CDER

CLIENT DEVELOPMENT EVALUATION REPORT

DEPARTMENT OF DEVELOPMENTAL SERVICES

STATE OF CALIFORNIA · HEALTH & WELFARE AGENCY

ERRATA

Please make the following changes in the CDER Manual, 1986 version:

1. Page VI.27.18: Evaluation Element item 47:

   Add:

   Level D - Too disabled to assess

2. Page VI.27.19: Evaluation Element item 48:

   Add:

   Level D - Too disabled to assess

July, 1986

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CLIENT DEVELOPMENT EVALUATION REPORT

FIELD MANUAL

Second Edition
March 1986

State of California
Department of Developmental Services 1986

INTRODUCTION

The purpose of this manual is to: (1) familiarize the user with the structure of, and (2) provide detailed instructions on how to complete and use, the Client Development Evaluation Report (CDER). A secondary purpose is to acquaint the user with the development and the need for CDER.

Instructions on how to complete CDER are presented in detail, as are the criteria for rating the client. The user of the instrument should read these instructions carefully prior to rating the client.

The Manual is presented in two parts. Part One presents an overview of the history of the development of CDER and the various legislative mandates that were the determinants of this development. Section I gives background on the development of CDER and the purposes and uses for which it is intended. This section also contains information on the reliability and validity of the instrument, and addresses the issue of confidentiality.

Section II addresses the need for an evaluation instrument such as CDER. It contains the specific legislative mandates as they relate to this need. Section III provides some practical uses to which CDER data can be employed at the local level.

Part Two consists of the Manual, as follows: Section IV gives a general description of the CDER booklet used to assess the client, Section V gives some general instructions for completing the booklet to conform to computerization requirements, and Section VI is the Manual itself. The Manual, in Section VI, provides the detailed instructions on how to rate the client and includes instructions on using the entirely revised Diagnostic Element of CDER, formerly form DS 3753. Both the form and the instructions for the Diagnostic Element have been changed significantly in this version. The Evaluation Element has not been changed; however, new instructions have been written for certain items within this portion of the CDER system.

PART ONE

OVERVIEW OF THE DEVELOPMENT OF THE CLIENT DEVELOPMENT EVALUATION REPORT

I. BACKGROUND

The Client Development Evaluation Report (CDER) is the assessment instrument that the Department of Developmental Services utilizes to (1) collect data on client diagnostic characteristics and (2) measure and evaluate on an ongoing basis the functioning levels of persons with developmental disabilities who receive services in the California developmental disabilities services system. It must be completed at least annually on each of these clients.

CDER was developed in response to the Lanterman Developmental Disabilities Services Act of 1977 (Division 4.5 of the Welfare and Institutions Code). It is based on the Client Centered Evaluation Model (CCEM) which was developed under the direction of the Health and Welfare Agency to meet the following requirements of the State Council on Developmental Disabilities:

- Be client-oriented.
- Track client throughout the service system.
- Provide measures of change in client independence in living settings.
- Provide measures of change in client productivity in work settings.

- o Be applicable in all service settings.
- o Be applicable to all types and levels of developmental disabilities.

CCEM underwent extensive field testing during 1976 and 1977. Analysis of the field test findings and input from those who had used CCEM pointed to the need for revisions to that instrument. The necessary revisions were made during 1978, and resulted in the 1979 version of the Client Development Evaluation Report.

Purposes and Uses of CDER

CDER is primarily a management tool. For management purposes, CDER data are used for: (1) determining the number of persons with developmental disabilities, the types of their disabilities, and their service needs; (2) budgetary purposes such as assisting in determining hospital staffing requirements and regional center caseloads; (3) establishing the priority of client services according to unmet needs identified during the assessment of the client; and (4) developing aggregated statistical reports to provide information on the types of disabilities, levels of developmental disabilities, and other measures of client functioning.

For operational purposes, CDER data are used to assist the regional center interdisciplinary team (IDT) in assessing the developmental status of individual clients. The data permit the IDT to identify the client's developmental level, the client's capabilities and needs, and the condition(s) which impedes the client's progress. Identification of these attributes is also necessary for planning purposes as well as for developing and initiating specific strategies to enhance the development of the client.

CDER Reliability

In 1982, the Department, in cooperation with the Association of Regional Center Agencies (ARCA) and the Neuropsychiatric Institute at University of California, Los Angeles, conducted a study on the interrater reliability of CDER. The study, based on a proportionate sample of active clients of all ages and levels of disability on the statewide caseload who lived in different placement settings and geographic locations, entailed the collection of independent ratings of clients' levels of functioning by two appropriate persons. The results, based on 360 matched ratings, yielded interrater reliability ranging between 0.8 and 0.9 for all but six of the 66 CDER evaluation items. This indicates that CDER is a highly reliable client assessment instrument.

CDER Validity

The validity of CDER was tested by the Department in 1983, in cooperation with the Mental Retardation Research Center at Lanterman State Hospital and the Neuropsychiatric Institute at UCLA. The study evaluated the concurrent validity of CDER by comparing it with two nationally recognized instruments -- the Corman-Escalona Object Permanence Scale for the cognitive portion, and the Behavior Development Survey (BDS) for self-help skills, cognition and affective development (social and emotional domains) portions of CDER. The BDS and CDER were administered to 82 severely and profoundly retarded residents of Lanterman State Hospital ranging from 14 to 25 years of age. Fifty-five of these 82 clients were also administered the Corman-Escalona Object Permanence Scale. The study yielded positive correlations ranging from 0.5 to 0.9 between CDER and BDS, indicating that CDER is a valid measure of cognition, adaptive behaviors, and maladaptive behaviors.

Confidentiality of CDER Data

The Department currently utilizes a Unique Client Identifier (UCI) to protect the confidentiality of the clients. The UCI is a seven-digit computer number

generated for each regional center to represent each of its clients, and is encoded on each of these clients' CDERs. CDER Answer Sheets are forwarded under the client identifier to DDS for processing.

The UCI allows the Department to fulfill its responsibilities while further safeguarding the confidentiality of client data.

The Client Master File and the CDER History File contain the Unique Client Identifier as the sole means of identification. Only under certain conditions is the client's name used on a CDER report. For example, in order to improve the serviceability of CDER reports and to speed the process of filing reports (such as client profiles) in the individual client record at the regional center, the name of the client is placed on the reports. In order to print the client name on these reports, a computer merge is used to link the CDER file with the Client Master File using the UCI as the common variable. This linkage is performed within the computer memory and is printed on the report and not maintained in machine-readable form. These reports are distributed by registered mail and are made available only to the originating agency.

A contract between the Department of Developmental Services and the regional centers stipulates that confidentiality safeguards must parallel the ones that the Department takes.

II. THE NEED FOR EVALUATION

The past decade has been characterized by an increased awareness of the rights and the service needs of persons with developmental disabilities. This awareness has resulted in an increase in both the availability and cost of public-supported human services designed to meet the special needs of these individuals.

The expansion of developmental services has been accompanied by an increased need for accurate and meaningful information about clients and the services that they receive. Organizations that are responsible for statewide planning and budgeting require information on the size, types of disabilities, and the service needs of the client population. Program managers and administrators need information on the cost and relative effectiveness of different types of services. Case managers and other direct service providers need information about the developmental status and needs of individual clients. Clients and their families require information about the services that are needed.

The need for valid, accurate information about clients and the services that they receive is reflected in State and Federal law.

This need has also been recognized by the agencies that are responsible for the provision of developmental services. The Department of Developmental Services utilizes the data collected on CDER in conjunction with costs and services information to respond to a wide range of requirements, including the following:

- Chapter 8, Division 4.5 of the Welfare and Institutions Code requires the Department of Developmental Services to report to the Legislature on the following:

  - Changes in the independence, productivity, and normality of clients' lives.

  - Progress or lack of progress made by the clients.

  - Type and amount of services provided to clients to obtain program results.

  - State expenditures associated with varying levels of program effectiveness.

- The Department of Developmental Services requires a wide range of information in order to administer the Developmental Disabilities Services Program. The information needed includes:

- The numbers, types and degrees of disability, and the location of clients served by the different programs under the jurisdiction of the Department.

- The types, numbers, capacity, and quality of programs serving the Department's clients.

- The types and amount of unmet service needs.

- The types, amount, and equity of services provided by different types of programs and case management agencies.

- The relative effectiveness of different case management agencies and different types and patterns of services, as measured by the degree of clients' developmental progress.

III. CDER USAGE AT THE LOCAL LEVEL

In addition to addressing the various legislative and departmental requirements, CDER can be used at the local level to assist in improving the delivery of service to the client. Following are ways in which this can be accomplished by making use of CDER data:

- o Appropriate Client Placement: Client assessment information derived from CDER can aid case managers in the selection of appropriate placement settings and/or the determination of the effectiveness of programming. It may be found that a client has good motor development and high levels of independent living, cognitive, communication, and vocational skills, but is lacking in social and emotional competence. Based on this assessed profile, a placement facility that specializes in behavior management and socialization training can be selected which will meet the specific needs of the client.

- o Monitoring Program Effectiveness: CDER client data can be used to determine the effectiveness of program placement. By measuring changes in the client's levels of functioning from one point to another point in time as a result of services received, a determination can be made as to whether to continue current programming or develop new strategies and initiate new programming.

- Planning Prevention Strategies: The newly revised diagnostic section of CDER will be helpful in planning for prevention services. Knowledge of the trends in diagnosis, probable etiology and associated risk factors will enable staff to establish priorities for prevention planning.

- Resource Development Planning: CDER data, when reviewed for an entire caseload or for specific subsets of the caseload, can be of great assistance in planning for future services. Knowing that a large group of clients are reaching age 22 and that the clients have certain developmental characteristics can, for example, be helpful in planning for the development of appropriate residential and/or day programs.

PART TWO

DESCRIPTION OF AND INSTRUCTIONS FOR THE CLIENT DEVELOPMENT EVALUATION REPORT

IV. DESCRIPTION OF THE CDER INSTRUMENT

The Client Development Evaluation Report consists of two components: Diagnostic Information, and Evaluation Information. These components are described briefly below.

The Diagnostic Element

The Diagnostic Element is the first component of CDER. It has been revised extensively since the 1979 version. It is that portion of the instrument on which developmental diagnostic information is recorded. It contains a comprehensive summary of the types, etiologies, and levels of severity of primary disabilities that the client has as well as the impact that these conditions have on programming. The Diagnostic Element must be completed by the attending physician and/or psychologist as appropriate.

The Evaluation Element

This component of CDER is for recording the client's levels of functioning. It is composed of 66 items which are designed to measure the client's competency in six areas of development. These areas are the (1) Motor

Domain, (2) Independent Living Domain, (3) Social Domain, (4) Emotional Domain, (5) Cognitive Domain, and (6) Communication Domain.

Measures of the client's competency ranges from no ability to perform the task to complete independence in performing the task.

The Evaluation Element must be completed by the persons who interact closely with the client on a regular basis.

V. GENERAL INSTRUCTIONS

Following are general instructions for completing the CDER Answer Sheet, form DS 3752 and the CDER Diagnostic Element, form DS 3753. The Answer Sheet is the document from which client data that are recorded on the Diagnostic Element booklet are key-data entered onto the computer. The Diagnostic Element, form 3752 contains the client information as well as the codes that are to be used.

Basic Instructions for Completing CDER Answer Sheet

1. When completing the Answer Sheet, write legibly with a pen; **DO NOT USE A PENCIL.**

2. On the front side at the bottom of the Answer Sheet, space has been provided for the signature(s) and title(s) of the person(s) completing the form. The appropriate person(s) must sign this form.

3. Space has also been provided for the addressograph imprint which must be on developmental center clients' CDERs.

4. Refer to the Manual for instructions regarding the specific codes to enter on the form.

Basic Instructions for Completing both Forms

1. The data on the CDER Diagnostic Element form, as well as the Answer Sheet, are currently key-data entered. Write legibly with a pen (preferably a fine ballpoint pen); **DO NOT USE A PENCIL.**

2. The computer does not know the difference between the letter "O" and the number "0." In order to reduce errors, make certain that the alpha "O" is written with a slash through it -- "Ø." The number zero must be written as is -- "0." **When completing the form, be certain to use Ø for alpha Os and 0 for zeros.**

3. If there is more than one box for numbers, all of them must be used, unless otherwise instructed, even when the response is a single digit. For example, if there are two boxes and the entry is the number "2," it must be written as "02." Following are some examples.

Date of birth, Nov. 22, 1955

1	1	2	2	5	5
M	M	D	D	Y	Y

Correct

Date of birth, June 1, 1901

0	6	0	1	0	1
M	M	D	D	Y	Y

Correct

Date of birth, June 1, 1901

6		1		1	
M	M	D	D	Y	Y

Incorrect

4. It is also very important to use the codes that are provided on the form or in the Manual. Do not create codes as this will cause the computer to generate an error. For example:

Client takes anticonvulsant medication

|1|	1 = Yes 2 = No	|Y|	1 = Yes 2 = No
	Correct		Incorrect

5. **Do not leave any items unanswered unless instructed to do so.** A careful check should be made to ensure that there is an entry for items in each section on the form.

6. In summary, when completing CDER, note the following:

   a. Responses must be clearly legible and in ink.
   b. Recorded responses must be a letter or number that is specified on the form or in the detailed instructions section of the Manual.
   c. The client identifier must be accurate and must be consistent throughout the form and entered in the appropriate locations.
   d. All pages of the set must be in the package.

e. All requested responses must be completed.

f. All entries in the Diagnostic and Evaluation elements must be correct.

g. The Answer Sheet must be signed.

Once a number of CDERs have been completed, the user will become familiar with the criteria and methods of rating. Most ratings can then be completed by a quick review of an item or an entry in the Manual.

VI. DETAILED INSTRUCTIONS: HOW TO RATE THE CLIENT

The following section presents detailed instructions for completing CDER. It is organized to correspond with the instrument itself. All necessary codes for completing CDER are contained in the instrument and in the Manual.

Each CDER item is presented and explained in the same order that it appears on the document. Under the Diagnostic Element, general explanations followed by more detailed explanation on coding are given for each specified disability and other pertinent information contained in this element. In addition, examples of coding each item are given.

Under the Evaluation Element, the items are presented for each of the six domains, with a general explanation to clarify criteria for each rating. The explanations of the levels of achievement contain examples of possible behaviors one may observe during the evaluation. Those items and levels which are self-explanatory do not have explanations to accompany them. Prior to assessing the client, read the insructions completely in order to become familiar with what is expected. When the assessment/evaluation is being completed, the rater can return to specific instructions, as necessary. As raters become familiar with the instrument, it will not be necessary to refer to the detailed instructions each time.

OVERVIEW OF CLIENT IDENTIFYING INFORMATION

The purpose of this portion of the Manual is to provide information which identifies and allows for the location of the client. It consists of two parts--Report and Client Identifier and Client Locator. The first part provides certain identifying client data; the second part provides data on the specific location of the client.

Client Identifying Information Section includes the following items.

Client Identifying Information

- o Overview of Client Identifying Information
- o Report and Client Identifier
  - Reporting date
  - Client identifier (UCI)
  - Client birthdate
  - Sex
  - Height

- Weight
- Date weighed

o Client Locator

- Program
- Section
- Unit

Following are instructions for completing these items.

1. **REPORTING DATE**

This is the date on which CDER is completed. In the appropriate boxes, indicate the completion date: month, day, and the last two digits of the year. If the month or date requires only one digit, enter a zero ("0") before it. For example, an evaluation date of April 5, 1985, would be recorded as

0	4	0	5	8	5
M	M	D	D	Y	Y

2. CLIENT IDENTIFIER (UCI)

This is the seven-digit code which uniquely identifies each client. It is assigned to the client by the regional center and follows the client throughout the system for as long as the client receives regional center services. If the client should exit the system at one point in time and reenters the system at a future point in time, the same Unique Client Identifier (UCI) is to be used to identify the client. The UCI not only uniquely identifies the client but protects the confidentiality of the client's records.

3. CLIENT BIRTHDATE

This item is used to record the client's date of birth: month, date, and the last two digits of the year. If the month or day requires only one digit, enter a zero ("0") before it. For example, a birthdate of March 15, 1986, would be recorded as

0	3	1	5	8	6
M	M	D	D	Y	Y

4. SEX

Enter the appropriate code "M" for male or "F" for female to record the client's gender.

5.-6. HEIGHT AND WEIGHT

This information is extremely important for assessing the client's care needs. Height and weight must be obtained for all clients in placement because they contribute to supervision needs or staffing calculations. For example, it is more difficult to care for a physically disabled person who is 150 pounds than for a person who weighs 35 pounds. Similarly, certain behaviors, such as temper tantrums, are more problematic if the client is 6 feet tall and weighs over 200 pounds than if the client is 3 feet tall and weighs 35 pounds.

NOTE: If height and weight information is not available for clients in their own homes, estimate height and weight and leave Item 7, "Date Weighed," blank.

5. HEIGHT

Enter the client's height in inches.

6. WEIGHT

Enter the client's weight in pounds. If the client's weight is less than 100 pounds, enter a zero ("0") in the first of the three boxes. Do not leave any boxes blank.

7. DATE WEIGHED

Enter the month and last two digits of the year on which the client was last weighed. If this information is not available for clients in their own homes, leave this item blank.

8.-10. PROGRAM SECTION, AND UNIT

These items are developed and used at the discretion of the agency completing the CDER document. Since agencies' organizational requirements vary, standard codes have not been developed, but left blank to be developed by the reporting agency (developmental center or regional center).

Within a regional center these items may be left blank, if they are not used; or, one or all three items may be used to specify which field office is responsible for a client or which staff person is responsible for a particular client. Within a state facility these items are used to specify the facility program and section or unit to which the client has been assigned. The codes entered in items 8-10 may be numeric, alpha, or alphanumeric, whichever is internally feasible for the reporting agency.

DEVELOPMENTAL DIAGNOSTIC

INFORMATION

OVERVIEW OF THE DIAGNOSTIC ELEMENT

REASON FOR THE REVISION

This manual presents the 1986 version of the Diagnostic Element of CDER. The Diagnostic Element of CDER has been revised for a number of reasons. First, the revision provides more comprehensive information on developmental disabilities than was available in the previous 1979 version. This will result in an improved capability to plan for individual programs and prevention activities.

Second, the revision will allow the comparison of the CDER data base with data bases maintained by other agencies, states, or even other countries. Currently the CDER data system maintained by the Department of Developmental Services and the regional center is unique in the United States, and indeed the world, in that it is the largest, most comprehensive data set for individuals with developmental disabilities. A rare opportunity exists in California, therefore, to utilize these data in conjunction with other data sets for a variety of purposes. In conjunction with the data maintained by California Children's Services (CCS) for example, it will be possible to identify virtually all children in the state who have significantly

disabling Cerebral Palsy and Mental Retardation. The characteristics of persons who enter and who do not enter the regional center system could then be compared, yielding important information for outreach and planning purposes.

Additionally, data from the expanded CDER data base can be used in conjunction with those from the California Birth Defects Monitoring Program (CBDMP) to establish a registry of persons with significantly disabling Cerebral Palsy and/or Mental Retardation throughout the state. The CDER diagnostic data also can be used as the basis for studies, such as basic descriptive epidemiology and etiological case studies, that could yield information useful for both the prevention and the treatment of specific disabilities.

In summary, the Diagnostic Element of CDER has been revised and expanded to provide more accurate and comprehensive data for:

- improved individual program planning;
- designing of prevention activities;
- establishing comprehensive statewide registries; and
- statewide and regional planning and forecasting.

TYPES OF CHANGES

The 1986 Diagnostic Element of CDER differs from the previous 1979 version in a number of ways. Among these differences are the following:

1. The ICD-9-CM (International Classification of Diseases, 9th Revision, Clinical Modification) system of classification of conditions and diagnoses will be used rather than the AAMD (American Association of Mental Deficiency) system because ICD-9-CM provides more detail for classifying conditions, manifestations or causes of diseases than does AAMD.

2. More detailed etiological information on the various developmental disabilities is required in this version than was requested in the previous version. Along with the ICD-9-CM codes, a supplementary coding for the presence of risk factors or conditions associated with the developmental disability has been included.

3. ICD-9-CM codes will be completed for chronic major medical conditions, not only for developmental disabilities. In the earlier version, information on these conditions was handwritten on the form and, as a result, was never key-entered or analyzed.

4. Seizure disorders are classified using the International Classification of Epileptic Seizures.

5. Diagnostic information on Cerebral Palsy will be entered using a uniform classification system that is compatible with that used by CBDMP and CCS. The classification system is designed to describe the type, location, and severity of motor dysfunctions.

6. Items have been added to the section to assess the following:

    a. Intelligence quotient and name of intelligence test that was used. (Developmental Centers only.)

    b. Adaptive behavior rating.

    c. Vision and hearing loss, both corrected and uncorrected.

    d. Types of prescribed medications for maladaptive behavior (replacing dosage items in previous version).

    e. History of prescribed medications for maladaptive behavior.

    f. Abnormal involuntary movements (Developmental Centers only).

g. Special health care requirements (replacing aids/equipment items in previous version).

h. Special conditions or behaviors such as stealing, fire setting, legal status, and other conditions that can impede community placement.

GENERAL INFORMATION

Source of Diagnostic Data: The diagnostic information for this form should be provided primarily by the client's physician and psychologist. The medical diagnoses shall be made by the physician. Diagnoses of mental disorders shall be made by those persons qualified to utilize the DSM-III system. Other information required for this form should be provided by persons most qualified to provide accurate data.

Multiple Diagnoses: Information on the various developmental disabilities--mental retardation, cerebral palsy, etc.--is arranged in separated sections on the form. For each section, information on "etiology" or "contributing factors" is requested, using ICD-9-CM codes. Two five-digit spaces are allotted for the ICD-9-CM coding of each disability. This permits entering both the major or primary cause and a secondary or contributing cause for each disability. When a client has more than one developmental disability it is possible that the same causal factor(s) have been found to be associated with the several conditions. For example, a premature infant with anoxic brain damage might have mental retardation, cerebral palsy and epilepsy. The ICD-9-CM codes for the prematurity and anoxic brain damage would then be entered for each of the three disabilities.

Coding of "Risk Factors": In order to provide more precise information for prevention planning, a series of "risk factors," or factors that could contribute to or be associated with the occurrence of developmental disabilities have been identified. The factors which include teenage pregnancy, accidents of near drowning, family history of mental retardation, and so forth, have been developed to permit classification of special conditions associated with the occurrence of developmental disabilities. The section on Risk Factors, items 35-49, follows the sections on the specific developmental disabilities.

Organization of Manual: In the following pages the various developmental disabilities and other diagnostic information are presented sequentially, in a series of sections that correspond to the items on the form. For each item within a section, a description of the item or concept is given first, followed by coding instructions and, usually, an example.

Item numbers given in the left margin in the manual refer to item numbers on the revised CDER form. Section title, page and date are provided on the bottom of each page to facilitate subsequent revisions of individual pages or sections.

MENTAL RETARDATION

Mental Retardation refers to significantly subaverage general intellectual functioning resulting in or associated with concurrent impairments in adaptive behavior and manifested during the developmental period, where general intellectual functioning is the results obtained by assessment with one or more individually administered standardized general intelligence tests; significantly subaverage is intelligence quotient of 70 or below on standardized measures of intelligence; impairments in adaptive behavior is significant limitations in an individual's effectiveness in meeting the standards of maturation, learning, personal independence, and/or social responsibility that is expected for age and cultural group, as determined by clinical assessment and usually standardized scales; and developmental period is that period of the time prior to the 18th birthday. "Developmental deficits" may be manifested by slow, arrested, or incomplete development resulting from brain damage, degenerative processes in the central nervous system (CNS) or regression from previously normal states due to psychosocial factors.

