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## PART I

**OVERVIEW**

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HIGH RISK INFANT FOLLOW-UP QUALITY OF CARE INITIATIVE: MANUAL OF DEFINITIONS – RELEASE 01.18 | 3
HRIF-QCI PROGRAM

CHAPTER 1

STATE SCD OFFICE / CPQCC STAFF AND HRIF-QCI COMMITTEE MEMBERS

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**MISSION AND GOAL**

Children’s Medical Services (CMS) Branch/California Children’s Services (CCS) Program has worked with the CCS/California Perinatal Quality Care Collaborative (CPQCC) High Risk Infant Follow-up (HRIF) Quality Care Initiative (QCI) to develop a web-based HRIF-QCI Reporting System to collect data for the CCS HRIF Program. The Reporting System will be able to identify quality improvement opportunities for NICUs in the reduction of long term morbidity; allow programs to compare their activities with all sites throughout the state; allow the state to assess site-specific successes; and support real-time case management. The system, collecting data on high-risk infants up to their third birthday, enrolled in the CCS HRIF Program, will add value to the current CPQCC data already collected.

**PROGRAM BACKGROUND**

The CCS HRIF Program was established in 1979 to identify infants who might develop CCS Program-eligible conditions after discharge from a CCS Program-approved Neonatal Intensive Care Unit (NICU). Since 1979, the CCS Program’s goal of identifying neonates, infants and children who may develop a CCS Program-eligible medical condition has not changed.

The CCS Program’s standards for NICUs require that each CCS Program-approved NICU ensure the follow-up of neonates and infants discharged from the NICU who have high risk for neurodevelopmental delay or disability. The CCS HRIF Program provides for three Standard Visits which include a limited number of outpatient diagnostic services for infants and children up to three years of age whose care was provided in a CCS Program-approved NICU. All three Standard Visits should occur, particularly for those neonates, infants and children identified with impairments or to be at high risk, including very low birth weight infants, even if the child has been referred to services and other resources.

Each CCS Program-approved NICU must have an organized HRIF Program for the provision of these core diagnostic services or a written agreement with another CCS Program-approved HRIF Program to provide these services.

The CCS HRIF Program revised medical eligibility criteria (P.L. 01-0606), effective July 1, 2006, with additional diagnostic services available for reimbursement. The policy in P.L. 01-1113 dated November 22, 2013 clarified the HRIF criteria for services to ensure all eligible infants have access to these diagnostic assessments. These criteria are reiterated in this manual.

P.L. 01-1113 included clarification on medical eligibility for those neonates who require direct admit to a CCS Program-approved Pediatric Intensive Care Unit (PICU), who are never admitted to a CCS Program-approved NICU, but who otherwise meet all medical eligibility criteria for HRIF services, as reiterated on page 9, Program Logistics, Medical Eligibility Criteria. These neonates are eligible for HRIF services.

The following are reimbursable diagnostic services:

A. **A Comprehensive History and Physical Examination**, including neurologic assessment, usually performed at approximately 4 to 8 months, 12 to 16 months, and 18 to 36 months (adjusted for chronological age). Earlier or more frequent visits (in addition to the three Standard Visits) may be determined to be medically necessary by the HRIF Program. Examinations may be completed by one of the following: a CCS Program-approved...
(also known as CCS Program-paneled) physician (pediatrician or neonatologist), or a pediatric nurse practitioner (PNP). A PNP functioning in this role does not require CCS Program-approval and is practicing under the direction of a physician.

B. **A Developmental Assessment** performed at each of the three Standard Visits (4 to 8 months, 12 to 16 months, and 18 to 36 months). At the 3rd and final Standard Visit (18 to 36 months), a developmental test such as the Bayley Scales of Infant Development (BSID) 3rd edition must be performed. Earlier or more frequent assessments (in addition to the three Standard Visits) may be determined to be necessary by the HRIF Program. Each assessment during the child’s three-year eligibility period may be performed by one of the following who has training in the evaluation of motor and sensory development of high-risk infants: a CCS Program-approved pediatrician or neonatologist, PNP, CCS Program-approved nurse specialist (registered nurse with a Bachelor’s of Science Degree in Nursing), CCS-approved physical therapist, CCS Program-approved occupational therapist, or CCS Program-approved psychologist. The PNP functioning in this role does not need to be CCS Program-approved.

C. **A Family Psychosocial and Needs Assessment** performed during each of the child’s Standard Visits by a CCS Program-approved social worker, PNP or CCS Program approved nurse specialist with expertise in family psychosocial assessment. Referral shall be made to a social worker upon identification of significant social issues by a PNP or nurse specialist. Additional assessments may be determined to be necessary by the social worker, PNP, or nurse specialist.

D. **A Hearing Assessment**, for infants:

1. **Under six months of age** who were not screened in the hospital: A referral shall be made to a Newborn Hearing Screening Program (NHSP)-certified Outpatient Infant Hearing Screening Provider for an automated Auditory Brainstem Response (ABR) hearing screen. A list of NHSP-certified screening providers is available on the NHSP website: [http://www.dhcs.ca.gov/services/nhsp](http://www.dhcs.ca.gov/services/nhsp) or by calling the NHSP toll-free number at 1-877-388-5301; or

2. **Over six months of age** who were not screened in the hospital: A referral shall be made to a CCS Program-approved Type C Communication Disorder Center (CDC) for a diagnostic audiology evaluation; or

3. Who did not pass the inpatient NICU hearing screen: A referral shall be made to a NHSP-certified Outpatient Infant Hearing Screening Provider for an automated ABR rescreen if under six months of age or to a Type C CDC for a diagnostic audiology evaluation if over six months of age; or

4. Who do not have a hearing loss (passed initial screen, passed rescreen, passed diagnostic evaluation) but has one or more risk factors for developing a progressive or late-onset hearing loss, (as per the most recent version of the Joint Committee on Infant Hearing Position Statement [www.jcih.org]): A referral shall be made to a Type C CDC for at least one diagnostic audiology evaluation by 24 to 30 months of age. Earlier or more frequent assessments may be indicated for infants and children at high risk.

E. **An Ophthalmologic Assessment**, performed by a CCS Program-approved ophthalmologist with experience and expertise in the retinal examination of the preterm infant. The
assessments are to be done in accordance with the American Academy of Pediatrics Policy Statement “Screening Examination of Premature Infants for Retinopathy of Prematurity” Pediatrics, Vol. 131: Number 1, January 2013, P.189-195 and until the ophthalmologist determines the child is no longer at risk for developing retinopathy of prematurity.

F. **A Home Assessment** for the purpose of evaluating the family for specific needs in the home environment (i.e. to determine if there are appropriate resources to assure access to services; evaluate the parent/infant interaction; and parent’s understanding of infant care, development, and special needs). The home assessment, when planned, shall be provided by a home health agency (HHA) nurse, preferably experienced in evaluating the maternal/infant environment, and is not to be utilized to perform direct services. Medical justification must be provided by the HRIF Program physician if additional home assessments are required beyond the first year’s initial two allowable visits.
TECHNICAL SUPPORT

CPQCC provides technical support for the web-based Reporting System. Please direct all your questions and comments regarding the HRIF-QCI Reporting System to HRIF Support:


Erika Gray, BA
CPQCC, HRIF QCI Program Manager
Email: erika@cpqcc.org

Mailing Address:
California Perinatal Quality Care Collaborative (CPQCC)
1265 Welch Road, MC: 5415
Medical School Office Building (MSOB)
1st Floor – West Wing, Perinatal Programs
Stanford, CA 94305

CCS HRIF PROGRAM POLICY AND PROCEDURE SUPPORT

Please direct all your questions and comments to the State Systems of Care Division (SCD) Office:

Support Email: HRIF@dhcs.ca.gov

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Web Address: http://www.dhcs.ca.gov/services/ccs/Pages/HRIF.aspx
CHAPTER 2

PROGRAM LOGISTICS

MEDICAL ELIGIBILITY CRITERIA

(See Appendix A)

Age Criteria

A neonate, infant or child is eligible for the HRIF Program from birth up to three years of age.

Residential Eligibility

The county CCS Program is responsible for determining whether the parent or legal guardian of a HRIF Program applicant is a resident of the county per CCS Program policy.

Financial Eligibility

Financial eligibility determination is not required for HRIF Program services as the HRIF Program provides diagnostic services only. While financial eligibility is not required, insurance information shall be obtained. See page 14, for information on authorization of HRIF services and other health coverage.

Medical Eligibility

A neonate, infant or child shall be medically eligible for the HRIF Program when the infant:

A. Met CCS Program medical eligibility criteria for NICU care, in a CCS Program-approved NICU regardless of length of stay (per Numbered Letter [N.L.] 05-0502, Medical Eligibility in a CCS Program-approved NICU, or the most current N.L.). \textbf{NOTE}: Medical eligibility includes neonates who require direct admit to a CCS Program-approved PICU, who are never admitted to a CCS Program-approved NICU, but who otherwise meet all medical eligibility criteria for HRIF services in this section.

\textbf{OR}

B. Had a CCS Program-eligible medical condition in a CCS Program-approved NICU regardless of length of stay, even if they were never CCS Program clients during their stay (per California Code of Regulations, Title 22 Section 41515.1 through 41518.9, CCS Program Medical Eligibility Regulations).

\textbf{AND}

C. The birth weight was less than or equal to 1500 grams or the gestational age at birth was less than 32 weeks.

\textbf{OR}

D. The birth weight was more than 1500 grams and the gestational age at birth was 32 weeks or more and one of the following documented criteria was met during the NICU stay:
1. pH less than 7.0 on an umbilical cord blood sample or a blood gas obtained within one hour of life) or an Apgar score of less than or equal to three at five minutes or an Apgar score of less than 5 at 10 minutes.

2. An unstable infant manifested by hypoxia, acidemia, hypoglycemia and/or hypotension requiring pressor support.

3. Persistent apnea which required caffeine or other stimulant medication for the treatment of apnea at discharge.

4. Required oxygen for more than 28 days of hospital stay and had radiographic finding consistent with chronic lung disease.

5. Infants placed on extracorporeal membrane oxygenation (ECMO).

6. Infants who received inhaled nitric oxide greater than four hours, and/or treatment during hospitalization with sildenafil or other pulmonary vasodilatory medications for pulmonary hypertension.

7. Congenital heart disease (CHD) requiring surgery or minimally invasive intervention.

8. History of observed clinical or electroencephalographic (EEG) seizure activity or receiving antiepileptic medication(s) at time of discharge.

9. Evidence of intracranial pathology, including but not limited to, intracranial hemorrhage (grade II or worse), white matter injury including periventricular leukomalacia, cerebral thrombosis, cerebral infarction or stroke, congenital structural central nervous system (CNS) abnormality or other CNS problems associated with adverse neurologic outcome.

10. Clinical history and/or physical exam findings consistent with neonatal encephalopathy.

11. Other documented problems that could result in a neurologic abnormality, such as:
   a. History of CNS infection.
   b. Documented sepsis.
   c. Bilirubin at excessive levels concerning for brain injury as determined by NICU medical staff.
   d. History of cardiovascular instability as determined by NICU medical staff due to: sepsis, congenital heart disease, patent ductus arteriosus (PDA), necrotizing enterocolitis, other documented conditions.
A. Each CCS-approved NICU that has its own HRIF Program is required to have a multidisciplinary team of professionals that may include pediatricians or neonatologists, pediatric nurse practitioners (PNPs), nurse specialists, ophthalmologists, audiologists, social workers, psychologists, physical therapists, and occupational therapists. All professionals listed must be CCS-approved. The PNP only requires CCS-approval when functioning in the CCS HRIF Program as the HRIF Coordinator.

As part of the NICU discharge planning process, the NICU must identify and refer to the CCS Program clients identified as potentially eligible for the HRIF Program.

1. This can be accomplished by submitting Service Authorization Requests (SARs) to the appropriate County CCS Program or State Systems of Care Division (SCD) Office.

2. The SARs are available online at the CCS Forms website, http://www.dhcs.ca.gov/formsandpubs/forms/Pages/CCSForms.aspx

3. Click on form DHCS 4488 (New Referral of CCS/GHPP Client SAR or form DHCS 4509, Established CCS/Genetically Handicapped Persons Program Client SAR).

4. These forms can be completed online. Print and fax to the appropriate county CCS Program or State SCD Office.

5. The approved or denied SARs for HRIF services will be mailed or faxed to the HRIF provider by the local county CCS Program or SCD Office, if the hospital facility is not approved to access online correspondence via the Provider Electronic Data Interchange (PEDI) system.

6. The facility’s designated PEDI Liaison is responsible for distributing copies of the authorization to all relevant facility providers.

7. The HRIF Coordinator is responsible for distributing copies of the authorization to HRIF team members and consultants responsible for the infant’s follow-up care.

B. NICU Program Referral Requirements

1. It is the responsibility of the discharging to home CCS NICU/Hospital or the last CCS NICU/Hospital providing care to make the referral to the HRIF Program.

2. The NICU referral process:

   a. Upon referring a neonate, infant or child to the HRIF Program, a “RR Form” is completed (except HRIF I.D. Number) and submitted via the web-based HRIF-QCI Reporting System (https://www.ccshrif.org/) by the discharge/referring NICU/Hospital at time of discharge to home.

   b. As noted above in B.1, the discharging/referring NICU/Hospital will submit a SAR to the local CCS Program Office for HRIF services. (Service Code Group [SCG] 06 should be requested.)
**HRIF PROGRAM RESPONSIBILITIES**

A. Each HRIF Program must designate one of its team members as the HRIF Coordinator. The PNP is only required to be CCS-approved when functioning as an HRIF Coordinator.

1. As the HRIF Program is a CCS Program Special Care Center (SCC), the required team members include a CCS Program-approved: HRIF Program medical director (pediatrician or neonatologist), HRIF coordinator, ophthalmologist, audiologist, social worker, and an individual to perform the developmental assessment. Each of these professionals may be reimbursed for the diagnostic services they provide. See page 6, *Program Background - Section B.* for description of the health care professionals who perform developmental assessments.

   **NOTE:** An individual provider may simultaneously serve in more than one role on the HRIF team.

2. All HRIF Programs shall develop policies and procedures, including job descriptions assigning function responsibilities, to ensure consistent implementation of the above policy regardless of staff changes. These documents shall be available for review during CCS Program site reviews.

3. Team members of CCS Program-approved HRIF Programs are to be listed on the CCS Program HRIF SCC Directory. Names of providers must be approved by the HRIF Program Medical Director to provide services to HRIF eligible infants and children. If your NICU does not have a HRIF Program, you are required to complete the CCS Program HRIF SCC Directory form to identify your NICU and the facility that you have made arrangements with to provide HRIF services. If there are subsequent changes to the HRIF Program SCC directory, you must submit an update.

   **NOTE:** HRIF Directory Forms are on the CCS Program website [http://www.dhcs.ca.gov/services/ccs/Pages/HRIF.aspx#hrifdirectory](http://www.dhcs.ca.gov/services/ccs/Pages/HRIF.aspx#hrifdirectory).

B. **HRIF Coordinator**

1. The HRIF Coordinator shall be a CCS Program-approved: pediatrician or neonatologist, PNP, nurse specialist, psychologist, social worker, physical therapist, or occupational therapist. The PNP only requires CCS Program-approval when functioning in the CCS HRIF Program as a HRIF Coordinator.

   The Coordinator has the key role in follow-up and coordination of services for eligible infants and children and their families. The specific responsibilities of the coordinator are:

   a. **Coordination**

      1. Serve as the primary person coordinating HRIF services among the local county CCS Programs, other HRIF Programs located in CCS Program-approved Regional, Community, and Intermediate NICUs, State Regional Offices, clients/families, and others in matters related to the client’s HRIF services.

      2. Participate in NICU discharge planning process or multidisciplinary rounds.
3. Ensure identification of HRIF eligible clients according to HRIF eligibility criteria.

4. Ensure the NICU discharge planning process includes referral and SAR submission to the County CCS Program or State SCD Office. (See page 10, NICU Program Responsibilities – Section B.)

5. Ensure copies of the authorizations are distributed to HRIF team members and consultants.

6. Gather medical reports and assessments for review by team members, and prepare a summary report.

7. Ensure that a copy of the summary report is sent to the local county CCS Program or State SCD Office.

8. Confer with parents regarding services provided and results of clinical evaluations and assessments of their infant or child.

9. Assist families in establishing a Medical Home for the infant or child.

10. Assist clients/families in making linkages to necessary medical and social services.

11. Ensure there is a system in place to follow-up with families including those who have missed appointments. Collect documentation of the reason for missed appointments and develop a plan of action for improving HRIF Program adherence for evaluations and assessments.

12. Provide coordination between the HRIF Program and the infant’s or child’s (pediatric) primary care physician, specialists, and local county CCS Program or State SCD Office when appropriate.

13. Coordinate HRIF services with the local county CCS Program and SCD Offices and other local programs.

14. Coordinate follow-up service needs among the CCS Program-approved Regional, Community and Intermediate NICUs within the community catchment area and with those NICUs that provide HRIF referrals to their agency.

b. Client Referral Services and Follow-Up

1. Ensure and document referrals are made to the Early Start (ES) Program for children who meet ES eligibility criteria. Refer to the Department of Developmental Services website for ES information: https://dds.ca.gov/General/Eligibility.cfm

2. Ensure referrals are made to the Regional Center when those services are appropriate.

3. Ensure referrals to HRIF diagnostic consultations and assessments are made with CCS Program-approved providers.
4. Ensure referrals to CCS Medical Therapy Program (MTP) are made as needed. **Reminder:** CCS Program eligibility and referral criteria for MTP are different from CCS/CPQCC HRIF data collection definitions for MTP eligibility.

5. Provide referral and resource information for other social and developmental programs within the community, as required.

c. **Education Services Program**

   1. Provide education and outreach about the HRIF Program and services, clinical care, required documentation on transfer, and referral options, including outreach to NICUs that have a Regional Cooperation Agreement to CCS Program-approved Community and Intermediate NICU’s and other community referral agencies, as appropriate.

   2. Develop and provide education to parents and family members about the high-risk infant’s medical condition(s), care and treatment, special needs and expected outcomes of care.

   3. Provide education to parents and family members about the system of care and services (including social services) available to help them nurture, support, and care for the high risk infant.

C. **HRIF Program Reporting Requirements**

   1. The HRIF Coordinator is responsible for ensuring that data is collected and reported to State SCD, CCS Program and CPQCC. Reporting forms referenced in CCS N.L. 10-1113 and HRIF P.L 01-1113 are superseded by this P.L. The HRIF Coordinator will:

      a. Coordinate the collection, collation, and reporting of required data.


