time or on a monthly basis |
| 2 | 26-74% of the time or on a weekly basis |
| 3 | ≥ 75% of the time or on a daily basis   |

**Question 7:**

How often does the amount of pain you experience, affect your caregiver’s ability to meet your needs?

|   |   |
|---|---|
| 0 | No Effect                               |
| 1 | ≤ 25% of the time or on a monthly basis |
| 2 | 26-74% of the time or on a weekly basis |
| 3 | ≥ 75% of the time or on a daily basis   |

**Question 8:**

How often do you experience uncontrollable body shakes that affect your caregiver’s ability to meet your needs?

|   |   |
|---|---|
| 0 | No Effect                               |
| 1 | ≤ 25% of the time or on a monthly basis |
| 2 | 26-74% of the time or on a weekly basis |
| 3 | ≥ 75% of the time or on a daily basis   |

**Question 9:**

How often does your ability to see things, affect your caregiver’s ability to meet your needs?

|   |  |
|---|--|
| 0 | No Effect                                    |
| 1 | ≤ 25% of the time or on a monthly basis      |
| 2 | 26-74% of the time or on a weekly basis      |
| 3 | ≥ 75% of the time or on a daily basis Effect |

-----

**Personal Care Modifier B** points THIS page \_\_\_\_ **Personal Care Modifier B** points **RUNNING TOTAL** \_\_\_\_



**COLORADO MEDICAID PEDIATRIC & PERSONAL CARE COMBINED ASSESSMENT TOOL**

**Section VI - PERSONAL CARE MODIFIERS A&B (to be filled out for personal care clients only and are patient or legal guardian responses)**

**Modifier Section B - Table A:**

| Risk Factor  | 1 Point                                | 2 Points  | 3 Points                                      | 4 Points               |
|--|--|---|---|------------------------|
| Are you able to recognize the need to move your body?        | Able 100% of the time                  | Some ability 25-50% of the time                                     | Limited ability less than 25% of the time     | Unable                 |
| Are you able to keep your skin dry?                          | Able 100% of the time                  | Some ability 25-50% of the time                                     | Limited ability less than 25% of the time     | Unable                 |
| Are you able to do physical activity?                        | Able to walk around whenever I want to | Some ability (walk occasionally but spend most time in a bed/chair) | Limited ability (mostly in a chair with help) | Unable (always in bed) |
| Are you able to move your body when you want to?             | Able 100% of the time                  | Some ability 25-50% of the time                                     | Limited ability less than 25% of the time     | Unable                 |
| Are you able to eat?   | Able 100% of any meals                 | Some ability 25-50% of the time                                     | Limited ability less than 25% of the time     | Unable                 |
| How much assistance do you need when you change position(s)? | Never Need Assistance                  | Usually need assistance   | Total assistance                              |                        |

**Total points from Table A \_\_\_\_\_**

| If Your Total Points from Table A are | Use this amount for "Personal Care Modifier B points from THIS page" |
|---------------------------------------|--|
| <b>≤ 9 points</b>                     | <b>0</b>   |
| <b>10-12 points</b>                   | <b>1</b>   |
| <b>13-14 points</b>                   | <b>2</b>   |
| <b>15-18 points</b>                   | <b>3</b>   |
| <b>19-23 points</b>                   | <b>4</b>   |

**STOP!**

**You have completed the assessment/tool.**

**Please go back and add up the points for each page/section before continuing.**

Personal Care Modifier B points from THIS page \_\_\_\_\_ Personal Care Modifier B points TOTAL \_\_\_\_\_



**COLORADO MEDICAID PEDIATRIC & PERSONAL CARE COMBINED ASSESSMENT TOOL**

**Combined Tool totals (this tool does *not* solely define the hours a client will receive)**

**II. Skilled Care Tasks and III. CNA Services**

| Score   | Recommended Time |
|---|------------------|
| 0-4   | 0                |
| 5-11  | Up to 1 hour     |
| 12-18   | Up to 2 hours    |
| 19-25   | Up to 3 hours    |
| 26-35   | Up to 4 hours    |
| 36-45   | Up to 5 hours    |
| 46-55   | Up to 6 hours    |
| 56-65   | Up to 7 hours    |
| ≥ 66  | Up to 8 hours    |
| Total points sections II (skilled only) + III |                  |
| Recommended Time (hours)                      |                  |