11. LEVEL OF MENTAL RETARDATION (ICD-9-CM Code)

This item refers to the severity or level of the client's mental retardation. The appropriate four-digit ICD-9-CM code is to be used to record this information.

The level of retardation is determined by considering both the level of general intellectual functioning--as obtained by one or more individually administered intelligence quotient (I.Q.) tests--and the level of the client's adaptive behavior. Typically, intellectual functioning and adaptive behavior are measured by standardized tests, the results of which form the basis for the psychologist's clinical diagnosis. **Determination of the level of Mental Retardation, level of intellectual functioning, and level of adaptive behavior must be consistent with Chapter 3, "Definitions", and Appendix A of the Classification in Mental Retardation, edited by H.J. Grossman and published by American Association of Mental Deficiency, 1983.**

The level of Mental Retardation should be obtainable from a psychological evaluation report or other source in the client's records.

The ICD-9-CM codes below represent the various levels of Mental Retardation. Enter the appropriate code in Item 11.

Mental Retardation Level Codes

000.0	No retardation
317	Mild
318.0	Moderate
318.1	Severe
318.2	Profound
319	MR Unspecified (level)

Use category 319, MR unspecified (level) in the following situations:

- If the client is retarded, but the level of retardation is not given.

- As a temporary coding until a determination can be made.

- If there is a strong belief that the person has mental retardation but for any number of reasons is untestable by standard intelligence tests; for example, the client is too impaired or uncooperative, or one or both I.Q. and adaptive behavior measures are lacking.

- If there is no information in the client's report regarding his/her mental retardation level or a proper diagnosis cannot be made.

Following is an example of coding Level of Retardation.

Example of Coding Mental Retardation Level

This example shows coding for a client who is severely mentally retarded.

Level of Retardation (ICD-9-CM Code)

11. |3|1|8| o |1|

000.0	No retardation
317	Mild
318.0	Moderate
318.1	Severe
318.2	Profound
319	MR unspecified (level)

12a. and 12b. ETIOLOGY OF MENTAL RETARDATION

Items 12a and 12b are to be used to record the major cause(s) of the client's Mental Retardation. **ICD-9-CM codes are to be used.**

- If the client is not mentally retarded, enter 000.00 in Item 12a and leave Item 12b blank.

- If the client is mentally retarded and the cause or contributing factor is known, enter the appropriate ICD-9-CM code in Item 12a; if more than one causal factor is known, record the additional factor in item 12b using the appropriate ICD-9-CM code.

- If the ICD-9-CM code is less than five digits, for example 317, leave the remaining digits blank but be sure to justify the number entered in relation to the decimal point.

- If the client is mentally retarded but etiological factors are not known, enter code 999.99 in Item 12a and leave Item 12b blank.

Refer to attachments I through III, at the end of Section VI, for additional information on coding etiology.

PLEASE NOTE: Risk factors and associated conditions related to the mental retardation, as well as to all other developmental disabilities, are to be coded in items 35-49. Manual instructions for these items are provided in sequence below.

Example of Coding Etiology of Mental Retardation

Following is an example of coding an infant with Down's Syndrome who had subsequent brain damage due to lack of oxygen at birth.

Down's Syndrome (primary cause) = code 758.0

Severe Birth Asphyxia (secondary cause) = code 768.5

Etiology of Mental Retardation		ICD-9-CM Code
12a.	(Down's Syndrome)	|7|5|8| o |0| |
12b.	(Severe Birth Asphyxia)	|7|6|8| o |5| |

13. DATE OF LAST EVALUATION

This is the most recent date (month and year) on which the last determination or review of the client's mental retardation level was made. It usually will be found in the psychologist's report.

If Item 11 is coded "000.0" or if there is no psychological evaluation report in the clients' records, enter "0000" in the boxes for this item.

The remaining items in this section are applicable to developmental center clients only. They may be but do not have to be completed for other regional center clients.

14. INTELLIGENCE QUOTIENT SCORES

Enter here the three-digit numerical Intelligence Quotient (I.Q.) which best represents the client's level of mental retardation, for example, 047. If the client has previously been evaluated, there should be a psychological evaluation report in which the psychologist will report one number as best representing the client's I.Q. If more than one number is reported, ask the client's psychologist to give and document the one best representative number.

This item cannot be scored unknown or left blank for developmental center clients.

15. INTELLIGENCE TEST NAME

Select the two-digit code listed below (p.VI.5.9) for the test used to give the I.Q. (actual or estimated) in Item 14. If more than one test is used, select the one that is given primary weight. If the test is not listed, or if the client's I.Q. has been determined by other means, use code 22 or 27, respectively.

Example of Coding a Client's Intelligence Quotient and Intelligence Test

1. Following is an example of coding a client whose most representative score was 67 on the Vineland Social Maturity Scale.

Intelligence Quotient

14. |0|6|7|

Intelligence Test

15. |2|3|

LISTING OF INTELLIGENCE TESTS

01 Cattell Infant Intelligence Scale

02 Stanford-Binet Intelligence Scale, L-M

03 Stanford-Binet Intelligence Scale, 4th Edition

04 Wechsler Adult Intelligence Scale

05 Wechsler Adult Intelligence Scale - Revised

06 Wechsler Intelligence Scale for Children

07 Wechsler Intelligence Scale for Children - Revised

08 Peabody Picture Vocabulary Test

09 Peabody Picture Vocabulary Test - Revised

10 Leiter International Performance Scale

11 Bayley Scales of Infant Development (Mental)

12 Slosson Intelligence Test

13 Columbia Mental Maturity Scale

14 Kaufman Assessment Battery for Children

15 McCarthy Scales of Children's Abilities

16 Merrill-Palmer Scale of Mental Tests

17 Raven Progressive Matricies

18 Gesell Developmental Examination

19 Shotwell-Kuhlmann-Binet Scale

20 Goodenough-Harris/Goodenough Draw-A-Man Test

21 Woodcock-Johnson Psychoeducational Battery

22 Other intelligence test

23 Estimate of Intelligence/Vineland Social Maturity Scale

24 Estimate of Intelligence/Vineland Adaptive Behavior Scale

25 Estimate of Intelligence/Fairview Adaptive Behavior Scales

26 Estimate of intelligence/Maxfield-Buchholz Scale of Social Maturity

27 Other Test or Means of Estimating Intelligence

2. This is an example of coding a client whose intelligence quotient of 55 was determined by means other than one of the tests on the list:

Intelligence Quotient

14. |0|5|5|

Intelligence Test

15. |2|7|

16. ADAPTIVE BEHAVIOR RATING

This item refers to the level of the client's ability to meet standards of maturation, learning, personal independence, and/or social responsibility that is expected for his/her age and cultural group. Adaptive behavior is used in conjunction with the intelligence quotient in determining mental retardation level.

The codes below represent the various levels of Adaptive Behavior. Enter the appropriate code, as listed below, in the space provided.

Adaptive Behavior Rating Codes

0 Normal

1 Mild

2 Moderate

3 Severe

4 Profound

5 Unknown

If the client has been previously evaluated, there should be a rating in the records. Enter the appropriate code "0" - "4". If there is nothing to indicate the client's adaptive behavior rating, enter "5" for unknown.

Examples of Coding Adaptive Behavior Rating

The client below has a moderate adaptive behavior rating.

Adaptive Behavior Rating

16. |2|

0	Normal	3	Severe
1	Mild	4	Profound
2	Moderate	5	Unknown

CEREBRAL PALSY

The term Cerebral Palsy (CP) refers to a group of nonprogressive lesions or disorders in the brain characterized by paralysis, spasticity, or abnormal control of movement or posture, such as poor coordination or lack of balance. These disorders may be due to developmental anomalies of the central nervous system or injury of the brain during intrauterine life, the perinatal period, or within the first few months of life, and are manifest prior to age two or three years.

Common prenatal causes of CP are maternal infections such as toxoplasmosis, rubella and cytomegalic inclusion disease. Examples of perinatal causes are cerebral trauma, anoxic or intracerebral bleeding during birth. In the first few months of life important etiological factors are kernicterus, meningitis, encephalitis or subdural hematoma.

Although diagnoses of progressive neurological disorders (e.g., lipid-storage disease and tumors) and well-defined congenital malformations (e.g., neural tube defects) are excluded from this CP definition, the motor dysfunctions associated with such conditions are similar to CP and, therefore, should be coded in this section. (See Item 17.)

In this section, Cerebral Palsy, attention is given both to Cerebral Palsy itself and to other motor dysfunction conditions that are similar to Cerebral Palsy. Items are provided below for recording either Cerebral Palsy or CP-like conditions. For example, if an older child was involved in an automobile accident with severe left cerebral damage in the motor area giving rise to a right hemiplegia, the category of motor dysfunction similar to CP could be used. In this example, the item for etiology would be reflected by code 803.2, Skull fracture - closed with subarachnoid, subdural, and extradural hemorrhage.

17. PRESENCE OF CEREBRAL PALSY

This item is for recording whether the client has Cerebral Palsy or some other condition that produces a CP-like motor dysfunction. Enter the appropriate code, as presented below:

Presence of Cerebral Palsy Codes

0 No CP or other significant diagnosis

1 Client has CP or other significant motor dysfunction

When coding Presence of Cerebral Palsy:

- If the client does not have Cerebral Palsy or another condition that produces a CP-like motor dysfunction, enter a "0" in box 17 and leave items 18a-22 blank.

- If the client has Cerebral Palsy or a significant CP-like motor dysfunction, enter code "1" then complete items 18a-22.

Example of Coding Presence of Cerebral Palsy

The following example shows the coding for a client who has Cerebral Palsy or another significant motor dysfunction.

17. |1| Presence of Cerebral Palsy

0 No CP or other significant motor dysfunction

1 Client has CP or other significant motor dysfunction

18a. & 18b. ETIOLOGY OF CEREBRAL PALSY OR SIGNIFICANT MOTOR DYSFUNCTION

Items 18a and 18b are to be used to record the major cause(s) of or contributing factor(s) to Cerebral Palsy or another significant motor dysfunction. ICD-9-CM codes are to be used to record the etiologic factor(s).

- If the client does not have Cerebral Palsy or another type of motor dysfunction, as indicated in Item 17, leave this item blank.

- If the client has Cerebral Palsy or CP-like condition, enter the appropriate ICD-9-CM code that indicates the major cause of or factor contributing to the disability in the five spaces provided in Item 18a. Add any additional factor in Item 18b.

- If the etiology of the client's motor dysfunction is not known, enter "999.99" in Item 18a and leave Item 18b blank.

NOTE: Code any risk factors associated with the disability in items 35-49 below.

Example of Coding Etiology of Cerebral Palsy or other Significant Motor Dysfunction

The following example shows the coding for a client with hemolytic disease due to RH isoimmunization.

		Etiology ICD-9-CM Code
18a.	(Cerebral Palsy or CP-like condition: RH isoimmunization)	|7|7|3| o |0| |
18b.		| | | | o | | |

19. LEVEL OF MOTOR DYSFUNCTION

This item refers to the degree of disability caused by Cerebral Palsy or another significant motor dysfunction. **The diagnosis is to be provided by a physician.**

The codes which describe the level or degree of impairment of Cerebral Palsy or other motor dysfunction are mild, moderate, and severe; however, there are no commonly accepted standards for these levels. Refer below for the definitions of the levels of impairment as they pertain to this manual.

Prior to rating the client's level of motor dysfunction, make certain that the correct entry has been made in Item 17, indicating whether or not Cerebral Palsy or a CP-like motor dysfunction is present.

The coding categories for Level of Motor Dysfunction are as follows:

Level of Motor Dysfunction Codes

1 Mild: Condition exists but it does not have limiting effects on daily activities and functions

2 Moderate: The level of impairment is between mild and severe with respect to performance of daily activities and functions

3 Severe: The disability significantly limits or precludes daily activities and functions

9 Condition suspected, level undetermined: The disability is known to be present or it is suspected to be present, but the level of impairment has not been determined

When coding Level of Motor Dysfunction:

- If the client does not have Cerebral Palsy or other motor dysfunction (a "0" in Item 17), leave this item and subsequent items in this section blank.

- If the client is diagnosed as having Cerebral Palsy or another type of motor dysfunction, enter the appropriate code as listed above.

- If the client is diagnosed as having Cerebral Palsy or CP-like condition but the level of severity is not known, or, if it is apparent from the client's records that the client has Cerebral Palsy or another type of motor dysfunction but it has not been diagnosed, then enter a "9" in Item 19.

Example of Coding Level of Motor Dysfunction

Following is an example of a client whose level of motor dysfunction significantly limits his/her daily activities and functions.

Level of Motor Dysfunction

19. |3 |

1 Mild: doesn't limit activity

2 Moderate: in between mild and severe

3 Severe: significantly impairs or precludes activity

9 Condition suspected, level undetermined

20. TYPE OF MOTOR DYSFUNCTION

The type of motor dysfunction should be included in the client's records. The codes for this item are listed below. Enter the appropriate code in the box provided.

Type of Motor Dysfunction Codes

1 Spasticity (includes hypertonia and rigidity): This type of motor dysfunction is defined as a "state of increased muscle tension. The major manifestation is increased or exaggerated stretch reflex that exhibits itself by an exaggerated contraction of a muscle when it is suddenly 'stretched.'" Hypertonia and Rigidity are differentiated from Spasticity by degree of increased muscle tension.

2 Ataxia: This type of motor dysfunction is characterized by "disturbance in postural balance and coordination of muscle activity; usually generalized but may be confined to one side of body or one extremity."

3 Dyskinesis (includes Athetosis and Dystonia): This type of motor dysfunction may be of two types--athetoid and dystonia. Athetosis is uncontrollable, involuntary and poorly coordinated movements of body, face, and extremities which result in bizarre patterns of muscular activities. Dystonia is persistent deviation of a body part due to abnormal muscle contraction. Partial or incomplete dystonia may consist of a tendency to abnormal deviation which can be overcome (at least temporarily) by volitional corrections; repetitious movements may result from this interaction between voluntary and involuntary movements.

4 Hypotonia: Hypotonia is characterized by a "lack of normal muscle tone or tension associated with muscle flaccidity and weakness."

5 Other: This category includes mixed motor dysfunctions.

(Refer to pages VI.6.13 and VI.6.14 for examples of coding instructions for Items 20-22.)

21. LOCATION OF MOTOR DYSFUNCTION

This item refers to the areas of the body which are affected by a motor dysfunction. Codes for the location of the motor dysfunction are listed below. Choose the correct code and enter it in the appropriate box.

Location of Motor Dysfunction Codes

1	Monoplegia:	Involves weakness or paralysis of a single extremity
2	Hemiplegia:	Involves both upper and lower extremities on one side
3	Diplegia:	Involves like parts on both sides of the body, not necessarily extremities. One area is usually more involved than the other
4	Triplegia:	Involves three extremities
5	Paraplegia:	Involves lower extremities only
6	Quadriplegia:	Involves all four extremities
7	Other	

Refer to examples on pages VI.6.13 and VI.6.14 for coding the location of the motor dysfunction.

22. CONDITION IMPACT

Condition Impact refers to the extent or degree to which Cerebral Palsy or another type of motor dysfunction affects the client's level of supervision/care required and/or program placement. Enter the most representative code, as presented below.

Condition Impact Codes

0	No evidence of impairment	
1	Mild . . .	Condition requires some special attention when planning for the client's placement and/or some extra supervision/care
2	Moderate .	Condition has a major impact upon the ability to obtain an appropriate placement for the client and/or requires a considerable amount of supervision/care
3	Severe . .	Condition is so substantial that it is exceedingly difficult to find an appropriate placement for the client and/or constant supervision/care is required
9	Condition suspected, impact undetermined	

When coding Condition Impact:

- If the client does not have Cerebral Palsy or another type of motor dysfunction, (code "0" in Item 17) leave this item (#22) blank.

- If the client has the condition but it does not have an impact upon the level of supervision and/or care required and/or program placement, enter code "0"--"No evidence of impairment.

Below are examples of coding items 20, 21, and 22.

Examples of Coding the Type, Location, and Condition Impact of Motor Dysfunction

1. This example is of a client with spastic Diplegia, the impact of which on supervision/care, and/or placement is mild.

Type of Motor Dysfunction

20. |3|

1 Spasticity (includes Hypertonia and Rigidity)
2 Ataxia
3 Dyskinesia (includes Atheosis and Dystonia)
4 Hypotonia
5 Other (includes mixed)

Location of Motor Dysfunction

21. |3|

1 Monoplegia
2 Hemiplegia
3 Diplegia
4 Triplegia
5 Paraplegia
6 Quadriplegia
7 Other

Condition Impact

22. |1|

2. This example is of a client with a motor dysfunction that is not included under codes "1"-"4"; it involves the upper extremities on both sides of the body and has a severe impact on supervision/care and/or placement.

Type of Motor Dysfunction

20. |5|

1 Spasticity (includes Hypertonia and Rigidity)

2 Ataxia

3 Dyskinesia (includes Atheosis and Dystonia)

4 Hypotonia

5 Other (includes mixed)

Location of Motor Dysfunction

21. |3|

1 Monoplegia

2 Hemiplegia

3 Diplegia

4 Triplegia

5 Paraplegia

6 Quadriplegia

7 Other

Condition Impact

22. |3|

AUTISM

Autism is a disability of uncertain etiology. For the Department's purposes, Autism is defined as a syndrome first appearing in the early years of life--usually before the age of three--which is characterized by extreme withdrawal, language disturbance, inability to form affective ties, frequent lack of responsiveness to other people, monotonously repetitive behaviors, inappropriate response to external stimuli, and an obsessive urge for maintaining sameness. Many, but not all, children may be severely impaired in intellectual capacities. If a person is diagnosed as autistic, where this condition was not clearly apparent by the age of three, the record must clearly indicate justification for this diagnosis.

The diagnosis in this section must be provided by a person qualified to diagnose Autism.

23. AUTISM

This item refers to the autistic state of the client; the codes below indicate the client's autistic state.

Autism Codes

0 None

1 Autism, full syndrome

2 Autism, residual state

9 Autism suspected, not diagnosed

When coding this item:

- If the client does not have Autism, use code "0", None, and leave items 24a-26 blank.

- If the client has Mental Retardation with autistic features, but does not meet the Autism criteria, code the client's level of mental retardation under Item 11, and code the client's autistic state "9", Autism suspected, not diagnosed.

Note that if the client is coded "9" because of autistic-like characteristics, the same should be reflected in the Emotional Domain of the CDER Evaluation Element. In other words, the client's ratings in the Emotional Domain should indicate characteristics such as depressive-like behavior, resistiveness, and/or repetitive body movements.

Refer to the example below for coding instructions.

Example of Coding Autism

1. The following example shows the coding for a client who has Autism in the residual state:

    23. |2| Autism

    0 None
    1 Autism, full syndrome
    2 Autism, residual state
    3 Autism suspected, not diagnosed

2. This example demonstrates the coding for a mentally retarded client with autistic-like features.

23. |9| Autism

0 None

1 Autism, full syndrome

2 Autism, residual syndrome

9 Autism suspected, not diagnosed

Note: This client would have an ICD-9-CM code (if known) entered in items 12a-12b (Etiology of Mental Retardation).

24a. and 24b. CONTRIBUTING FACTORS FOR AUTISM

Items 24a and 24b are used to record the major contributing factor(s) to Autism. **The diagnosis for items in this section are to be provided by a person qualified to diagnose Autism.**

The exact etiology of Autism is not fully known, but many conditions such as Rubella and other factors producing severe mental retardation are associated with autistic-like behavior. These items are to be used to record any major condition(s) thought to contribute to the Autism.

When coding this item:

- If the client does not have Autism (Code "0" in Item 23), leave this item blank.

- If the client has Autism, enter any additional factor(s) contributing to the disability, using ICD-9-CM codes, in items 24a and 24b.

- If the client has Autism but the contributing factor(s) is (are) not known, code 24a as 999.99 and leave Item 24b blank.

- Code any associated risk factors in items 35-49 below.

Examples of Coding Etiology of Autism

1. The example below shows the coding for the etiology of Autism in a client where the contributing factors are not known.

		ICD-9-CM Code
24a.	(Autism: contributing factor unknown)	|9|9|9| o |9|9|
24b.		|_|_|_|_| o |_|_|_|

2. This example shows the coding for a child who had Meningitis associated with H. influenzae.

		ICD-9-CM Code
24a.	(Autism: Meningitis, [H. influenzae])	|3|2|0| o |0| |
24b.	(Autism)	| | | | o | | |

25. DATE OF DETERMINATION

This is the date (month and year) on which the client was first diagnosed as having Autism. It may or may not be the same date as the most recent assessment of the client.

- If the client does not have Autism, (code "0" in Item 23), leave Item 25 blank.

- If the client has Autism, enter the date on which the client was first assessed as having Autism.

Refer to page VI.7.8 for example of coding this item.

26. CONDITION IMPACT

Condition Impact refers to the extent or degree to which the client's autistic state affects the level of supervision/care and/or program placement. Enter the most representative code, as presented below.

Condition Impact Codes

0 No evidence of impairment

1 Mild . . . . Condition requires some special attention when planning for the client's placement and/or some extra supervision/care

2 Moderate . . Condition has a major impact upon the ability to obtain an appropriate placement for the client and/or requires a considerable amount of supervision/care

3 Severe . . . Condition is so substantial that it is exceedingly difficult to find an appropriate placement for the client and/or constant supervision/care is required

9 Condition suspected, impact undetermined

When coding Condition Impact:

- If the client does not have Autism, leave Item 26 blank.

- If the client has been diagnosed as having Autism, but in the present state it does not affect program placement, and/or supervision/care, enter code "0", No evidence of impairment.

Example of Coding Date of Determination and Condition Impact

The following is an example of coding a client who was determined to have Autism (which is now in the residual state) in April 1970. The disability has a mild impact on the level of supervision/care, and/or placement.

Date of Determination	Condition Impact
25. |0|4|7|0| (M M Y Y)	26. |1|

EPILEPSY/SEIZURE DISORDERS

The purpose of the items in this section is to determine the cause(s) and type(s) or classification of clients' seizure disorders. In order to maintain consistency with current national and international usage, the "International Classification of Epileptic Seizures" is employed. Under this system of classification, seizures are categorized into two main types: (1) Partial (or focal) seizures, which have the onset in a single area of the brain, and (2) Generalized seizures, which have their onset from widespread and diffuse areas of the brain.

Partial, or focal, seizures are divided into two groups: the first group are those with elementary symptomatology and are generally without the client losing consciousness; the second group are those with complex symptomatology and are generally with the client losing consciousness.

27a.-29a. TYPE OF SEIZURE

These items are to record the type(s) of seizures. Three spaces have been allowed for three different types of seizures. Coding of these items must be consistent throughout items 27a-29c. If the client has two types of seizures and entries have been made in 27a and 28a, then the corresponding items, 27b and 28b, and 27c and 28c, must be completed.

<u>These items must be completed even if the client's seizures are under control through the use of medication</u>.

The medical diagnosis for this subsection must be made by a qualified physician.

The codes below represent the various types of seizures. They are based on the International Classification of Epileptic Seizures.

<u>Type of Seizure Codes</u>

0 Does not have seizure disorder

1 Partial, with elementary symptomatology

These types of seizures begin locally and are generally without impairment of consciousness. Included in this classification are seizures with associated motor symptoms, sensory or somatosensory symptoms, and autonomic symptoms. They are also present in compound forms.