      The reporting forms include:

      1. Referral/Registration (RR) Form
      2. Standard Visit (SV) Form
      3. Additional Visit (AV) Form
      4. Client Not Seen/Discharge (CNSD) Form

      c. Ensure required data is submitted accurately and in a timely fashion to the CCS/CPQCC HRIF QCI and meets all required deadlines.

      d. Review and share results of the HRIF Summary Report and the HRIF CCS Program Annual Report and the NICU Summary Report with members of the HRIF program team, the referring NICU Medical Directors, and the NICU team.
e. In collaboration with the NICU Medical Director, ensure that the HRIF Program fully participates in the CCS Program evaluation, including submission of required information and data.

- Required Reports for Case Management

A summary report of the HRIF Team Visit is required to be submitted to the local county CCS Program or State SCD Office. This information is necessary for the local county CCS Program or State SCD Office staff case management activities.

The HRIF Program can download a template HRIF Team Visit Report form at http://www.dhcs.ca.gov/services/ccs/Documents/hrifteamvisit.pdf or submit its own team report which shall include the required summary reporting elements.

A copy of the HRIF Team Visit Report and copy of the comprehensive physician report (either the template form or in lieu of this form, a dictated team report and physician report) should also be distributed to the:

a. County CCS Program or State SCD Office,
b. NICU Medical Director (if the director is not directly involved with HRIF Program),
c. Medical Home (or primary care provider), and
d. Other providers involved in the infant’s or child’s care.

AUTHORIZATION OF HRIF SERVICES

A. As part of the NICU discharge planning process, the NICU must identify and refer to the CCS Program infants identified as potentially eligible for the HRIF Program. Refer to Section IV.B regarding NICU referral and SAR submission information. The approved SARs for HRIF services will be sent to the HRIF Coordinator who is responsible for distributing copies of the authorization to all relevant HRIF team members and consultants responsible for the infant’s follow-up care.

B. The HRIF Program will receive an authorization of services for SCG 06 for each infant or child determined eligible for the HRIF Program.

C. SCG 06 contains billable codes for diagnostic services provided by medical and other allied health professionals. The provider group entitled “Other Allied Health Professionals” includes pediatric nurse specialists, nurse specialists, psychologists, social workers, physical therapists, occupational therapists, and audiologists.

SCG 06 allows HRIF Program providers to render limited core diagnostic services only for a CCS Program client without the submission of a separate request for each service required. No additional codes are approved for HRIF diagnostic services.

1. Refer to the CCS Program website for HRIF SCG 06 codes and descriptions http://www.dhcs.ca.gov/services/ccs/cmsnet/Pages/SAR Tools.aspx.
2. Refer to the Medi-Cal Provider Manual for the most current code list and billing guidelines: http://files.medi-cal.ca.gov/publications/masters-mtp/part2/calchildser_m00i00o03o04o07o09o11a02a04a05a06a07a08p0_0v00.doc.


NOTE: On July 1, 2013, the Department implemented new pricing methodology based on “Diagnosis Related Groups” (DRGs) for reimbursement of inpatient stays at private hospitals for both CCS Program and Medi-Cal. DRG inpatient reimbursement methodology does not affect CCS Program eligibility or service authorization for outpatient services. This includes and applies to HRIF diagnostic services.

D. At the time of the referral for HRIF authorization, an authorization for two home assessments by the HHA nurse, preferably experienced in evaluating the maternal/infant environment, may be separately authorized if needed.

1. The HRIF Program must inform the local county CCS program which HHA is to be authorized for skilled nursing home assessment(s).

2. The authorization will be for up to two home assessments during the first year.

3. These visits are only to assess the home environment. They are not to be used as the venue for the provision of HRIF diagnostic services.

4. Additional home assessments by the HRIF HHA nurse requires medical necessity justification from the HRIF Program physician.

E. When a CCS Program-eligible medical condition is discovered as part of the HRIF diagnostic assessments, the HRIF Coordinator is responsible for referring the client to the local county CCS program or State SCD Office. The program eligibility, including financial eligibility, will be determined by the local CCS program staff for treatment of the CCS Program-eligible medical condition.

If found to be eligible for the CCS Program, treatment services for the child will be separately authorized to the most appropriate CCS Program-approved provider. HRIF services (SCG 06) will continue to be authorized up to the child’s third birthday. An overview of CCS Program-eligible conditions can be found on the CCS Program website at http://www.dhcs.ca.gov/services/ccs/Pages/medicaleligibility.aspx.

F. When the CCS HRIF Program staff identifies the HRIF client as having other health coverage (OHC), i.e., commercial third party health insurance or Health Maintenance Organization (HMO), the HRIF staff must bill the OHC prior to billing the CCS Program. A denial of benefits or Explanation of Benefits (EOB) must be attached to each claim. CCS Program/Medi-Cal is the payor of last resort.

1. The State SCD Office expects HRIF clients identified as high-risk and authorized for HRIF diagnostic services to receive these services. HRIF programs that do not provide diagnostic services as authorized because the client has OHC with an unmet deductible or co-payment must notify the client’s CCS Program county nurse case manager.
2. The local CCS county program county or State SCD Office staff will contact the State HRIF Program manager to report any unresolved issues of a CCS Program HRIF client who is unable to access authorized services to assure HRIF-eligible clients receive services.

G. Provision of HRIF diagnostic services may be terminated prior to the child’s third birthday if the HRIF Program indicates that the child no longer has high risk for neurodevelopmental concerns and HRIF services are no longer required. This may occur when the child is found to be doing well on neurodevelopmental examination and testing.

**NOTE:** If an infant who has been discharged from HRIF Program services, is later identified, prior to the third birthday, as being at risk for neurodevelopmental issues, that child may be reinstated into the HRIF Program.

### CLAIMS SUBMISSION

This section provides general guidelines for HRIF Program billing. HRIF services are reimbursable to the HRIF Program when provided by CCS Program-approved HRIF providers. Providers listed in the HRIF directory have been approved to provide services to the HRIF-eligible child.

#### A. General Requirements

1. The HRIF SCG 06 SAR only covers reimbursement of diagnostics services (codes) included in the SCG 06.

   a. Ophthalmology diagnostic services, as listed in the SCG, may be billed by the ophthalmologist using the SAR number.

   b. Audiology diagnostic services, as listed in the SCG, may be billed by the approved Type C CDC performing the services using the SAR number.

   c. Psychologists are only authorized to bill for limited diagnostic developmental assessment procedure codes included in SCG 06. Procedure codes that represent intervention (treatment) services are not payable with the SAR.

   d. Developmental testing procedures rendered by either a Nurse Specialist or a Physical or Occupational Therapist must be billed by the facility with the facility’s outpatient Medi-Cal provider number.

2. Providers must be enrolled in the Medi-Cal Program and use their active Medi-Cal provider number on all authorized claims for all CCS Program HRIF clients.

3. Allied healthcare providers (e.g., physical/occupational therapists, audiologists, and social workers) who are employees of a hospital or facility are exempt from the Medi-Cal provider number requirement since the facility bills for their services using the facility’s Medi-Cal provider number.

4. If applicable, providers must request authorization from a client’s other commercial third party health insurance carrier or HMO prior to providing services, and bill the client’s other
commercial health insurance carrier or HMO plan prior to billing the CCS Program. A denial of benefits or an EOB must be attached to each claim. CCS Program/Medi-Cal is the payor of last resort.

NOTE: See page 15, Authorization of HRIF Service, Section E., regarding other health coverage and provision of HRIF diagnostic services.

B. Claims Submission

1. Providers billing for HRIF patients with a SAR issued to the SCC must adhere to the specific instructions described in the Medi-Cal Provider Manual when completing the claim form. For claim completion instructions, refer to the Medi-Cal Provider Manual.

2. For claim submission information, refer to the Computer Media Claims (CMC) section of the Medi-Cal Program and Eligibility manual located at: http://www.medi-cal.ca.gov/cmc_instructions.asp or call the Telephone Services Center at 1-800-541-5555.

3. Claims authorized for CCS Program/Medi-Cal children residing in Marin, Napa, San Mateo, Santa Barbara, Solano, and Yolo counties must be sent to the issuing county for approval and processing. Refer to the Medi-Cal Provider Manual, CCS Program Billing Guidelines.

NOTE: If you have any questions regarding HRIF services, please submit your inquiry to the State SCD office via e-mail at: HRIF@dhcs.ca.gov.
REPORTING SYSTEM

CHAPTER 3  INTRODUCTION TO THE DATA FORMS  page 20
CHAPTER 4  DEFINITIONS OF DATA ITEMS  page 22

1. Referral/Registration (RR) Form
2. Standard Visit (SV) Form
3. Additional Visit (AV) Form
4. Client Not Seen/Discharge (CNSD) Form
INTRODUCTION TO THE HRIF DATA FORMS

Visit the HRIF-QCI Program – Resource Corner page to download copies of the reporting forms: https://www.cpqcc.org/perinatal-programs/ccscpqcc-hrif-qci/resource-corner

SUMMARY OF REPORTING FORMS

REFERRAL/REGISTRATION (RR) FORM

It is the responsibility of the discharging to home California Children’s Services (CCS) Neonatal Intensive Care Unit (NICU) /Hospital OR the last CCS NICU/Hospital providing care to make the referral to the HRIF Program.

Upon referring an infant to the HRIF Program, a “RR Form” is completed (except HRIF I.D. Number) by the discharge/referring NICU/Hospital at time of discharge to home.

NOTE: Only refer patients who are alive at the time of discharge to home.

HRIF Program Referral Process:
Communication is between the CCS-approved NICU and HRIF Program.

- The discharging/referring NICU/Hospital will refer eligible infants to the HRIF Program at time of discharge to home, and complete the “RR Form” via the web-based HRIF-QCI Reporting System.
- The discharging/referring NICU/Hospital will submit a Service Authorization Request (SAR) to the local CCS Office for HRIF services. (Service Code Group [SCG] 06, should be requested). http://www.dhcs.ca.gov/services/ccs/cmsnet/Pages/SARTools.aspx (See page 14, for information on authorization of HRIF services.)
- The discharging/referring NICU/Hospital will send a copy of the Discharge Summary to the HRIF Program.
- The HRIF Program will accept the infant’s case and all applicable information will be carried forward to the “SV Form” as appropriate to decrease entering data that is already in the system.

STANDARD VISIT (SV) FORM

The HRIF Program has three core visits that take place during the following time periods: Visit #1 (4-8 months), Visit #2 (12-16 months) and Visit #3 (18-36 months).

NOTE: The time frames for the core visits are only recommendations and guidelines that were decided by the HRIF-QCI Executive Committee.

At each core visit, a “SV Form” is completed and submitted via the web-based HRIF-QCI Reporting System. At the 3rd and final Standard Visit (18 to 36 months), a developmental test such as the Bayley Scales of Infant Development (BSID) 3rd edition must be performed and reported. It is highly recommended that an Autism Spectrum Screening tool such as the MCHAT be performed between 16-30 months of age.
Although the HRIF Program is designed for three core visits, some infants may require fewer visits. At the end of each SV Form is a “Disposition”. This section should be completed after each visit.

**Incomplete Standard Visits**

The most common reasons for an incomplete core visit are due to difficulties in obtaining a neurologic or developmental assessment. If you cannot obtain a neurologic or developmental assessment during the core visit, indicate the reason why the assessment was not performed and then schedule a return visit for the infant to complete the assessment(s). When the infant returns the missing neurologic or developmental assessment data can be entered on the incomplete “SV Form”. The date of the return visit should be entered in to the “Date Performed” field(s).

**NOTE:** Patient measurements should be taken at the time when the neurologic and developmental assessments are performed. See page 37, Patient Assessment.

If situational information has changed between the incomplete core visit and the return visit, this should be updated. Such information includes: name, address, caregiver, Child Protective Services (CPS) placement, etc.

**ADDITIONAL VISIT (AV) FORM**

If an infant requires additional visits for further assessment, an “AV Form” must be completed. Additional visits may occur before, between and/or after the recommended time frames for standard visits.

This form **only** captures the date, reason (social risk, case management, concerns with neuro/developmental course or other) and disposition for the additional visit.

**CLIENT NOT SEEN/DISCHARGE (CNSD) FORM**

The “CNSD Form” should be used for the following case scenarios:

- Infant referred to your HRIF Program, but HRIF Program staff was unable to contact the infant’s parent (primary caregiver) to establish an initial core visit.
- No Show: parent (primary caregiver) reschedule (less than 24 hours) or does not show for a scheduled core visit.
- Infant eligible for HRIF Program, but parent (primary caregiver) declines service.
- Infant expired prior to core visit, family relocated, insurance denial, etc.
- Infant transferred/referred to another CCS HRIF Program for follow-up services.

This form captures **only** the date, category, reason and disposition for the client not seen visit.
## DEFINITIONS OF DATA TERMS

### REFERRAL/REGISTRATION (RR) FORM (SECTIONS)

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### STANDARD VISIT (SV) FORM (SECTIONS)

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### ADDITIONAL VISIT (AV) FORM (SECTIONS)

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### CLIENT NOT SEEN/ DISCHARGE (CNSD) FORM (SECTIONS)

- Category ............................................................................................................................... page 72
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- Hospital/Center Information (Optional) ......................................................................... page 75
REFERRAL/REGISTRATION (RR) FORM
(See page 20 for the summary of “RR Form”)

The discharging to home California Children’s Services (CCS) Neonatal Intensive Care Unit (NICU) /Hospital OR the last CCS NICU /Hospital providing care is responsible for submitting the RR Forms to the HRIF Program Coordinator. RR Form submissions should be made at time of discharge to home.

**REQUIRED FIELD** MUST be entered to save web-based entry screens. Saved entry screens can be recalled later to make necessary updates. Required fields are mandatory to improve the data linkage between the CMQCC Maternal Database with CPQCC Network Database and the CCS HRIF-QCI Program Database.

**REFERRED HRIF PROGRAM CLINIC** – (“NEW PATIENT REFERRAL” WEB-BASED ENTRY FORM)
Select the HRIF Program where the infant/child will be receiving follow-up services.

**UNABLE TO COMPLETE FORM** – CHECKBOX (WEB-BASED ENTRY FORM)
Use only when the HRIF Program is unable to complete the RR Form, because the infant/child was lost to follow-up, expired prior initial visit or the primary caregiver(s) refused follow-up service.

**NOTE:** Submit a “CNSD Form” to capture the reason why the RR Form is unable to be completed. (See page 20 of this manual for the summary of “CNSD Form”.)

**THIS FORM IS CLOSED** – CHECKBOX (WEB-BASED ENTRY FORM)
This checkbox feature serves as an electronic signature confirmation that all available data has been entered.

**HRIF IDENTIFICATION (I.D.) NUMBER** – AUTOMATICALLY COMPUTER GENERATED
This number consists of a unique HRIF Program 3-digit prefix number (assigned and provided by California Perinatal Quality Care Collaborative [CPQCC]) and a 5-digit computer generated number. This 8-digit number identifies the infant/child enrolled in the HRIF Program.

**NOTE:** The HRIF I.D. Number is created after submitting the “RR Form” in the web-based Reporting System.

**HOSPITAL/CENTER INFORMATION** (OPTIONAL)

**HOSPITAL SPECIFIC MEDICAL I.D. NUMBER**
Enter the infant/child’s hospital medical record number.

**INFANT’S FIRST NAME**
Enter the infant/child’s first name using the hospital record.

**INFANT’S LAST NAME**
Enter the infant/child’s last name using the hospital record.

**INFANT’S AKA (ALSO KNOWN AS)-1 LAST NAME**
Enter the infant/child’s last name if it is different from the hospital record or if the infant/child has two last names.

**INFANT’S AKA-2 LAST NAME**
Enter the infant/child’s last name if it is different from the hospital record and previous AKA-1 Last Name.
**PRIMARY CAREGIVER’S FIRST NAME**  
Enter the primary caregiver’s first name. (see page 31, for definition of Primary Caregiver)

**PRIMARY CAREGIVER’S LAST NAME**  
Enter the primary caregiver’s last name. (see page 31, for definition of Primary Caregiver)

**STREET ADDRESS**  
Enter the permanent physical street address of the primary caregiver’s residence.

**CITY**  
Enter the permanent physical city of the primary caregiver’s residence.

**STATE/COUNTRY**  
Select the permanent physical state/country of the primary caregiver’s residence.

**ZIP CODE**  
Enter the permanent 5-digit zip code of the primary caregiver’s residence.

**HOME PHONE NUMBER**  
Enter the most common 10-digit phone number where the family can be reached.

**ALTERNATE STREET ADDRESS**  
Enter the alternate physical street address of a relative or other contact person.

**CITY**  
Enter the alternate physical city of a relative or other contact person.

**STATE AND COUNTRY**  
Select the alternate permanent physical state and country of a relative or other contact person.

**ZIP CODE**  
Enter the alternate 5-digit zip code of a relative or other contact person.

**ALTERNATE HOME PHONE NUMBER**  
Enter the alternate 10-digit phone number where the family can be reached.

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**PROGRAM REGISTRATION INFORMATION**

**Infant enrolled in a CCS clinic (service) other than the HRIF Program**  
(Added Jan. 2018)

- Check **No** if the infant/child is not enrolled in a CCS clinic.
- Check **Yes** if the infant/child is enrolled in a CCS clinic other than the HRIF Program.
  - Other CCS clinics include:
    - Medical Therapy Program  
      (http://www.dhcs.ca.gov/services/ccs/Pages/MTP.aspx)
    - Special Care Centers (other than HRIF)  
      (http://www.dhcs.ca.gov/services/ccs/scc/Pages/SCCType.aspx)
- Check **Unknown** if the information cannot be obtained.
CALIFORNIA CHILDREN’S SERVICES (CCS) NUMBER
Enter the 7-digit CCS Number of the infant/child. This number is given to the infant/child when his/her case has become active and is assigned within a few days of the child’s eligibility for CCS. If a CCS number is not assigned to the infant/child leave it blank.

NOTE: The Alpha letter “T” is acceptable to enter and indicates that the CCS Number is temporary. Example of a temporary CCS number “T” + seven-digits = T1234567.

INFANT NOT CPQCC ELIGIBLE
Check the “Infant NOT CPQCC Eligible”, if the infant/child does not qualify for the CPQCC NICU eligibility criteria (see Appendix E), and therefore does not have a CPQCC Network Patient ID Number, enter “99999” as the CPQCC Network Patient ID Number.

