State of Illinois
Department of Healthcare and Family Services

LEVEL OF CARE TOOL FOR THE MFTD WAIVER

Child's Name: _____ DSCC ID: _____ Care Coordinator: _____

Primary Diagnosis: _____

Date of Initial LOC: _____ Date of Current LOC: _____ Date of Previous LOC: _____

I. TECHNOLOGY NEEDS:	Points	Previous	Current	#	Total	Justification
A. Ventilator Support						
Dependent (16 or more hrs/day)	50					
Intermittent (less than 16 hrs/day)	45					
B. CPAP, BIPAP, NON-INVASIVE VENTILATOR						
Via tracheotomy (non-ventilator)	45					
Via mask, pneumo-belt or sip and puff ventilator	35					
C. Tracheotomy	43					
D. Nasal Stents	20					
E. Oxygen Therapy						
Continuous, unstable (12 or more hrs/day)	35					
Intermittent - based on O2 sats (less than 12 hrs/day)	20					
Continuous, stable (6 or more continuous hrs/day)	15					
F. IV Infusion	40					
G. NG Tube						
Continuous (6 or more continuous hrs/day)	40					
Bolus	25					
H. G-Tube and/or J-Tube						
Continuous feeding with reflux (6+ continuous hrs/day)	35					
Continuous feeding (6+ continuous hrs/day)	15					
Bolus feeding with reflux	10					
Bolus feeding	5					
I. Peritoneal Dialysis	35					
SUBTOTAL TECHNOLOGY				If score for technology is 0, client is not eligible for MFTD waiver.		

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

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II. CARE NEEDS	Points	Previous	Current	#	Freq*	Justification
A. Suctioning: Child can do? Yes☐ No☐						
Daily	3					
B. Tracheotomy Care: Child can do? Yes ☐ No☐	5					
C. Vital Signs Instability	3					
D. Special Treatments:						
4 or more times per day	8					
3 times per day	6					
2 times per day	4					
Once per day	2					
E. Medication:						
Complex (7 or more routine medications)	8					
Moderate (3-6 routine medications)	4					
Simple (1-2 routine medications)	2					
F. IV/Total Parenteral Nutrition						
Continuous (16 or more continuous hrs/day)	8					
8-15 hours per day	6					
4-7 hours per day	4					
Less than 4 hours per day	2					
G. NG/GT Feeding						
Continuous (6 or more continuous hrs/day)	5					
Every 2 hours	4					
Every 3 hours	3					
Every 4 or more hours	2					
H. Aspiration Precautions with NG/GT Feeding	2					

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CARE NEEDS (Cont'd)	Points	Previous	Current	#	Freq*	Justification
I. **Specialized I/O Monitoring**	5					
J. **Intermittent Catheterization:** Child can do? Y☐ N☐	4					
K. **Seizure Precautions Required**	1					
L. **Seizures Requiring Intervention**						
Daily	3					
Less than daily but more than once per month	2					
Less frequently than once per month	1					
M. **Dressings, Sterile**						
3 times per day or more	3					
Less than 3 times per day	2					
N. **Hospitalization/ER Visits/Emergency Hours**	5					
SUBTOTAL CARE NEEDS				If Care Needs or Technology Needs Score is 0, client is not eligible for MFTD Waiver.		
SUBTOTAL TECHNOLOGY NEEDS						
TOTAL LOC SCORE **Care Coordinator's Initials** _____				If total score is less than 50, client is not eligible for MFTD Waiver.		

III. HISTORY OF HOSPITAL/EMERGENCY ROOM VISITS AND EMERGENCY HOURS		#
A. **Number of hospital admissions in the last 12 months**		
When and why?		
B. **Number of emergency room visits in the last 12 months**		
When and why?		
C. **Number of times emergency hours provided to prevent hospitalization in the last 12 months**		
D. ***Has the child ever lived in the home?***	Yes ☐	No ☐

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