2 Partial, with complex symptomatology

These types of seizures begin locally and often include impairment of consciousness. Associated with these

seizures are (a) impairment of consciousness only, (b) cognitive symptomatology, (c) affective symptomatology, (d) psychosensory symptomatology, and (e) psychomotor symptomatology (automatisms). They are also present in compound forms.

3 Partial, secondarily generalized

These seizures are usually tonic-clonic and arise from any of the above as a secondary event. The preceding partial seizure may be termed an aura.

4 Generalized, Absences (Petit Mal)

In this classification, seizures start in the midline (brainstem) and are bilaterally symmetrical. "Petit Mal" is characterized by "very short episodes of cessation of activity with a fixed staring appearance." Other absences may show increased or decreased muscle tone (atonic seizures; "drop attacks") or autonomic phenomena.

5 Generalized, Bilateral massive epileptic myoclonic

This type of seizure begins without local onset and is bilaterally symmetrical.

6 Generalized, Infantile spasms

These are myoclonic seizures which occur during infancy or very early childhood with EEG pattern of "hypsarhythmia." They involve short generalized muscle contraction; infant suddenly and forcibly flexes the head on the chest and the thighs on the abdomen; may involve over-extension of neck and arching of back; consciousness invariably lost, but the episode is of very short duration.

7 Generalized, Tonic-Clonic (Grand Mal)

These seizures are associated with generalized spiking in the EEG with loss of consciousness, generalized tonic and clonic muscle activity followed by a period of sleep. A sensory or autonomic aura frequently precedes the seizure, which may last from 30 seconds to some minutes.

8 Generalized, Atonic/Akinetic

These seizures are classified in the "Absence" category and are manifested clinically by a sudden loss of postural tone.

9 Other

This includes seizure disorders not specified above and may be used if undetermined types of seizures are present.

Refer to the Table of Seizures Classification, Attachment IV, at the end of the Diagnostic Element for additional information on seizure classification.

When coding Type of Seizures:

- If the client does not have a seizure disorder, enter a zero ("0") in box 27a and leave items 28a-32 blank.

- If the client has a seizure disorder(s), enter the appropriate code, as listed above, in 27a. Enter any additional types of seizures in items 28a and 29a. Up to three distinct types of seizure may be entered for each client.

- If the client has more than one distinct type of seizure, enter the appropriate codes in the respective "b" and "c" boxes. Leave unneeded boxes blank if the client has fewer than three types of seizures.

- The type of seizure should be in the client's medical records with the specified diagnosis. If it is not in the medical records and clarifying information is not available or if a seizure disorder is suspected but not diagnosed, enter code "9," indicating "Other/Undetermined" type of seizure not listed above.

An example of coding Type of Seizure can be found on page VI.8.7.

27b.-29b. SEIZURE FREQUENCY

These items provide an indication of how often the client experiences seizures and whether the client has experienced seizures in the past. Enter the approximate frequency as listed below for each type of seizure that the client currently experiences or has experienced in the past two years; for example, enter the frequency of seizure disorder in 27b for the seizure type indicated in 27a, the frequency of seizure disorder entered in 28b for the seizure type indicated in 28a, etc.

Seizure Frequency Codes

1 History of seizures, none in two years

2 History of seizures, none in one year

3 One to 11 per year

4 One per month (approximate)

5 One per week (approximate)

6 One per day (approximate)

7 More than one per day

9 Suspected, frequency undetermined

If the client does not have a seizure disorder, leave these items blank.

Examples of Coding Type of Seizure and Seizure Frequency

1. The following is an example of coding a client who has Generalized Absences (Petit Mal) seizures approximately once a week and Generalized, Tonic-Clonic (Grand Mal) seizures at least 14 times per year.

Type of Seizures		Seizure Frequency	
27a.	|4|	27b.	|5|
28a.	|7|	28b.	|4|
29a.	| |	29b.	| |

2. This second example is of a client who has a history of experiencing bilateral massive epileptic myoclonus seizures, but which have been controlled by anticonvulsant medication for 18 months.

Type of Seizures		Seizure Frequency	
27a.	|5|	27b.	|1|
28a.	| |	28b.	| |
29a.	| |	29b.	| |

27c.-29c. CONDITION IMPACT

Condition Impact refers to the degree or extent to which the seizure disorder affects the level of supervision/care required for and/or program placement of the client.

Condition Impact codes are shown below.

Condition Impact Codes

0	. . . . .	No evidence of impairment
1	Mild	Condition requires some special attention when planning for the client's placement and/or some extra supervison/care
2	Moderate . .	Condition has a major impact upon the ability to obtain an appropriate placement for the client and/or requires a considerable amount of supervision/care
3	Severe . . .	Condition is so substantial that it is exceedingly difficult to find an appropriate placement for the client and/or constant supervision/care is required
9	Condition suspected, impact undetermined	

Enter one of the appropriate codes above in the spaces provided.

- If the client does not have seizures (code "0" in Item 27a, leave these items blank.

- If the client has a seizure disorder but it does not affect the level of supervision/care and/or program placement, code the client "0"--"No evidence of impairment."

Example of Coding Condition Impact

The following example shows that the condition impact for the above client, who has Petit Mal seizures approximately once a week and Grand Mal seizures at least 14 times per year, is "Moderate" in both cases. In other words, the types and frequencies of the seizures have a major impact upon placement and/or supervision/care of this client.

Condition Impact

27c. |2|

28c. |2|

29c. | |

30a. and 30b. ETIOLOGY OF EPILEPSY/SEIZURE DISORDER

These items are used to record the major cause(s) or contributor(s) to Epilepsy or other type of seizure disorder.

The medical diagnosis and coding for etiology of seizure disorders must be provided by a physician.

- If the client does not have Epilepsy or any other type of seizure disorder (code "0" in Item 27a), leave this item blank.

- If the client has Epilepsy or another type of seizure disorder, enter the major cause or contributing factor, using ICD-9-CM codes, in the spaces provided in Item 30a. **(Do not code the type of seizure disorder.)** Enter any additional contributing factors in Item 30b.

- If the client does have Epilepsy or other seizure disorder but the etiological factors are not known, enter "999.99" in Item 30a and leave Item 30b blank.

NOTE: Code any risk factors associated with the disability in Items 35-49.

Example of Coding Etiology of Epilepsy/Seizure Disorder

The following example shows the coding for a client who has epileptic seizure due to Hemophilus Meningitis.

Etiology of Epilepsy/Seizure Disorder

	ICD-9-CM Code
29a. (Hemophilus Meningitis)	|3|2|0| o |0| |
29a.	| | | | o | | |

31. CLIENT TAKES ANTICONVULSANT MEDICATION

This item is included to identify those clients whose seizures are being controlled by medication. Code this item "1" if the client is taking medication to control seizures, or "2" if the client is not taking medication.

Example of Coding Client Takes Anticonvulsant Medication

This is an example of coding a client whose seizure disorders are being controlled by medication.

31. |1| Client takes anticonvulsant medication.

32. STATUS EPILEPTICUS

This item is included to determine if the client has or has had Status Epilepticus in the past year. In order to be diagnosed as such, there must be continued seizure activity for a duration of twenty (20) minutes. It is left to the physician's discretion whether to employ intervention treatment to terminate the seizure prior to such time. If this occurs, the client would still be considered as having Status Epilepticus. **The diagnosis of Status Epilepticus must be made by the physician.**

- If the client does not have a seizure disorder (code "0" in Item 27a) leave this item blank.

- If the client has had Status Epilepticus within the past year, enter "1" for Yes in box 32; if the answer is No, enter a "2."

- If it is not known whether the client has had Status Epilepticus, enter "3" for "Not Known."

Examples of Coding Status Epilepticus

1. This client had a Status Epilepticus seizure nine months ago.

   |1| Has the client had Status Epilepticus in the past year?

   1 = Yes 2 = No 3 = Not Known

2. This client had a Status Epilepticus seizure 20 months ago.

   |2| Has the client had Status Epilepticus in the past year?

   1 = Yes 2 = No 3 = Not Known

OTHER DEVELOPMENTAL DISABILITY

This section is for identifying and recording developmental disabilities other than those enumerated above. "Other" developmental disabilities are conditions which are similar or closely related to Mental Retardation or which require treatment or services similar to that required for mentally retarded individuals. It does <u>not</u> include handicapping conditions that are solely physical in nature. Examples of conditions that could be included in this section are intracranial neoplasms, degenerative brain disease, spina bifida, etc., resulting in substantial handicap.

33a.-33b. TYPE OF OTHER DEVELOPMENTAL DISABILITY

Items 33a and 33b are to be used to record the type(s) of disability(ies). Using ICD-9-CM codes, enter the code for the particular disability in Item 33a. If the "hard copy" of this form is to be placed in the client's chart, you may want to write the name of the disability in the "specify" space provided. If the client has more than one disability, record the second one in Item 33b using ICD-9-CM codes.

If the client does not have a related disability, enter 000.00 in Item 33a and leave Item 33b as well as Items 34a-34b blank.

Following is an example of coding these items.

Example of Coding Other Type of Developmental Disability

The client in this example Werdnig-Hoffman disease, a severe and progressive infantile spinal atrophy:

		Type of Other Disability (ICD-9-CM)
33a.	Werdnig-Hoffman disease (specify)	|3|3|5| o |0| |
33b.	_____ (specify)	| | | | o | | |

34a.-34b. ETIOLOGY OF OTHER DEVELOPMENTAL DISABILITY

These items refer to any causal or contributing factors associated with the conditions codes in items 33a and 33b.

- If the client does not have such a disability, as indicated by 000.00 in Item 33a, leave the item blank.

- If the client has such a disability, enter any additional contributing factor associated with the disability, using ICD-9-CM codes, in Item 34a.

- If the client has two such disabilities, as indicated by entries in both Item 33a and Item 33b, enter any contributing or associated factor for the second disability in Item 34b.

- If the client has such a disability but the secondary contributing factor(s) is not known, enter "999.99" in Item 34a and/or Item 34b.

Example of Coding Etiology of Other Developmental Disability

This example shows the coding for a client who has spina bifida with hydrocephalus and with a secondary condition of H. Influenzae meningitis.

Etiology of Other Developmental Disability

		ICD-9-CM Code
34a.	(Spina bifida with hydrocephalus)	|7|4|1| o |0| |
34b.	(H. influenzae meningitis)	|3|2|0| o |0| |

35.-49. RISK FACTORS

The purpose of these items is to record any risk factors or conditions associated with any of the client's developmental disabilities. Used in conjunction with the ICD-9-CM codes discussed above, they provide more precise informaton regarding the possible causes of the client's disabilities. Such information will be useful in planning prevention activities.

Twelve specific risk factors are provided on the form. Space is available to add additional factors--in the blank columns 48 and 49--at a later point in time if new factors are identified. For now, please place a code number in the space provided next to Risk Factor items 35 through 47. LEAVE ITEMS 48 AND 49 BLANK.

As was mentioned in earlier portions of the Manual, the risk factors may be associated with any of the client's developmental disabilities. If the client has more than one specific disability, answer the Risk Factor items for all of the client's disabilities.

Codes "1" = Yes, "2" = No, and "9" = Unknown are to be used for each Risk Factor. Enter "1" for Yes if there are reasonable data to suggest that the disability was associated with or significantly impacted by the given Risk Factor. Enter "2" for No if the Risk Factor does not pertain to the disability. Enter "9" for Unknown if there is no definitive information on whether or not the Factor was associated with the disability.

PLEASE ENTER "1", "2", OR "9" FOR EACH RISK FACTOR, ITEMS 35 THROUGH 47. LEAVE ITEMS 48 AND 49 BLANK.

35. Low birth weight or preterm labor with complications
36. Teenage pregnancy (17 years and younger)
37. Maternal age 35 years or older at time of delivery
38. Accidents of near drowning
39. Accidents involving an automobile
40. Accidents involving other types of vehicles
41. Accidents of other types
42. Environmental toxins (pesticids, lead, etc.)
43. Drug or alcohol abuse
44. Psychosocial (environmental) deprivation
45. Family history of mental retardation
46. Child abuse or neglect
47. Other cause(s)
48.
49.

Example of Coding Risk Factors

This example shows the coding for a client who is mentally retarded and who has a seizure disorder, both etiologically connected to H. influenzae meningitis (ICD-9-CM coding under etiology above as 320.0 in items 12b and 30a). In addition, the client was born to a family with a history of Mental Retardation (Risk Factor Item 45), and was premature and of low birth weight (Risk Factor Item 35).

Example of coding Risk Factors

Risk Factor (for use in etiology items 12a-b, 18a-b, 24a-b, 30a-b, and 34a-b.)

1 = Yes 2 = No 9 = Unknown

Indicate whether each of the following factors contributed to the client's developmental disability(ies), as specified above.

35. |1| Low birth weight or preterm labor with complications
36. |2| Teenage pregnancy (17 years and younger)
37. |2| Maternal age 35 years or older at time of delivery
38. |2| Accidents of near drowning

39. |2 | Accidents involving an automobile

40. |2 | Accidents involving other types of vehicles

41. |2 | Accidents of other types

42. |2 | Environmental toxins (pesticides, lead, etc.)

43. |2 | Drug or alcohol abuse

44. |2 | Psychosocial (environmental) deprivation

45. |1 | Family history of mental retardation

46. |2 | Child abuse or neglect

47. |9 | Other causes

48. | |

49. | |

MENTAL DISORDERS

The items in this section indicate whether or not the client has a mental disorder in addition to a developmental disability. A mental disorder is a clinically significant behavioral or psychological syndrome that occurs in an individual which is typically associated with a painful symptom, an impairment of functioning, or a failure of adjustment. The disorder may be either functional or organic in cause and is assumed to exist within the individual and in his/her personal relationships. Such a disorder cannot be limited to a conflict between the individual and society.

When rating the client:

- Use the diagnostic criteria for Mental Disorder in the Diagnostic and Statistical Manual of Mental Disorders (DSM III).

- Complete this section only if a psychological or psychiatric diagnosis of a mental disorder has been made by a qualified professional.

- Enter significant Axis I and Axis II condition(s) in Items 50a-53a, if applicable.

Axis I comprises the entire classification of mental disorders as well as conditions not attributable to mental disorders that are an important focus for treatment. Axis II involves personality disorders and the specific developmental disorders. The client may have disorders in both axes.

NOTE: Although Autism is classified as a mental disorder, it should not be coded here. If the client has a diagnosis of Autism, it should be addressed in the Autism section above, items 23-26, rather than here.

The mental disorder diagnosis(es) is to be made by a qualified psychologist or psychiatrist.

50a.-53a. TYPE OF MENTAL DISORDER (DSM-III CODE)

These items indicate the types of mental disorders that the client may have, as set forth in DSM-III.

It is important that clients with a developmental disability and a mental disorder ("dual diagnosis") be coded in both the Developmental Disabilities Section and the Mental Disorders Section (Items 11-34b and 50a-53c, respectively). However, do not code the client's developmental disability diagnosis in this section. As the client's developmental disability has been coded in previous items, code here only those specific mental disorders that meet the criteria set forth in DSM-III.

When coding Type of Mental Disorder:

- If the client has a mental disorder(s), enter the appropriate DSM-III code and complete the respective "b" (Date of Last Evaluation) and "c" (Condition Impact) items for the particular mental disorder recorded in the "a" (Axis column). In other words, if an entry has been made in 50a and 52a, then Items 50b and c and 52b and c should be completed.

- If the client has no psychiatric diagnosis, enter "000.00" in 50a and leave all other items in the Mental Disorder section blank.

- If two diagnoses are made on either Axis, code the most significant condition requiring treatment as the first diagnostic code within the Axis.

- If the diagnosis is deferred on either Axis I or Axis II, code as "799.90." **NOTE: Mental disorder diagnoses are not to be deferred for longer than one year.**

- If there is a diagnosis for Axis I but no Axis II diagnosis, enter the appropriate DSM III code under Axis I and enter code "V71.09" under Axis II. Conversely, if there is an Axis II diagnosis but no Axis I diagnosis, code Axis I as "V71.09" and code the appropriate DSM III diagnosis under Axis II.

Following are examples of coding Items 50a-53a.

Examples of Coding Type of Mental Disorder

1. Following is an example of coding for a person with an adjustment disorder with mixed emotional features. Additionally, the person has a personality disorder which is characterized as atypical.

Type of Mental Disorder

(Adjustment Disorder)

Axis I

50a. |3|0|9| o |2|8|

51a. | | | | o | | |

(Personality Disorder)

Axis II

52a. |3|0|1| o |8|9|

53a. | | | | o | | |

2. This example represents a client with the same personality disorder as the one above, but he/she does not have a mental disorder under Axis I.

Type of Mental Disorder

Axis I

50a. |V|7|1| o |0|9|

51a. | | | | o | | |

Axis II

52a. |3|0|1| o |8|9|

53a. | | | | o | | |

50b.-53b. DATE OF LAST EVALUATION

Date of Last Evaluation is the date on which the client was most recently assessed as having the mental disorder(s) coded under items 50a-53a. Enter the two-digit month and two-digit year date on which the client was assessed as having the mental disorder.

- If the client has no mental disorder, this item should be left blank.

- If the client has a mental disorder but the date is not in the client's records, or is otherwise not available, enter 9999 in the date item.

Examples of Coding Date of Last Evaluation

1. This client was last assessed as having the above mental disorders on March 21, 1985.

Date of Last Evaluation

(Axis I)

50b. |0|3|8|5|
m m y y

51b. | | | | |
m m y y

Date of Last Evaluation

(Axis II)

52b. |0|3|8|5|
m m y y

53b. | | | | |
m m y y

2. In this example, the records showed that this client was diagnosed as having a personality disorder, but the date on which the client was assessed as having the disorder was illegible in the client's records.

Type of Mental Disorder		**Date of Last Evaluation**	
(Axis I)		(Axis I)	
50a.	|3|0|9|o|2|8|	50b.	|0|3|8|5|
51a.	| | | |o| | |	51b.	| | | | |
Axis II		(Axis II)	
52a.	|3|0|1|o|8|9|	52b.	|9|9|9|9|
53a.	| | | |o| | |	53b.	| | | | |

50c.-53c. CONDITION IMPACT

Condition Impact refers to the extent or degree to which the diagnosed mental disorder affects the level of supervision/care required and/or the program placement of the client. Enter the appropriate code, as shown below, in one of the spaces provided.

Condition Impact Codes

0 No evidence of impairment

1 Mild . . . Condition requires some special attention when planning for the client's placement and/or some extra supervision/care

2 Moderate . Condition has a major impact upon the ability to obtain an appropriate placement for the client and/or requires a considerable amount of supervision/care

3 Severe . . Condition is so substantial that it is exceedingly difficult to find an appropriate placement for the client and/or constant supervision/care is required

9 Condition suspected, impact undetermined

When coding Condition Impact:

- If the client has no mental disorder, these items should be left blank.

- If the client has a mental disorder, but it does not have an affect upon supervision/care and/or program placement, use code "0".

Example of Coding Condition Impact

The following example shows the coding for the client described above where the impact that the adjustment disorder has on the level of supervison required is moderate and the impact that the personality disorder has on supervision required is mild.

Condition Impact (Axis I)

50c. |2|

51c. | |

Condition Impact (Axis II)

52c. |1|

53c. | |

CHRONIC MAJOR MEDICAL CONDITION

54a.-59a. CONDITION TYPE

These items indicate the presence of major, chronic medical problems that limit or impede the client or significantly impact the provision of service. Using ICD-9-CM code(s), specifically list the client's significant medical condition(s). Do not list the AAMD diagnoses, the DSM-III diagnoses, nor the causes of Mental Retardation, for example, phenylketonuria. Do not list acute, self-limiting illnesses (such as pneumonia, measles, etc.), nor any static nonlimiting condition (such as acne). List only those major conditions that are chronic and require continued medical follow-up or treatment and have a significant impact on the client's functioning. Such conditions include, but are not limited to, diabetes mellitus, hypertension, congenital or arteriosclerotic heart disease, upper respiratory infections, etc.

Because of the significant impact of chronic hepatitis or the presence of its carrier state, the following hepatitis coding should be included among the client's Major Medical Conditions. Please use the following ICD-9-CM codes to indicate immune status for Hepatitis B:

070.0	Viral Hepatitis B
070.30	Hepatitis B susceptible
070.31	Hepatitis B immune
070.32	Hepatitis B carrier
070.33	Hepatitis B vaccination in progress
070.34	Hepatitis B immune status unknown

When coding Condition Type:

- Enter the appropriate ICD-9-CM code as listed above for Hepatitis in Item 54a.

- Enter ICD-9-CM codes in items 55a through 59a, using as many items as necessary, to record the client's Major Medical Condition(s) other than Hepatitis.

- If the "hard copy" of the CDER form is to be retained in the client's record and if it is desired, write the name of the condition in the "specify" space provided.

- If the client has no major medical condition, enter 000.00 in Item 55a and leave all other items in this section (including Condition Impact items) blank.

Examples of Coding Type of Chronic Major Medical Conditions

1. Client who is a carrier of Hepatitis B

Condition Type(s) (Specify)		ICD-9-CM Code
54a.	Hepatitis B Carrier	|0|7|0| o |3|2|
55a.		|_|_|_|_| o |_|_|
56a.		|_|_|_|_| o |_|_|

2. Client with two major chronic medical conditions

Condition Type(s) (Specify)		ICD-9-CM Code
54a.	Hypertension (benign)	|4|0|1| o |1|_|
55a.	Atherosclerosis (of Aorta)	|4|4|0| o |0|_|
56a.		|_|_|_|_| o |_|_|

54b.-59b. CONDITION IMPACT

This refers to the extent or degree to which the major chronic medical condition(s) affects the level of supervision/care required for and/or program placement of the individual.

Enter one of the appropriate codes as listed below in the spaces provided.

Condition Impact Codes

0 No evidence of impairment

1 Mild . . . Condition requires some special attention when planning for the client's placement and/or some extra supervision/care

2 Moderate . Condition has a major impact upon the ability to obtain an appropriate placement for the client and/or requires a considerable amount of supervision/care

3 Severe . . Condition is so substantial that it is exceedingly difficult to find an appropriate placement for the client and/or constant supervision/care is required

9 Condition suspected, impact undetermined

- If the client has no chronic medical condition, leave these Items 54b-59b blank.

- If the client has a chronic medical condition, but this condition does not affect level of supervision required and/or program placement, code the client "0"--"No evidence of impairment."

- If the client has a major medical condition, enter the code which represents the degree of impact on supervision/care and/or placement.

Example of Coding Condition Impact for Chronic Major Medical Condition

This is an example of coding a client whose hypertension requires some special attention (mild impact) and whose heart disease requires a considerable amount of care (moderate impact).

Condition Impact

54b. |1|
55b. |2|
56b. | |
57b. | |
58b. | |
59b. | |

HEARING

60. LEVEL OF HEARING LOSS UNCORRECTED

Items 60-61 are concerned with the client's hearing, first without the use of corrective measures and then with the use of corrective measures, if they are necessary. The purpose of recording the client's hearing before and after correction is to determine if it can be improved, as this can be a factor in placement and/or level of supervision/care required. Code the uncorrected level of hearing loss in Item 60; code the level of hearing loss after corrective measures have been made in Item 61.

The rating levels in this item indicate the client's hearing capabilities. Ideally, hearing should be tested relative to the client's ability to hear under everyday conditions. If the client requires a hearing aid, he/she is to be tested and rated first without the hearing aid.