CPQCC REFERENCE NUMBER (*REQUIRED FIELD)
Enter the last six-digits of the discharging/referring or birth CCS NICU hospital’s Office of Statewide Health Planning and Development (OSHPD) facility code (Appendix E) and the infant/child’s CPQCC Network Patient Identification Number from the discharging/referring or birth CCS NICU hospital, where the infant/child was born or admitted within 28 days of birth. The CCS NICU discharging the infant/child home could also be the same facility referring the infant/child to the HRIF Program.

The OHSPD facility code and CPQCC Network Patient ID Number must match. If you use the birth hospital’s OSHPD code then you must use the birth hospital’s CPQCC Network Patient ID Number.

NOTE: Enter “99999” as the CPQCC Network Patient ID Number or check the “Infant NOT CPQCC Eligible” checkbox, for infants who did not qualify for CPQCC NICU eligibility criteria.

Every CPQCC / CCS NICU hospital has a CPQCC data contact person that keeps a record of each patient who meets the CPQCC NICU eligibility criteria (see Appendix E). The “CPQCC & HRIF-QCI Directory” is available in the Reporting System located under the “Admin” tab => “Update Directory” => “Download Directory”, use this directory to identify the CPQCC data contact person(s) from the discharging/referring or birth CCS-approved NICU hospital.

NOTE: Enter “00000” as the CPQCC Network Patient ID Number, if you are not sure if the infant met the CPQCC NICU eligibility criteria or the CPQCC data contact person is backlogged and, therefore has not assigned a CPQCC Network Patient ID Number for the infant. Use the “CPQCC Reference Number Report” to replace assigned CPQCC Network Patient ID Number(s).

NOTE: Enter “77777” as the CPQCC Network Patient ID Number, if the infant met CPQCC NICU eligibility criteria, but was not assigned a CPQCC Network Patient ID Number.

DATE OF BIRTH (*REQUIRED FIELD)
Enter the date of birth for the infant/child using MM/DD/YYYY.

BIRTH HOSPITAL (*REQUIRED FIELD)
Select the hospital where the infant/child was born.
**BIRTH WEIGHT (REQUIRED FIELD)**
Enter the birth weight in grams (gm). Weight parameters 300 – 6,000 gm.

**GESTATIONAL AGE (REQUIRED FIELD)**
Enter the estimate of gestational age in weeks and days based on available data in medical record.

**SINGLETON/MULTIPLE BIRTH GESTATION (REQUIRED FIELD)**
- Select “Singleton” for any single live birth.
- Select “Multiple” if product of multiple pregnancy and birth order.
  
  **Multiple Gestation Information**
  If Multiple Gestation is selected, indicate the infant’s birth order (i.e.: first born = A, second born = B, etc.) as well as the total number of infants actually delivered (count both live born and still born infants). For example, the second infant born of triplets would be entered as “3B”.

**INFANT’S GENDER (REQUIRED FIELD)**
- Select “Male” or “Female”.
- Select “Unknown” if sex cannot be determined.

**INFANT’S ETHNICITY**
- Select “Hispanic/Latino” if the infant/child is a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.
- Select “Non-Hispanic” if the infant/child’s ethnicity is not of Hispanic or Latino origin as defined above.
- Select “Unknown” if this information cannot be obtained.
- Select “Declined” if parent (or primary caregiver) declines.

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**Ethnic and Racial Information**
Ethnic and racial data help us to monitor differences in perinatal risks and outcomes in California, and to adjust for these differences when comparing hospitals with diverse populations.

*Finding Race and Ethnicity Data,* The Automated Vital Statistics System (AVSS) is now used in all birthing hospitals in California to produce paper and electronic birth certificates. It is important for CPQCC Data Collectors to understand that the AVSS system is probably used in your Center and that it collects ethnicity and race data in a manner consistent with new State and Federal standards for multiple race reporting. CPQCC encourages members to use their Center’s AVSS system as the primary source of race and ethnicity data.
**Self-Identification [Child’s Parent [or Primary Caregiver]]**

Ethnicity and Race should be completed by or with direct assistance of the infant/child’s parent or primary caregiver. Appearance, language, or other personal attributes do not necessarily determine ethnicity or race. The responses for the Ethnicity and Race should be obtained by review of the birth certificate or personal interview with the infant/child’s parent (or primary caregiver). Obtaining the information from a review of medical records is less preferable.

**NOTE:** The parent (or primary caregiver) determines the self-identification of the infant. If the Parent (or primary caregiver) is unable or unwilling to declare the infant’s race; it is appropriate to report the ethnicity and race of the mother for that of the infant.

**INFANT’S RACE**

- Select “Single” if the infant/child’s race is reported by the parent (or primary caregiver) as a single race.
- Select “Multiracial” if the infant/child’s parent (or primary caregiver) identifies with more than one race category.

**Multiracial Information (Infant/Child)**

Many hospitals now record multiple races in their database systems. For data collection, in cases where multiple races have been recorded, use the following hierarchy: Black or African American; Asian; Native Hawaiian or Other Pacific Islander; American (North, South or Central) Indian or Alaskan Native; White and Other. From the multiple races reported, **choose the race that appears first in the above hierarchy**.

- For example, the infant/child’s race recorded as Black, Asian, and White should be coded as Black.
- An infant/child’s race recorded as Native American and White should be coded as American Indian.
- Do not code a multiracial infant/child as “Other” or “Unknown”. These categories are reserved for an infant/child by the parent (or primary caregiver) who claims a race not represented in the available codes, and for situations in which information on race is truly unknown.

The infant/child’s race shall be reported as one choice from the following list of alternatives under race:

- Select **“Black or African American”**, a person having origins in or who identifies with any of the black racial groups of Africa including Botswanan, Ethiopian, Liberian, Namibian, Nigerian, Zairian, Barbadian, Dominican, Haitian, Jamaican, Tobagoan, Trinidadian, and West Indian.
- Select **“Asian”**, A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodian, Chinese, Indian, Japanese, Korean, Malaysian, Pakistani, Philippine, Thai, and Vietnamese. It includes “Asian Indian,” “Chinese,” “Filipino,” “Korean,” “Japanese,” “Vietnamese,” and “Other Asian.”
- **Asian Indian**. Includes people who indicated their race as “Asian Indian” or identified themselves as Bengalese, Bharat, Dravidian, East Indian, or Goanese.
• **Chinese.** Includes people who indicate their race as "Chinese" or who identify themselves as Cantonese, or Chinese American. In some census tabulations, written entries of Taiwanese are included with Chinese while in others they are shown separately.

• **Filipino.** Includes people who indicate their race as "Filipino" or who report entries such as Philipino, Philippine, or Filipino American.

• **Japanese.** Includes people who indicate their race as "Japanese" or who report entries such as Nipponese or Japanese American.

• **Korean.** Includes people who indicate their race as "Korean" or who provide a response of Korean American.

• **Vietnamese.** Includes people who indicate their race as "Vietnamese" or who provide a response of Vietnamese American.

• **Cambodian.** Includes people who provide a response such as Cambodian or Cambodia.

• **Hmong.** Includes people who provide a response such as Hmong, Laohmong, or Mong.

• **Laotian.** Includes people who provide a response such as Laotian, Laos, or Lao.

• **Thai.** Includes people who provide a response such as Thai, Thailand, or Siamese.

• **Other Asian.** Includes people who provide a response of Bangladeshi, Bhutanese, Burmese, Indochinese, Indonesian, Iwo Jima, Madagascar, Malaysian, Maldivian, Nepalese, Okinawan, Pakistani, Singaporean, Sri Lankan, or Other Asian specified and Other Asian, not specified.

• Select “**Native Hawaiian or Other Pacific Islander**”, a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. It includes people who indicate their race as “Native Hawaiian,” "Guamanian or Chamorro,” "Samoan,” and "Other Pacific Islander."

• **Native Hawaiian.** Includes people who indicate their race as “Native Hawaiian” or who identify themselves as "Part Hawaiian" or "Hawaiian."

• **Guamanian or Chamorro.** Includes people who indicate their race as such, including written entries of Chamorro or Guam.

• **Samoan.** Includes people who indicate their race as "Samoan" or who identify themselves as American Samoan or Western Samoan.

• **Other Pacific Islander.** Includes people who provide a write-in response of a Pacific Islander group such as Carolinian, Chuukese (Trukese), Fijian, Kosraean, Melanesian, Micronesia, Northern Mariana Islander, Palauan, Papua New Guinean, Pohnpeian, Polynesian, Solomon Islander, Tahitian, Tokelauan, Tongan, Yapese, or Pacific Islander, not specified.

• Select “**American (North, South, or Central) Indian or Alaska Native**”, a person having origins in or who identifies with any of the original peoples of North and South America, and who maintains cultural identification through tribal affiliation or community recognition.

• Select “**White**”, a person having origins in or who identifies with any of the original Caucasian peoples of Europe, North Africa, or the Middle East. This may include the following groups: Armenian, English, French, German, Irish, Italian, Polish, Scottish, Middle Eastern, North African, Assyrian, Egyptian, Iranian, Iraqi, Lebanese, Palestinian, Syrian, Afghanista, Israeli, and Arab.
• Select “Other”, if the race is not represented by any of the above categories.
• Select “Unknown”, if the parent or primary caregiver cannot identify her race.
• Select “Declined”, if the parent or primary caregiver refuses to declare race.


HOSPITAL DISCHARGING TO HOME (*REQUIRED FIELD)
Select the name of the hospital discharging the infant/child to home.

REFERRING CCS NICU
If the discharging hospital is not making a referral to the HRIF Program, select the name of the hospital that is making the referral to a HRIF Program under “Referring CCS NICU”.

The CCS NICU discharging the infant/child home could also be the same facility referring the infant/child to a HRIF Program.

DATE OF DISCHARGE TO HOME (*REQUIRED FIELD)
Enter the date when the infant/child was discharged Home (Foster Care or Medical Foster Care) from your hospital without ever transferring to another hospital using MM-DD-YYYY.

NOTE: Discharge to home occurs when an infant goes home from your hospital, not the NICU.

INFANT STILL IN HOSPITAL
(Added Jan. 2014)
If the infant/child is still hospitalized in the NICU or other unit in the hospital at 8 months’ chronological age.

BIRTH MOTHER’S DATE OF BIRTH (*REQUIRED FIELD)
• Enter the biological or gestational carrier/surrogate mother’s date of birth using MM-DD-YYYY.

NOTE: For the maternal items, enter maternal data on the “Birth Mother”, the woman who delivered the infant, even if she is a gestational carrier/surrogate.

Biological Mother
The woman from whom one inherits half of one’s DNA and who is the source of one’s mitochondrial DNA; related by birth, cell or organism.

Gestational Carrier/Surrogate Mother
A woman who bears a child on behalf of another woman, either from her own egg fertilized by the other woman’s partner, or from the implantation in her uterus of a fertilized egg from the other woman

NOTE: Surrogate, who also donates the egg, is the biological mother.

• Check “Unknown” if the birth mother’s (biological or gestational carrier/surrogate) date of birth at time of delivery is unknown.
The modification of these maternal items will improve the data linkage between the CMQCC Maternal Database with CPQCC Network Database and the CCS HRIF-QCI Program Database.

**Birth Mother’s Ethnicity**
- Select “Hispanic/Latino” if the birth mother is a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.
- Select “Non-Hispanic” if the birth mother’s ethnicity is not of Hispanic or Latino origin as defined above.
- Select “Unknown” if this information cannot be obtained.
- Select “Declined” if the birth mother declines.


**Ethnic and Racial Information**

*Self-Identification (Birth Mother)*. Maternal Ethnicity and Race should be completed by or with direct assistance of the informant. Appearance, language, or other personal attributes do not necessarily determine ethnicity or race. A woman who speaks Spanish, was born in Mexico, and says that she is not Hispanic, but claims to be a Native American, should be recorded as non-Hispanic Native American. The responses for the Ethnicity and Race should be obtained by review of the birth certificate or personal interview with the mother. Obtaining the information from a review of medical records is less preferable.


**Birth Mother’s Race**
- Select “Single” if the birth mother’s race is reported by her as a single race.
- Select “Multiracial” if the birth mother’s race is reported by her identifies with more than one race category.

Multiracial Information (Birth Mother)
Many hospitals now record multiple races in their database systems. For data collection, in cases where multiple races have been recorded, use the following hierarchy: Black or African American; Asian; Native Hawaiian or Other Pacific Islander; American (North, South or Central) Indian or Alaskan Native; White and Other. From the multiple races reported, **choose the race that appears first in the above hierarchy**.
- For example, the birth mother’s race recorded as “Black, Asian, and White” should be coded as “Black”.
- A birth mother’s race recorded as “American Indian and White” should be coded as “American Indian”.
- Do not code a multiracial birth mother as “Other” or “Unknown”. These categories are reserved for a birth mother who claims a race not represented in the available codes, and for situations in which information on race is truly unknown.
The birth mother’s race shall be reported as one choice from the following list of alternatives under race:

- **Select “Black or African American”,** a person having origins in or who identifies with any of the black racial groups of Africa including Botswanan, Ethiopian, Liberian, Namibian, Nigerian, Zairian, Barbadian, Dominican, Haitian, Jamaican, Tobagoan, Trinidadian, and West Indian.
- **Select “Asian, A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietn amb. It includes “Asian Indian,” “Chinese,” “Filipino,” “Korean,” “Japanese,” “Vietnamese,” and "Other Asian.”**
  - **Asian Indian.** Includes people who indicated their race as “Asian Indian” or identified themselves as Bengalese, Bharat, Dravidian, East Indian, or Goanese.
  - **Chinese.** Includes people who indicate their race as “Chinese” or who identify themselves as Cantonese, or Chinese American. In some census tabulations, written entries of Taiwanese are included with Chinese while in others they are shown separately.
  - **Filipino.** Includes people who indicate their race as “Filipino” or who report entries such as Filipino, Philippine, or Filipino American.
  - **Japanese.** Includes people who indicate their race as "Japanese" or who report entries such as Nipponese or Japanese American.
  - **Korean.** Includes people who indicate their race as "Korean" or who provide a response of Korean American.
  - **Vietnamese.** Includes people who indicate their race as "Vietnamese" or who provide a response of Vietnamese American.
  - **Cambodian.** Includes people who provide a response such as Cambodian or Cambodia.
  - **Hmong.** Includes people who provide a response such as Hmong, Laohmong, or Mong.
  - **Laotian.** Includes people who provide a response such as Laotian, Laos, or Lao.
  - **Thai.** Includes people who provide a response such as Thai, Thailand, or Siamese.
  - **Other Asian.** Includes people who provide a response of Bangladeshi, Bhutanese, Burmese, Indochinese, Indonesian, Iwo Jiman, Madagascar, Malaysian, Maldivian, Nepalese, Okinawan, Pakistani, Singaporean, Sri Lankan, or Other Asian specified and Other Asian, not specified.
  - **Select “Native Hawaiian or Other Pacific Islander”,** a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. It includes people who indicate their race as “Native Hawaiian,” “Guamanian or Chamorro,” “Samoa,” and “Other Pacific Islander.”
  - **Native Hawaiian.** Includes people who indicate their race as "Native Hawaiian" or who identify themselves as "Part Hawaiian" or "Hawaiian."
• **Guamanian** or **Chamorro**. Includes people who indicate their race as such, including written entries of Chamorro or Guam.

• **Samoan**. Includes people who indicate their race as "Samoan" or who identify themselves as American Samoan or Western Samoan.

• **Other Pacific Islander**. Includes people who provide a write-in response of a Pacific Islander group such as Carolinian, Chuukese (Trukese), Fijian, Kosraean, Melanesian, Micronesia, Northern Mariana Islander, Palauan, Papua New Guinean, Pohnpeian, Polynesian, Solomon Islander, Tahitian, Tokelauan, Tongan, Yapese, or Pacific Islander, not specified.

• Select “**American (North, South, or Central) Indian or Alaska Native**”, a person having origins in or who identifies with any of the original peoples of North and South America, and who maintains cultural identification through tribal affiliation or community recognition.

• Select “**White**”, a person having origins in or who identifies with any of the original Caucasian peoples of Europe, North Africa, or the Middle East. This may include the following groups: Armenian, English, French, German, Irish, Italian, Polish, Scottish, Middle Eastern, North African, Assyrian, Egyptian, Iranian, Iraqi, Lebanese, Palestinian, Syrian, Afghanistani, Israeli, and Arab.

• Select “**Other**”, if the race is not represented by any of the above categories.

• Select “**Unknown**”, if the birth mother cannot identify her race.

• Select “**Declined**”, if the birth mother refuses to declare race.


**INSURANCE**
Check all insurance options that apply at the time of visit. Valid insurance status options are “CCS”, “Commercial Health Maintenance Organization (HMO)”, “Commercial Preferred Provider Organization (PPO)”, “Medi-Cal”, “Point of Service/Exclusive Provider Organization (EPO)”, “No Insurance/Self Pay”, “Other” or “Unknown”.

**NOTE:** Healthy Families Program transition to Medi-Cal in 2013. Select “Medi-Cal” for Medi-Cal Managed Care plans.

**PRIMARY CAREGIVER**
Indicate the primary caregiver (parent/legal guardian[s] who are responsible for caring for the infant/child). If the infant/child’s primary caregiver changed between the time from NICU Discharging to Home & Referring to HRIF Program, check the category that best describes the infant/child’s current living situation with his (or her) primary caregiver.

**NOTE:** The Primary Caregiver is **not** the babysitter or child care/daycare provider.

Check only one option.

• Select “**Mother**” if the infant/child lives with one biological parent and she serves as the primary caregiver in the home.

• Select “**Father**” if the infant/child lives with one biological parent and he serves as the primary caregiver in the home.

• Select “**Both Parents**” if the infant/child lives with both biological parents or same-sex partner (one partner is the biological parent) and they serve as the primary caregivers at home.
• Select “Other Relatives/Not Parents” if the infant/child lives with a relative(s) who is not the biological parent and they serve as the primary caregiver(s) at home.

• Select “Non Relative” if the infant/child lives with someone who is not related and not appointed by State Authority as the primary caregiver at home.

• Select “Foster Family/Child Protective Services (CPS)” if the infant/child is temporarily placed with certified, stand-in “parent(s)” to care for a minor infant/child who has been removed from his/her birth parents or other custodial adults by State authority as the primary caregiver at home.

• Select “Foster Family/Adoptive Family” if the infant/child through legal action has been permanently placed with guardian(s) who are not the birth (or “biological”) mother or father, as the primary caregiver at home.

