Parent Skills Checklist Disabled Child Living at Home

This completed form is required with every application. The purpose of this checklist is to include additional information with the Disabled Child Living at Home (DCLH) application packet for the child who receives skilled treatment or therapy **personally performed** by a parent or unpaid caregiver. Qualification for the DCLH category of eligibility is not based on diagnosis or disability alone, but the child's medically documented institutional level of care needs from the most recent 12 months. Children qualifying for DCLH require more complex care at home and often parents/guardians are trained by skilled healthcare professionals to perform skills that would ordinarily be provided by a skilled healthcare professional, such as a nurse or therapists.

Member Name	Medicaid ID#	Age

DOES THE PARENT OR LEGAL GUARDIAN PROVIDE ANY TREATMENT OR SKILLED CARE NEEDS FOR THE CHILD?

☐	**NO**	I am the parent and/or legal guardian and I acknowledge that I **DO NOT** provide any treatment and/or skilled care needs for my child. **If NO, please sign here and submit with the application packet.** No further information is needed on this form.

Parent/Legal Guardian	Signature	Date

☐	**YES**	I am the parent and/or legal guardian and I acknowledge that I **DO** provide treatment and/or skilled care needs for my child. **If YES, please complete the checklist** and sign the acknowledgement at the end of the form.

Instructions: Parents should complete the form to the best of their ability to help the application review team better understand the daily healthcare needs of the child. You may request help from your child's healthcare team to complete the form.

1. Review the list of Treatment or Care Needs listed in the 1st column.
2. Place a check mark (√) for each treatment performed by a parent or unpaid caregiver in the 2nd column.
3. List the number of times the treatment(s) are done each day in the 3rd column.
4. Describe how often the treatments are performed in the home in the 4th column.
5. Describe who is performing the treatments (father, mother, other family member, etc.) in the 5th column.
6. In the last section (on page 3), describe how the training was received to perform the treatments at home.

Treatments or Care Needs	☑	# Times per Day	Describe how often the treatments are performed. For example, is it a routine task or only when needed?	List the person(s) providing the services in the home. Describe special precautions that may be needed to perform the treatment or care need.
Respiratory Care				
Tracheostomy Care				
Oxygen/CPAP/BIPAP				
Suctioning				
Ventilator				
Pulse oximetry/Apnea Monitoring				
Nebulizers				

Chest Physiotherapy/Cough Assistance				
Chest Tube				
Other; specify:				
Neurological Treatment				
Seizure medication				
Seizure precautions/interventions				
Other; specify				
Nutritional Care				
Tube feeding (Indicate whether this is continuous or a certain amount each day)				
Tube feeding or flushes used only for medications				
Other; specify:				
IV Therapy & Medication Administration				
IV flush				
Lab draws through a port or other IV line				
IV therapy (indicate medication)				
Any subcutaneous medications				
Other; specify				
Urinary treatments				
Catheterization (Indicate whether daily or as needed)				
Peritoneal Dialysis				
Other; specify				
Glucose Management				
Glucose Monitoring				
Other; specify				
Skin Care				
Skin breakdown (indicate stage, if known)				
Complex cast care				
Sterile dressing change				
Stoma care				
Other; specify				
Therapy (PT/OT/ST)				
Specify Treatment:				
Other Type of Treatment not Listed				
Specify Treatment:				

For treatments that are checked above, provide the details of the training received. For example:

- □ Who was the person teaching you? (doctor, nurse, respiratory therapists, etc.)
- □ Where did you receive the training? (in a doctor's office, by a nurse in your home, specialty hospital, etc.)
- □ How long did you receive the training?
- □ Who do you contact for questions or problems?

#1 **Treatments or Care Need - Example**
Tube feedings *Both parents were trained in the hospital after the feeding tube was placed. The nurse in the hospital showed us how to take care of the stoma so it would not get infected, how to measure the tube feeding, and how to flush the tube before and after the feeding. The nurse watched both parents perform the tube feeding for several days before discharge to make sure it was done right and to answer any questions. We were given written instructions. If there are questions or concerns now, we call our pediatrician for advice.*
#2 **Treatments or Care Need**
#3 **Treatments or Care Need**
#4 **Treatments or Care Need**

If the information cannot be entered in the space allowed, please attach additional documentation.

My signature acknowledges that the information provided on this checklist is true and accurate. As the parent and/or legal guardian of the beneficiary receiving services, my signature confirms that I have received training and I personally provide the services checked on this form.

Name of Parent or Legal Guardian	Signature	Date