The codes below represent the client's hearing capability without correction.

Level of Hearing Loss Codes (Uncorrected)

0 Hearing within normal limits

1 Mild to moderate hearing loss
Indicates hard of hearing

2 Severe hearing loss
Indicates that conversation must be very loud or shouted to be heard

3 Profound hearing loss
Indicates that the client does not rely on hearing as a primary channel of communication

4 Hearing loss, one ear
Indicates that the client has severe or worse hearing loss in one ear and hearing within normal limits in the other ear

9 Hearing loss suspected, severity not determined Indicates that hearing has been tested but the severity is undetermined, or hearing has not been tested, but loss is evident

When rating the client's hearing loss uncorrected:

- If hearing has been tested and the results are reported in the client's record, enter the appropriate code in box 60 (levels "0"-"4"), as listed above.

- If hearing has been tested but the severity of impairment has not been determined, rate the client at Level "9".

- If hearing loss is evident but the client has not been tested, rate the client at Level "9."

NOTE: **Rate at Level "4"--Hearing loss, one ear--the client who has severe or worse hearing loss in one ear and hearing within normal limits in the other ear. If the client has partial hearing loss (moderate or better) in one ear, and hearing within normal limits in the other ear, rate the client's overall level of hearing loss; do not rate at Level "4" in this case.**

Refer below for an example of coding in this section.

61. LEVEL OF HEARING LOSS (CORRECTED)

This item refers to the client's hearing capability after being corrected with the use of a hearing aid.

The codes below represent the client's hearing capability after being corrected with a hearing aid.

Level of Hearing Loss Codes (Corrected)

0 Hearing within normal limits

1 Mild to moderate hearing loss

2 Severe hearing loss

3 Profound hearing loss

8 Correction not possible (because of medical or other reasons)

9 Hearing loss not corrected

When rating the client:

- If the client's hearing has been corrected and he/she wears the hearing aid more than 50 percent of the time, rate the client while wearing the hearing aid at the appropriate level "0" - "3".

- If, for any reason, it is not possible to correct the clients hearing, for example, hearing is not correctable due to medical reasons, or the client's behavior (such as constant bumping of head) precludes the wearing of a hearing aid, rate the client at Level "8"--Correction not possible.

- If the client's hearing is within normal limits when uncorrected--Item 60 coded "0"--leave this item blank.

- If the client's hearing loss is not corrected or he/she does not wear a hearing aid most of the time, rate at Level "9".

Example of Coding Level of Hearing Loss

Following are examples of coding for a client with severe hearing loss (uncorrected) in one ear and hearing within normal limits in the other ear; and the same client whose hearing has been corrected, and as a result, hearing improved to moderate hearing loss in one ear and hearing within normal limits in the other ear.

Level of Hearing Loss Uncorrected

60. |4|

0 Hearing within normal limits
1 Mild to moderate hearing loss (hard of hearing)
2 Severe hearing loss
3 Profound hearing loss
4 Hearing loss, one ear
9 Hearing loss suspected

Level of Hearing Loss Corrected

61. |1|

0 Hearing within normal limits
1 Mild to moderate hearing loss
2 Severe hearing loss
3 Profound hearing loss
8 Correction not possible
9 Hearing loss not corrected

62. LEVEL OF VISION LOSS UNCORRECTED

The rating levels in these items indicate the degree of the client's visual impairment without glasses or contact lenses. It refers to a functional limitation of the eye (for example, limited visual acuity or visual field), and should be distinguished from visual disability (such as limited reading skills). If the client requires glasses or contact lenses, he/she is to be tested first without them.

The purpose of rating the client's vision before and after correction is to determine if visual acuity can be improved, as visual impairment can affect supervision/care or the placement of the client.

If tests other than those that measure acuity are used, then the results are to be transferred into acuity levels of measurement.

The codes below represent the various levels of vision impairment without corrective aids.

Level of Vision Loss Codes (Uncorrected)		Acuity
0	Vision within normal limits.....	20/12 to 20/30
1	Mild impairment.....	20/31 to 20/70
2	Moderate impairment	20/71 to 20/200
3	Severe impairment (legally blind) ..	Greater than 20/200
4	Total blindness	No light perception Must rely on other senses entirely.
5	Vision loss, one eye	Greater than 20/200 Indicates severe impairment or worse in one eye and vision within normal limits in the other eye.
9	Vision loss suspected, severity not determined	Indicates that vision impairment is evident but the client has not been tested.

When coding the client's level of vision loss uncorrected:

- If vision has been tested (without corrective lenses) and the results have been reported in the client's record, enter the appropriate code (levels "0"-"5") as listed above, in box 62.

- If vision impairment is evident but there is no record of testing, rate the client at at Level "9."

NOTE: Rate at Level "5"--Vision loss, one eye--the client who has severe or worse vision loss (acuity greater than 20/200 in on eye and vision within normal limits in the other eye. If the client has partial vision loss (moderate or better) in one eye, and vision within normal limits in the other eye, rate the client's overall level of vision loss; do not rate at Level "5" in this case.

Refer below for an example of coding this item.

63. LEVEL OF VISION LOSS CORRECTED

Item 63 refers to the client's level of vision after being corrected with glasses or contacts. If the client's vision is corrected and he/she wears the corrective lenses more than 50 percent of the time, rate the client wearing them at the appropriate level "0"-"3".

The codes below represent the client's level of vision after it has been corrected.

Level of Vision Loss Codes (Corrected)

0	Vision within normal limits
1	Mild impairment
2	Moderate impairment
3	Severe impairment
8	Correction not possible
9	Vision not corrected

When coding the client's level of vision loss corrected:

- If, for any reason, correction is not possible, for example, medical reasons or client's behavior precludes the use of corrective lenses, rate the client at Level "8".

- If the client's vision uncorrected is within normal limits--code "0" in Item 62--leave this item (63) blank.

- If the client's vision impairment is not corrected or he/she does not wear glasses or contacts most of the time, rate at Level "9".

Examples of Coding Level of Vision Loss

1. The example below shows coding for a client whose uncorrected vision in one eye is severely impaired and is mildly impaired in the other eye; after correction with glasses the level of vision impairment in one eye is moderate and in the other eye is mild.

Level of Vision Loss Uncorrected

62. |3|

0 No vision loss

1 Near normal

2 Moderate impairment

3 Severe impairment (legally blind)

4 Total blindness (no light perception)

5 Vision loss, one eye

9 Vision loss suspected, severity undetermined

Level of Vision Loss Corrected

63. |1|

0 Vision within normal limits

1 Mild to moderate vision loss

2 Severe vision loss

3 Profound vision loss

8 Correction not possible

9 Vision loss not corrected

2. This example is of a client whose uncorrected level of vision loss is severe and whose corrected vision loss is still severe.

Level of Vision Loss Uncorrected

62. |3|

0 No vision loss

1 Near normal

2 Moderate impairment

3 Severe impairment

4 Total blindness

5 Vision loss, one eye

9 Vision loss suspected, severity undetermined

Level of Vision Loss Corrected

63. |2|

0 Vision within normal limits

1 Mild to moderate vision loss

2 Severe vision loss

3 Profound vision loss

8 Correction not possible

9 Vision loss not corrected

64.-69. TYPE(S) OF PRESCRIBED MEDICATION FOR MALADAPTIVE BEHAVIOR

The purpose of these items is to determine if the client is receiving medication specifically prescribed to control "Maladaptive Behavior." Maladaptive Behavior includes hyperactivity, self-injurious behavior, aggression, and poor impulse control--generally those behavior items in the Emotional Domain of the CDER Evaluation Element. It also includes behaviors or symptoms associated with psychiatric diagnoses; for example, behaviors associated with thought disorders, hallucinations, depression, mania, severe mood swings, or anxiety would be included. **Medications that result in the control of maladaptive behavior, but are prescribed for other purposes, should not be included here.**

Enter code "1" = Yes or "2" = No for each of the following types of medications.

Type(s) of Prescribed Medication for Maladaptive Behavior

64. Antipsychotic
65. Antidepressant
66. Antianxiety
67. Sedative/Hypnotic
68. Stimulant
69. Other Psychotropic Drug

On the following pages, for reference, are many drugs (not all inclusive) which are used to control Maladaptive Behavior. Trade names are in bold type and generic names are in regular type. If a drug is being given for Maladaptive Behavior and it is not on the list, ask a physician where it should be classified.

If a drug that the client is taking to control Maladaptive Behavior does not fit into any of the types given, code Item 69, Other Psychotropic Drug, "1" for Yes. **Item 69 should only be used for psychotropic drugs that can not be categorized under items 64-68.**

For "combination" drugs, code all parts of the combination separately in the appropriate category type; for example, Limbitrol (Amitripyline and Chlordiazepoxide) would be coded "1" = Yes in Items 65 (antidepressant) and 66 (antianxiety).

Note that in situations where the client has a "paradoxical response" to a certain medication, rate the client according to the formulary--in other words, its original purpose. For example, if a sedative type of medication has a stimulating (opposite) effect on a client, the medication would still be designated as a sedative medication; therefore enter Code "1" in Item 67.

An example of coding this section follows the list of medications.

LIST OF MEDICATIONS FOR CONTROL OF MALADAPTIVE BEHAVIOR

Medication	Type
Acetophenazine	Antipsychotic
Adapin	Antidepressant
Amitripyline	Antidepressant
Amobarbital	Sedative/Hypnotic
Amoxapine	Antidepressant
Amphetamine	Stimulant
Amytal	Sedative/Hypnotic
Asendin	Antidepressant
Atarax	Antianxiety
Ativan	Antianxiety
Aventyl	Antidepressant
Benzedrine	Stimulant
Butabarbital	Sedative/Hypnotic
Butaperazine	Antipsychotic
Butisol	Sedative/Hypnotic
Cobalith-S	Antidepressant
Centrax	Antianxiety
Chloral Hydrate	Sedative/Hypnotic
Chlordiazepoxide	Antianxiety
Chlormezanone	Antianxiety
Chlorpramazine	Antipsychotic
Chlorprothixene	Antipsychotic
Clorazepate	Antianxiety
Compazine	Antipsychotic
Corphenazine	Antipsychotic
Cylert	Stimulant
Dalmane	Sedative/Hypnotic
Deserpidine	Antipsychotic
Desipramine	Antidepressant
Desirel	Antidepressant
Desoxyn	Stimulant
Dexedrine	Stimulant
Dextroamphetamine	Stimulant
Diazepam	Antianxiety
Doxepin	Antidepressant
Elavil	Antidepressant
Endep	Antidepressant
Eskalith	Antidepressant
Eutonyl	Antidepressant
Equanil	Antianxiety
Fluphenazine	Antipsychotic
Flurazepam	Sedative/Hypnotic
Halazepam	Antianxiety
Haldol	Antipsychotic
Haloperidol	Antipsychotic
Harmonyl	Antipsychotic
Hydroxyzine	Antianxiety
Imipramine	Antidepressant
Inderal	Other
Isocaboxazid	Antidepressant
Librium	Antianxiety
Lithane	Antidepressant
Lithium	Antidepressant
Lithobid	Antidepressant
Lithonate	Antidepressant
Lorazepam	Antianxiety
Loxapine	Antipsychotic
Loxitane	Antipsychotic
Ludiomil	Antidepressant
Maprotiline	Antidepressant
Marplan	Antidepressant
Mellaril	Antipsychotic
Meprobamate	Antianxiety
Meprospan	Antianxiety
Mesoridazine	Antipsychotic
Methamphetamine	Stimulant
Methylphenidate	Stimulant
Metrotabs	Antianxiety
Miltown	Antianxiety
Moban	Antipsychotic
Molindone	Antipsychotic
Nardil	Antidepressant
Navane	Antipsychotic
Nembutal	Sedative/Hypnotic
Noctec	Sedative/Hypnotic
Norpramin	Antidepressant
Nortriptyline	Antidepressant
Oxazepam	Antianxiety
Pamelor	Antidepressant
Pargyline	Antidepressant
Permitil	Antipsychotic
Parnate	Antidepressant
Paxipam	Antianxiety
Pemoline	Stimulant
Pentobarbital	Sedative/Hypnotic
Pentotal	Sedative/Hypnotic

List of Medications (continued)

Medication	Type
Perphenazine	Antipsychotic
Pertofrane	Antidepressant
Phenelzine	Antidepressant
Piperacetine	Antipsychotic
Prazepam	Antianxiety
Prochlorperazine	Antipsychotic
Proketazine	Antipsychotic
Prolixin	Antipsychotic
Promazine	Antipsychotic
Propanolol	Other
Protriptyline	Antidepressant
Quide	Antipsychotic
Repoise	Antipsychotic
Ritalin	Stimulant
Secobarbital	Sedative/Hypnotic
Seconal	Sedative/Hypnotic
Serax	Antianxiety
Serentil	Antipsychotic
Sinequan	Antidepressant
Sparine	Antipsychotic
Stelazine	Antipsychotic
Surmontil	Antidepressant
Taractan	Antipsychotic
Thioridazine	Antipsychotic
Thiothixene	Antipsychotic
Thorazine	Antipsychotic
Tindal	Antipsychotic
Tofranil	Antidepressant
Trancopal	Antianxiety
Tranxene	Antianxiety
Tranylcypromine	Antidepressant
Trazodone	Antidepressant
Trifluoperazine	Antipsychotic
Triflupromazine	Antipsychotic
Trilafon	Antipsychotic
Trimipramine	Antidepressant
Valium	Antianxiety
Vespria	Antipsychotic
Vistaril	Antianxiety
Vivactil	Antidepressant

Example of Coding Types of Prescribed Medication for Maladaptive Behavior

This client has been prescribed Haldol and Valium in order to control maladaptive behavior. Haldol is an antipsychotic and Valium is an antianxiety medication.

Types of Prescribed Medication for Maladaptive Behavior

1 = Yes 2 = No

64. |1| Antipsychotic
65. |2| Antidepressant
66. |1| Antianxiety
67. |2| Sedative/Hypnotic
68. |2| Stimulant
69. |2| Other Psychotropic Drug

70. HISTORY OF PRESCRIBED MEDICATION FOR MALADAPTIVE BEHAVIOR

This item is concerned with the present and past status of the client's medication treatment for Maladaptive Behavior (see definition given with the preceding item). Enter in Item 70 the appropriate code "1" - "5" if the client has or has had a prescription for a drug which is or has been used continuously. "Continuously" means used daily for more than a month or on some other regular basis, such as a long-acting drug given intramuscularly on a weekly or biweekly basis. "Continuously" does not include occassionally, such as for dental work. If there is no known information that the client has received medication for Maladaptive Behavior, use code "6".

The medications of interest in this item are listed in the previous item and are categorized as antipsychotic, antidepressant, antianxiety, sedative/hypnotic, and stimulant.

The codes below represent the status of the client's history of medication taken continuously for the purpose of controlling Maladaptive Behavior.

History of Prescribed Medication for Maladaptive Behavior Codes

1 Currently receiving one or more prescribed medication(s)

2 Medication(s) discontinued within six months

3 Medication(s) discontinued more than six months but less than one year

4 Medication(s) discontinued more than one year but less than four years

5 Has not received medication(s) during past four years

6 No known documented history of receiving medication(s)

Example of Coding History of Prescribed Medication for Maladaptive Behavior

1. The example below shows the coding for a client who has taken medication to control Maladaptive Behavior but has not taken any in the past three months.

History of Prescribed Medication for Maladaptive Behavior

70. |2|

1 Currently receiving one or more prescribed medication(s)

2 Medication(s) discontinued within six months

3 Medication(s) discontinued more than six months but less than one year

4 Medication(s) discontinued more than one year but less than four years

5 Has not received medication(s) during past four years

6 No known documented history of receiving medication(s)

2. The example below shows the coding for a client who (in the past) has taken medication prescribed to control Maladaptive Behavior, but has been off for two and one-half years.

History of Prescribed Medication for Maladaptive Behavior

70. |4|

1 Currently receiving one or more prescribed medication(s)

2 Medication(s) discontinued within six months

3 Medication(s) discontinued more than six months but less than one year

4 Medication(s) discontinued more than one year but less than four years

5 Has not received medication(s) during past four years

6 No known documented history of receiving medication(s)

71.-75. TYPE(S) OF INVOLUNTARY MOVEMENT(S)

THESE ITEMS ARE TO BE COMPLETED FOR DEVELOPMENTAL CENTER CLIENTS ONLY.

Involuntary movements may be caused by inherited or acquired factors. However, in rating the items no etiology is implied. There are many types of involuntary movements, but only five types have been distinguished for classification here. The client's physician is responsible for assuring the accuracy of the ratings. <u>These items may only be completed or based on information given by a person specifically trained to recognize these movements.</u> Each of the following items should be coded "1" = Yes if the movement is present or "2" = No if the movement is not present. A movement need not be persistent to be coded "1". It should be coded "1" even if it does not occur often.

Following are definitions of the movements of concern:

71. Parkinsonism is a constellation of symptoms characterized by abnormal slowness diminished spontaneity and associative movements, rigidity, and resting tremor. Typical symptoms include: bradykinesia, diminished arm swing, small steps, rigidity, cogwheeling, masked face (diminished spontaneous facial expression), sialorrhea (drooling), seborrhea (greasy skin), resting tremors, micrographia, postural instability, stooped posture, turning "en bloc," hypotonia, positive glabellar response, and diminished rate of blinking.

72. Dystonia is persistent deviation of a body part due to abnormal muscle contraction. Partial or incomplete dystonia may consist of a tendency to abnormal deviation which can be overcome (at least temporarily) by volitional corrections; repetitious movements may result from this interaction between voluntary and involuntary movements. Examples of Dystonia movements include: ocular (e.g., "oculogyric crisis"), tongue deviation, neck deviation (e.g., retrocollis, torticollis), limb deviation, and trunk deviation. Hypertonia need not be part of the deviation.

73. Dyskinesia is involuntary choreoathetoid movements which may appear to be semipurposeful (cf. rhythmic or explosive). The name "Athetosis" refers to a slow, torsional movement.

74. Akathisia (or Acathisia) is motor restlessness. Symptoms include shifting of position while standing, alternate sitting and standing, rocking, and inappropriate pacing. Akathisia is different from "hyperactivity" which is less rhythmetic.

75. Paroxysmal is abrupt, nonpurposeful movement of body parts (e.g., tics, twitches, which are not part of a convulsive seizure).

Example of Coding Abnormal Involuntary Movements

Following is an example of coding a developmental center resident who persistently experiences Parkinsonism. The reason he/she has the movement disorder is of no concern here, i.e., the client could have inherited the disorder or acquired it through prolonged use of any type of psychotropic drug.

Types of Involuntary Movements

1 = Yes 2 = No

71. |1|
72. |2|
73. |2|
74. |2|
75. |2|

76.-85. SPECIAL HEALTH CARE REQUIREMENTS

The purpose of this section is to determine if the client has any special requirement(s) due to a chronic long-term condition and to identify such requirement(s). Special health care requirements refer only to those medications, treatments, equipment, etc., that represent normal, routine procedures. Do not code medications, treatments, equipment, etc., that are necessary for nonchronic, short-term conditions.

- If the client does not have such a requirement, enter "00" in Item 76 and leave Items 77-85 blank.

- If the client has a special health care requirement, enter the appropriate two-digit code as listed on the following pages.

- As many as ten special health care requirements may be entered. If the client has more than ten, enter the ten most significant requirements.

- If the client has more than one special requirement one year but in the following year no longer has one or more of these requirements, in the new year re-enter the remaining requirements, beginning with Item 76. In other words, move the requirements forward so that there will not be blank spaces before or between the requirements.

Examples of Coding Special Health Care Requirements

1. Client has an ileostomy (code 21), is on a special diet (code 42), and needs to use a walker (code 55) for ambulation.

76.	77.	78.	79.	80.
|2|1|	|4|2|	|5|5|	| | |	| | |

81.	82.	83.	84.	85.
| | |	| | |	| | |	| | |	| | |

2. Client requires decubitus care (code 64), frequent turning in bed (code 65), a gastrostomy tube (code 43), and an indwelling catheter (code 22).

76.	77.	78.	79.	80.
|2|2|	|4|3|	|6|4|	|6|5|	| | |

81.	82.	83.	84.	85.
| | |	| | |	| | |	| | |	| | |

Following is the list of and definitions for Special Health Care Requirements.

SPECIAL HEALTH CARE REQUIREMENTS

(Refer to Items 76-85)

Enter medication(s), treatment(s), equipment, and other aid(s) that the client requires as part of a regular regimen.

Health Care Requirement	Code
I. SPECIAL TREATMENT/TESTING NEEDS	
Sterile Dressings	1 1
A procedure where, in a sterile environment, dressings are changed for a chronic condition on a daily basis.	
Diabetic Test	1 2
The client is diagnosed as being diabetic and requires daily testing.	
Diabetic or Other Injections	1 3
The client has a medical condition which requires at least weekly injections.	
Other	1 4
II. ELIMINATION NEEDS	
Ostomy Equipment	2 1
The client has a colostomy or ileostomy and requires direct care and treatment by another person (including changing colostomy bag, application of dressing, and irrigations). The client may be able to perform some of the tasks, but requires close supervision.	

Health Care Requirement	Code
Catheter The client has a condition which necessitates the use of either an indwelling or external catheter on a daily basis.	2 2
Enemas The client requires regularly prescribed enemas on an ongoing basis.	2 3
Other	2 4
III. RESPIRATORY NEEDS	
Apnea Monitor The client is diagnosed as having apnic spells that require the use of an apnea monitor.	3 1
Tracheostomy Care The client presently has a tracheostomy, including relevant suctioning care.	3 2
Suctioning The client's respiratory condition is such that he/she requires suctioning on a daily basis. Do not include suctioning required by tracheostomy.	3 3
Inhalation Therapy The client requires inhalation therapy three times a week or more.	3 4
Oxygen The client requires oxygen assistance more than once a week.	3 5
Respirator The client needs mechanical assistance to maintain adequate ventilation.	3 6

Health Care Requirement	Code
Other	3 7

IV. EATING NEEDS

Special Eating Utensils	4 1
The client requires special cups, plates, spoons, knives, forks, etc., in order to feed self.	
Special Diet	4 2
Client requires modified consistency diet (inclusive) other than that which is routinely provided in the home; for example, diabetic, PKU, Prader-Willi, low sodium and other endocrine, and metabolic deficiencies.	
Nasal/Gastric Tube or Gastronomy	4 3
The client requires all dietary needs via nasal/gastric tube or gastrostomy tube, or oral feedings are supplemented with nasal/gastric tube or gastrostomy tube feedings.	
Parenteral Equipment	4 4
The client requires parenteral (intravenous or other) feedings to augment existing diet or as a primary source of nutrition.	
Other	4 5

V. MOBILITY NEEDS

Prosthetic Device (limb, hand, etc.)	5 1
The client requires a prosthetic device, such as an artificial limb, hand, etc., in order to ambulate or complete activities of daily living.	

Health Care Requirement	Code
Electric Wheelchair	5 2
The client uses an electric wheelchair	
Manual Wheelchair	5 3
The client uses a manual wheelchair.	
Special Chair	5 4
The client uses a specially designed chair for positioning purposes.	
Walker	5 5
The client needs the assistance of a walker for ambulation.	
Braces/Splints/Casts/Orthopedic Shoes	5 6
Client wears braces, splints, casts, or orthopedic shoes on a daily basis to prevent contractures and aid in ambulation.	
Crutches/Cane	5 7
The client uses a cane and/or crutch.	
Other	5 8

VI. ADAPTIVE POSITIONING NEEDS

Special Bed	6 1
The client's medical needs are such that they require other than the standard bed.	
Floatation Cushion/Pad	6 2
The client requires a floatation cushion or pad, or similar device.	