• Select “Pediatric Subacute Facility” if the infant/child has extensive medical needs requiring continuous nursing care in a medical facility.

• Select “Other” if the infant/child’s primary caregiver is not already described.

• Select “Unknown” if the infant/child’s primary caregiver is not known.

**ZIP CODE OF PEDIATRIC SUBACUTE FACILITY**

Enter the 5-digit zip code of the address for the pediatric subacute facility. If the zip code is not applicable, unavailable or unknown, leave blank.

**ZIP CODE OF PRIMARY CAREGIVER RESIDENCE**

Enter the 5-digit zip code of the address for the primary caregiver. If the zip code is unavailable or unknown, leave it blank.

**EDUCATION OF PRIMARY CAREGIVER**

If more than a single individual Primary Caregiver was selected (i.e. Both Parents), the Education of the Primary Caregiver should reflect the highest-level education of the individual caregivers.

**NOTE:** If Pediatric Subacute Facility was selected as the primary caregiver, select “Unknown” for Education of Primary Caregiver.

• Select “<9th Grade” if the primary caregiver has completed less than 9th Grade.

• Select “Some High School” if the primary caregiver has attained grade school education and some high school education (12th Grade), but no diploma.

• Select “High School Degree/GED” if the primary caregiver graduated from High School, received a diploma or earned a General Educational Development (GED) credential.

• Select “Some College” if the primary caregiver has attained some college or university education, but no degree.

• Select “College Degree” if the primary caregiver graduated from college or university receiving an Associate degree (e.g., AA, AS) or Bachelor’s degree (e.g., BA, AB, BS).

• Select “Graduate School or Degree” if the primary caregiver graduated from college or university and has attained some graduate school education or received a Master’s degree (e.g., MA, MS, MSW, MBA); Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DO, DDS, DVM, JD).
• Select “Other” if the primary caregiver attended classes from a trade, technical, or vocational school and/or received a certification upon completion.

• Select “Unknown” only if the infant/child lives in a chronic care facility (or institution); or if the highest level of education of the primary caregiver is not known or is unclear.

• Select “Declined” if the primary caregiver declines.

**CAREGIVER EMPLOYMENT**

If more than a single individual Primary Caregiver was selected (i.e. Both Parents), select the Caregiver Employment of the individual whose education level was provided under Education of the Primary Caregiver. If Both Parents have the same level of Education, please select the employment of the primary caregiver who spends the most time with the infant/child. Check only one option.

**NOTE:** If Pediatric Subacute Facility was selected as the primary caregiver, select “Unknown” for Caregiver Employment.

- Select “Full-Time” if the caregiver has a paying job that involves 35 or more (usually 40) hours of work during a week.
- Select “Part-Time” if the caregiver has a paying job that involves less than 35 hours of work during a week.
- Select “Temporary” if the caregiver is hired for contingent work; paid per the hours worked; and draws no benefits that are commonly available to regular employees.
- Select “Multiple Jobs” if the caregiver is holding more than one job either part-time or full-time.
- Select “Work from Home” if the caregiver has a work arrangement in which s/he has flexibility in working locations and hours.
- Select “Not Currently Employed” if the caregiver is without work, available to work, is currently seeking work; or chooses not to work.
- Select “Unknown” only if the infant/child lives in a chronic care facility or institution or if the caregiver’s employment is not known or is unclear.
- Select “Declined” if the caregiver declines.

**PRIMARY LANGUAGE SPOKEN AT HOME**

Select only one primary language spoken at the home as reported by the mother or primary caregiver.


**SECONDARY LANGUAGE SPOKEN AT HOME (OPTIONAL)**

Select only one secondary language spoken at the home as reported by the mother or primary caregiver.

- Select “N/A”, if a secondary language is not spoken at home.

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HIGH RISK INFANT FOLLOW-UP QUALITY OF CARE INITIATIVE: MANUAL OF DEFINITIONS – RELEASE 01.18 | 34
MEDICAL ELIGIBILITY PROFILE

Check all that apply for the infant’s CCS HRIF Medical Eligibility. (*REQUIRED FIELD)

Entry into the HRIF Program is available to children under three years of age who meet California Children’s Services (CCS) Program HRIF medical eligibility criteria and who met CCS Program medical eligibility criteria for Neonatal Intensive Care Unit (NICU) care OR had a CCS Program eligible medical condition at some time during their stay in a CCS Program-approved NICU, even if they were never a CCS client. Data should be collected on the following.

A neonate, infant or child shall be medically eligible for the HRIF Program when the infant:

A. Met CCS medical eligibility criteria for NICU care, in a CCS Program-approved NICU (regardless of length of stay) (as per Numbered Letter [N.L.] 05-0502, Medical eligibility in a CCS Program-approved NICU, or the most current N.L.). NOTE: Medical eligibility includes neonates who require direct admit to a CCS Program-approved PICU, who are never admitted to a CCS Program-approved NICU, but who otherwise meet all medical eligibility criteria for HRIF services in this section.

OR

B. Had a CCS Program eligible medical condition in a CCS Program-approved NICU (regardless of length of stay, even if they were never CCS clients during their stay), (as per California Code of Regulations, Title 22, Section 41515.1 through 41518.9, CCS Medical Eligibility Regulations).

AND

C. The birth weight was less than or equal to 1500 grams or the gestational age at birth was less than 32 weeks.

OR

D. The birth weight was more than 1500 grams and the gestational age at birth was 32 weeks or more and one of the following documented criteria was met during the NICU stay:

1. pH less than 7.0 on an umbilical cord blood sample or a blood gas obtained within one hour of life) or an Apgar score of less than or equal to three at five minutes or an Apgar score of less than 5 at 10 minutes.

2. An unstable infant manifested by hypoxia, acidemia, hypoglycemia and/or hypotension requiring pressor support.

3. Persistent apnea which required caffeine or other stimulant medication for the treatment of apnea at discharge.

4. Required oxygen for more than 28 days of hospital stay and had radiographic finding consistent with chronic lung disease.

5. Infants placed on extracorporeal membrane oxygenation (ECMO).
6. Infants who received inhaled nitric oxide greater than four hours, and/or treatment during hospitalization with sildenafil or other pulmonary vasodilatory medications for pulmonary hypertension.

7. Congenital heart disease (CHD) requiring surgery or minimally invasive intervention. *(Added Jan. 2017)*

**Was the Norwood or a single ventricle palliation procedure performed? (Added Jan. 2018)**

Indicate if the Norwood procedure or a single ventricle palliation for hypoplastic left ventricle or hypoplastic right ventricle was performed.

- Check “No” if the Norwood or a single ventricle palliation procedure was not performed.
- Check “Yes” if the Norwood or a single ventricle palliation procedure was performed.

8. History of observed clinical or electroencephalographic (EEG) seizure activity or receiving antiepileptic medication(s) at time of discharge.

9. Evidence of intracranial pathology, including but not limited to, intracranial hemorrhage (grade II or worse), white matter injury including periventricular leukomalacia, cerebral thrombosis, cerebral infarction or stroke, congenital structural central nervous system (CNS) abnormality or other CNS problems associated with adverse neurologic outcome.

10. Clinical history and/or physical exam findings consistent with neonatal encephalopathy.

11. Other documented problems that could result in a neurologic abnormality, such as:

- History of CNS infection.
- Documented sepsis.
- Bilirubin at excessive levels concerning for brain injury as determined by NICU medical staff.
- History of cardiovascular instability as determined by NICU medical staff due to: sepsis, congenital heart disease, patent ductus arteriosus (PDA), necrotizing enterocolitis, other documented conditions.

**REMINDE**

**REQUESTS FOR SERVICE AUTHORIZATION REQUESTS (SARS) TO LOCAL CCS OFFICE AND DISCHARGE SUMMARY TO THE HRIF PROGRAM**

- The discharging/referring CCS NICU/Hospital or HRIF Program will submit a Service Authorization Request (SAR) to the Local CCS Office for HRIF services. (Service Code Group [SCG] 06, should be requested).
  [http://www.dhcs.ca.gov/services/ccs/cmsnet/Pages/SARTools.aspx](http://www.dhcs.ca.gov/services/ccs/cmsnet/Pages/SARTools.aspx)
- The discharging/referring CCS NICU/Hospital will send a copy of the Discharge Summary to the HRIF Program.
STANDARD VISIT (SV) FORM
(See page 20 for the summary of “SV Form”)

**REQUIRED FIELD** MUST be entered to save web-based entry screens. Saved entry screens can be recalled later to make necessary updates.

**INFANT NAME** – AUTOMATICALLY COMPUTER GENERATED
Enter the infant/child’s Last Name and First Name using the hospital record.
**NOTE:** The Infant/Child’s Name is displayed in the web-based Reporting System banner for this infant/child.

**HRIF I.D. NUMBER** – AUTOMATICALLY COMPUTER GENERATED
This number consists of a unique assigned High Risk Infant Follow-up Program 3-digit prefix number (assigned and provided by CPQCC) and a 5-digit computer generated number. This 8-digit number identifies the infant/child previously enrolled in the HRIF Program.
**NOTE:** The HRIF I.D. Number is displayed in the web-based Reporting System banner for this infant/child.

**THIS FORM IS CLOSED** – CHECKBOX (WEB-BASED ENTRY FORM)
This check box feature serves as an electronic signature confirmation that all available data has been entered.

**DATE OF VISIT** (*REQUIRED FIELD)
Enter the date of the core visit using MM-DD-YYYY. This is the date the infant/child was seen at the High Risk Infant Follow-up Program.

**VISIT ASSESSMENT**

**CORE VISIT** (*REQUIRED FIELD)
The HRIF Program has three core visits that take place during the following recommended time periods: Visit #1 (4-8 months), Visit #2 (12-16 months) and Visit #3 (18-36 months).
Enter the appropriate Core Visit by selecting “1”, “2”, or “3”.
**NOTE:** Core Visit #1 is the initial first visit to the follow-up program, even if the patient is older than 8 months corrected age.

**INFANT ENROLLED IN A CCS CLINIC OTHER THAN THE HRIF PROGRAM** *(Added Jan. 2018)*
- Check “No” if the infant/child is not enrolled in a CCS clinic.
- Check “Yes” if the infant/child is enrolled in a CCS clinic other than the HRIF Program.
  - Other CCS clinics include:
    - Medical Therapy Program *(http://www.dhcs.ca.gov/services/ccs/Pages/MTP.aspx)*
    - Special Care Centers (other than HRIF) *(http://www.dhcs.ca.gov/services/ccs/scc/Pages/SCCType.aspx)*
- Check “Unknown” if the information cannot be obtained.

**ZIP CODE OF PRIMARY CAREGIVER**
Enter the zip code of the primary caregiver who is caring for the infant/child. Or, check the box indicating that the zip code should be updated automatically from the RR Form.
**CHRONOLOGICAL AGE – AUTOMATICALLY COMPUTER GENERATED**

Enter the infant/child’s chronological age from birth in months and days.

**NOTE:** The web-based Reporting System will automatically generate the Chronological Age. Once you complete and “Submit” the web-based entry screen, the calculated Chronological Age will display in the banner.

**ADJUSTED AGE – AUTOMATICALLY COMPUTER GENERATED**

Enter the infant/child’s adjusted age in months and days. The corrected age is used for an infant/child up to 3 years of age who was born prematurely and represents the age of the infant/child from the expected date of the delivery.

**NOTE:** The web-based Reporting System will automatically generate the Adjusted Age. Once you complete and “Submit” the web-based entry screen, the calculated Adjusted Age will display in the banner.

**INTERPRETER USED**

Indicate if an interpreter was used to facilitate communication between the individual filling out the form or performing the assessment and the parent (or primary caregiver).

- Check “No” if no interpreter was used.
- Check “Yes” if there was an interpreter used or the HRIIF Program staff acted as the interpreter during the core visit and check the appropriate language used. Select the appropriate language interpreter.
- Select “Other” if a language interpreter was used and the language interpreted is not described.
- Select “Unknown” if a language interpreter was used but the language interpreted is unknown.
- Select “Declined” if the parent (or primary caregiver) declined an interpreter that would have facilitated the visit.

**INSURANCE**

Check all insurance options that apply at the time of visit. Valid insurance status options are “CCS”, “Commercial Health Maintenance Organization (HMO)”, “Commercial Preferred Provider Organization (PPO)”, “Medi-Cal”, “Point of Service/Exclusive Provider Organization (EPO)”, “No Insurance/Self Pay”, “Other” or “Unknown”.

**NOTE:** Healthy Families Program transition to Medi-Cal in 2013. Select “Medi-Cal” for Medi-Cal Managed Care plans.

**PATIENT ASSESSMENT**

Measurements should be taken at the time when the Neurologic and Developmental Assessments are performed.

**WEIGHT**

Enter the weight in either kilograms (kg) or pounds (lbs) and ounces (oz) recorded at time of core visit. Formats: kg (XX.XX) or lbs (XX) oz (XX). Weight parameters 1 - 30 kg.

If “Not Measured” was checked, Select the appropriate reason why not measured. *(Added Jul. 2016)*
**LENGTH**

Enter the length in either centimeters (cm) or inches (in) recorded at time of core visit. Formats: cm (XXX.X) or in (XX.XX). Length parameters 26 – 110 cm.

If “Not Measured” was checked, Select the appropriate reason why not measured. *(Added Jul. 2016)*

**HEAD CIRCUMFERENCE**

Enter the head circumference in either centimeters (cm) or inches (in) recorded at time of core visit. Formats: cm (XXX.X) or in (XX.XX). Head Circumference parameters 30 – 55 cm.

If “Not Measured” was checked, Select the appropriate reason why not measured. *(Added Jul. 2016)*

**GENERAL ASSESSMENT**

**IS THE CHILD CURRENTLY RECEIVING BREASTMILK?** *(Added Jan. 2015)*

Indicate if the infant/child is receiving breastmilk at the time of the core visit. This question is meant to determine the length of breastmilk exposure a child is receiving.

**NOTE:** If a child is receiving breastmilk and solid foods, then the child will be receiving “Some” breastmilk.

- Select “Exclusively” if the infant/child is receiving only breastmilk.
- Select “Some” if the infant/child is receiving breastmilk and formula.
- Select “None” if the infant/child receives only formula.

**LIVING ARRANGEMENT OF THE INFANT/CHILD**

Indicate the infant/child’s current living arrangement with the primary caregiver(s). If the infant/child’s living arrangement has changed since the last visit, check the appropriate category that best describes the infant/child’s current living arrangement.

Select only one option.

- Select “Both Parents” if the infant/child lives with both biological parents and they serve as the primary caregivers at home.
- Select “One Parent” if the infant/child lives with one biological parent and he/she serves as the primary caregiver at home.
- Select “One Parent/Other Relatives” if the infant/child lives with one biological parent and with a relative(s) who are not the biological parent and they serve as the primary caregiver at home.
- Select “Other Relatives/Not Parents” if the infant/child lives with a relative(s) who is not the biological parent and they serve as the primary caregiver(s) at home.
- Select “Non Relative” if the infant/child lives with someone who is not related and not appointed by State authority as the primary caregiver at home.
- Select “Foster/Adoptive Family” if the infant/child’s living arrangement through legal action has been permanently placed with guardian(s) who are not the birth (or “biological”) mother or father, as the primary caregiver at home.
- Select “Foster Family/CPS” if the infant/child’s living arrangement is temporarily placed with certified, stand-in “parent(s)” to care for minor children who have been removed from their birth parents or other custodial adults by State authority as the primary caregiver at home.
• Select “Pediatric Sub-Acute Facility” if the infant/child has extensive medical needs requiring continuous nursing care in a medical facility.

• Select “Other” if the infant/child’s living arrangement is not already described.

• Select “Unknown” if the infant/child’s living arrangement is not known.

**EDUCATION OF PRIMARY CAREGIVER** (Added Jan. 2014)
If more than a single individual Primary Caregiver was selected (i.e. Both Parents), the Education of the Primary Caregiver should reflect the highest-level education of the individual caregivers.

If the infant/child’s primary caregiver has changed since the last visit, check the appropriate category that best describes the infant/child’s current primary caregiver’s education.

**NOTE:** If Pediatric Subacute Facility was selected as the primary caregiver, select “Unknown” for Education of Primary Caregiver.

• Select “<9th Grade” if the primary caregiver has completed less than 9th Grade.

• Select “Some High School” if the primary caregiver has attained grade school education and some high school education (12th Grade), but no diploma.

• Select “High School Degree/GED” if the primary caregiver graduated from High School, received a diploma or earned a General Educational Development (GED) credential.

• Select “Some College” if the primary caregiver has attained some college or university education, but no degree.

• Select “College Degree” if the primary caregiver graduated from college or university receiving an Associate degree (e.g., AA, AS) or Bachelor’s degree (e.g., BA, AB, BS).

• Select “Graduate School or Degree” if the primary caregiver graduated from college or university and has attained some graduate school education or received a Master’s degree (e.g., MA, MS, MSW, MBA); Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DO, DDS, DVM, JD).

• Select “Other” if the primary caregiver attended classes from a trade, technical, or vocational school and/or received a certification upon completion.

• Select “Unknown” only if the infant/child lives in a chronic care facility (or institution); or if the highest level of education of the primary caregiver is not known or is unclear.

• Select “Declined” if the primary caregiver declines.

**CAREGIVER EMPLOYMENT** (Added Jan. 2014)
If more than a single individual Primary Caregiver was selected (i.e. Both Parents), select the Caregiver Employment of the individual whose education level was provided under Education of the Primary Caregiver. If Both Parents have the same level of Education, please select the employment of the primary caregiver who spends the most time with the infant/child.

Check only one option. If the infant/child’s primary caregiver has changed since the last visit, check the appropriate category that best describes the infant/child’s current primary caregiver’s employment.

**NOTE:** If Pediatric Subacute Facility was selected as the primary caregiver, select “Unknown” for Caregiver Employment.
• Select “Full-Time” if the caregiver has a paying job that involves 35 or more (usually 40) hours of work during a week.

• Select “Part-Time” if the caregiver has a paying job that involves less than 35 hours of work during a week.

• Select “Temporary” if the caregiver is hired for contingent work; paid according to the hours worked; and draws no benefits that are commonly available to regular employees.

• Select “Multiple Jobs” if the caregiver is holding more than one job either part-time or full-time.

• Select “Work from Home” if the caregiver has a work arrangement in which s/he has flexibility in working locations and hours.

• Select “Not Currently Employed” if the caregiver is without work, available to work, is currently seeking work; or chooses not to work.