**IV. RN-LPN Services**

| Highest Score                 | Recommended RN visits           |
|-------------------------------|---------------------------------|
| 0                             | 0 RN visits                     |
| 1                             | PRN visits, based on care needs |
| 2                             | Up to 1 visit per monthly       |
| 3                             | Up to 2 visits monthly          |
| 4                             | Up to 1 visit weekly            |
| 5                             | Up to 3 visits weekly           |
| 6                             | Up to 1 visit daily             |
| 7                             | Up to 4 visits daily            |
| Highest score from section IV |                                 |
| Recommended RN visits (hours) |                                 |

**V. Skilled Care Modifiers**

**Modifier A**

| Score  | Time      |
|--|-----------|
| 1-4  | .5 hours  |
| 5-8  | 1 hour    |
| ≥ 9  | 1.5 hours |
| Total points section V - <b>Modifiers A</b> only |           |
| Recommended Time (hours)                         |           |

**Modifier B**

| Score  | Time     |
|--|----------|
| 1-8  | .5 hours |
| ≥ 9  | 1 hour   |
| Total points section V - <b>Modifiers B</b> only |          |
| Recommended Time (hours)                         |          |

**Skilled Care Totals**

|   |  |
|---|--|
| Sum II + III + V (Do NOT add in section IV) |  |
| Total recommended time (hours)              |  |

**II. Personal Care Tasks**

| Score                                   | Recommended Time |
|---|------------------|
| 0-6                                     | Up to 1 hour     |
| 7-12                                    | Up to 2 hours    |
| 13-18                                   | Up to 3 hours    |
| 19-25                                   | Up to 4 hours    |
| 26-32                                   | Up to 5 hours    |
| ≥ 33                                    | Up to 6 hours    |
| Total points section II (personal only) |                  |
| Recommended Time (hours)                |                  |

**VI. Personal Care Modifiers**

**Modifier A**

| Score   | Time      |
|---|-----------|
| 1-4   | .5 hours  |
| 5-8   | 1 hour    |
| ≥ 9   | 1.5 hours |
| Total points section VI - <b>Modifiers A</b> only |           |
| Recommended Time (hours)                          |           |

**Modifier B**

| Score   | Time     |
|---|----------|
| 1-8   | .5 hours |
| ≥ 9   | 1 hour   |
| Total points section VI - <b>Modifiers B</b> only |          |
| Recommended Time (hours)                          |          |

**If your client is receiving Skilled Care services, enter modifier points & hours from their pre-existing PAT. The Skilled Care modifier hours will be used in place of the Personal Care modifier hours.**

**Skilled Care Modifier A**

|  |  |
|--|--|
| Total points section V - <b>Modifiers A</b> only |  |
| Recommended Time (hours)                         |  |

**Skilled Care Modifier B**

|  |  |
|--|--|
| Total points section V - <b>Modifiers B</b> only |  |
| Recommended Time (hours)                         |  |

**PAR Episode Number from the approved PAT (EPS-XXXXXXXX)**

**Personal Care Totals**

|  |  |
|--|--|
| Sum II + VI (or Sum II + Skilled mod points) |  |
| Total recommended time (hours)               |  |



### Instructions for Submitting:

Please submit via CareWebQI (CWQI) through The Colorado PAR Program  
@ [www.ColoradoPAR.com](http://www.ColoradoPAR.com)

### Important:

This tool does **not** solely define the number of hours a client will be allocated for their care needs. Provider orders, CMS 485 Home Health Certification (Plan of Care), and relevant clinical documentation are all reviewed to determine an individual client's allocated time.

### Things to note:

- The legally responsible adult may provide **Skilled Care services** to the client only if said legally responsible adult is also a qualified DORA licensed provider
- The legally responsible adult **may not**, under any circumstances, be paid to provide **Personal Care services** to the client
- PARs must be submitted at least 10 days **prior** to the PAR start date
- A decline in condition and/or an ongoing need must be documented for all client tasks
- Home Health Care Agencies are required to create and maintain a client care plan for all services a client receives, not only the tasks listed on this assessment