Health Care Requirement	Code
Belly Board The client has to be placed on a belly board as part of daily program.	6 3
Decubitus Care and Equipment The client has decubiti and requires frequent turning, medical treatment and/or special mattresses.	6 4
Frequent Turning in Bed The client is unable to reposition self, and requires frequent repositioning.	6 5
Head Protective Device The client has to wear a helmet or similar protective device as part of a daily program.	6 6
Other	6 7
VII. OTHER HEALTH REQUIREMENTS NOT LISTED ABOVE	7 1

SPECIAL CONDITIONS OR BEHAVIORS

Items in this section are optional. Please rate them only when it is necessary to know this information for rate-setting and placement decisons.

The purpose of this section is to determine if the client has a condition or behavior which may affect placement in a suitable living arrangement or day program. Items in this section are meant to act as flags to alert those persons who are responsible for placement to certain conditions or behaviors that the client may have that could make finding a living arrangement or participating in a program difficult. Additionally, items in this section are not meant to duplicate items already in the Evaluation Element of CDER.

86.-94. SPECIAL CONDITIONS OR BEHAVIORS (OPTIONAL)

Items 86-94 are specific conditions and behaviors of concern that may preclude or make difficult the placement of the client. Make an entry, 1 = Yes, 2 = No, or 3 = Unknown for each behavior/condition.

Please use the code 1 = Yes only when documents or other data indicate the existence of the given condition or behavior. If the answer to a particular item is unknown, please code 3 = Unknown.

Following are the definitions of the special conditions or behaviors.

86. Does the client display maladaptive sexual behavior?

This item should be answered "yes" if the client manifests any of the following:

Use of inappropriate sex object
Inappropriate touching of self
Sexual fixation
Masturbation in public
Displaying genitals in public
Assaultive behavior of a sexual nature against minors
Assaultive behavior of a sexual nature against adults

87. Has the client engaged in any assaultive behaviors that have or could have resulted in serious bodily injury or death?

This item should be answered "yes" if the client has committed or attempted to commit homicide (including murder, voluntary or involuntary manslaughter), robbery, or felonious assault.

88. Has the client attempted suicide in the past five years?

This item should be answered "yes" if the client has attempted suicide in the past five years.

89. Does the client habitually engage in theft?

This item should be answered "yes" if the client has habitually engaged in stealing either in the community or in the living arrangement during the past five years. Note that the concern here are those persons who are aware of what they are doing--they know that the act that they are committing is taking that which does not belong to them.

90. Has the client participated in acts of vandalism or other acts of property destruction?

This item should be answered "yes" if the client has engaged in acts of vandalism or similar acts of property destruction,such as breaking windows, furniture, etc., during the past five years.

91. Has the client been convicted of any substance- or alcohol-abuse related offenses?

This item should be answered "yes" if the client has been convicted of any substance-abuse or alcohol-abuse related offenses, such as selling or possession of controlled substances, during the past five years.

92. Does the client have a recent history of abusing drugs or alcohol?

This item should be answered "yes" if the client is currently abusing or has within the past three years abused drugs or alcohol.

93. Does the client have a history of habitual lying?

This item should be answered "yes" if the client habitually lies and thereby creates problems, or has created problems in his or her program or living arrangement during the past three years.

94. Does the client display behaviors which could result or have resulted in fire setting?

This item should be answered "yes" if the client has a history of setting fires or engaging in behaviors which could result in fires. Examples of such behaviors include but are not limited to: fascination with matches, lighters, and fire; collecting matches and lighting them, but setting nothing on fire; setting off false fire alarms; setting small fires to express frustration; and having the inability to resist the impulse to set fires after much preparation.

This section refers to any special legal conditions pertaining to the client. Included here are probationary or parole status, diversion under Penal Code sections 1001.20 et seq., commitment under Welfare and Institutions Code section 6500, conservatorship under Lanterman-Petris-Short (LPS), conservatorship under the Probate Court, and dependent child status under Welfare and Institutions Code section 300 et seq.

95.-100. SPECIAL LEGAL CONDITIONS

Make an entry 1 = Yes, 2 = No for each of the following items.

Complete for all clients.

95. Is the client currently on probation, county or state parole, or commitment under Penal Code or Welfare and Institutions Code sections relating to a criminal offense?

This item should be answered "yes" if the client is currently on probation, county or state parole or under commitment under (1) Penal Code Section 1367 et seq., as incompetent to stand trial, or (2) under Penal Code Section 1026, as not guilty of a criminal offense by reason of insanity, or (3) W&I Code Section 1756 as a person transferred from the Youth Authority or from Department of Corrections (PC Section 2684) to DDS for placement. The client may be placed either in a state facility or directly into the community. Additionally, these would be clients who may be returned to the community under Penal Code 1608 et seq.

96. Is the client currently on Diversion pursuant to Penal Code section 1001.20 et seq.?

This item should be answered "yes" if the client is on Diversion status. A Diversion client is a developmentally disabled person "diverted" out of the criminal justice system pursuant to Penal Code statutes relating to drug abuse and family violence. Included are developmentally disabled persons who are returned to the community from the Department of Corrections on parole or into a work-furlough program. Most of these persons will be adults, as children are usually dealt with through the Welfare and Institutions Code. NOTE: these clients are usually not housed in state developmental centers.

97. Is the client currently a person within the provisions of Welfare and Institutions Code Section 6500 et seq. (i.e., dangerous mentally retarded individual committed by the Court)?

This item should be answered "yes" if the client is currently under a W&I Code Section 6500 commitment. Persons committed under this section are a danger to self and others and are thus committed by the court to DDS for appropriate placement.

98. Is the client currently under a Lanterman, Petris, Short (LPS) (mental health) conservatorship?

This item should be answered "yes" if the client has an LPS conservator.

99. Is the client currently a conservatee under the Probate Code?

This item should be answered "yes" if the client has a conservator under the Probate Code (i.e., client was admitted or continued as client of regional center to make informed application and consent to treatment).

100. Is the client currently a dependent child of the Court (Welfare and Institutions Code Section 300 et seq.)?

This item should be answered "yes" if the client is currently a dependent child of the Court.

ATTACHMENTS

TO THE

DIAGNOSTIC ELEMENT

NUMERICAL INDEX OF DISEASES AS CLASSIFIED IN THE INTERNATIONAL CLASSIFICATION OF DISEASES 9TH EDITION, CLINICAL MODIFICATION (ICD-9-CM)

ATTACHMENT I is a listing of general types of categories of diseases that provides the ICD-9-CM code number group for each type of disease. This listing is provided to serve as a guide in locating a given coding for a specific condition within a group of diseases.

NUMERICAL INDEX OF DISEASES AS CLASSIFIED IN THE INTERNATIONAL CLASSIFICATION OF DISEASES 9TH EDITION, CLINICAL MODIFICATION (ICD-9-CM)

1. **Infectious and Parasitic Diseases (001 - 139)**

   This group of diseases includes diseases generally recognized as communicable or transmissible. Infections of the CNS (such as meningitis, encephalitis, toxic encephalitis--including heavy metal effects) are specifically coded elsewhere under Inflamatory Diseases of the CNS (320 - 326).

2. **Neoplasms (140 - 239)**

3. **Endocrine, Nutritional and Metabolic Diseases, and Immunity Disorders (240 - 279).**

   This group excludes endocrine and metabolic disturbances specific to the fetus and newborn (775.0 - 775.9).

4. **Diseases of the Blood and Blood-forming Organs (280 - 289).**

5. **Mental Disorders (290 - 319).**

   a. Psychoses (290 - 299)
   b. Neurotic Disorders, Personality Disorders, and other Nonpsychotic Mental Disorders (300 - 316)
   c. Mental Retardation (317 - 319)

6. **Diseases of the Nervous System and Sense Organs**

   a. Inflammatory Diseases of the CNS (320 - 326)
   b. Hereditary and Degenerative Disease of the CNS (330 - 337)
   c. Other Disorders of the CNS (340 - 349)

      This group (other disorders) includes demyelinating diseases, infantile cerebral palsy, and epilepsy.

7. **Diseases of the Circulatory System (390 - 459)**

8. **Diseases of the Respiratory System (460 - 519)**

9. **Diseases of the Digestive System (520 - 579)**

10. **Diseases of the Genitourinary System (580 - 629)**

11. **Complications of Pregnancy, childhood, and the Puerperium (630 - 676)**

12. **Diseases of the Skin and Subcutaneous Tissue (680 - 709)**

13. **Diseases of the Musculoskeletal System and Connective Tissue (710 - 739)**

14. **Congenital Anomalies (740 - 759)**

    This group includes congenital malformations and chromosomal disorders.

15. **Certain Conditions Originating in the Perinatal Period (760 - 779)**

    This group includes prematurity, asphyxia, infections specific to perinatal period, fetal and neonatal hemorrhage hemolytic disease of the newborn.

ATTACHMENT II

TABULAR LIST OF DISEASES
(ICD-9-CM Conversion Table)

ATTACHMENT II gives the ICD-9-CM numerical coding for the diseases and conditions formerly diagnosed with ICD-9-CM coding. This listing may be helpful in converting AAMD coding for conditions to the ICD-9-CM codes.

MEDICAL ETIOLOGICAL CLASSIFICATION

(Refer to AAMD Classification in Mental Retardation, 1983 Revision, pp. 130-134)*

AAMD Code	0	ICD-9-CM Code
00	**INFECTIONS AND INTOXICATIONS**	
01	**Prenatal infection**	
011	Cytomegalic inclusion disease, congenital	771.1
012	Rubella, congenital	771.0
013	Syphilis, congenital	090.9
014	Toxoplasmosis, congenital	771.2
018	Other maternal infection (unspecified)	**
019	Other maternal infection possibly associated with congenital abnormalities (i.e., herpes simplex, coxsackie-virus Group B	***
02	**Postnatal cerebral infection**	
021	Viral (specify)	***
022	Bacterial (specify)	***
028	Other (unspecified) postnatal cerebral infection	**
029	Other (specify) postnatal cerebral infection	***
03	**Intoxication**	
031	Toxemia of pregnancy	760.0
032	Other maternal intoxications (specify)	***
033	Other maternal disorders (e.g., Maternal PKU) (specify)	760.4/***
034	Hyperbilirubinemia (specify)	***
035	Lead	***
036	Post immunization	***
037	Fetal alcohol syndrome	760.71
038	Other (unspecified) maternal intoxication disease	**
039	Other (specify) maternal intoxication disease	***

* Expanded definitions included to aid in clarification.

** Other unspecified disease which would be categorized under the general classification heading. Refer to ICD-9-CM for code.

*** Other specified disease categorized under the general classification heading. Refer to ICD-9-CM for code for specific disease.

AAMD Code		ICD-9-CM Code
	I	
10	**TRAUMA OR PHYSICAL AGENT**	
11	Prenatal injury (specify)	***
12	Mechanical injury at birth	763
13	Perinatal hypoxia	768
14	Postnatal hypoxia (specify)	***
15	Postnatal injury (specify)	***
	II	
20	**METABOLISM OR NUTRITION**	
21	Neuronal lipid storage diseases	
211	Ganglioside storage diseases (specify)	330.1/***
212	Lipofuscin storage diseases (specify)	330.1/***
213	Other Glycolipidoses with neuronal involvement (specify)	330.1/***
22	**Carbohydrate disorders**	
221	Galactosemia	271.1
222	Glycogenoses (glycogen storage disease) (specify)	271.0/***
223	Fructosemia (Hereditary fructose intolerance)	271.2
224	Hypoglycemia	251.2
228	Other (unspecified) carbohydrate disorders	
229	Other (specify) carbohydrate disorders	
23	**Amino acid disorders**	
231	Phenylketonuria	270.1
238	Other (unspecified) amino acid disorders	**
239	Other (specify) disorders, e.g., involving tyrosine, cystine, tryptophan, etc.	***
24	**Other and unspecified disorders of metabolism**	277

** Other <u>unspecified</u> disease which would be categorized under the general classification heading. Refer to ICD-9-CM for code.

*** Other <u>specified</u> disease categorized under the general classification heading. Refer to ICD-9-CM for code for specific disease.

AAMD Code		II	ICD-9-CM Code
	25	**Mineral disorders**	275
		251 Wilson disease	275.1
		252 Idiopathic hypercalcemia	275.4
		258 Other (unspecified) mineral disorders	**
		259 Other (specify) mineral disorders	***
	26	**Endocrine disorders**	
		261 Thyroid dysfunction, congenital	243
		268 Other (unspecified) endocrine disorder	**
		269 Other (specify) endocrine disorder	***
	27	**Nutritional disorders (specify substance and time postnatal)**	***
	28	**Other (unspecified) metabolism or nutrition disorder (includes failure to thrive, postnatal)**	**
	29	**Other (specify) metabolism or nutrition disorder**	***
		III	
30		**GROSS BRAIN DISEASE (POSTNATAL)**	
	31	**Neurocutaneous dysplasia**	
		311 Neurofibromatosis (von Recklinghausen disease)	237.7
		312 Trigeminal cerebral angiomatosis (Sturge-Weber-Dimitri disease)	759.6
		313 Tuberous sclerosis	759.5
		318 Other (unspecified)	**
		319 Other (specify)	***
	32	**Tumors (specify)**	***

** Other unspecified disease which would be categorized under the general classification heading. Refer to ICD-9-CM for code.

*** Other specified disease categorized under the general classification heading. Refer to ICD-9-CM for code for specific disease.

AAMD Code			ICD-9-CM Code
		III	
	33	**Cerebral white matter, degenerative**	
	331	Sudanophilic leukodystrophy	330.0
	332	Sudanophilic leukodystrophy of Pelizaeus-Merzbacher type	330.0
	338	Other (unspecified) degenerative brain disease of cerebral white matter	**
	339	Other (specify) degenerative brain disease of cerebral white matter	***
	34	**Specific fiber tracts or neural groups, degenerative**	
	341	Huntington disease	333.4
	342	Spinocerebellar disease (specify)	334/***
	348	Other (unspecified)	**
	349	Other (specify)	***
	35	**Cerebrovascular system**	
	38	**Other (unspecified) gross brain disease**	**
	39	**Other (specify) gross brain disease**	***
		IV	
40		**UNKNOWN PRENATAL INFLUENCE**	
	41	**Cerebral malformation**	
	411	Anencephaly	740.0
	418	Other (unspecified)	**
	419	Other (specify) cerebral malformation, including microencephaly	***
	42	**Craniofacial anomaly**	
	421	Holoprosencephaly	742.2
	422	Cornelia de Lange syndrome	759.8
	423	Microcephalus	742.1

** Other unspecified disease which would be categorized under the generalclassification heading. Refer to ICD-9-CM for code.

*** Other specified disease categorized under the general classification heading. Refer to ICD-9-CM for code for specific disease.

AAMD Code		IV	ICD-9-CM Code
	424	Macroencephaly	742.4
	425	Crouzon syndrome	756.0
	426	Apert syndrome	755.55
	427	Craniostenosis (specify suture and type)	756.0
	428	Other (unspecified) craniofacial anomaly	**
	429	Other (specify) (includes Rubinstein-Taybi; Oral-Facial-Digital; Laurence-Moon-Biedl syndrome)	759.8/***
43		**Status dysraphicus**	
	431	Meningoencephalocele	742.0
	432	Meningomyelocele	741.9
	438	Other (unspecified) status dysraphicus disease	**
	439	Other (specify) status dysraphicus disease	***
44		**Hydrocephalus, congenital**	742.3
45		**Hydranencephaly**	742.3
46		**Multiple malformations (specify)**	***
47		**Single umbilical artery**	747.5
48		**Other (unspecified)**	**
49		**Other (specify)**	***
		V	
50		**CHROMOSOMAL ANOMALIES (758)** Includes syndromes associated with anomalies in the number and form of chromosomes. The code numbers used in this section are from the ICD-9-CM	
		Down syndrome Mongolism Translocation Down syndrome Trisomy 21 or 22, Trisomy G	758.0

** Other unspecified disease which would be categorized under the general classification heading. Refer to ICD-9-CM for code.

*** Other specified disease categorized under the general classification heading. Refer to ICD-9-CM for code for specific disease.

AAMD Code	V	ICD-9-CM Code
	Patau syndrome Trisomy 13, Trisomy D_1	758.1
	Edwards syndrome Trisomy 18 Trisomy E_3	758.2
	Autosomal deletion syndromes Antimongolism syndrome Cri-du-chat syndrome	758.3
	Balanced autosomal translocation in normal individual	758.4
	Other conditions due to autosomal anomalies Accessory autosomes NEC	758.5
	Gonadal dysgenesis Ovarian dysgenesis Turner syndrome XO syndrome	758.6
	Excludes pure gonadal dysgenesis	752.7
	Klinefelter syndrome XXY syndrome	758.7
	Other conditions due to sex	758.8
	Chromosome anomalies Additional sex chromosome Sex chromosome mosaicism Triple X syndrome XXX syndrome XYY syndrome	
	Conditions due to anomaly of unspecified chromosome	758.9
	VI	
60	**OTHER CONDITIONS ORIGINATING IN THE PERINATAL PERIOD**	
61	**Disorders relating to short gestation and unspecified low birthweight**	765
611	Extreme immaturity	765.0
612	Other preterm infants	765.1
62	**Slow fetal growth and fetal malnutrition**	764

AAMD Code			ICD-9-CM Code
		VI	
	621	"Light-for-dates" without mention of fetal malnutrition	764.0
	622	"Light-for-dates" with signs of fetal malnutrition	764.1
	623	Fetal malnutrition without mention of "light-for-dates"	764.2
	624	Fetal growth retardation, unspecified	764.9
63		**Disorders relating to long gestation and high birthweight**	766
	631	Exceptionally large baby	766.0
	632	Other "heavy-for-dates" infants	766.1
67		**Maternal nutritional disorders**	760.4
68		**Other (unspecified) conditions** originating in the perinatal period	**
69		**Other (specified)**	***
		VII	
70		**FOLLOWING PSYCHIATRIC DISORDER (SPECIFY)**	
71		**Psychosis (refer to DSM III)**	
79		**Other psychiatric disorder**	
		VIII	
80		**ENVIRONMENTAL INFLUENCES**	
81		**Psychosocial disadvantage**	
82		**Sensory deprivation (specify)**	
88		**Other (unspecified)**	
89		**Other (specify)**	
		IX	
90		**OTHER CONDITIONS**	
91		**Defects of special senses (specify) see pp. 151-152 of AAMD, 1983 Revision). For Unspecified Mental Retardation, use ICD-9-CM Code 319.**	

** Other unspecified disease which would be categorized under the general classification heading. Refer to ICD-9-CM for code.

*** Other specified disease categorized under the general classification heading. Refer to ICD-9-CM for code for specific disease.

ATTACHMENT III

CHROMOSOME ANOMALIES
EXPANDED CODING SYSTEM

ATTACHMENT III is an expanded coding series for detailed recording of chromosome anomalies. This coding system is based on the British Pediatric Association (B.P.A.) Classificaiton of Diseases and it is the system that currently is being used by the California Birth Defects Monitoring Program. The codes are compatible with those of the ICD-9-CM system and represent an expansion of chromosome anomalies coding that currently is not available in ICD-9-CM. This expansion permits much more precise coding than would be possible with ICD-9-CM coding used alone.

758

CHROMOSOME ANOMALIES
EXPANDED CODING SYSTEM

758.0	DOWN SYNDROME (clinical Trisomy 21)
.00	Trisomy 21
.01	Trisomy G, NOS
.02	translocation - duplication of a 21
.03	translocation - duplication of a G, NOS
.04	mosaic trisomy 21
.05	mosaic trisomy G, NOS
.06	_____
.07	_____
.08	_____
.09	Down Syndrome, NOS
758.1	PATAU SYNDROME (clinical trisomy 13)
.10	Trisomy 13
.11	Trisomy D, NOS
.12	translocation - duplication of a 13
.13	translocation - duplication of a D, NOS
.14	mosaic trisomy 13
.15	mosaic trisomy D, NOS
.16	_____
.17	_____
.18	_____
.19	Patau Syndrome, NOS
758.2	EDWARD SYNDROME (clinical trisomy 18)
.20	Trisomy 18
.21	Trisomy E, NOS
.22	translocation - duplication of an 18
.23	translocation - duplication of an E, NOS
.24	mosaic trisomy 18
.25	mosaic trisomy E, NOS
.26	_____
.27	_____
.28	_____
.29	Edward Syndrome, NOS
758.3	AUTOSOMAL DELETION SYNDROMES (excluding deletion due to unbalanced translocation)
.30	Deletion involving an A group chromosome (1,2,3, A-NOS)
.31	Cri du Chat syndrome - karyotype 4p-, deletion of B-NOS, clinical NOS

.32 Wolff Hirschorn Syndrome - karyotype 4p-, deletion of B-NOS, clinical NOS

.33 deletion involving a D group chromosome (13,14,15, D-NOS)

.34 deletion involving an E group chromosome (16,17,18)

.35 deletion involving an F group chromosome (19,20)

.37 deletion involving a C group chromosome (6,7,8,9,10,11,12, C-NOS)

.38 deletion involving a G group chromosome (21,22) includes antimongolism syndrome

.39 chromosome deletion, NOS

758.4 BALANCED AUTOSOMAL TRANSLOCATION IN NORMAL INDIVIDUAL

758.5 OTHER AUTOSOMAL DUPLICATION SYNDROMES
Excluding duplication due to unbalanced translocation

.50 Trisomy 8

.51 Other trisomy C syndromes (6,7,8,9,10,11,12)

.52 Trisomy D, exluding Patau Syndrome (14,15)

.53 Trisomy 22

.54 Additional marker chromosome

.55 Other complete trisomy, specified

.56 Complete trisomy, NOS

.57 Polyploidy, includes mosaic polyploidy, excludes triploidy

.58 Multiple chromosome abnormalities excluding mosaicism (example - trisomy and translocation in same individual)

.59 Structural chromosome abnormality, NOS

758.6 GONADAL DYSGENESIS - Excludes Pure Gonadal Dysgenesis (752.72)

.60 Turner phenotype - karyotype 45, X (XO)

.61 Turner phenotype - variant karyotypes (excludes normal 46,XX karyotype)

.62 Turner phenotype, karyotype normal

.63 Turner syndrome, karyotype unspecified

.64 Bonneville-Ullrich syndrome, NOS

.65 _____

.66 _____

.67 _____

.68 _____

.69 Other gonadal dysgenesis phenotype XY, female phenotype

758.7 KLINEFELTER'S SYNDROME

.70 Klinefelter phenotype, karyotype 47,XXY

.71 Klinefelter phenotype, other karyotype (excludes normal 46,XY karyotype)

.72 Klinefelter phenotype, karyotype 46,XX

.73 _____

.74 _____

.75 _____

.76 _____

.77 _____

.78 _____

.79 Klinefelter syndrome, NOS

758.8 OTHER CONDITIONS DUE TO SEX CHROMOSOME ANOMALIES
Excluding Turner (758.61) or Klinefelter phenotypes (758.71)

.80 Mosaic XO/XY

.81 Mosaic XO/XX

.82 Mosaic XY/XXY

.83 Mosaic XX/XY

.84 XYY male, includes mosaic XY/XYY

.85 XXX female

.86 Multiple sex chromosome mosaicism not involving Y chromosomes (example XO/XX/XXX)

.87 Multiple sex chromosome mosaicism involving Y chromosome (example XO/XY/XXY)

.88 Other, not described above

.89 Sex chromosome abnormality, NOS

758.9 MISCELLANEOUS CHROMOSOME ANOMALIES

.90 Fragile X in a developmentally delayed individual

.91 Fragile X in a normal individual

.92 Autosomal fragile site(s)

.93 Increased chromosome breakage

.94 Ring chromosome

.95 Monosomy G mosaicism

.96 _____

.97 _____

.98 _____

.99 Other

ATTACHMENT IV

TABLE OF SEIZURES CLASSIFICATION

ATTACHMENT IV presents the International Classification of Epileptic Seizures (after Gastaut, 1970), which is a classification of seizure types, not epilepsies.