• Select “Unknown” only if the infant/child lives in a chronic care facility or institution or if the caregiver’s employment is not known or is unclear.

• Select “Declined” if the caregiver declines.

ROUTINE CHILD CARE

Routine Child Care identifies the infant/child’s typical weekly schedule of infant/child care in the home or outside the home, provided by non-family members.

Routine Child Care includes: Extended family, paid in-home nannies, day care out of home (center or family care), or specialized medical setting. Also, consider if a infant/child is in day care 5 days a week > 9 hours/day, which is identified as significant variable in the infant/child’s development.

• Check “None”, if the infant/child does not have Routine Child Care. Proceed to the next category – Caregiver Concerns of the Child.

• Check “Yes”, if the infant/child does have Routine Child Care. Proceed to check all that apply.

• Check “Unknown” if this information cannot be obtained. Proceed to the next category – Caregiver Concerns of the Child.

Indicate the current types of Routine Child Care the infant/child receives daily. If the infant/child’s Routine Child Care changes between each core visit, check all the options that describe the infant/child’s current routine infant/child care at that time.

• Check “Child Care Outside of Home” if the infant/child is cared for outside the home or home based setting.

• Check “Home Babysitter/Nanny” if the infant/child has regular care provided each week in his/her permanent residence.

• Check “Not Used Routinely” if the infant/child’s primary caregiver or immediate family member(s) provide the majority of care each week.

• Check “Specialized Medical Setting” if the infant/child’s medical needs require routine child care such as in a sub-acute medical facility or skilled nursing home care on a part-time or full-time basis.

• Check “Other” if the infant/child care arrangement is not already described.
CAREGIVER CONCERNS OF THE CHILD

Concerns and priorities of the parents (or primary caregiver) about the infant/child’s behavior, self-calming, interactions, habits, temperament, development, illness, problems in the environment, etc.

The social concerns and caregiver/infant concerns were developed using researched guidelines from Zero to Three (National Center For Infants, Toddlers, and Families) and their Diagnostic Manual (DC0-3R) of psychological and environmental stressors experienced from the infant’s perspective demonstrated to negatively impact overall development. Most significant are disruptions in the caregiver-infant attachment relationship such as long separations & changes (divorce, incarceration, prolonged military service, frequent changes in nannies, etc.) violence/trauma directly experienced by the infant or vicariously experienced, maternal/paternal mental illness (anxiety, depression, other psychiatric disorders).

NOTE: Parent-child relationship difficulties cluster primarily around feeding, sleeping, self-calming, and parental attunement to infant/child’s needs. Open-ended questions are the most effective in obtaining information, such as “What are the biggest concerns you have about your infant/child or in your relationship?”

- Check “None”, if the parent (or primary caregiver) does not have Caregiver Concerns of the Child. Proceed to the next section – Interval Medical Assessments.
- Check “Yes”, if the parent (or primary caregiver) does have Caregiver Concerns of the Child. Proceed to check all that apply.
- Check “Unknown” if this information cannot be obtained. Proceed to the next section – Interval Medical Assessments.

Indicate the current Caregiver Concerns of the infant/child. If the primary caregiver(s) concern of the infant/child changes between each core visits, check all the options that describe the primary caregiver(s) concerns of the infant/child at that visit.

- Check “Behavioral” if the caregiver identifies infant/child behaviors that he/she does not feel competent managing or interpreting. In infancy these would include “fussiness” and in toddlerhood tantrums, discipline, and separation problems may be included. These behaviors may be constitutional difficulties within the infant/child, a lack of attunement on the parent’s part, or need for education or training.
- Check “Calming/Crying” if the caregiver assessment of infant/child’s difficulty with self-soothing/calming when distressed and crying. Example: How does your infant/child calm her/himself down?
- Check “Feeding & Growth” if the caregiver identifies problems with the infant/child’s weight gain nutritional intake, including quantity, difficulty swallowing or gagging, adjustment to texture, transitioning to oral feeds or solid foods, food restrictiveness, etc. Behavioral problems at meals including tension between the caregiver and infant/child, power struggles, developmental appropriateness of self-feeding is included.
- Check “Frequent Illness” if the caregiver reports frequent illness such as the result of chronic diseases such as asthma, or frequent or persistent infections.
- Check “Gastrointestinal/Stooling/Spitting-up” if the caregiver identifies concerns with the infant/child’s gastrointestinal system, i.e. stooling concerns, feeding intolerance (such as reflux), etc. (Added Jan. 2010)
• Check “Hearing” if the caregiver identifies concerns about infant/child hearing, including listening or attending to sounds or voices.

• Check “Medications” if the caregiver identifies any concerns about the infant/child’s medications, i.e. how to give medications, reaction to medications, etc. *(Added Jan. 2010)*

• Check “Motor Skills, Movement” if the caregiver identifies concern about infant/child’s lack of age appropriate gross or fine motor ability, balance, quality of movement, etc.

• Check “Pain” if the caregiver reports signs and symptoms such as crying, rapid breathing, rapid heart rate, muscle tension, etc.

• Check “Sensory Processing” if the caregiver identifies problems with the infant/child regulating his/her behavior or positive/negative emotions at home, with specific adults, peers, certain circumstances or environments.

• Check “Sleeping/Napping” if the caregiver identified problems getting the infant/child to sleep, staying asleep, duration of sleep, or duration of naps.

• Check “Speech & Language” if the caregiver expresses concerns about infant/child’s communication abilities, both expressive and receptive. These may include gesture and nonverbal communications, receptive language and verbal expression of wants and needs.

• Check “Stress” if the caregiver acknowledges significant level of his/her own stress in the care giving relationship with the infant/child, often exacerbated by environmental risk factors and/or reduced emotional wellbeing (depression, anxiety) that interferes with functioning. Present as an open-ended question such as “How are you doing?” *(Validates interest in them as an important part of their child’s wellbeing).*

• Check “Vision” if the caregiver identifies concerns about the infant/child’s vision. Parents may report symptoms such as sensitivity to light, squinting, jerky eye movements, poor eye contact, etc.

• Check “Other” if the caregiver concern is not already described.

**INTERVAL MEDICAL ASSESSMENT**

**DOES THE CHILD HAVE A PRIMARY CARE PROVIDER?** *(Added Jan. 2012)*
A health care professional (General/Family Practitioner, Pediatrician, Nurse Practitioner), who acts as the first point of consultation for the infant/child.

• Check “No”, if the infant/child does not have a Primary Care Provider.

• Check “Yes”, if the infant/child does have a Primary Care Provider.

• Check “Unknown”, if this information cannot be obtained.

**DOES THE PRIMARY CARE PROVIDER ACT AS THE CHILD’S MEDICAL HOME?** *(Added Jan. 2012)*
The health care professional (identified as the primary care provider), provide what is defined as a Medical Home, per The American Academy of Pediatrics (AAP).

• Check “No”, if the primary care provider does not act as the infant/child’s Medical Home.

• Check “Yes”, if the primary care provider does act as the infant/child’s Medical Home.

• Check “Unknown” if this information cannot be obtained.
The American Academy of Pediatrics (AAP) believes that the medical care of infants, children, and adolescents ideally should be accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective. It should be delivered or directed by well-trained physicians who provide primary care and help to manage and facilitate essentially all aspects of pediatric care. The physician should be known to the child and family and should be able to develop a partnership of mutual responsibility and trust with them. These characteristics define the “medical home. The American Academy of Pediatrics, Policy Statement: The Medical Home, Pediatrics Vol. 110 No. 1 (July 2002), 184-186.

HOSPITALIZATIONS SINCE LAST VISIT
If this is the infant/child’s first core visit, indicate if the infant/child was hospitalized since NICU discharge and prior to the first HRIF core visit. If this is the second or third Core visit, indicate if the infant/child was hospitalized between HRIF Core assessment visits.

NOTE: A hospitalization is defined as admission and at least an overnight stay in the hospital. This should be distinguished from a long emergency room visit or urgent care outpatient clinic visit that may or may not have been over night during interviews with the family.

- Check “No”, if the infant/child has not been hospitalized since the last visit. Proceed to the next category – Surgeries Since Last Visit.
- Check “Yes”, if the infant/child has been hospitalized since the last visit and “Enter” the number of hospitalizations since the last visit. Hospitalization Limit: 1-15. Proceed to check all reasons that apply during the time of hospitalizations.

Hospitalization Reasons: “Gastrointestinal Infection(s)”, Meningitis Infection(s)” “Nutrition/Inadequate Growth”, “Respiratory Illness”, “Seizure Disorder”, “Urinary Tract Infection(s)”. “Other Infection(s)”, “Other Medical Rehospitalizations”, and “Unknown”.

- Check “Unknown” if this information cannot be obtained. Proceed to the next category – Surgeries Since Last Visit.

EXAMPLE: Patient had 2 hospitalizations: “Nutrition/Inadequate Growth” and “Gastrointestinal and Meningitis Infections.”

<table>
<thead>
<tr>
<th>Hospitalization Reasons</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastrointestinal Infection(s)</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Meningitis Infection(s)</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Nutrition/Inadequate Growth</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
SURGERIES SINCE LAST VISIT
Indicate if the infant/child had any surgeries, since NICU discharge and prior to the first HRIF Core visit and/or if the infant/child had any surgeries between HRIF Core assessment visits.

- Check “No”, if the infant/child had no surgeries since the last visit. Proceed to the next category – Medications Since Last Visit.

- Check “Yes”, if the infant/child has had surgeries since the last visit and “Enter” the number of surgeries since the last visit. Surgery Limit: 1-15. Proceed to check all surgeries that apply.


- Check “Unknown” if this information cannot be obtained. Proceed to the next category – Medications Since Last Visit.

MEDICATIONS SINCE LAST VISIT
If this is the infant/child’s first core visit check the pertinent medications the infant/child has taken since NICU discharge and is taking now. If this is the child’s second core visit check all the medications the child has taken since the first core visit and is taking now. If this is the child’s third core visit check all the medications the child has taken since the second core visit and is taking now.

NOTE: The purpose of this question is to capture the significant and/or consistent medications that the child is taking or has taken during the intervals described. Occasional use of acetaminophen, ibuprofen, or over the counter cough or cold medications should not be captured.

- Check “No”, if the child has had no medications since the last visit. Proceed to the next category – Equipment Since Last Visit.

- Check “Yes”, if the infant/child has had medication since the last visit. Proceed to check all medications that apply.


NOTE: There are two selections under Nutrition Supplements: “Enteral Nutrition” is for special formulas and “Dietary Supplements” is for vitamins, minerals, modulars and other nutrition additives. (Added Jan. 2010)

Select “Oxygen” for infants receiving oxygen after discharge. Only enter the infant’s chronological post-natal age, if the oxygen was discontinued.

- Check “Unknown”, if this information cannot be obtained. Proceed to the next category – Equipment Since Last Visit.
EQUIPMENT SINCE LAST VISIT
If this is the infant/child’s first core visit check all the equipment the infant/child has received since NICU discharge and is using now. If this is the infant/child’s second core visit check all the equipment the infant/child has received since the first core visit and is using now. If this is the infant/child’s third core visit check all the equipment the infant/child has received since the second core visit and is using now.

- Check “No”, if the infant/child is not using any equipment since the last visit. Proceed to Medical Services Review.
- Check “Yes”, if the infant/child has been using equipment since the last visit. Proceed to check all equipment that applies.


NOTE: Enteral Feeding Equipment replaces and is a merger of NG/NJ Tube Feeding Equipment and Gastrostomy and Feeding Equipment. (Added Jan. 2012)

- Check “Unknown” if this information cannot be obtained. Proceed to Medical Services Review.

MEDICAL SERVICES REVIEW
IS THE CHILD RECEIVING OR BEING REFERRED FOR MEDICAL SERVICES?
Prior to Current Evaluation/HRIF Assessment:

- Check “No”, if the infant/child is not receiving or being referred for Medical Services. Proceed to Neurosensory Assessment.
- Check “Yes”, if the infant/child is being referred for Medical Services. Complete the Medical Services below.
- Check “Unknown” if this information cannot be obtained. Proceed to Neurosensory Assessment.

If the infant/child is receiving or being referred for medical services between standard visits, indicate the status of each medical service for the infant/child. Select “Receiving” as the status, even if the infant/child is no longer receiving at time of visit.


Select the appropriate status for each Medical Service:

- “Does Not Need”
- “Receiving”
- “Complete”, if the infant/child no longer needs the service. (Added Jan. 2010)
- “Referred at Time of Visit”
- “Referred, but Not Receiving – Missed Appointment”
- “Referred, but Not Receiving – Visit Pending” (Added Jan. 2010)
- “Referred, but Not Receiving – Re-Referred”, initially referred did not receive, now referred for services. (Added Jan. 2012)
- “Referred, but Not Receiving – Insurance / HMO Denied”
- “Referred, but Not Receiving – Parent Declined /Refused Service”
- “Referred, but Not Receiving – Service Not Available”
- “Referred, but Not Receiving – Other / Unknown Reason”
NEUROSENSORY ASSESSMENT

VISION ASSESSMENT HISTORY

DOES THE CHILD HAVE HISTORY OF RETINOPATHY OF PREMATURITY (ROP)? *(Added Jan. 2012)*

- Check "No", if the infant/child does not have history of ROP. Proceed to Does the Child Have a Visual Impairment?
- Check “Yes”, if the infant/child does have history of ROP. If “Yes” was checked because the infant/child has history of ROP, indicate if “Eye Surgery and/or Treatment with Anti-VEGF (i.e. Avastin)”? was performed.
  - Select “No” if eye surgery was not performed.
  - Select “Yes” if eye surgery was performed.
  - Select “Scheduled” if eye surgery is scheduled to be performed.
  - Select “Unknown” if this information cannot be obtained.

Location of ROP
If “Yes” was checked because the infant/child has history of ROP, indicate the location of the ROP. Select either “Unilateral” or “Bilateral”.
- Select “Unknown” if this information cannot be obtained.

DOES THE CHILD HAVE A VISUAL IMPAIRMENT?

- Check “No”, if the infant/child does not have a visual impairment per a specialized clinical exam or parent report. Proceed to Hearing Assessment History.
- Check “Yes”, if the infant/child does have a visual impairment per a specialized clinical exam or parent report.
- Check “Unknown”, if unable to answer the question “Does the Child Have a Visual Impairment?”

If “Unknown” was selected for “Does the child have a visual impairment?”, then answer the next question “Why is Visual Impairment Unknown?”

Select one of the options provided: “Exam Results Unknown”, “No Ophthalmology Exam Performed”, “Needs Referral for Exam”, “Referred for Exam, Not Received”, “Referred, but Service Not Available”, “Referred, but Parent Declines/Refuses Service”, “Referred, but Insurance/HMO Denied”, “Referred, but Missed Appointment”, “Referred for Functional Vision Assessment”, or “Functional Vision Assessment in Progress”.

A. IMPAIRMENT DUE TO

If “Yes” was checked because the infant/child has a visual impairment, check all type(s) of impairment(s) that apply at the time of the core visit. Type of impairments are: “No, Type of Visual Impairment at Visit”, “Strabismus”, “Cataract”, “Retinoblastoma”, “Cortical Visual Impairment”, “Refractive Errors”, “Nystagmus”, and “ROP”.
- Check “Other” if the type of visual impairment is not already described.
- Check “Unknown” if the type of visual impairment is not known.
Indicate if “Eye Surgery” was performed for either “Strabismus”, “Cataract”, or “Retinoblastoma” if one of these impairment(s) was checked.

- Select “No” if eye surgery was not performed.
- Select “Yes” if eye surgery was performed.
- Select “Scheduled” if eye surgery is scheduled to be performed.

B. LOCATION OF IMPAIRMENT
If “Yes” was checked because the infant/child has a visual impairment, indicate the location of the impairment. Select either “Unilateral” or “Bilateral” for the location of the impairment.

- Select “Unknown” if this information cannot be obtained.

C. CORRECTIVE LENS(ES) RECOMMENDED
If “Yes” was selected because the infant/child has a visual impairment, indicate if “Corrective Lens(es) Recommended” at the time of the core visit.

- Select “No” if corrective lens(es) were not recommended by the Ophthalmologist or noted in the medical record.
- Select “Yes” if corrective lens(es) were recommended by the Ophthalmologist or noted in the medical record.
- Select “Unknown” if unable to determine whether corrective lens(es) were recommended by the Ophthalmologist or noted in the medical record.

D. CORRECTIVE LENS(ES) USED
If “Yes” was selected because the infant/child has a visual impairment, indicate if “Corrective Lens(es) Used” at the time of the core visit.

- Select “No” if corrective lens(es) are not used by the infant/child.
- Select “Yes” if corrective lens(es) are used by the infant/child.
- Select “Unknown” if this information cannot be obtained to determine whether the infant/child is using the corrective lens(es).

E. IS THERE FUNCTIONAL VISION? (Added Jan. 2012)
Blindness is defined as visual acuity of less than 20/400, or corresponding visual field loss to less than 10 degrees, in the better eye with best possible correction. Legal blindness is defined at 20/200 and less than 20 degrees of Visual Field. Visual acuity of 20/200 and 20/70 are considered low vision.

**NOTE:** 20/400 is in Snellen unit and 6/120 is equivalent at measured at 6 feet.

- Select “Yes” if infant/child has functional vision “Not Blind”.
- Select “No” if the infant/child has no functional vision “blindness or loss of functional vision”.

If “No” was checked because the infant/child has no functional vision “blindness or loss of functional vision” indicate the location of “Blindness”.

- Select either “Unilateral”, “Bilateral”, or “Unknown”.
- Select “Unknown” if this information cannot be obtained.
HEARING ASSESSMENT HISTORY

DOES THE CHILD HAVE A HEARING LOSS (HL)?
- Check “No” if the infant/child does not have a hearing loss per a specialized clinical exam or parent report. Proceed to Neurologic Assessment.
- Check “Yes” if the infant/child does have a hearing loss per a specialized clinical exam or parent report.
- Check “Unknown Hearing Loss” if unable to answer the question “Does the Child Have a Hearing Loss (HL)?”
  If “Unknown Hearing Loss” was selected for “Does the Child Have a Hearing Loss (HL)?”, then answer the next question “Why is Hearing Loss Unknown?”
  Select one of the options provided: “Exam Results Unknown”, “No Audiology Exam Performed”, “Needs Referral for Exam”, “Referred for Exam, Not Received”, “Referred, but Service Not Available”, “Referred, but Parent Declines/Refuses Service”, “Referred, but Insurance/HMO Denied Services”, or “Referred, but Missed Appointment”.
- Check “Hearing Assessment in Progress” if the infant/child’s hearing assessment is in progress and unable to check the prior options of “No”, “Yes”, or “Unknown Hearing Loss”. Proceed to Neurologic Assessment.