TABLE OF SEIZURES CLASSIFICATION

(H. Gestaut, 1970, Epilepsia, 11, 102-113)

I. PARTIAL SEIZURES. These start usually in one focus in one hemisphere and often do not spread; they may produce a focally abnormal EEG or a normal one.

A. Elementary Symptoms

1. Motor

a. Focal, without march
b. Jacksonian, with march
c. Versive (usually contraversive)
d. Postural
e. Somatic inhibitory
f. Aphasic
g. Vocalization or arrest of speech

2. Sensory

a. Somatosensory
b. Visual
c. Auditory
d. Olfactory
e. Gustatory
f. Vertiginous

3. Autonomic

4. Compound forms

B. Complex Symptoms. May grow from a seizure with elementary symptoms; often include impairment of consciousness.

1. Impaired consciousness alone

2. Cognitive symptoms

a. Disturbances of memory (amnesia, deja vu, deja vecu)

b. Disturbances of ideation (forced thinking, dreamy state)

3. Affective symptoms (fear, rage, etc.)

4. Psychosensory symptoms (illusions, hallucinations)

5. Psychomotor symptoms (automatisms)

6. Compound forms

C. Generalized Seizures. (Usually tonic-clonic) arising from any of the above as a secondary event; the preceding partial seizure may then be termed an aura.

II. GENERALIZED SEIZURES. These start in the midline (brainstem) or symmetrical regions of grey matter bilaterally synchronously.

A. Absences (Often associated with 3-per-second-spike-and-wave on EEG - petit mal).

1. Simple (loss of consciousness only) - brief or extended

2. Clonic components added (myoclonic absences)

3. Increased tone added (retropulsive absences)

4. Decreased tone added (atonic seizures; "drop attacks")

5. Automatisms added (automatic absences)

6. Autonomic phenomena added (e.g., enuretic absences)

7. Mixed forms

B. Bilateral massive epileptic myoclonus

C. Infantile spasms (myoclonic seizures in children, with characteristic EEG pattern of "hypsarhythmia")

D. Clonic seizures (especially in children)

E. Tonic seizures (especially in children)

F. Tonic-clonic seizures (all ages). Generalized spiking in EEG-grand mal.

III. UNILATERAL OR PREDOMINANTLY UNILATERAL SEIZURES. Seen only in neonates and infants and likely a variant of generalized seizure seen in older individuals.

IV. UNCLASSIFIED EPILEPTIC SEIZURES

CLIENT EVALUATION INFORMATION

OVERVIEW OF THE EVALUATION ELEMENT

The Evaluation Element is the means by which the client's developmental growth is measured. It is composed of 66 items which are designed to allow the assessment of developmental status in six (6) areas (or domains) of development. The six areas are:

1. The Motor Domain, which measures the client's mobility capabilities;

2. The Independent Living Domain, which measures the client's competency in caring for himself/herself;

3. The Social Domain, which measures the extent to which the client interacts with others;

4. The Emotional Domain, which measures the client's emotional state and how he/she reacts in different situations;

5. The Cognitive Domain, which measures the client's perceptual and conceptual capabilities; and

6. The Communication Domain, which measures the client's ability to express and receive ideas by speech or nonverbal means.

Not all of these six domains are discrete, in the sense that behaviors represented in one domain are independent of behavior in the other domains. For example, some of the behaviors in the independent living domain involve motor skills measured in the motor domain.

Each of the domains consists of measurements using a number of key indicators. These indicators provide measures of the level of functioning in each domain. Successive administration of CDER at specified intervals provides a longitudinal measure of the magnitude and direction of developmental change.

Each item in the CDER Evaluation Element provides measures from no ability to perform the task to completely independent functioning. This permits the evaluator to record observations of an individual's growth and development from a level of no skills through one where the individual has completely mastered the particular skill. This applies to skills acquired through the normal process of maturation as well as to skills acquired through specified intervention strategies.

Most items are written so that the rating can be based on observed behavior. Each level of an item is presented in behavioral terms, which in most cases are readily observable. However, in some instances, ratings will have to be derived through the use of other methods, usually those commonly used in clinical assessment.

The Evaluation Element must be completed by the person(s) who works closely with and has responsibility for the client.

NOTE: The client's privacy must be respected at all times when rating the client, regardless of how the data are obtained, i.e., whether by interview, observation, or demonstration.

MOTOR DOMAIN

Age is the determining factor in the motor domain. Rate the client at the highest level of independent accomplishment even though the client may not be able to perform a step at an earlier level of development.

1. ROLLING AND SITTING

This item is designed to measure the client's level of independence in rolling and sitting.

Level 1 - Does not lift head when lying on stomach.

Level 2 - Lifts head when lying on stomach.

Level 3 - Lifts head and chest using arm support when lying on stomach.

Level 4 - Rolls from side to side.

Level 5 - Rolls from front to back only.

Level 6 - Rolls from front to back and back to front.

Level 7 - Maintains sitting position with minimal support for at least five (5) minutes. Minimal support may include resting on chairs, propping with pillows, or hand support. It does not include special equipment or ties.

Level 8 - Sits without support for at least five (5) minutes. The client does not achieve the sitting position independently, but is able to maintain the sitting position for at least five minutes.

Level 9 - Assumes and maintains sitting position independently. The client both achieves and maintains the sitting position independently.

DEMONSTRATION FOR ITEMS 2 & 3

Hand use and arm use can both be observed by asking the client to take an object (such as car keys, a pencil or some object belonging to the client) from you. Hold the object at a distance which requires extension of the client's arm.

Observe whether the thumb and finger are used in opposition. Ask the client to hold the object with other than index finger (to see whether there is independent use of the fingers) and then to return it to you to determine the extension (straightening at elbow joint) and flexion (bending at elbow joint) of the arm. If the client does not participate in this demonstration with you, observe if this skill is present in the rest of the interview. Ask someone who knows the client whether such skills are demonstrated under other circumstances.

2. HAND USE

This item measures the level of coordination of the more frequently used hand.

Level 1 - Has no functional use of either hand.

Level 2 - Uses raking motion or grasps with hand. A raking motion of the hand means that the thumb and fingers are rigid, but are used together to direct objects (for example, across a table top).

Level 3 - Uses thumb and fingers of hand in opposition. The thumb and fingers cooperate in grasping object.

Level 4 - Uses fingers independently of each other.

3. ARM USE

This item measures the level of coordination of the more frequently used arm.

Level 1 - Has functional use of either arm.

Level 2 - Moves arm from shoulder but does not extend or flex arm (i.e., does not have control of elbow joint).

Level 3 - Partially extends or flexes arm.

Level 4 - Fully extends or flexes arm.

DEMONSTRATION FOR ITEMS 4, 5, 6, & 7

Crawling and Standing, Ambulation, Climbing Stairs and Wheelchair Mobility can be demonstrated by asking the client to accompany you from the room where you are sitting to the outside of the building or to an interior staircase/ramp. You will be able to observe the client's ability to crawl, stand, walk, climb or utilize a wheelchair if it is needed. At least three stairs are needed for a demonstration. If there are not enough stairs present at the site, seek the information from a person familiar with the client's achievements.

Any way in which the client moves on the stairs (or ramps) is rated, including crawling, sliding, etc.

4. CRAWLING AND STANDING

This item refers to the progression from immobility to standing alone, unsupported.

Level 1 - Does not crawl, creep or scoot.

Level 2 - Crawls, creeps, or scoots.

Level 3 - Pulls to a standing position. Standing position may or may not be maintained.

Level 4 - Stands with support for at least one (1) minute. Support can be from staff or special equipment.

Level 5 - Stands unsteadily alone for at least one (1) minute.

Level 6 - Stands well alone; balances well for at least five (5) minutes.

5. AMBULATION

This item refers to the extent to which the client can walk. If a client typically uses a wheelchair, rate at Level 1.

Level 1 - Does not walk.

Level 2 - Walks with support. Indicates that the client requires support by staff or by special equipment such as a walker, braces, or crutches in order to walk.

Level 3 - Walks unsteadily alone at least ten (10) feet. Level 3 may be used for a client who stumbles, trips, etc., or has an atypical gait, but who can cover a minimum of ten (10) feet unassisted and unsupported.

Level 4 - Walks well alone at least twenty (20) feet; also balances well. Clients who have an unusual or awkward gait but are not in danger of stumbling or falling should also be rated at this level.

6. CLIMBING STAIRS

This item refers to a client's skills in negotiating stairs. (Also rate use of ramps for persons using wheelchairs.)

Level N - No opportunity to use stairs (or ramps).

Level 1 - Does not move up or down stairs (or ramps).

Level 2 - Moves up or down stairs (or ramps) with help from individuals or equipment; may or may not alternate feet.

Level 3 - Moves up or down stairs (or ramps) using handrail independently; may or may not alternate feet. Indicates that the client does not require any additional assistance beyond use of handrail.

Level 4 - Moves up or down stairs (or ramps) without need for handrail; may or may not alternate feet. If there is a handrail where the individual is demonstrating his/her skill, ask that it not be used if he/she attempts to do so. **Rate clients who move up or down ramps independently with wheelchair at this level.**

7. WHEELCHAIR MOBILITY

This item measures the degree of independence and/or human assistance required by a client who uses a wheelchair for mobility 50 percent or more of the time. This may be a standard wheelchair (manual or electric), or one that is specially designed for the client.

Level N - Does not use wheelchair.

Level 1 - Sits in wheelchair; does not move wheelchair by self. Indicates that the client is able to sit in a chair after being placed--and may or may not require "props" such as a pillow--but is not able to move the wheelchair independently.

Level 2 - Assists in moving wheelchair. Indicates that the client can assist in moving the wheelchair, either by helping turn the wheels, or by activating the electric device, but is unable to steer independently.

Level 3 - Moves self with some bumping and/or difficulty in steering. Indicates that the client can independently propel the chair, but does not steer the wheelchair without bumping into objects, people, etc.

Level 4 - Moves or guides chair independently and smoothly.

INDEPENDENT LIVING DOMAIN

This domain measures the extent to which an individual is self-sufficient. Adequate programming requires an accurate and current assessment of a client's achievements towards self-reliance. In some cases the rater may not be able to directly observe the client's performance for some items in this domain. Therefore, the rater may have to interview the client's parent or service provider.

An infant (0 - 4 years) may be scored at Level Y (Too Young to Assess) on any of the 19 items in this domain. This is not a value judgment, nor does it mean that the young child is expected to do something that typical children do not do.

Level N is to be used when the client has no opportunity to perform the described task(s). If the client participates in these activities in another setting--such as school, activity center, etc.--give the rating that best describes the client's skill level in performing the task--regardless of the environment in which the skill is demonstrated.

8. FOOD PREPARATION

Level Y - Too young to assess.

Level N - No opportunity to perform desired tasks.

Level 1 - Does not prepare food.

Level 2 - Prepares simple food without cooking (sandwich, cold cereal, etc., or other culturally appropriate food).

Level 3 - Cooks simple foods (eggs, soup, frozen dinners, etc., or other culturally appropriate food).

Level 4 - Prepares complete meal. Indicates that the client coordinates the preparation of foods with different cooking times.

9. **BEDMAKING**

Level Y - Too young to assess.

Level N - No opportunity to perform desired tasks.

Level 1 - Does not make bed.

Level 2 - Attempts or assists in bedmaking, but does not complete.

Level 3 - Makes bed completely but not neatly, or neatly but not completely, or needs reminders (for example, sheets and blankets appear wrinkled, bedspread is on crooked, etc.).

Level 4 - Completes bedmaking neatly and independently. Indicates that the client needs no assistance or prompting.

10. WASHING DISHES

Level Y - Too young to assess.

Level N - No opportunity to perform desired tasks.

Level 1 - Does not wash dishes.

Level 2 - Attempts or assists in dishwashing, but does not complete.

Level 3 - Completes dishwashing but with unacceptable results (dishes not clean, water left on counter, etc.).

Level 4 - Completes dishwashing neatly and independently, without breakage or water spillage. Needs no assistance or prompting.

11. **HOUSEHOLD CHORES** (typical chores other than food preparation, bedmaking, and washing dishes)

This item refers to the extent to which the client completes tasks in the living environment, such as dusting, emptying trash, cleaning the bathroom, etc.

Level Y - Too young to assess.

Level N - No opportunity to perform desired tasks.

Level 1 - Does not do household chores.

Level 2 - Attempts household chores but does not complete. Indicates that the client may initiate or assist in doing household chores, but never finishes tasks started or cannot do all of the tasks.

Level 3 - Completes household chores, but with unacceptable results (leaves dirt on floor, spills garbage, etc.) without reminders.

Level 4 - Completes household chores neatly and independently. Indicates that the client needs no assistance or prompting.

DEMONSTRATION FOR ITEM 12

Ask the client, "What do you do if you cut your finger...have a headache,...a cold?" Make your rating based on client's answers according to the scale, 1 - 4. If you are not sure of the rating's accuracy, interview staff/family to determine level of skill.

12. **BASIC MEDICAL SELF-HELP** (first aid, nonprescription medication)

This item measures whether the client takes care of minor injuries or illnesses, such as cuts, scratches, headaches, etc.

Level Y - Too young to assess.

Level N - No opportunity to perform desired tasks.

Level 1 - Does not perform any medical self-help tasks.

Level 2 - Seeks aid in treatment of minor injuries.

Level 3 - Performs simple first-aid tasks, such as applying bandaids, taking aspirin with reminders, etc.

Level 4 - Has basic medical self-help skills and uses nonprescription medications (aspirin, cough drops, etc.) appropriately, independently, and without reminders.

13. SELF-MEDICATION

This item is designed to measure the client's skill in administering prescription medication to him/herself.

Level Y - Too young to assess.

Level N - No opportunity to perform desired tasks.

Level 1 - Does not initiate the taking of any medication. Relies on others for administering medication.

Level 2 - Takes own medication with supervision and/or assistance.

Level 3 - Takes own medication if reminded of time and/or dosage. Indicates that the client takes medication if given verbal assistance.

Level 4 - Takes own medication independently, as prescribed.

14. EATING

This item measures the extent to which a client is able to feed himself/herself.

NOTE FOR LEVELS 4, 5 & 6

Special eating utensils and/or assistive devices may be used in Levels 4, 5 and 6.

Level Y - Too young to assess.

Level N - No opportunity to perform desired tasks.

Level 1 - Does not feed self, must be fed completely. This may include tube or intravenous feeding.

Level 2 - Attempts to finger feed but needs assistance.

Level 3 - Finger feeds self without assistance. Indicates that the client can feed himself/herself independently, but uses no utensils.

Level 4 - Feeds self using spoon, with spillage.

Level 5 - Feeds self using spoon and fork, with spillage. Client may need reminder to use appropriate utensil.

Level 6 - Uses appropriate eating utensils with no spillage and without reminders.

15. TOILETING

This item refers to the extent to which a client independently completes toileting.

Level Y - Too young to assess.

Level N - No opportunity to perform desired tasks.

Level 1 - Not toilet trained. Indicates that the client does not toilet self.

Level 2 - Is habit trained. Indicates that the client uses toilet or bedpan when put on a regular schedule. May require physical assistance.

Level 3 - Can indicate the need to toilet self and/or must be placed on toilet or bedpan. The client recognizes and communicates the need for toileting, but requires physical assistance to use a toilet or bedpan.

Level 4 - Goes to toilet by himself/herself, but needs assistance to complete toileting (for example, needs assistance or reminder with hygiene, flushing, or clothing).

Level 5 - Goes to toilet by himself/herself, completing all activities associated with using toilet independently.

NOTE FOR ITEMS 16 AND 17

Episodes may occur when the client experiences a lack of bladder or bowel control; the rating should reflect the most consistent level of control.

An individual with an indwelling urinary catheter is considered to be at Level 1, unless the catheter is only temporary and for use during a convalescent period. For the individual with chronic constipation, rate level of bowel control by actual movements even if induced by laxatives or suppositories. For the individual for whom enemas are the sole means of bowel movement, rate at Level 1.

For both of these items, deliberate "accidents" to express hostility or to get attention, or accidents due to distraction and/or indifference, etc., should be rated at Level 2 if the accidents occur during waking hours once a week or more. If accidents are less frequent than once a week, rate the client at Level 3.

16. LEVEL OF BLADDER CONTROL

Level Y - Too young to assess.

Level N - No opportunity to perform desired tasks.

Level 1 - No bladder control.

Level 2 - Some bladder control; accidents occur during waking hours (once a week or more).

Level 3 - Bladder control during the day; wets at night (once a week or more).

Level 4 - Complete bladder control.

17. LEVEL OF BOWEL CONTROL

Level Y - Too young to assess.

Level N - No opportunity to perform desired tasks.

Level 1 - No bowel control.

Level 2 - Some bowel control; accidents occur during waking hours (once a week or more).

Level 3 - Bowel control during day; soils at night (once a week or more).

Level 4 - Complete bowel control.

18. PERSONAL HYGIENE

This item refers to the extent of a client's self-care skills (brushing teeth, washing, and behaviors specifically related to gender and age, e.g., shaving, hair care, menses, use of deodorant, etc.).

Level Y - Too young to assess.

Level N - No opportunity to perform desired tasks.

Level 1 - Does not tend to own personal hygiene.

Level 2 - Tends to some personal hygiene needs but does not complete. The client can perform task(s) but requires reminders to initiate and complete the task(s). Indicates that the client participates in an activity--such as brushing hair--but needs someone else to complete it. For example, the client can brush his/her hair, but someone else must make the part, or the client can brush own teeth after someone puts toothpaste on the brush. The client may need prompting.

Level 3 - Tends to and completes some but not all personal hygiene tasks. Indicates that the client may need an occasional reminder for personal hygiene tasks that he/she can do on own (e.g., a reminder about when to wash hair). Also, Level 3 should be for individuals who can perform independently only a few (but not all) personal hygiene tasks.

Level 4 - Initiates and completes own personal hygiene independently.

19. BATHING

Level Y - Too young to assess.

Level N - No opportunity to perform desired tasks.

Level 1 - Does not bathe or shower self.

Level 2 - Performs some bathing or showering tasks, but not all. Indicates that the client bathes or showers self but needs help or prompting with washing or drying self.

Level 3 - Bathes or showers self independently. Indicates that the client takes bath or shower without any assistance, including drawing the water, checking and regulating water temperature, drying off, etc.

20. DRESSING

Level Y - Too young to assess.

Level N - No opportunity to perform desired tasks.

Level 1 - Does not put on any clothing by self. Indicates that the client does not cooperate in dressing and must be completely dressed.

Level 2 - Cooperates in putting on clothes (raises arms, etc.)

Level 3 - Puts on some clothes by self but requires assistance and prompting.

Level 4 - Puts on all clothes but does not tie shoes, close all fasteners, attend to other details, or needs reminding.

Level 5 - Dresses self completely including all fasteners and other details (buttons, zippers, shoes).

21. MOVEMENT IN FAMILIAR SETTING

This item refers to a client's skill in purposeful movement (i.e., moving about and finding his/her way in familiar environments. It includes all kinds of movement: wheelchair, walking, creeping and crawling, etc. **If client does not ambulate rate at Level 1.**

Level Y - Too young to assess.

Level N - No opportunity to perform desired tasks.

Level 1 - Makes no attempt to move about in a familiar setting.

Level 2 - Moves about in a familiar setting but does not successfully move around obstructions or from room to room. Indicates the client can not find his/her way around the setting and requires continuous assistance to avoid bumping into objects.

Level 3 - Moves about Purposefully in a familiar setting and moves successfully around objects, but may experience difficulty going from room to room.

Level 4 - Moves about successfully in a familiar setting. Indicates that the client can find his/her way around the setting and can independently move about without stumbling, tripping, bumping into objects or the need for assistance from others.

22. MOVEMENT IN UNFAMILIAR SETTING

Level Y - Too young to assess.

Level N - No opportunity to perform desired tasks.

Level 1 - Makes no attempt to move about in an unfamiliar setting.

Level 2 - Moves about in an unfamiliar setting but does not successfully move around obstructions or from place to place. Indicates that the client does not know his/her way around the setting (random movement), and requires continuous assistance to avoid bumping into objects.

Level 3 - Moves about purposefully in an unfamiliar setting and successfully moves around objects, but may experience difficulty going from place to place.

Level 4 - Moves about successfully and finds way around in an unfamiliar setting. Indicates that the client can independently move about without stumbling, tripping, bumping into objects, or the need for assistance from others and can find his/her way around the setting.

23. TRANSPORTATION ABOUT COMMUNITY

This item refers to a client's skills in using public transportation.

Level Y - Too young to assess.

Level N - No opportunity to perform desired tasks.

Level 1 - Does not use public transportation. No public transportation available or no training has been provided for its use.

Level 2 - Uses public transportation with physical assistance and/or accompaniment.

Level 3 - Uses public transportation independently for a simple direct trip. This level should be used for situations in which instructions and directions have been given to the individual. Clients using Dial-a-Ride, for example, should be rated at this level.

Level 4 - Uses public transportation independently for a complex route. Indicates that the client can transfer from one bus to another and change modes of transportation (for example, from a taxi to a bus).

DEMONSTRATION FOR ITEM 24

A dollar in change, including five pennies, plus a dollar bill are necessary for this demonstration. ***RATE THE CLIENT ACCORDING TO HIGHEST ACHIEVEMENT.***

Holding out a handful of change, use the following to asess the client's skill level.

a. *Cannot handle money. If the client does not understand the concept of money, rate at Level 1.*

b. *Ask the client to pick out a penny, a nickel, a dime. If the client makes the selections correctly, rate at Level 2.*

c. *Ask the client to pick out 30¢ (a nickel and a quarter, or any correct combination). If the client makes the selection correctly, rate at Level 3.*

d. *Ask the client to add the coins up to $1.00. If this is accomplished, rate at Level 4.*

e. *Ask the client to give you your change from $2.00 after you have made a $1.73 "purchase". If the client can perform this task, rate at Level 5.*

24. MONEY HANDLING

This item refers to the client's skills in using money for purchasing various items or services.

Level Y - Too young to assess.

Level N - No opportunity to perform desired tasks.

Level 1 - Cannot use money. Indicates that the client does not understand the concept of money.

Level 2 - Can use money, but is unable to provide the appropriate amount. (For example, gives 10¢ to purchase any item in store, regardless of price.) Indicates that the client understands the concept of payment for purchases, or the manner in which it is spent, but does not understand the actual value of coins or bills in relation to purchasing.

Level 3 - Can use money, but does not usually make and/or count change correctly, out of $1.00. For example, the client offers the shopkeeper sufficient money (up to $1.00) for the purchase, but asks him/her to pick out the correct amount.

Level 4 - Can use money. Adds coins of various denominations, makes and/or counts change, up to $1.00. Indicates that the client can make purchases correctly up to $1.00.

Level 5 - Can use money. Makes and/or counts any amount of change. Indicates that the client can make purchases, and can make or count change in bills as well as in coins.