A. IS THERE LOSS IN ONE OR BOTH EARS?
  If “Yes” was checked because the infant/child has a hearing loss, indicate the location of the hearing loss. Select either “One” or “Both” if the infant/child has documented hearing loss in one or both ears.
  - Select “Assessment in Progress” if assessment has not been completed to determine if the infant/child has any evidence of hearing loss.
  - Select “Unknown” if this information cannot be obtained (or if unable to determine if the infant/child has any evidence of hearing loss).

B. DOES THE CHILD USE AN ASSISTIVE LISTENING DEVICE (ALD)
  If “Yes” was selected because the infant/child has a hearing loss, indicate if the infant/child uses an assistive listening device.
  - Select “No” if there is documentation that an ALD was not recommended.
  - Select “Yes, ALD Recommended and Received” if there is documentation or communication by the parent (or primary caregiver) that an ALD was recommended and received.
  - Select “Yes, ALD Recommended, but not Received” if there is documentation or communication by the parent (or primary caregiver) that an ALD was recommended, but not received.
  - Select “Unknown” if unable to determine whether an ALD was recommended by the Audiologist or noted in the medical record.
C. Type of ALD(s) Used
If “Yes, ALD Recommended and Received” was selected for “Does the Child Use an Assistive Listening Device (ALD)”, check all the type(s) of ALD(s) the child uses “Bone Anchored Hearing Aid (BAHA)”, “Cochlear Implant”, “FM System”, or “Hearing Aid”.
- Check “Other” if the type of ALD is not already described.
- Check “Unknown” if the type of ALD is not known.

NEUROLOGIC ASSESSMENT

WAS A NEUROLOGIC EXAM PERFORMED DURING THIS CORE VISIT? (*REQUIRED FIELD)
- Check “No” if the infant/child did not have a neurologic exam performed during this core visit. Leave the Date Performed blank.
  If “No” was selected for “Was a Neurologic Exam Performed?”, then answer the next question “Reason Why Exam NOT Performed”.
  Select one of the options provided: “Acute Illness”, “Behavior Problems”, “Examiner Not Available”, “Known SEVERE Developmental Disability”, “Primary “Caregiver Refused”, “Primary Language”, “Significant Sensory Impairment/Loss”, “Other Medical Condition”, and “Other”.
- Check “Yes” if the infant/child did have a neurologic exam performed during this core visit. Enter the Core visit date performed for the neurologic exam using MM/DD/YYYY.

NOTE: The web-based Reporting System has a “Same as Date of Visit” check box, when checked it will input the date of visit.

If you cannot obtain a neurologic assessment during the core visit, schedule a return visit for the infant to complete the assessment(s) and indicate the reason why the assessment was not performed. When the infant returns the missing neurologic assessment, data can be entered on the incomplete “SV Form.” The date of the return visit should be entered in the “Date Performed” field, using MM-DD-YYYY.

Enter the new weight, height, and head circumference measurements in the “Patient Assessment” section.

SUMMARY OF NEUROLOGIC ASSESSMENT
- Check “Normal” if the infant/child’s neurologic assessment exam indicates the infant/child is normal. If “Normal” was checked, proceed to Developmental Assessment.
- Check either “Abnormal” or “Suspect” if the infant/child’s neurologic assessment exam indicates the infant/child is abnormal or suspect.
A. ORAL MOTOR FUNCTION
If “Abnormal” or “Suspect” was checked for neurologic assessment exam, indicate the status of the assessment for each Oral Motor Function. Make sure that the infant/child is demonstrating age appropriate responses for the oral motor functions of “Feeding”, “Swallowing”, and “Management of Secretions” by selecting one of the options:

- “Normal”
- “Abnormal” (includes excessive drooling, poor coordination of suck and swallow, inability to chew in children with molars).
- “Suspect”
- “Unable to Determine”, unable to establish, assess, or determine any of the above.

B. MUSCLE TONE
If “Abnormal” or “Suspect” was checked for neurologic assessment exam, indicate the status of the assessment for Muscle Tone listed for each region “Neck”, “Trunk”, “Right Upper Limb”, “Left Upper Limb”, “Right Lower Limb”, and “Left Lower Limb” by selecting one of the options:

- “Normal”
- “Increased” (Hypertonic)
- “Decreased” (Hypotonic)
- “Suspect” if you suspect muscle tone is hypertonic or Hypotonic.
- “Unable to Determine”, unable to establish, assess, or determine any of the above.

C. IS THERE SCISSORING OF THE LEGS ON VERTICAL SUSPENSION? (Added Jan. 2013)
If “Abnormal” or “Suspect” was checked for neurologic assessment exam, indicate if there is persistent “scissoring” (crossing of the legs) when the infant/child is vertically suspended (supported under arms).

- Check “No”, if there is no scissoring of the legs on vertical suspension present.
- Check “Yes”, if there is scissoring of the legs on vertical suspension present.

D. DEEP TENDON REFLEXES
If “Abnormal” or “Suspect” was checked for neurologic assessment exam, indicate the status of the assessment for Deep Tendon Reflexes listed for each region “Right Upper Limb” or “Left Upper Limb” by selecting only one of the options:

- “Normal” if the deep tendon reflex is between 1+ and 2+.
- “Increased” if the deep tendon reflex is 3+, usually with clonus or asymmetrical.
- “Decreased” if the deep tendon reflex < 1+.
- “Suspect” if you suspect DTR is increased or decreased, but you are not certain. (Added Jan. 2012)
- “Unable to Determine”, unable to establish, assess, or determine any of the above.
Indicate the status of the assessment for **Deep Tendon Reflexes** listed for each region “**Right Lower Limb**” and “**Left Lower Limb**” by selecting only **one** of the options:

- **“Normal”** if the deep tendon reflex is between 1+ and 2+.
- **“Increased”** if the deep tendon reflex is 3+ or greater.
- **“Decreased”** if the deep tendon reflex < 1+.
- **“Clonus”** (5 beats or more is considered abnormal).
- **“Suspect”** if you suspect DTR is increased or decreased, but you are not certain.
- **“Unable to Determine”**, unable to establish, assess, or determine any of the above.

**Clonus:** is a series of involuntary muscular contractions due to sudden stretching of the muscle (rapidly flexing the foot upward, in dorsiflexion). Only sustained clonus (5 beats or more) is considered abnormal.

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**E. ARE PERSISTENT PRIMITIVE REFLEXES PRESENT?**

In particular Moro > 4 months adjusted age and Fencer (ATNR) > 6 months adjusted age.

- Select **“No”**, if there are no persistent primitive reflexes present.
- Select **“Yes”**, if there are persistent primitive reflexes present.
- Select **“Unknown”**, if this information cannot be obtained.

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**F. ARE ABNORMAL INVOLUNTARY MOVEMENTS PRESENT?**

- Select **“No”**, if there are no abnormal involuntary movements present.
- Select **“Yes”**, if there are abnormal involuntary movements present.

If “**Yes**” was checked, for abnormal involuntary movements present; check **all** that apply: “**Ataxia**”, “**Choreoathetoid**”, or “**Tremors**”.

- Select **“Unknown”**, if this information cannot be obtained.

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**G. QUALITY OF MOVEMENT AND POSTURE (Added Jan. 2013)**

If “**Abnormal**” or “**Suspect**” was checked for neurologic assessment exam, indicate the quality of movement and posture.

- **“Normal”**

- **“Abnormal”** includes any of the following: extensor posturing, abnormal posturing of limb, asymmetric movement/laterality (favoring 1 side of body) or motor incoordination.

- **“Suspect”** if you suspect quality of movement and posture, but you are unsure.

- **“Unable to Determine”**, unable to establish, assess, or determine any of the above.
**FUNCTIONAL ASSESSMENT**

Indicate the functional assessment of the infant/child for “Bimanual Function”, “Right Pincer Grasp”, and “Left Pincer Grasp” by selecting only one of the options:

**NOTE**: Only complete Right and Left Pincer Grasp if the infant/child is ≥ 15 months adjusted age.

- Select “Normal”
- Select “Abnormal”, if lack of bimanual integration ≥ 4 months adjusted age or lack of grasp at > 9 months adjusted age and lack of fine pincer at >15 months adjusted age.
- Select “Suspect” if you are unsure.
- Select “Unable to Determine”, if unable to establish, assess, or determine any of the above.

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**CEREBRAL PALSY (CP)**

As presented by Bax, et al. (1) cerebral palsy is a broad descriptive term encompassing a group of permanent disorders of the development of movement and posture, causing activity limitation, that are attributed to non-progressive disturbances that occurred in the developing fetal or infant brain. The motor disorders of cerebral palsy are often accompanied by disturbances of sensation, perception, cognition, communication, and behavior, by epilepsy, and by secondary musculoskeletal problems.

Although the detailed characterization of cerebral palsy can be extremely complex, for the purposes of the CCS HRIF QCI, the focus is on everyday motor function, an approach in concert with international proposals and reports for consistency in neurodevelopmental follow up structures for high risk infants (2). As such, the definition of cerebral palsy will be based on having abnormalities in both areas 1 and 2 below.

1. **Definite abnormalities observed in neuromotor exam**, which includes passive muscle tone, deep tendon reflexes, coordination and movement (3).

2. **A delay in motor milestones**. This would be reflected as abnormalities in functional gross motor skills for age, including head and neck and/or trunk postural function abnormalities, and/or upper limb or lower limb gross motor skills.

In addition, abnormalities in protective reactions (“parachute”, lateral protective reactions) and primitive reflexes may be present.

**DOES THE CHILD HAVE CEREBRAL PALSY (CP)?**

- Check “No”, if the infant/child does not have cerebral palsy. Proceed to Developmental Assessment.
- Check “Yes”, if the infant/child has cerebral palsy.
- Check “Suspect” *(Added Jan. 2013)*
  
  If “Yes” or “Suspect” was checked, select the appropriate responses for Gross Motor Function Classification System (GMFCS).

- Check “Unable to Determine”, if unable to determine if the infant/child has cerebral palsy.
**Gross Motor Function Classification System (GMFCS)** (4, 5)
For children with cerebral palsy, the severity of functional motor abilities and limitations should be further characterized. The Gross Motor Function Classification System (GMFCS) is a widely used and validated scale, arranged by age bands.

If “Yes” or “Suspect” was selected for identifying the infant/child has cerebral palsy at the time of the core visit, select the child’s **Gross Motor Function Classification System (GMFCS)** level for the appropriate adjusted age grouping (18 - 24 months adjusted age or 24 – 36 months adjusted age). Baxter, P. (2008). *The Definition and Classification of Cerebral Palsy*. Developmental Medicine and Child Neurology, 49(s109), 1-44.

**Infants 18 - 24 months of age (adjusted age)**
- Check “**Level I**”, if infant/child walks without the need for any assistive mobility device.
- Check “**Level II**”, if infant/child maintain floor sitting but may need to use his/her hands for support to maintain balance. Infant/child creeps on his/her stomach or crawls on hands and knees. Infant/child may pull to stand and take steps holding on to furniture.
- Check “**Level III**”, if infant/child maintain floor sitting when the low back is supported. Infant/child rolls and creeps forward on his/her stomach.
- Check “**Level IV**”, if infant/child has head control but trunk support is required for floor sitting. Infant/child can roll to supine and may roll to prone.
- Check “**Level V**”, if physical impairments limit voluntary control of movement. Infant/child is unable to maintain antigravity head and trunk postures in prone and sitting. Infant/child requires adult assistance to roll.
- Check “**Unsure/Unable to Determine**”, cannot adequately complete the evaluation to assess.

**Infants 24 - 36 months of age (adjusted age)**
- Check “**Level I**”, infant/child floor sits with both hands free to manipulate objects. Movements in and out of floor sitting and standing are performed without adult assistance. Infant/child walks as the preferred method of mobility without the need for any assistive mobility device.
- Check “**Level II**”, infant/child floor sits but may have difficulty with balance with both hands are free to manipulate objects. Movements in and out of sitting are performed without adult assistance. Infant/child pulls to stand on a stable surface. Infant/child crawls on hand and knees with a reciprocal pattern, cruise holding onto furniture, and walks using an assistive mobility device as preferred methods of mobility.
- Check “**Level III**”, infant/child maintains floor sitting often with “W-sitting” and may require adult assistance to assume sitting. Infant/child creeps on his/her stomach and crawls on hands and knees as his/her primary methods of self-mobility. Infant/child may pull to stand on a stable surface and cruise short distances. Infant/child may walk short distances indoors using a hand-held mobility device and adult assistance for steering and turning.
- Check “**Level IV**”, infant/child floor sits when placed, but is unable to maintain alignment and balance without use of his/her hands for support. Infant/child frequently requires adaptive equipment for sitting and standing. Self-mobility for
short distances is achieved through rolling, creeping on stomach, or crawling on hands and knees without reciprocal leg movement.

- Check “Level V”, physical impairments restrict voluntary control of movement and the ability to maintain antigravity head and trunk postures. All areas of motor function are limited. Functional limitations in sitting and standing are not fully compensated for through the use of adaptive equipment and assistive technology. At Level V, infant/child has no means of independent movement and is transported.

- Check “Unsure/Unable to Determine”, cannot adequately complete the evaluation to assess.


DEVELOPMENTAL CORE VISIT ASSESSMENT

WAS A DEVELOPMENTAL ASSESSMENT SCREENER OR TEST PERFORMED DURING THIS CORE VISIT? (*REQUIRED FIELD)
- Check “No” if the infant/child did not have a developmental screener or developmental test performed during this core visit. Leave the Date Performed blank.

- If “No” was selected for “Was a Developmental Screener or Test Performed during this Core Visit?” then answer the next question “Reason Why Assessment NOTPerformed”

Select one of the options provided: “Acute Illness”, “Behavior Problems”, “Examiner Not Available”, “Known SEVERE Developmental Disability”, “Primary Caregiver Refused”, “Primary Language”, “Significant Sensory Impairment/Loss”, “Other Medical Condition”, and “Other”

- Proceed to Early Start (ES) Program.

- Check “Yes” if the infant/child did have a developmental assessment screener or developmental assessment test performed during this core visit. Enter the core visit date performed for the developmental screener or developmental test using MM/DD/YYYY.

NOTE: The web-based Reporting system has a “Same as Date of Visit” check box, when checked it will input the date of visit.
If you cannot obtain a developmental assessment during the core visit, schedule a return visit for the infant to complete the assessment(s) and indicate the reason why the assessment was not performed. When the infant returns the missing developmental assessment data can be entered on the incomplete “SV Form.” The date of the return visit should be entered into the “Date Performed” field, using MM/DD/YYYY. Enter the new weight, height, and head circumference measurements in the “Patient Assessment” section.

DEVELOPMENTAL ASSESSMENT SCREENERS

Determine the appropriate developmental assessment screener to be performed during this core visit with the infant/child. **NOTE:** Developmental Assessment Screeners cannot be used in the last or third (18 to 36 month) core visit.

Scores / Cutoffs For Each Developmental Screener

<table>
<thead>
<tr>
<th>Standard Scores</th>
<th>Scale Scores</th>
<th>T Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>M 100</td>
<td>10</td>
<td>50</td>
</tr>
<tr>
<td>SD 15 = 1 SD</td>
<td>3 = 1 SD</td>
<td>10 = 1 SD</td>
</tr>
</tbody>
</table>

M = Mean  
SD = Standard Deviation

(1) BAYLEY INFANT NEURODEVELOPMENTAL SCREENER (BINS)
This screener is scored using raw scores.
- Check the appropriate range for the “Overall Classification” for the BINS Screener: “Low Risk”, “Medium Risk”, or “High Risk”.
- Check “Unable to Assess” if the infant/child was uncooperative with the screening or if this information cannot be obtained.

The following are the raw score ranges:

**Raw Score Ranges**
- “Low Risk” if the raw score falls within the “Low Risk” range on the table for the child’s age in months.
- “Medium Risk” if the raw score falls within the “Medium Risk” range on the table for the child’s age in months.
- “High Risk” if the raw score falls within the “High Risk” range on the table for the child’s age in months.
(2) BATTELLE DEVELOPMENTAL INVENTORY SCREENING TEST, 2ND EDITION (BDIST)
This screener is scored using raw scores for each domain (Adaptive, Personal-Social, Communication, Motor, and Cognitive).
- Check the appropriate range for each domain of the BDIST Screener: “Pass” or “Refer”.
- Check “Unable to Assess” if the infant/child was uncooperative with the screening or if this information cannot be obtained.
- Check “Did Not Assess” if the domain is not used for the infant/child’s developmental assessment.

The following are the raw score ranges:

**Raw Score Ranges**
Domains: Adaptive, Personal-Social, Communication, Motor, and Cognitive
- “Pass” if the raw score is greater than the negative 1.5 cut score for the child’s age in months.
- “Refer” if the raw score is less than or equal to the negative 1.5 cut score for the child’s age in months.

(3) BAYLEY SCALES OF INFANT AND TODDLER DEVELOPMENTAL SCREENING TEST, 3RD EDITION SCREENER (BAYLEY III SCREENER)
This screener is scored using raw scores for each domain (Cognitive, Receptive Language, Expressive Language, Fine Motor, and Gross Motor) which are converted into “Competent”, “Emerging” and “At Risk” categories using cut-score ranges found in the table appropriate for the child’s age in months and days.
- Check the appropriate range for each domain of the Bayley III Screener: “Competent”, “Emerging”, or “At Risk”.
- Check “Unable to Assess” if the infant/child was uncooperative with the screening or if this information cannot be obtained.
- Check “Did Not Assess” if the domain is not used for the infant/child’s developmental assessment.

The following are the classifications:

**Classifications**
Domains: Cognitive, Receptive Language, Expressive Language, Fine Motor, and Gross Motor
- “Competent” if the raw score falls within the “Competent” range on the table for the child’s age in months and days.
- “Emerging” if the raw score falls within the “Emerging” range on the table for the child’s age in months and days.
- “At Risk” if the raw score falls within the “At Risk” range on the table for the child’s age in months and days.
(4) THE CAPUTE SCALES/ THE COGNITIVE ADAPTIVE TEST/ CLINICAL LINGUISTIC AND AUDITORY MILESTONE SCALE SCREENER (CAPUTE/CAT-CLAMS)

This screener is scored using standard scores for each domain [(Language Auditory (CLAMS), Cognitive Adaptive (CAT), Full Scale Capute)].

Enter the score at the appropriate range for each domain of the Capute/CAT-CLAMS Screener: "Normal", "Borderline", or "Deficient".

- Check "Unable to Assess" if the infant/child was uncooperative with the screening or if this information cannot be obtained.
- Check "Did Not Assess" if the domain is not used for the infant/child’s developmental assessment.

The following are the standard score ranges:

**Standard Scores**

Domains: Language Auditory (CLAMS), Cognitive Adaptive (CAT), Full Scale Capute
- "Normal" if the standard score is greater than or equal to (≥) 85 or less (<) than 1 SD from the mean.
- "Borderline" if the standard score is between 71 to 84 or between 1 to 2 SD below the mean.
- "Deficient" if the standard score is less than or equal to (<) 70 or greater (> ) than 2 SD below the mean.

(5) OTHER/NOT LISTED SCREENER

Enter the full name of the Other/Not Listed screener used for assessment of the infant/child. Check the appropriate range for each domain of this screener: “Normal”, “Mild/Moderate”, or “Significant”.

- Enter the name of the “Other Domain” if the domain is not already listed.
- Check "Unable to Assess" if the infant/child was uncooperative with the screening or if this information cannot be obtained.
- Check "Did Not Assess" if the domain is not used for the infant/child’s developmental assessment.

The following are the standard, scale, T, and raw score ranges:

**Standard Scores**
- Within Normal Limits ≥ 85 (1 SD from the mean)
- Mild/Moderate Delay 71 - 84 (between 1-2 SD below the mean)
- Significant Delay ≤ 70 (2 SD below the mean)

**Scale Scores**
- Within Normal Limits ≥ 7 (1 SD from the mean)
- Mild/Moderate Delay 5 - 6 (between 1-2 SD below the mean)
- Significant Delay ≤ 4 (2 SD below the mean)

**T Scores**
- Within Normal Limits ≥ 40 (1 SD from the mean)
- Mild/Moderate Delay 31 - 39 (between 1-2 SD between the mean)
- Significant Delay $\leq 30$ (2 SD below the mean)

**Raw Scores**
- Within Normal Limits if raw score is less than ($<$) 1 SD from the mean
- Mild/Moderate Delay if the raw score is between 1 to 2 SD below the mean
- Significant Delay if the raw score is greater than ($>$) 2 SD below the mean

**DEVELOPMENTAL ASSESSMENT TESTS**

Determine the appropriate developmental assessment test to be performed during this core visit with the infant/child.

**NOTE:** A Developmental Assessment Test **must** be used in the last or third (18 to 36 month) core visit.

**Scores / Cutoffs For Each Developmental Test**

<table>
<thead>
<tr>
<th></th>
<th>Standard Scores</th>
<th>Scale Scores</th>
<th>T Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>M</strong></td>
<td>100</td>
<td>10</td>
<td>50</td>
</tr>
<tr>
<td><strong>SD</strong></td>
<td>$15 = 1 SD$</td>
<td>$3 = 1 SD$</td>
<td>$10 = 1 SD$</td>
</tr>
</tbody>
</table>

$M =$ Mean \hspace{1cm} $SD =$ Standard Deviation

(1) **BAYLEY SCALES OF INFANT AND TODDLER DEVELOPMENT, 3RD EDITION TEST (BAYLEY III)**

(Interactive/Score)

This test is scored using both **Standard Scores** and **Scale Scores**.
- Standard scores are used for 5 domains (Cognitive Composite, Language Composite, Motor Composite, Social-Emotional Composite, and Adaptive-Behavioral Composite).
- Scale scores are used for 4 sub-domains (Receptive Language, Expressive Language, Fine Motor, and Gross Motor).

**Enter** the score at the appropriate range for each domain of the Bayley III Test: “Normal”, “Mild/Moderate”, or “Significant”.
- Check “Unable to Assess” if the infant/child was uncooperative with the test or if this information cannot be obtained.
- Check “Did Not Assess” if the domain/scale is not used for the infant/child’s developmental assessment.

The following are the standard and scale score ranges:

**Standard Scores**

- Within Normal Limits $\geq 85$ (1 SD from the mean)
- Mild/Moderate Delay 71 - 84 (between 1-2 SD below the mean)
- Significant Delay $\leq 70$ (2 SD below the mean)

**Scale Scores**

- Within Normal Limits $\geq 7$ (1 SD from the mean)
• Mild/Moderate Delay 5 - 6 (between 1-2 SD below the mean)
• Significant Delay ≤ 4 (2 SD below the mean)

(2) BATTELLE DEVELOPMENTAL INVENTORY, 2nd EDITION TEST (BDI-2)
This test is scored using both Standard scores and Scale scores.
• Standard scores are used for 5 domains (Adaptive, Personal-Social, Communication, Motor, and Cognitive).
• Scale scores are used for 4 sub-domains (Receptive Language, Expressive Language, Fine Motor, and Gross Motor).

Enter the score at the appropriate range for each domain of the BDI-2 Test: “Normal”, “Mild/Moderate”, or “Significant”.
• Check “Unable to Assess” if the infant/child was uncooperative with the test or if this information cannot be obtained.
• Check “Did Not Assess” if the domain/scale is not used for the infant/child’s developmental assessment.

The following are the standard and scale score ranges:

**Standard Scores**
Domains: Adaptive, Personal-Social, Communication, Motor, and Cognitive
• Within Normal Limits ≥ 85 (1 SD from the mean)
• Mild/Moderate Delay 71 - 84 (between 1-2 SD below the mean)
• Significant Delay ≤ 70 (2 SD below the mean)

**Scale Scores**
Domains: Receptive Language, Expressive Language, Fine Motor, and Gross Motor
• Within Normal Limits ≥ 7 (1 SD from the mean)
• Mild/Moderate Delay 5 - 6 (between 1-2 SD below the mean)
• Significant Delay ≤ 4 (2 SD below the mean)

(3) Revised Gesell and Amatruda Developmental and Neurologic Examination Test (Gesell)
This test is scored using standard scores for each domain (Language Development, Fine Motor, Gross Motor, Personal-Social, and Adaptive).
• Enter the score at the appropriate range for each domain of the Gesell Test: “Normal”, “Mild/Moderate”, or “Significant”.
• Check “Unable to Assess” if the infant/child was uncooperative with the test or if this information cannot be obtained.
• Check “Did Not Assess” if the domain/scale is not used for the infant/child’s developmental assessment.

The following are the standard score ranges:

**Standard Scores**
Domains: Language Development, Fine Motor, Gross Motor, Personal-Social, and Adaptive
• Within Normal Limits ≥ 85 (1 SD from the mean)
• Mild/Moderate Delay 71 - 84 (between 1-2 SD below the mean)
• Significant Delay ≤ 70 (2 SD below the mean)
This test is scored using both standard scores and T scores.

- Standard score is used for 1 domain (Early Learning Composite).
- T scores are used for 4 scales (Visual Perception, Receptive Language, Expressive Language, Fine Motor, and Gross Motor).

Enter the score at the appropriate range for each domain of the Mullen Test: “Normal”, “Mild/Moderate”, or “Significant”.

- Check “Unable to Assess” if the infant/child was uncooperative with the test or if this information cannot be obtained.
- Check “Did Not Assess” if the domain/scale is not used for the infant/child’s developmental assessment.

The following are the standard and T score ranges:

### Standard Scores
**Domain:** Early Learning Composite
- Within Normal Limits ≥ 85 (1 SD from the mean)
- Mild/Moderate Delay 71 - 84 (between 1-2 SD below the mean)
- Significant Delay ≤ 70 (2 SD below the mean)

### T Scores
**Domains:** Visual Perception, Receptive Language, Expressive Language, Fine Motor, and Gross Motor
- Within Normal Limits ≥ 40 (1 SD from the mean)
- Mild/Moderate Delay 31 - 39 (between 1-2 SD below the mean)
- Significant Delay ≤ 30 (2 SD below the mean)

(5) OTHER/NOT LISTED TEST

Enter the full name of the Other/Not Listed test used for assessment of the infant/child. Available domains/scales for Other/Not Listed test to choose from follow: Cognitive, Expressive Language, Receptive Language, Language Composite, Gross Motor, Fine Motor, Motor Composite, Personal-Social, Adaptive, or Other Domain.

- Enter the name of the “Other Domain” if the domain is not already listed.
- Check the appropriate range for each domain/scale of this test: “Normal”, “Mild/Moderate”, or “Significant”.
- Check “Unable to Assess” if the infant/child was uncooperative with the testing or if this information cannot be obtained.
- Check “Did Not Assess” if the domain/scale is not used for the infant/child’s developmental assessment.

The following are the standard, scale, T, and raw score ranges:

### Standard Scores
- Within Normal Limits ≥ 85 (1 SD from the mean)
- Mild/Moderate Delay 71 - 84 (between 1-2 SD below the mean)
- Significant Delay ≤ 70 (2 SD below the mean)

### Scale Scores
- Within Normal Limits ≥ 7 (1 SD from the mean)
- Mild/Moderate Delay 5 - 6 (between 1-2 SD below the mean)
- Significant Delay ≤ 4 (2 SD below the mean)
T Scores
- Within Normal Limits ≥ 40 (1 SD from the mean)
- Mild/Moderate Delay 31 - 39 (between 1-2 SD below the mean)
- Significant Delay ≤ 30 (2 SD below the mean)

Raw Scores
- Within Normal Limits if raw score is less than (<) 1 SD from the mean
- Mild/Moderate Delay if the raw score is between 1 to 2 SD below the mean
- Significant Delay if the raw score is greater than (> ) 2 SD below the mean

AUTISM SPECTRUM SCREEN (Optional)

As per the Johnson CP, et al "Identification and evaluation of children with autism spectrum disorders" (Pediatrics 2007) and the AAP statement "Identifying infants and young children with developmental disorders in the medical home" (Pediatrics, 2006): For general developmental screening and surveillance, the "AAP recommends administering a standardized autism-specific screening tool on all children at the 18 month preventive care visit." The AAP Autism Expert Panel responded to the statement with a commentary that suggested a repeat screening be performed at 24 months of age to identify those who may regress after 18 months of age.


WAS AN AUTISM SPECTRUM SCREEN PERFORMED DURING THIS VISIT?
- Check “No” if the infant/child did not have an Autism Spectrum Screen performed during this core visit. Proceed to Early Start (ES).
- Check “Yes” if the infant/child did have an Autism Spectrum Screen performed during this core visit. Complete the Autism Spectrum Screen questions below.

Select the autism spectrum screening tool used:

Select the autism spectrum screening results: “Pass” or “Did Not Pass”

NOTE: M-CHAT-RF screening results:
"Pass", if the score is 0 - 2 (low risk)
"Fail", if the score is => 3 (medium/high risk)

WAS THE INFANT REFERRED FOR FURTHER AUTISM SPECTRUM ASSESSMENT?
- Select “No” if the infant/child was not referred for further autism spectrum assessment. Proceed to Early Start (ES).
- Select “Yes” if the infant/child was referred for further autism spectrum assessment.
EARLY START (ES) PROGRAM

The Early Start Program is California’s response to federal legislation ensuring that early intervention services to infants and toddlers with disabilities and their families are provided in a coordinated, family-centered network. Website: http://www.dds.ca.gov/earlystart/Home.cfm

IS THE CHILD CURRENTLY RECEIVING EARLY INTERVENTION SERVICES THROUGH EARLY START (REGIONAL CENTER AND/OR LOCAL EDUCATIONAL AGENCY [LEA])? (Revised Jan 2018)

“Local Educational Agency (LEA)” a public board of education or other public authority legally constituted within a state for either administrative control or direction of, or to perform a service function for, public elementary or secondary schools in a city, county, township, school district, or other political subdivision of a state, or for a combination of school districts or counties as are recognized in a state as an administrative agency for its public elementary or secondary schools.

Check only one option that applies at the time of core visit.

- Select “Yes” if the infant/child is currently receiving services
- Select “No, Not Required” if the infant/child is not receiving services
- Select “No, Referred at Visit” if the infant/child is being referred at the time of visit or was initially referred, but did not receive the service and is being referred again.
- Select “No, Referral Failure” if the infant/child was referred in the past, but not picked up for services.
- Select “No, Pending Services” if the infant/child was referred, but is currently pending an appointment
- Select “No, Parent Refused” if the parents refused the service.
- Select “No, Determined Ineligible by ES” if the infant/child was referred, but ES determined ineligible for services.
- Select “Unknown” if this information cannot be obtained

MEDICAL THERAPY PROGRAM (MTP)

The Medical Therapy Program (MTP) is a special program within California Children’s Services that provides physical therapy (PT), occupational therapy (OT) and medical therapy conference (MTC) services for children who have handicapping conditions, generally due to neurological or musculoskeletal disorders. Website: http://www.dhcs.ca.gov/services/ccs/Pages/MTP.aspx

IS THE CHILD CURRENTLY RECEIVING SERVICES THROUGH CCS MEDICAL THERAPY PROGRAM (MTP)? (Added Jan. 2013 / Revised Jan 2018)

Check only one option that applies at the time of core visit.

- Select “Yes” if the infant/child is currently receiving services
- Select “No, Not Required” if the infant/child is not receiving services
- Select “No, Referred at Visit” if the infant/child is being referred at the time of visit or was initially referred, but did not receive the service and is being referred again.
- Select “No, Referral Failure” if the infant/child was referred in the past, but not picked up for services.
- Select “No, Pending Services” if the infant/child was referred, but is currently pending an appointment
- Select “No, Parent Refused” if the parents refused the service.
- Select “No, Determined Ineligible by MTP” if the infant/child was referred, but MTP determined ineligible for services.
- Select “Unknown” if this information cannot be obtained
IS THE CHILD RECEIVING OR BEING REFERRED FOR SPECIAL SERVICES BECAUSE OF THE CURRENT EVALUATION/HRIF ASSESSMENT?
- Check “No” if the infant/child is not receiving or being referred for special services. Proceed to Resources and Social Concerns.
- Check “Yes” if the infant/child is receiving or being referred for special services.
- Check “Unknown” if this information cannot be obtained. Proceed to Resources and Social Concerns.

If the infant/child is receiving or being referred for special services, select both the status of each special service and one service provider for the infant/child. If there is more than one service provider, select the provider most frequently used.

Special services being reviewed are “Behavior Intervention”, “Feeding Therapy”, “Infant Development Services”, “Hearing Services”, “Nutritional Therapy”, “Occupational Therapy (OT)”, “Physical Therapy (PT)”, “Speech/Language Communication”, “Social Work Intervention”, “Visiting, Public Health, and/or Home Nursing”, and “Vision Services” list the same options for status possibilities:
- “Does Not Need”
- “Receiving”
- “Complete”, if the infant/child no longer needs the service. (Added Jan. 2010)
- “Referred at Time of Visit”
- “Referred, but Not Receiving – Missed Appointment”
- “Referred, but Not Receiving – Waiting List”
- “Referred, but Not Receiving – Re-Referred”, initially referred did not receive, now referred for services. (Added Jan. 2012)
- “Referred, but Not Receiving – Insurance/HMO Denied”
- “Referred, but Not Receiving – Service Not Available”
- “Referred, but Not Receiving – Service Cancelled” (Added Jan. 2010)
- “Referred, but Not Receiving – Parent Declined/Refused Service”
- “Referred, but Not Receiving – Other/Unknown Reason”

BEHAVIOR INTERVENTION
- Select the appropriate status of the infant/child receiving (or being referred) for Behavior Intervention Services.
- Select one service provider: “Early Intervention Specialist”, “Licensed Clinical Social Worker”, “Psychologist”, “Other”, and “Unknown”.

FEEDING THERAPY
- Select the appropriate status of the infant/child receiving (or being referred) for Feeding Therapy Services.
INFANT DEVELOPMENT SERVICES
Also referred to as “Infant Stim” or “Infant Stimulation”
• Select the appropriate status of the infant/child receiving (or being referred) for Infant Development Services.
• Select one service provider: Early Intervention Specialist, Licensed Clinical Social Worker, Occupational Therapist, Physical Therapist, Psychologist, Registered Nurse, Medical Social Worker (MSW), Speech/Language Pathologist, “Other”, and “Unknown”.

HEARING SERVICES
• Select the appropriate status of the infant/child receiving (or being referred) for Hearing Services.
• Select one service provider: Audiologist, Early Intervention Specialist, ENT, Speech/Language Pathologist, Teacher of the Deaf, “Other”, and “Unknown”.

NUTRITIONAL THERAPY
• Select the appropriate status of the infant/child receiving (or being referred) for Nutritional Services.
• Select one service provider: Certified Lactation Consultant, Public Health Nurse, Physician, Registered Dietitian, Registered Nurse, “Other”, and “Unknown”.

OCCUPATIONAL THERAPY (OT)
• Select the appropriate status of the infant/child receiving (or being referred) for Occupational Services.
• Select one service provider: Occupational Therapist, “Other”, and “Unknown”.

PHYSICAL THERAPY (PT)
• Select the appropriate status of the infant/child receiving (or being referred) for Physical Intervention Services.
• Select one service provider: “Physical Therapist”, “Other”, and “Unknown”.

SPEECH/LANGUAGE COMMUNICATION
• Select the appropriate status of the infant/child receiving (or being referred) for Speech/Language Communication Services.
• Select one service provider: “American Sign Language”, “Early Intervention Specialist”, “Teacher of the Deaf”, “Speech/Language Pathologist”, “Other”, and “Unknown”.

SOCIAL WORK INTERVENTION
• Select the appropriate status of the infant/child receiving (or being referred) for Social Work Intervention Services.
• Select one service provider: “Licensed Clinical Social Worker”, “Marriage and Family Therapist”, “Psychologist”, “Physician”, “MSW”, “Other”, and “Unknown”.
VISITING, PUBLIC HEALTH AND/OR HOME NURSING
- Select the appropriate status of the infant/child receiving (or being referred) for Visiting, Public Health and/or Home Nursing Services.

VISION SERVICES
- Select the appropriate status of the infant/child receiving (or being referred) for Vision Services.

SOCIAL CONCERNS AND RESOURCES
Social Concerns and Resources provide a framework to identify multiple sources of psychosocial or environmental stressors experienced by a infant/child and his/her family, noting severity and duration.