25. MAKING PURCHASES

This item measures the client's skills in selecting items for purchase. This may include purchases from vending machines or stores. Money handling itself is not measured in this item.

Level Y - Too young to assess.

Level N - No opportunity to perform desired tasks.

Level 1 - Does not make purchases. Client does not select items desired.

Level 2 - Does not make purchases, but identifies items desired.

Level 3 - Makes purchases with some difficulty. For example, the client has a problem finding the check-out stand, getting the attention of the sales clerk, knowing where to stand in line, and/or requires either assistance or prompting to complete the transaction.

Level 4 - Makes purchases independently.

DEMONSTRATION FOR ITEM 26

Ask the client, "When you go to a restaurant, how do you get the food you want?" If client names a simple food, such as, "I ask for a chocolate ice cream cone," ask what else he/she might order if he/she were hungry. If client names a simple meal which he/she will order (e.g., hamburger and fries), but does not avail self of the chance for a complete meal with variety, ask what else he/she might order. Also ask how he/she would make the "order" known.

26. ORDERING FOOD IN PUBLIC

This item refers to the extent to which a client can order food independently at public eating places such as restaurants, snack shops, or refreshment stands. It does not refer to the payment for the food.

Level Y - Too young to assess.

Level N - No opportunity to perform desired tasks.

Level 1 - Does not order food at public eating places.

Level 2 - Orders snacks (ice cream, hot dogs, tacos, etc.). Indicates that the client orders one-item snacks. The client may make choices known by pointing, signing, or telling a companion.

Level 3 - Orders simple meals (hamburgers and fries, tacos and beans, etc.). Indicates that the client orders more than one item, but may require assistance. Client may make choices known by pointing, signing, or telling a companion.

Level 4 - Orders complete meals independently. Indicates that the client has a favorite full meal that he/she orders independently without verbal assistance, or that the client can read from a simple menu and make desired selections.

SOCIAL DOMAIN

The items in the Social Domain are designed to measure the nature and extent of client interactions with others in both individual and group situations. In many cases, the rater may not be able to directly observe the client's behavior. Therefore, it is acceptable to complete the ratings by means of an interview with the client's care provider, parents, etc. Note that these items in the Social Domain should be rated even for a client with severe physical limitations. In such cases, the rater should consult with someone who is very familiar with the client. Remember to rate the client's typical performance.

NOTE FOR ITEMS 27 & 28

On both of these items, interaction and communication includes verbal and nonverbal behavior, such as spontaneity in smiling, reaching out to another person, hugging, etc. A willingness to communicate manifested by an expectant look or an expression of interest would be considered responsive.

27. ONE-TO-ONE INTERACTION WITH PEERS

This item refers to one-to-one interaction with peers. It concerns the extent to which the client communicates, shares with,

and interacts positively with another person who is a friend, classmate, or co-worker.

Level 1 - Does not interact with others.

Level 2 - Interacts appropriately only when others initiate. Indicates that the client typically does not interact with a person who is not in his/her peer group, but does respond to others' attempts at interaction.

Level 3 - Initiates appropriate interaction only in familiar or previously successful situations or settings. Indicates that the client does initiate interaction with a peer in settings such as the living area, classroom, or work area, but does not initiate peer interaction in unfamiliar situations or settings.

Level 4 - Initiates appropriate interactions in both familiar and unfamiliar situations or settings. Indicates that the client is comfortable in most situations and seeks out social interactions.

28. ONE-TO-ONE INTERACTION WITH PERSONS OTHER THAN PEERS

This item refers to the extent to which the client communicates, shares with, and interacts positively on a one-to-one basis with another person who is not a peer, such as a store clerk, foster parent, teacher, or bus driver.

Level 1 - Does not interact with others.

Level 2 - Interacts appropriately only when others initiate. Indicates that the client typically does not interact with a person who is not in his/her peer group, but does respond to others' attempts at interaction.

Level 3 - Initiates appropriate interaction only in familiar or previously successful situations or settings. Indicates that the client does initiate interaction with staff in the living area, classroom, or work area, but does not initiate any interaction in unfamiliar situations or settings.

Level 4 - Initiates appropriate interactions in both familiar and unfamiliar situations or settings. Indicates that the client is comfortable in most situations and seeks out social interactions with a person who is not a peer, regardless of the setting.

29. **FRIENDSHIP FORMATION** (close social relationships)

This item refers to the ability to establish a close social relationship with another person, i.e., close social relationship between two individuals characterized by mutual affection and sharing. It refers only to the process of establishing a friendship and not to the maintainance of friendship over a period of time.

Level 1 - Does not form friendships.

Level 2 - Potential friends must initiate friendships. Indicates that the client does not seek out contacts, but does respond to social approaches on the part of potential friends.

Level 3 - Initiates and establishes friendships. Indicates that the client actively establishes friendships.

30. **FRIENDSHIP MAINTENANCE** (for at least three months)

This item refers to whether the client continues a friendship for at least a three-month period.

Level 1 - Does not maintain friendships.

Level 2 - Maintains friendships only in stable or familiar settings (classroom, residence, etc.). For example, the client may establish a friendship with a classmate, but will maintain that friendship only in the familiar school environment.

Level 3 - Maintains friendships in a variety of different settings. For example, the client may make a friend at school and keep the friendship through school, work, etc., where circumstances permit.

31. PARTICIPATION IN SOCIAL ACTIVITIES

This item refers to the client's involvement (both active participation and/or passive enjoyment) in social or recreational activities which include more than one individual, (e.g., bowling, baseball, dances, picnics, hikes, club meetings, etc.). **Rate the client's typical performance.**

Level 1 - Does not participate in or enjoy social activities.

Level 2 - Participates in or enjoys social activities only with considerable encouragement. Indicates that with considerable prompting, reassurance or support, the client participates in social activities.

Level 3 - Participates in or enjoys social activities with some encouragement. Indicates that, with verbal encouragement (for example, "Let's go and join that group"), the client participates.

Level 4 - Does not need encouragement to participate in or enjoy social activities. Indicates that the client participates in social activities without any prompting.

32. PARTICIPATION IN GROUP PROJECTS

This item refers to the extent to which the client gets along with others in a group activity and contributes efforts to benefit the group activity which involves the completion of a task. For example, tasks may include joint hobby projects, doing chores together, decorating for a party, etc. Contributing to group projects may also be seen as lending support to enhancing team spirit by one's enthusiastic presence.

Level 1 - Does not participate in group projects.

Level 2 - Participates in group projects, but the client's efforts do not contribute to group effort. Indicates that the client joins group projects but participation is counter-productive or not goal-directed. For example, the client may be resistive or easily distractable.

Level 3 - Participates in group projects, but the client's efforts only partially contribute to group efforts. Indicates that the client gets along well with others during group projects but efforts lag behind and slow down completion of the joint project.

Level 4 - Participates in group projects, and efforts contribute to the completion of the project. Indicates that the client gets along well with others and cooperates during group projects, and that his/her efforts are beneficial and appropriate to the completion of the task.

33. UNACCEPTABLE SOCIAL BEHAVIOR

This item refers to those unacceptable social behaviors that interfere with positive social functioning, for example, taking items away from others, excessive screaming, teasing others, lying, etc.

Level 1 - Unacceptable social behaviors prevent social participation. Indicates that, without close supervision or redirection, the client's unacceptable social behaviors make positive social participation impossible.

Level 2 - Unacceptable social behaviors often disrupt social participation. Indicates that unacceptable social behaviors often occur and present problems that are severe enough to interrupt positive social participation.

Level 3 - Unacceptable social behaviors seldom interfere with social participation. Indicates that unacceptable social behaviors occur, but are not severe and do not interrupt positive social participation.

Level 4 - Does not exhibit unacceptable social behaviors.

EMOTIONAL DOMAIN

The items in this domain measure the client's emotional state and reactions to various situations. The items address a number of behaviors and reactions that can interfere with the client's daily functioning and that may require intervention on the part of the family or care provider.

Ratings on Emotional Domain items require close familiarity with the client. Some of the items (such as Reaction to Frustration, Hyperactivity, Repetitive Body Movements, and Resistiveness) can be rated by observing the client if these are customary behaviors substantiated by the case history. Other items will have to be rated after interviewing the family or care provider or reviewing the case records. The attempt here is to measure the client's customary emotional reaction, rather than atypical, one-time occurrences.

Several of the items in this domain may not be reliably rated for clients who are very young and/or have a serious disability. In these cases an option is provided: when a client does not function at a level sufficiently high to permit the performance of the behavior in question, rate the client "Y" (for too young) or "D" (for too disabled) where appropriate. However, if the client's behavior can be rated, then rate it regardless of age or severity of disability.

The use of the "D" rating generally means that the client is both incapable of independent movement, and/or appears to be unaware of his or her environment.

Some of the behaviors surveyed in the emotional domain are commonly treated by medication and/or behavior intervention techniques. For those behaviors which are treated with medication and/or behavior intervention techniques, rate the client at his or her current level of performance.

34. AGGRESSION

This item is intended to measure the extent to which a client has violent episodes involving physical attacks directed at others, (staff, other clients, etc.) using such means as throwing rocks, chairs, punching, biting, etc.

Level Y - Too young to assess.

Level D - Too disabled to assess.

Level 1 - Has had one or more violent episodes, causing serious physical injury within the past year. Serious injury to others is defined as an injury or trauma, requiring immediate medical attention by a physician.

Level 2 - Has had one or more violent episodes, causing minor physical injury within the past year. Minor injuries include bruises, small cuts or lacerations, bloody noses, etc. These injuries may require medical attention, but immediate attention by a physician is not necessary.

Level 3 - Typically resorts to verbal abuse and threats but has not caused physical injury within the past year. Clients who bully other clients, push them around, but do not cause injury, should be rated at this level.

Level 4 - Episodes of displaying aggressive behavior are undetected or rare, and appropriate to the situation.

35. FREQUENCY OF SELF-INJURIOUS BEHAVIOR

This item is intended to measure the frequency with which a client engages in behavior which causes himself/herself physical injury. Examples of self-injurious behaviors include repeatedly picking at skin, slapping oneself on the ears, biting oneself on the arm, provoking others to assault, using objects in the immediate vicinity to inflict injury on oneself, etc.

Level Y - Too young to assess.

Level D - Too disabled to assess.

Level 1 - Displays self-injurious behavior at least once a day and/or may require restraint as a preventive measure.

Level 2 - Displays self-injurious behavior at least once a week, but not as often as daily.

Level 3 - Displays self-injurious behavior at least once a month, but not as often as weekly.

Level 4 - Displays self-injurious behavior not more than three times a year.

Level 5 - Rarely or never displays self-injurious behavior. Such behavior occurs less frequently than three times per year.

36. SEVERITY OF SELF-INJURIOUS BEHAVIOR

This item is designed to measure the seriousness of self-injurious behaviors. Examples of self-injurious behaviors include repeatedly picking at skin, slapping oneself on ears, biting oneself on the arm, provoking others to assault, using objects in the immediate vicinity to inflict injury to oneself, etc.

Level Y - Too young to assess.

Level D - Too disabled to assess.

Level 1 - Displays self-injurious behavior causing severe injury and requiring a physician's immediate attention at least once a week.

Level 2 - Displays self-injurious behavior causing severe injury and requiring a physician's immediate attention at least once a month (but not weekly). Also rate at this level clients who display self-injurious behavior causing minor injury and requiring first-aid at least once a week (but not daily).

Level 3 - Displays self-injurious behavior causing severe injury requiring a physician's immediate attention at least once a year (but not monthly). Also rate at this level clients who display self-injurious behavior causing minor injury and requiring first-aid at least once a month (but not weekly).

Level 4 - Displays self-injurious behavior, but no apparent injury occurs. Clients who exhibit behavior that is potentially self-injurious should be rated at this level.

Level 5 - Rarely or never displays self-injurious behavior.

37. SMEARING

Smearing refers to the spreading of substances (including bodily substances) by the client as a reaction to a situation or as a means or method of expressing hostility, frustration, aggression, etc.

Level Y - Too young to assess.

Level D - Too disabled to assess.

Level 1 - Smears at every opportunity unless prevented.

Level 2 - Smears once a week or more.

Level 3 - Smears less than once a week.

Level 4 - Smears only when agitated or nervous. Clients who smear on rare occasions should be rated at this level.

Level 5 - Never smears.

38. PROPERTY DESTRUCTION

This item refers to those acts of aggression and/or frustration which are perpetrated by a client on an inanimate object as a means of release or displacement of such affect. This does not refer to an isolated incident, but to a customary pattern of releasing pent-up emotions. Serious property damage includes breaking windows, slashing tires, repeatedly tearing clothing, destroying furniture, etc. Minor property damage includes damages such as throwing a chair and breaking it, deliberately tearing clothing, etc.

Level Y - Too young to assess.

Level D - Too disabled to assess.

Level 1 - Has caused serious property damage within the past year.

Level 2 - Has caused minor property damage on six or more occasions within the past year.

Level 3 - Has caused minor property damage on two to five occasions within the past year.

Level 4 - Has caused minor property damage once during the past year.

Level 5 - Has not caused property damage during the past year.

39. RUNNING OR WANDERING AWAY

This item is designed to measure a client's misuse of independence in reality-testing or exploring the environment by wandering or running away or by not following along on group excursions. It assumes that clients have programmatically structured opportunities to explore their environment in a sound developmental sequence. This item also refers to clients who choose "elopement" as a means of problem-solving with or without a destination in mind.

If an individual is kept from movement without permission by constant staff vigilance and/or physical barriers without training, use code "N".

Level Y - Too young to assess.

Level D - Too disabled to assess.

Level N - Not applicable.

Level 1 - Runs or wanders away daily unless prevented. Indicates that the client requires continuous supervision.

Level 2 - Runs or wanders away weekly, but not daily unless prevented. Indicates that the client requires close supervision to prevent this behavior. For example, a client whose whereabouts must be checked at least hourly should be rated at this level.

Level 3 - Runs or wanders away at least once a month. Indicates that the client occasionally requires supervision and/or redirection to avoid running or wandering away.

Level 4 - Runs or wanders away at least once every three months.

Level 5 - Runs or wanders away at least once a year.

Level 6 - Threatens but does not attempt to run or wander away.

Level 7 - Does not run or wander away. Indicates that the client does not talk about, threaten, or actually run or wander away.

40. DEPRESSIVE-LIKE BEHAVIOR

This item refers to behaviors which indicate a customary pattern in the client of withdrawal, apathy, and lack of energy, and which are not attributable to physical illnesses or injuries. Such behaviors may include neglect of self-care, loss of self-help skills, loss of appetite, refusal to participate in activities, disruption of normal sleeping pattern, etc. This item also includes behaviors that may be caused by medication, psychological trauma, etc. In very young or seriously disabled clients, the changes wrought by depression may be more subtle in their effect.

Level Y - Too young to assess.

Level D - Too disabled to assess.

Level 1 - Depressive-like behavior inhibits all functions (prevents interaction with others, daily activities, etc.). The client is so severely depressed that his/her total needs must be provided for. Examples would be a client who refuses to eat and might be tube fed, a client who completely withdraws from all personal contact, or a toilet-trained client who no longer controls bladder and bowel functions.

Level 2 - Depressive-like behavior substantially affects all functions (limits communication and typical performance in daily activities, etc.). The client is affected to the extent that he/she no longer participates regularly in a daily program.

Level 3 - Depressive-like behavior has a minimal effect on functioning (attends to daily activities with slight decrease in performance, etc.). Daily activities are interrupted as a result of such behaviors.

Level 4 - No evidence of depressive-like behavior (maintains typical daily activities). Note that depressive-like behavior may occur on occasion but does not interfere with typical daily functioning.

41. REACTION TO FRUSTRATION

This item is intended to measure how the clients respond to disappointments, such as being prevented from doing or having something which is desired, or continuing the daily routine. Reactions may include withdrawal, self-abuse, loss of appetite, screaming, crying, or general hostility.

Reactions to frustration may be plotted on a continuum from adverse (i.e., the expression of an emotion by behavior not designed to alter the disappointing condition) to effective (i.e., the attempt to change the disappointing condition by negotiation, making alternative plans, etc.).

Level Y - Too young to assess.

Level D - Too disabled to assess.

Level 1 - Reacts adversely to common situations daily when thwarted, hindered, or obstructed.

Level 2 - Reacts adversely at least once a week when thwarted, hindered, or obstructed.

Level 3 - Reacts adversely less than once a week when thwarted, hindered, or obstructed. Indicates that it is not unusual for the client to react ineffectively to such situations.

Level 4 - Reacts effectively with frustrating situations when thwarted or hindered. Indicates that dealing effectively with such situations is characteristic of this client.

42. REPETITIVE BODY MOVEMENTS

This item is designed to measure the extent to which a client engages in certain mannerisms which interfere with daily social interactions and/or functioning.

These mannerisms tend to be the habitual residue of attempts at self-stimulation, and are manifest during periods which are unproductive, boring, unstructured or perceived to be somewhat stressful. Examples of such stereotypic mannerisms are rocking, rapid finger and hand movements, etc.

Level Y - Too young to assess.

Level D - Too disabled to assess.

Level 1 - Repetitive body movements occur without cessation during waking hours.

Level 2 - Repetitive body movements occur continuously, but client can be distracted from behavior when attending to a task, etc. For example, a client who, when unoccupied, displays hand flapping, but stops the hand flapping temporarily when given a task to perform, would be rated at this level.

Level 3 - Some repetitive body movements occur daily regardless of situation. Clients who exhibit repetitive body movements daily (not continuously) but stop independently for even a short period of time, should be rated at this level.

Level 4 - Repetitive body movements occur only under conditions of excitement and/or stress. For example, a client may find waiting for a parent to come for a visit or waiting for meals to be stressful; and when doing such waiting the client may begin rocking. When the parent arrives or the meal is ready, the rocking behavior stops.

Level 5 - No apparent repetitive body movements.

43. INAPPROPRIATE UNDRESSING

This item is meant to measure bizarre or marginal behavior that needs structured programming to prevent an individual from being considered a social outcast. The item is not intended to document casual social customs or behavior that is appropriate to a particular cultural situation; nor is it limited solely to the removal of clothing for the purpose of exposing the genitals. It also includes the removal of articles of clothing such as shoes and socks or shirts in situations where such undressing would be inappropiate.

Level Y - Too young to assess.

Level D - Too disabled to assess.

Level 1 - Inappropriately undresses self in public places such as shopping centers, playgrounds, or schoolrooms. This does not refer to a single incident but to a customary pattern of behavior.

Level 2 - Inappropriately undresses self in residence more than once per week. Clients who inappropriately undress more than once a week, but only in their place of residence, should be rated at this level.

Level 3 - Inappropriately undresses self in residence not more than once per week.

Level 4 - Does not undress self inappropriately.

44. HYPERACTIVITY

This item measures the severity of abnormally increased activity (hyperkinesia).

Developmental hyperactivity is characterized by constant motion and usually accompanied by distractibility and low tolerance for frustration. Include here activity which is manifested by over-excitability, restlessness, and/or constant movement. Exclude spastic movements.

Level Y - Too young to assess.

Level D - Too disabled to assess.

Level 1 - Is hyperactive in all environments even with individual, one-to-one supervision. Clients who are hyperactive in all environments, even with medication and/or one-to-one supervision or clients who do not have a formal, ongoing behavior-shaping or other remedial plan in effect, should be rated at this level.

Level 2 - Is hyperactive except when given individual, one-to-one supervision. When hyperactivity is not controlled by medication alone, but must be accompanied by individual attention, rating should be at this level.

Level 3 - Is hyperactive only in stressful situations (when in groups of unfamiliar people, when being reprimanded, etc.); hyperactivity is otherwise controlled by behavior modification techniques and/or medication. Clients for whom hyperactivity is a problem only under stressful situations should be rated at this level.

Level 4 - Is hyperactive, but the client is making satisfactory progress toward control of hyperactivity under current behavior-shaping or behavior modification techniques.

Level 5 - No apparent abnormal increase in activity.

45. TEMPER TANTRUMS/UNCONTROLLED EMOTIONAL OUTBURSTS

This item is intended to measure the extent to which a client exhibits behaviors such as episodes of rage, uncontrolled crying, throwing self about, flailing arms, and/or pounding fists and kicking feet. This is where the outburst is diffuse with no particular target in mind. Clinical judgment must be exercised to distinguish between this item and Item 38 -- Property Destruction. Generally speaking, this item deals with behaviors which are infantile in nature, expressions of displeasure, willful expressions of rage, anger, etc. **Keep in mind those behaviors that are not acceptable in typical community settings. Pay attention to ratings given on items 34-39, 41, 43, and 46.**

Level Y - Too young to assess.

Level D - Too disabled to assess.

Level 1 - Displays outbursts daily. Include at Level 1, clients who must be physically restrained in order to control the effects of temper tantrums because they have not yet reached the developmental level necessary to build inner controls or because they have not participated in a behavior management program.

Level 2 - Typically displays outbursts at least once a week, but not daily.

Level 3 - Typically displays outbursts at least once a month, but not weekly.

Level 4 - Displays outbursts not more than three times a year.

Level 5 - Does not display outbursts.

46. RESISTIVENESS

This item is intended to measure the extent to which a client is inappropriately uncooperative and stubborn. Recalcitrant behavior may take either an active or passive form.

Level Y - Too young to assess.

Level D - Too disabled to assess.

Level 1 - Is resistive in all situations. Indicates that the client requires one-to-one supervision or interaction.

Level 2 - Is resistive under certain specific circumstances. For example, a client who refuses to get out of bed in the morning, or who refuses to obey rules he or she does not like, should be rated at this level.

Level 3 - Is resistive only in stressful situations. Stressful situations include being in groups of unfamiliar people, being reprimanded, or being taken to the doctor or dentist. The client who hides in order to avoid such situations should be rated at this level. Also rate at this level the client who cannot communicate apprehension or who does not have a plan to be taught to handle stressful situations.

Level 4 - Is not resistive. Client is typically responsive and usually cooperative.

NOTE FOR ITEMS 47 & 48

Raters should be cautious not to include appropriate negative behavior in their ratings on these items. If the client behaves negatively because he/she perceives the new situation to be less satisfying than the prior one, this should not be considered inappropriate or inadequate adjustment.

47. ADJUSTMENT TO CHANGES IN SOCIAL RELATIONSHIPS

This item is intended to measure the way in which clients cope with changes in their interactions with their primary associates, such as the dissolving of a friendship or a change in care provider or parent figure.

Level N - No recent significant changes in social relationships.

Level 1 - Changes in social relationships cause a change from the client's typical behavior which extends over at least a three-month period.

Level 2 - Changes in social relationships cause a change from the client's typical behavior, but there is improvement within one month and/or disruption subsides within three months.

Level 3 - Changes in social relationships do not appreciably alter the client's typical behavior. Clients who show no reaction to change should be rated at this level.

Level 4 - Changes in social relationships appear to lead to improvement and personal growth. Clients who respond to changes in social relationships positively (by seeking new friends or by responding positively to new people) should be rated at this level, even when the change was preceded by a period of readjustment.

48. ADJUSTMENT TO CHANGES IN PHYSICAL ENVIRONMENT

This item is intended to measure the ability of the client to cope with changes in his/her immediate surroundings. Such changes may include a change in residence, change in living arrangement within a residential setting, or change in furnishings or furniture arrangement. Negative reactions may include persistent attempts on the part of the client to undo the change in his or her physical environment--such as moving furniture back to a previous arrangement, becoming apprehensive, hostile, withdrawn or physically ill--in response to this change. This item is rated in the same way as is the previous item.

Level N - No recent significant changes in physical environment.

Level 1 - Changes in physical environment cause a change from the client's typical behavior which extends over at least a three-month period.

Level 2 - Changes in physical environment cause a change from the client's typical behavior, but there is improvement within one month and/or disruption subsides in three months.

Level 3 - Changes in physical environment do not appear to affect the client in any way.

Level 4 - Changes in physical environment appear to lead to improvement and personal growth. Clients who respond positively to changes in their environment, by assisting with the planning and making of such changes, etc., should be rated at this level, even when this was preceded by a period of readjustment.

COGNITIVE DOMAIN

The cognitive domain items measure a wide range of perceptual and conceptual skills which represent the foundation of learning experiences and productivity. For some clients, the person in the best position to rate these items will be a teacher or an instructor.

DEMONSTRATION FOR ITEM 49

a. *Stand behind client and make any very loud noise: yell, clap, call his/her name, etc. If the client does not respond, rate at Level 1.*

b. *Perform the above demonstration. If the client has a startled response to the loud noise, rate the client at Level 2.*

c. *Perform the above demonstration. If the client turns or looks toward the loud sound, rate the client at Level 3.*

d. *Compare the client's reactions to moderate-level sounds (out-of-sight) and voices (out-of-sight) to determine whether the client reacts or pays attention*

to voices as opposed to reacting to just any sound or noise. If the client can discriminate between the two, rate at Level 4.

e. *By interview, determine if the client can distinguish between the voices of certain staff members (out-of-view) and voices of unfamiliar persons (out-of-view). One way to accomplish this would be to ask the client to identify the person(s) named. If the client responds discriminately to the voices, rate at Level 5.*

f. *By interview, determine if the client can distinguish between different sounding words (such as "hand" and "foot," "nose" and "mouth," etc.). If the client can do this, rate at Level 6.*

g. *By interview, determine if the client can distinguish between similar sounding words (such as "tree" and "see" "pear" and "bear," etc.). If the client can discriminate between such words, rate at Level 7.*

49. AUDITORY PERCEPTION (hearing aid may be worn)

This item refers to the client's reactions to sounds. The item represents a progression from no reaction to different responses to similar sounds. Demonstrations for each level of performance on the item may need to be conducted.

Level 1 - Does not react to sounds.

Level 2 - Demonstrates startle response to loud sounds. Indicates that the client flinches, jumps, etc., in response to a loud noise.

Level 3 - Turns head or eyes towards the source of the sound. Indicates that the client displays an orienting response.

Level 4 - Discriminates between voices and other sounds in the environment (by smiling or paying attention to the voices).

Level 5 - Responds to voices of familiar people differently from voices of strangers.

Level 6 - Recognizes words that sound different. Indicates that the client can distinguish between different sounding words (Examples: "food" and "bed", "chair" and "table", "hand" and "foot", "nose" and "mouth", etc.).

Level 7 - Discriminates between words that sound the same. Indicates that the client can tell the difference between similar sounding words (Examples: "potato" and "tomato", "tree" and "see", "pear" and "bear", "glass" and "gas").

DEMONSTRATION FOR ITEM 50

It may be necessary to use a demonstration using an object that interests the client (such as a colorful ball) to obtain the rating. Be sure that the object is sufficiently interesting to motivate the client. If the client is blind or fixates (stares continuously), rate at Level 1. However, the rater should ascertain whether the client is simply not interested in (bored) or not aware of (fixates) the task at hand or the object used in the demonstration.

a. *Take an object of visual interest such as a colorful ball and put it out of reach in the client's direct view. If the client fails to look at the object or stares continuously, rate the client at Level 1.*

b. *Hold an object of visual interest in the client's view and slowly move it around, up and down, and side to side, to see if the client's eyes follow the object. If the client looks at the object but does not visually follow the object, rate at Level 2. Note that the client may visually explore his/her environment but does not fixate upon objects presented due to physiological impairment; if this is the case, also rate the client at this level.*

c. *Use the same demonstration as indicated for Level "2". If the client visually follows the object, rate at Level 3.*

d. *If the client follows the object of visual interest by turning his/her head when it is moved slowly out of direct view and obviously explores the visual surroundings, rate at Level 4.*

e. *Drop or quickly move an object of visual interest out of the client's immediate view. If the client searches for the object or attempts to recover it, rate at Level 5. Be sure that the object is sufficiently interesting to the client to motivate such a search.*

f. *Present two objects such as a ball and a pencil in the client's direct view. If the client responds differently to the objects, rate at Level 6. For example, ask the client to give you the ball, or vary the position of the objects and determine if the client has a consistent preference.*

g. *By interview, determine if the client reacts differently when he/she sees objects that look similar (for instance, a small ball and an apple, or a frisbee and*

a dinner plate). You may employ techniques as mentioned in "f" in order to determine whether a client is "reacting differently" to the objects. If the client distinguishes the difference between similar objects, rate at Level 7.

h. *To receive a rating at Level 8, the client must correctly sort objects according to color, size, or shape. This may require an interview; however, rate at this level only if staff report convincing evidence of real color, size, or shape discrimination beyond mere object preference.*

50. VISUAL PERCEPTION (glasses may be worn)

This item refers to the client's use of sight. The item represents a progression of responses to visual stimuli.

Level 1 - Does not explore visually (includes continuous staring).

Level 2 - Some visual exploration, but does not follow moving objects.

Level 3 - Eyes follow moving objects.

Level 4 - Rotates head and inspects surrounding (if no motor limitations).

Level 5 - Searches for object which disappears from sight.

Level 6 - Discriminates between grossly different objects, such as ball and pencil, glass and knife, shoe and hat, etc.

Level 7 - Responds differently to similar objects such as cat and dog, fork and spoon, sheet and tablecloth, shoe and boot, etc.

Level 8 - Responds differently to objects based on differences of color, size, or shape. Indicates that the client responds differently to objects which are distinguishable only by some detail. Examples: red pants and blue pants, juice glass and beverage glass, wash cloth and face towel.

DEMONSTRATION FOR ITEM 51

If rating by "demonstration" yields uncertain responses, use staff interview.

a. *Client does not answer any of the following questions specified in levels 2 through 4. Rate at Level 1.*

b. *Client gives acceptable answer to "What do you do in the morning . . . .evening?" Rate at Level 2.*

c. *Client correctly answers "What time do you eat dinner?" Answer must specify clock time. Rate at Level 3.*

d. *Client correctly answers "What did you do yesterday? What time?" and "What will you do tomorrow? What time?" Rate at Level 4.*

51. ASSOCIATING TIME WITH EVENTS AND ACTIONS

This item refers to the extent to which a client knows when an event or action is to take place -- to the client's sense of time.

Level 1 - Does not appear to associate events and actions with time.

Level 2 - Associates regular events with morning, noon or night. Refers to events which occur on a daily or weekly basis. For example, "we go to school in the morning," "I go to bed at night." Clients who do not understand time but know the sequence of the daily routine should be rated at this level. Also rate at Level 2 those individuals who associate a certain hourly position on the clock with certain events, such as a television program.

Level 3 - Associates regular events with at least a rote understanding of time and hours. Examples: dinner is at 6:00, the store opens at 9:00, the movies start at 7:00, etc.

Level 4 - Associates events with specific time in past, present, and future (e.g., the ball game is at 6:00 tomorrow).

DEMONSTRATION FOR ITEM 52

Ask the client to count to ten.

a. *Does not count numbers or objects. Rate at Level 1.*

b. *Attempts to count by word, gesture, or selection of requested numbers of objects, but makes mistakes or counts with no number sense. Rate at Level 2.*

c. *Knows or selects "1 to 10" and can show you what each number means. Ask to be shown four fingers or four beads, etc. Rate at Level 3.*

d. *Ask "Which is more, 8 or 3? 4 or 7?" etc. Groups of objects may also be used here. Be sure to vary position of correct answer. Rate at Level 4.*

e. *If Level 4 is passed, ask client to count, for example, 17 out of 20 objects. If a client is in a large group of people ask him/her to count out more than ten of them, or the client may use his/her own fingers and those of the rater.*

52. NUMBER AWARENESS

This item refers to the extent to which the client is aware of numbers. The client's number awareness may be evidenced either by counting or by nonverbal means, such as indicating the correct number of beads or other objects.

Level 1 - Does not count. Includes the client who says numbers at random. Also includes the client who, using nonverbal means, does not respond purposefully to requests to select a certain number of objects.

Level 2 - Counts, but inaccurately or by rote. Indicates that the client has some number awareness, but skips numbers, or that the client counts but it has no meaning for him/her. Also indicates that the client, using nonverbal means, responds to requests to select a certain number of objects but characteristically makes errors.

Level 3 - Counts to ten and associates single-digit numbers with quantities. Examples: I have three sisters, nine pennies, two dogs, etc. Using nonverbal means, the client selects the correct number of objects.

Level 4 - Counts to ten and understands relative values (8 is larger than 3). Indicates that the client can count and understands the relative values of the numbers from one to ten (i.e., 8 is larger than 3; 3 is smaller than 7, etc.) Again, this may be done nonverbally, using quantities of beads, etc. If the client consistently selects the larger/smaller of two groups of objects regardless of the space occupied by those objects, rate at this level.

Level 5 - Counts, using multi-digit numbers, and associates multi-digit numbers with quantities. Indicates that the client can count up to and including numbers like 24, 120, 250, and associates those numbers with quantities. For example, there are 16 students in the class, "I have $25.00", etc. It would be expected that those clients using nonverbal means be able to select 17 of 20 objects (as in Level 5 of the preceding demonstration).

NOTE FOR ITEMS 53 & 54

Clients should be rated in their primary languages. Clients should be prompted to demonstrate these skills.

53. **WRITING SKILLS** (including Braille and typing)

Level 1 - Does not copy or trace numbers or alphabetic characters.

Level 2 - Copies from a model or traces numbers or alphabetic characters.

Level 3 - Prints single letters or name only, without copying from a model.

Level 4 - Prints single words only. The rater should ask the client to demonstrate these skills.

Level 5 - Prints words and sentences legibly. The rater should ask the client to demonstrate these skills.

Level 6 - Uses longhand for words and sentences. The rater should ask the client to demonstrate these skills.

If the client uses a typewriter or Braille writer independently, rate at this level.

54. **READING SKILLS** (including Braille)

This item refers to the extent to which a client understands the meaning of reading materials.

Level 1 - Does not read.

Level 2 - Recognizes single letters.

Level 3 - Reads simple words but appears not to comprehend. Indicates that the client sounds out but does not know the meaning of one-syllable words, such as ball, tree, etc.

Level 4 - Reads and comprehends simple words. Indicates that the client sounds out and knows the meaning of one-syllable words.

Level 5 - Reads and comprehends simple sentences. For example, the client knows the meaning of "I went home", "Ice is cold", etc.

Level 6 - Reads and comprehends complex sentences and stories.

NOTE FOR ITEM 55

Direct observation--by watching the client's performance in the following demonstrations--or interview, can be used as a basis for this rating, which may then be substantiated by someone who knows the client well.

55. ATTENTION SPAN

This item refers to activities such as school activities, looking at printed materials, etc., which require the client to focus his/her efforts. It does not include simple, direct commands.

Level 1 - Does not keep attention focused on a single activity.

Level 2 - Keeps attention focused on a single activity for less than one minute.

Level 3 - Keeps attention focused on a single activity between one and five minutes.

Level 4 - Keeps attention focused on a single activity between five and fifteen minutes.

Level 5 - Keeps attention focused on a single activity between fifteen and thirty minutes.

Level 6 - Keeps attention focused on a single activity for more than thirty minutes.

56. **SAFETY AWARENESS** (following safety rules and avoiding hazardous situations)

This item refers to the extent to which the client follows the basic rules of safety regarding electricity, fire, water, tools, traffic, etc., as well as the extent to which the client responds to other dangers, such as an open trench, a broken window, etc. **This item does not refer to self-injurious behavior.**

Level 1 - Endangers self frequently, and must be supervised at all times. Indicates that one-to-one attention is necessary in any potentially hazardous situation.

Level 2 - Endangers self occasionally; requires supervision on a daily basis. Routine guidance of a supervisor makes it unlikely that the client will endanger himself/herself.

Level 3 - Endangers self only in unfamiliar situations or settings. Client may require some supervision in special circumstances.

Level 4 - Typically does not endanger self. Indicates independent functioning with regard to potential danger.

DEMONSTRATION FOR ITEM 57

Put a pen or other small object on a table. Say: "I'm going to pick this up," (then do it), "put it in the other hand" (transfer it), "tap it on the table" (tap), and "put it back down where it was," (replace it on the table).

Then, interpose about 30 seconds of conversation and ask that the client do just what you did with the object. If client has difficulty, give one needed prompt. If the client is still not able to repeat task, repeat the demonstration and have the client attempt the task again.

OR: Give the client verbal instructions involving a series of actions, such as "Go to your room and get your brush, then go to the kitchen and get a cup."

57. REMEMBERING INSTRUCTIONS AND DEMONSTRATIONS

This item refers to the extent to which the client recalls the example of how to complete a specific task as demonstrated and/or as verbally directed on how to accomplish the task (instructions).

Level 1 - Does not memorize verbal instructions or demonstrations.

Level 2 - Memorizes verbal instructions or demonstrations if they are repeated three or more times and the client is prompted to recall them.

Level 3 - Memorizes verbal instructions or demonstrations if they are given once and the client is prompted in recall.

Level 4 - Memorizes verbal instructions or demonstrations without prompting if they are given once.

COMMUNICATION DOMAIN

The items in the communication domain are designed to measure the client's skills in expressing and receiving ideas by speech or by nonverbal means, including sign language or specialized communication aids. Some means of communication clearly are not relevant to certain clients. For example, a speaking client does not require skills in the use of remedial communication aids.

NOTE FOR ITEMS 58 - 66

Where it is stated that the client "demonstrates understanding" of communication, it is not required that the client responds appropriately or complies with a request. A client may understand, yet not do what is expected. In some cases, only those who are well acquainted with a client will be able to determine whether the client actually "demonstrates understanding."

58. WORD USAGE

This item refers to the extent and usefulness of the client's vocabulary, not to the client's ability to use appropriate sentence structure.

Level 1 - Does not use words. Indicates that the client has no vocabulary skills.

Level 2 - Uses simple, common (mostly one-syllable) words and associates words with appropriate objects.

Level 3 - Uses complex words and associates words with appropriate objects, but has a limited (50 words or ten signs) vocabulary. Indicates that the client characteristically uses multi-syllable words and associates them with appropriate objects, but has a limited vocabulary which hinders full or clear expression of thoughts, feelings, etc.

Level 4 - Has a broad vocabulary; understands the meaning of words and uses them in appropriate contexts. Indicates that the client has a sufficiently large vocabulary to fully and clearly express himself/herself.

59. EXPRESSIVE NONVERBAL COMMUNICATION

This item refers to the degree to which the client expresses himself/herself by using manual, facial and other body gestures. It does not include sign language or communication aids.

Level N - Skills not needed, client is verbal.

Level 1 - Has no expressive nonverbal communication. Indicates that the client's reactions are not interpretable even by those people most familiar with him/her.

Level 2 - Expresses needs or reactions by squirming, returning smiles, etc. Indicates that the client's reactions are often interpretable; some basic needs are evident from the client's behavior.

Level 3 - Communicates by pointing, shaking head, leading by the hand, etc. Indicates that the client actively expresses himself/herself by using a few (no more than three) simple gestures.

Level 4 - Gestures with hand and uses facial expressions for communication. Indicates that the client uses a variety (four or more) of standard forms of nonverbal communication that would be readily understood by people unfamiliar with him/her.

60. RECEPTIVE NONVERBAL COMMUNICATION (excluding sign language)

This item refers to the degree to which the client understands others' hand, facial, and body gestures. It does not include sign language. Responsiveness to facial expressions, touches, and hand gestures may be most accurately rated by interview with someone who knows the client well.

Level N - Understands verbal communication; skills not needed.

Level 1 - Does not demonstrate understanding of gestures, touching, or facial expressions. Indicates that the client does not appear to respond to touching gestures or facial expressions.

Level 2 - Demonstrates understanding of simple gestures. Simple gestures, for these purposes, include only "yes", "no", or pointing to an object.

Level 3 - Demonstrates understanding of complex gestures, touching, or facial expressions. Includes gestures other than "yes", "no", or pointing to an object. Examples include facial expressions which indicate feelings, and gestures which require carrying out instructions such as a hand cupped to the ear in order to get the client's attention.

Level 4 - Demonstrates understanding of a series of gestures, touching or facial expressions. The client responds with understanding to combinations of gestures, facial expressions and touching. An example would be nodding the head ("yes, you can do it") while putting the index finger to lips ("but please be quiet").

61. RECEPTIVE LANGUAGE

This item measures the client's understanding of spoken language. Clients who do not hear and are unable to read lips should be rated at Level 1 on this item.

Level 1 - Demonstrates no observable comprehension of language.

Level 2 - Responds to simple words, for example, his/her name, names of objects and/or activities such as ball, coffee, breaktime.

Level 3 - Understands simple phrases or instructions, for example: "It's time to work", "let's go outside", "please clean up your room", etc.

Level 4 - Understands the meaning of simple conversation, questions and combination of verbal instructions. Simple conversation and questions means talking about everyday events, for example, the clothes you're wearing, the weather, etc.

Level 5 - Understands the meaning of story plot and complex conversation. Indicates that the client responds with understanding to more abstract conversations and comprehends stories which require tying events together in order to get the sense of what is going on.

62. EXPRESSIVE LANGUAGE

This item measures a client's skills in communicating thoughts and feelings with words or sounds.

Level 1 - Makes no communication sound. Clients who make no speech-like sounds should be rated at this level. Clients who are completely silent or who only cry or laugh should also be rated at this level.

Level 2 - Says no words. Indicates that the client makes speech-like sounds which may include personal language and guttural sounds that are understood by those who know the client well.

Level 3 - Says simple words, for example, his/her name, names of places, names of people and things, "baby", "eat", etc. **Clients who have echolalia (merely repeat what they have heard) should be rated at this level because they say words, but do not communicate their own ideas.**

Level 4 - Says two-word phrases or sentences, for example, "I go", "give me", "me big", etc.

Level 5 - Says sentences of three or more words. The sentences should include subject, verb, and object or modifier. For example, "I run fast", "I like my job").

Level 6 - Carries on simple converstaion. Simple conversations means brief but meaningful exchanges of thoughts, needs, or complaints. For example:

"I'm hungry."
"What do you want to eat?"
"Let's have a sandwich."

Level 7 - Carries on more complex conversation. More complex conversation means detailed or abstract exchanges which reflect some understanding of shades of meaning in language. For example:

"I can hardly wait until Sunday."
"Why? What's happening on Sunday?"
"We're going skiing."
"How will you get there?"
"Our club has chartered a bus."

63. RECEPTIVE SIGN LANGUAGE

This item measures the client's understanding of formal sign language. The client should behave in ways to indicate his/her understanding as explained in each level. **This item may be rated for clients who do not hear and/or do not speak. If a client does not need these skills but has learned or is learning sign language, the client may be rated on this item if it is used 50% of the time.**

Level N - Skills not needed. Client hears.

Level 1 - Does not respond to signs or fingerspelling.

Level 2 - Responds to less than ten basic signs (e.g., coffee, water, restroom, hot, work, etc.). Common signs refer to those signs most often used in the client's own environment. Indicates that the client responds by shaking his/her head, by simple gestures (does not necessarily use formal expressive sign language), or by following instructions. Again, the client does not necessarily use formal sign language, but does carry out the request or point to clothing and food.

Level 3 - Responds to signed phrases ("It's time to work." "Let's go outside." "Please clean up your room."). The client may or may not use formal expressive sign language, but does respond to the communication.

Level 4 - Responds to signed complex statements, directions and explanations with a combination of signs and simple fingerspelling. The client may or may not use formal expressive sign language but follows the direction and indicates he/she understands explanations.

Level 5 - Responds to signed questions (three or more words) using a combination of signs and fingerspelling. Questions are asked in complete sentences. The client may or may not respond with formal expressive sign language.

64. EXPRESSIVE SIGN LANGUAGE

This item measures the client's expressive skills using formal sign language. Independent use (spontaneity) is the key in rating the client's skills and should not be confused with imitation. An interview may be necessary in order to rate this item. This item may be rated for clients who do not hear and/or do not speak. If the client does not need these skills but has learned or is learning sign language, the client may be rated on this item if it is used at least 50 percent of the time.

Level N - Skills not needed. Client speaks.

Level 1 - Does not sign or imitate signs.

Level 2 - Imitates sign language but makes no meaningful signs. This level indicates that the client has developed the concept of symbols for expression but does not yet have the skills to execute signs.

Level 3 - Makes less than ten signs independently to make needs known. Indicates that the client uses these signs as an ongoing form of expression and can be clearly understood by persons around him/her who understand sign language.

Level 4 - Makes ten or more signs independently to make needs known. Indicates that the client uses these signs as an ongoing form of expression and can be clearly understood by persons around him/her who understand sign language.

Level 5 - Makes twenty or more signs independently to make needs known and/or to carry on simple conversation. Indicates that the client has some receptive skills at this level and can carry on a simple conversation.

Level 6 - Makes fifty or more signs, fingerspells simple words and makes simple sentences or can carry on simple conversations.

Level 7 - Signs and fingerspells indepehdently in carrying on conversations as well as expressing needs. Indicates that the client is able to sign and fingerspell fluently with those who understand formal sign language.

65. EXPRESSIVE COMMUNICATION WITH AIDS

This item refers to the extent to which the client can express himself/herself with communication aids. It refers to all types of special communication aids which are designed to compensate for a client's handicap so that he or she may express messages. Examples of such aids are communication board with pictures to which the client points, or typewriters with modifications for people with physical handicaps. This item may be rated for clients who are both deaf and nonverbal.

Level N - Aids not needed.

Level 1 - Does not communicate with aids. Indicates that the client who might benefit from such aids either has not learned to utilize them or has not been provided with such communication aids.

Level 2 - Communicates single words or ideas. Indicates that the client conveys one idea at a time, for example, communicating that he/she is "thirsty," using a communication aid. Basic needs and reactions are expressed in this manner.

Level 3 - Communicates, forming short sentences, with subject and verb. Indicates that the client combines ideas into an understandable sentence. For example, "I like music," "My finger hurts."

Level 4 - Communicates combinations of sentences and groups of ideas together. Indicates a higher level of proficiency with a communication aid. The client not only expresses, but also interrelates, many ideas which have meaning.

NOTE FOR ITEM 66

It may be necessary to prompt some clients to speak in order to rate this item. Prompting might best be done by someone whom a client knows well, so that the client will be comfortable and so that the subject matter and words are within the client's vocabulary.

66. CLARITY OF SPEECH

This item refers to the client's ability to speak distinctly. The client may have a well-developed vocabulary, but due to speech problems, he/she may not be understood.

Level 1 - Makes no sounds.

Level 2 - Does not speak distinctly. Indicates that the client is not understood by anyone.

Level 3 - Speech is understood only by those who know the client. Indicates that the client can be understood by those who are familiar with him/her.

Level 4 - Speech is understood by strangers with some difficulty. Indicates that the client's speech is understandable by persons not well-acquainted with him/her, but due to the lack of clarity, not all of the words are understood and the listener must pay close attention in order to understand.

Level 5 - Speech is readily understandable to a stranger. Indicates that the client's speech is clear, even to those who are not familiar with him/her, and that no special effort is required in order to understand the client.