CAREGIVER – CHILD DISRUPTIONS OR CONCERNS
Choose one of the options if intervention is necessary; in the instance that the infant/child’s primary caregiver is a single parent, divorced, has a prolonged separation (incarceration, military service), multiple changes in caregivers/daycare, or the caregiver has a chronic illness.
- Select “No”
- Select “Yes, Referral Not Necessary”
- Select “Yes, Referred to Social Worker”
- Select “Yes, Referred to Other Community Resources”

ECONOMIC/ENVIRONMENTAL CONCERNS/STRESSORS
Choose one of the options if intervention is necessary; in the instance that the primary caregiver has housing insecurity, lack of resources, money issues, insurance (or high co-pay), lack of reliable transportation for medical needs.
- Select “No”
- Select “Yes, Referral Not Necessary”
- Select “Yes, Referred to Social Worker”
- Select “Yes, Referred to Other Community Resources”
COMMUNITY & RELATIONSHIP CONCERNS
Choose one of the options if intervention is necessary: in the instance that the child/primary caregiver does not have perceived emotional support from family/friends, a supportive and safe intimate relationship, safe neighborhood, and resources for needs.
- Select “No”
- Select “Yes, Referral Not Necessary”
- Select “Yes, Referred to Social Worker”
- Select “Yes, Referred to Other Community Resources”

PARENT – CHILD CONCERNS
Choose one of the options if intervention is necessary: if the child/primary caregiver has problems regarding feeding and growth, calming, behavior, sleep, and other.
- Select “No”
- Select “Yes, Referral Not Necessary”
- Select “Yes, Referred to Social Worker”
- Select “Yes, Referred to Other Community Resources”

CHILD PROTECTIVE SERVICES (CPS)

IS A CHILD PROTECTIVE SERVICES (CPS) CASE CURRENTLY OPENED?
Select one option that applies at the time of core visit.
- Select “No”
- Select “Yes”, if CPS referral is pending or currently opened
- Select “Referred at Time of Visit”

OTHER MEDICAL CONDITIONS

WERE THERE ADDITIONAL MEDICAL CONDITIONS IDENTIFIED THAT MAY IMPACT THE CHILD’S OUTCOME? (Added Jan 2018)
Select one option that applies at the time of core visit.
- Select “No”, if there are no additional medical conditions identified.
- Select “Yes”, if there are additional medical conditions identified that may impact the child’s outcome.

Check all categories that apply and provide a description of the diagnosis.

Categories: Cardiovascular and Circulatory; Endocrine and Metabolic; Eye, Ear, Nose; Gastrointestinal and Hepatobiliary; Genetic; hematologic, Immunology, Or Oncologic/Neoplasm; Infectious Diseases; Injuries, Accident, Poisoning; Renal and Genitourinary Tract; Respiratory System; Nervous System; and Other.

By including categories and text field for specificity, we hope to identify other diagnoses and disorders that may impact outcomes and resource utilization above and beyond the initial HRIF eligibility criteria-related diagnoses.
Disposition is the status of the need for continued High Risk Infant Follow-up for this infant/child after the visit.

**DISPOSITION (*REQUIRED FIELD)*

Select only **one** option that applies at the time of core visit.

- Select "Scheduled to Return", the infant/child will be scheduled for another follow-up core visit at the HRIF Program.

- Select "Completed HRIF Core Visits, Scheduled to Return", the child has completed the three HRIF Program follow-up core visits, before the child’s third birthday and is scheduled to return for additional resources. *(Added Jul. 2016)*

- Select “Will Be Followed by Another CCS HRIF Program” when the infant/child is transferred and receiving follow-up care from another CCS HRIF Program.

**NOTE:** Complete the Transfer Patient Record Process for patient(s) who will be followed by another CCS HRIF Program. Submit a Help Desk ticket at: [https://www.cpqcchelp.org/](https://www.cpqcchelp.org/)

- Select “Discharged, Graduated”, the infant/child has completed the three HRIF Program follow-up core visits and has reached the 3-year age limit. **No further data will be submitted to CMS/CCS.** *(Added Jan. 2015)*

- Select “Discharged, Will Be Followed Elsewhere”, when the infant/child will be receiving follow-up care from a NON-CCS HRIF Program in California. **No further data will be submitted to CMS/CCS.** *(Added Jan. 2015)*

- Select “Discharged, Closed Out of Program”, the HRIF Program has determined that the infant/child is no longer needs to be followed within a CCS HRIF Program. **No further data will be submitted to CMS/CCS.** *(Added Jan. 2015)*

- Select “Discharged, Family Withdrew Prior To Completion”, the infant/child’s primary caregiver(s) decides not to return or continue follow-up core visits at the CCS HRIF Program, before the final (3rd) visit or the child’s third birthday. **No further data will be submitted to CMS/CCS.** *(Added Jan. 2015)*

- Select “Discharged, Completed HRIF Core Visits, Referred for Additional Resources”, the child has completed the three HRIF Program follow-up core visits, has reached the 3-year age limit and referred for additional resources. **No further data will be submitted to CMS/CCS.** *(Added Jan. 2015)*
**ADDITIONAL VISIT (AV) FORM**

*(See page 21 for the summary of “AV Form”)*

- **REQUIRED FIELD** MUST be entered to save web-based entry screens. Saved entry screens can be recalled later to make necessary updates.

- **INFANT NAME** – AUTOMATICALLY COMPUTER GENERATED
  Enter the infant/child’s Last Name and First Name using the hospital record.
  **NOTE:** The Infant Name is displayed in the web-based Reporting System banner for this infant/child.

- **HRIF I.D. NUMBER** – AUTOMATICALLY COMPUTER GENERATED
  This number consists of a unique assigned High Risk Infant Follow-up Program 3-digit prefix number (assigned and provided by CPQCC) and a 5-digit computer generated number. This 8-digit number identifies the infant/child previously enrolled in the HRIF Program.
  **NOTE:** The HRIF I.D. Number is displayed in the web-based Reporting System banner for this infant/child.

- **THIS FORM IS CLOSED** – CHECKBOX (WEB-BASED ENTRY FORM)
  This checkbox feature serves as an electronic signature confirmation that all available data has been entered.

- **DATE OF ADDITIONAL VISIT** (*REQUIRED FIELD*)
  Enter the date of the additional visit using MM-DD-YYYY. This is the date the infant/child was seen at the High Risk Infant Follow-up Program.

- **REASON FOR ADDITIONAL VISIT** (*REQUIRED FIELD*)
  Indicate the reason for the infant/child’s additional visit to the High Risk Infant Follow-up Program.
  - Select “Social Risk”, if there are concerns regarding any disruption with the primary caregiver(s), such as divorce, military, etc., strained family relationship, poor economic status, and/or safety issues.
  - Select “Concern with Neuro/Developmental Course”, if the infant/child needs additional assessment of Neurologic or Developmental status.
  - Select “Case Management”, if the infant/child needs additional access to, linking with, referring to, or coordinating and/or monitoring of services.
  - Select “Other”, if the reason for the additional visit is not already described. Use the text field to type in the reason that best describes why the infant/child needed an additional visit.
**DISPOSITION**

**DISPOSITION (*REQUIRED FIELD*)**

Disposition is the status of the need for continued High Risk Infant Follow-Up for this infant/child after the visit.

Select only **one** option that applies at the time of core visit.

- Select “Scheduled to Return”, the infant/child will be scheduled for another follow-up core visit at the HRIF Program.
- Select “Will Be Followed by Another CCS HRIF Program” when the infant/child is transferred and receiving follow-up care from another CCS HRIF Program.

**NOTE:** Complete the Transfer Patient Record Process for patient(s) who will be followed by another CCS HRIF Program. Submit a Help Desk ticket at: https://www.cpqcchelp.org/

- Select “Discharged, Graduated”, the child has completed the three HRIF Program follow-up core visits and has reached the 3-year age limit. **No further data will be submitted to CMS/CCS.**
- Select “Discharged, Family Moving Out of State/Country”, when the family is moving out of state/country. **No further data will be submitted to CMS/CCS. (Added Jan. 2015)**
- Select “Discharged, Will Be Followed Elsewhere”, when the infant/child will be receiving follow-up care from a NON-CCS HRIF Program in California. **No further data will be submitted to CMS/CCS.**
- Select “Discharged, Closed Out of Program”, the HRIF Program has determined that the infant/child is no longer needs to be followed within a CCS HRIF Program. **No further data will be submitted to CMS/CCS**
- Select “Discharged, Family Withdrew Prior To Completion”, the infant/child’s primary caregiver(s) decides not to return or continue follow-up core visits at the CCS HRIF Program, before the final (3rd) visit or the child’s third birthday. **No further data will be submitted to CMS/CCS.**
- Select “Discharged, Completed HRIF Core Visits, Referred for Additional Resources”, the child has completed the three HRIF Program follow-up core visits, has reached the 3-year age limit and referred for additional resources. **No further data will be submitted to CMS/CCS.**

**HOSPITAL/CENTER INFORMATION (OPTIONAL)**

**HOSPITAL SPECIFIC MEDICAL I.D. NUMBER**

Enter the infant/child’s hospital medical record number.

**INFANT’S FIRST NAME**

Enter the infant/child’s first name using the hospital record.
**INFANT’S LAST NAME**
Enter the infant/child’s last name using the hospital record.

**INFANT’S AKA (ALSO KNOWN AS)-1 LAST NAME**
Enter the infant/child’s last name if it is different from the hospital record or if the infant/child has two last names.

**INFANT’S AKA-2 LAST NAME**
Enter the infant/child’s last name if it is different from the hospital record and previous AKA-1 Last Name.

**PRIMARY CAREGIVER’S FIRST NAME**
Enter the primary caregiver’s first name. *(See page 31, for definition of Primary Caregiver)*

**PRIMARY CAREGIVER’S LAST NAME**
Enter the primary caregiver’s last name. *(See page 31, for definition of Primary Caregiver)*

**STREET ADDRESS**
Enter the permanent physical street address of the primary caregiver’s residence.

**CITY**
Enter the permanent physical city of the primary caregiver’s residence.

**STATE/COUNTRY**
Select the permanent physical state/country of the primary caregiver’s residence.

**ZIP CODE**
Enter the permanent 5-digit zip code of the primary caregiver’s residence.

**HOME PHONE NUMBER**
Enter the most common 10-digit phone number where the family can be reached.

**ALTERNATE STREET ADDRESS**
Enter the alternate physical street address of a relative or other contact person.

**CITY**
Enter the alternate physical city of a relative or other contact person.

**STATE AND COUNTRY**
Select the alternate permanent physical state and country of a relative or other contact person.

**ZIP CODE**
Enter the alternate 5-digit zip code of a relative or other contact person.

**ALTERNATE HOME PHONE NUMBER**
Enter the alternate 10-digit phone number where the family can be reached.
CLIENT NOT SEEN/DISCHARGE (CNSD) FORM
(See page 21 for the summary of “CNSD Form”)

**REQUIRED FIELD** MUST be entered to save web-based entry screens. Saved entry screens can be recalled later to make necessary updates.

**INFANT NAME** – AUTOMATICALLY COMPUTER GENERATED
Enter the infant/child’s Last Name and First Name using the hospital record.
*NOTE:* The Infant Name is already displayed in the web-based Reporting System banner for this infant/child.

**HRIF I.D. NUMBER** – AUTOMATICALLY COMPUTER GENERATED
This number consists of a unique assigned HRIF Program 3-digit prefix number (assigned and provided by CPQCC) and a 5-digit computer generated number. This 8-digit number identifies the infant/child previously enrolled in the HRIF Program.
*NOTE:* The HRIF I.D. Number is displayed in the web-based Reporting System banner for this infant/child.

**THIS FORM IS CLOSED** – CHECKBOX (WEB-BASED ENTRY FORM)
This checkbox feature serves as an electronic signature confirmation that all available data has been entered.

**DATE CLIENT NOT SEEN/DISCHARGED** (*REQUIRED FIELD*)
A core visit rescheduled or canceled (24 hours prior) does not constitute as a “no show”.
- If the infant/child is “lost to follow-up”, **Enter** the last attempted date to contact the family to schedule an appointment. Use the date format MM-DD-YYYY.
- **Enter** the date the infant/child was a “no show”. Use the date format MM-DD-YYYY.
- **Enter** the date the infant/child expired prior to the core visit, family relocated, insurance denial, etc. Use the date format MM-DD-YYYY.
- **Enter** the date when the infant/child was transferred/referred to another HRIF Program for follow-up services. Use the date format MM-DD-YYYY.

**CATEGORY** (*REQUIRED FIELD*)
Select the appropriate category, describing why the infant/child was not seen at the High Risk Infant Follow-up Program.
- Select “No Appointment Scheduled”, if the infant/child was referred to HRIF, but the staff unable to establish an initial core visit.
- Select “Core Visit Appointment Scheduled”, if the infant/child was on the schedule, but not seen.
- Select “Discharged”, if the infant/child will be referred to another CCS HRIF Program or other program (Non-CCS HRIF Program) for follow-up services.
REASON FOR CLIENT NOT SEEN/DISCHARGE

REASON FOR CLIENT NOT SEEN/DISCHARGE (**REQUIRED FIELD)**
Indicate the reason why the infant/child was not seen at the High Risk Infant Follow-up Program.

- Select “Infant Illness”, the infant/child is ill on the day of the appointment, but will be rescheduled for another visit.
- Select “Infant Hospitalized”, the infant/child is hospitalized on the day of the appointment, but will be rescheduled for another visit
- Select “Infant Referred to Another HRIF Program”, the HRIF Coordinator has contacted the other HRIF Program and has shared the records accordingly.
- Select “Infant/Family Moved Within California”, if the family cannot make the appointment due to moving from their primary residence and have changed city or county within California.

The HRIF Coordinator should try to link the family to an HRIF Program in their new location.

- Select “Infant/Family Moved Out of State”, if the family lives or is moving out of state or country. *(Added Jan. 2015)*

The HRIF Coordinator should try to link the family to an HRIF Program in their new location.

- Select “Infant Expired”, if the infant/child has died.

The HRIF Coordinator should note in the chart that the infant/child has expired and close the case.

- Select “Parent Illness”, if the caregiver was ill and was unable to bring the infant/child to the appointment.
- Select “Parent Refused”, the family believes the infant/child does not need the services provided by the HRIF Program.

The HRIF Coordinator should contact the family to determine the reason for refusing the appointment and work with the family to appear for appointments.

- Select “Parent Competing Priorities”, if the primary caregiver cannot bring the infant/child to the appointment for the following reasons: Work schedule, family issues, forgetfulness, etc.

The HRIF Coordinator should work with the family to schedule a HRIF appointment that will not be a conflict with other obligations and to educate the family on the importance of these follow-up services.

- Select “Parent Declines Due to Cost”, if the family cannot afford to bring the infant/child to the HRIF Program due to insurance deductibles (co-pays/share of cost). *(Added Jan. 2012)*

- Select “Insurance Authorization Problems”, if the family has been unsuccessful in securing insurance authorization for HRIF services.
The HRIF Program will work with the family to secure insurance authorization for the HRIF Services.

- Select “CCS Denied”, if the local (county) CCS Program office denied the infant/child for HRIF services.
- Select “Lack of Transportation”, if the family has mechanical issues with the car; no bus route available; no neighborhood support for securing a ride to the appointment; etc.

The HRIF Coordinator should contact the family and attempt to secure transportation for the next scheduled appointment.

- Select “Lost to Follow-up”, unable to contact the family after multiple attempts.
- Select “Unable to Contact”, if the HRIF Coordinator is not able to get in contact (phone, letter, email, etc.) with the family after multiple attempts to schedule an appointment.

The HRIF Coordinator should inform the infant/child’s Pediatrician of being unable to contact the family.

- Select “Other”, for why the infant/child was not seen when a reason has not already been described. Use the text field to type in the reason that best describes why the infant/child was not seen.
- Select “No Show/Reason Unknown”, if no specific reason is available or known for why the infant/child was not seen.

DISPOSITION

DISPOSITION (*REQUIRED FIELD)
Disposition is the status of the need for continued HRIF Follow-Up for this infant/child after missing a scheduled appointment.

Select only one option that applies at the time the infant/child was not seen.

- Select “Scheduled Appointment”, if the infant/child has been scheduled for a return follow-up core visit.
- Select “Will Schedule Appointment”, if the infant/child will be scheduled for a return follow-up core visit.
- Select “Will Be Followed by Another CCS HRIF Program” when the infant/child is transferred and receiving follow-up care from another CCS HRIF Program.

NOTE: Complete the Transfer Patient Record Process for patient(s) who will be followed by another CCS HRIF Program. Submit a Help Desk ticket at: https://www.cpqcchelp.org/

- Select “Discharged, Family Moving Out of State/Country”, when the family is moving out of state/country. No further data will be submitted to CMS/CCS. (Added Jan. 2015)
- Select “Discharged, Will be Followed Elsewhere”, when the infant/child will be receiving follow-up care from a NON CCS HRIF Program in California. No further data will be submitted to CMS/CCS.
- Select “Discharged, Closed Out of Program”, the infant/child is no longer being followed within a CCS HRIF Program. No further data will be submitted to CMS/CCS.
HOSPITAL SPECIFIC MEDICAL I.D. NUMBER
Enter the infant/child’s hospital medical record number.

INFANT’S FIRST NAME
Enter the infant/child’s first name using the hospital record.

INFANT’S LAST NAME
Enter the infant/child’s last name using the hospital record.

INFANT’S AKA (ALSO KNOWN AS)-1 LAST NAME
Enter the infant/child’s last name if it is different from the hospital record or if the infant/child has two last names.

INFANT’S AKA-2 LAST NAME
Enter the infant/child’s last name if it is different from the hospital record and previous AKA-1 Last Name.

PRIMARY CAREGIVER’S FIRST NAME
Enter the primary caregiver’s first name. (See page 31, for definition of Primary Caregiver)

PRIMARY CAREGIVER’S LAST NAME
Enter the primary caregiver’s last name. (See page 31, for definition of Primary Caregiver)

STREET ADDRESS
Enter the permanent physical street address of the primary caregiver’s residence.

CITY
Enter the permanent physical city of the primary caregiver’s residence.

STATE/COUNTRY
Select the permanent physical state/country of the primary caregiver’s residence.

ZIP CODE
Enter the permanent 5-digit zip code of the primary caregiver’s residence.

HOME PHONE NUMBER
Enter the most common 10-digit phone number where the family can be reached.

ALTERNATE STREET ADDRESS
Enter the alternate physical street address of a relative or other contact person.

CITY
Enter the alternate physical city of a relative or other contact person.

STATE AND COUNTRY
Select the alternate permanent physical state and country of a relative or other contact person.

ZIP CODE
Enter the alternate 5-digit zip code of a relative or other contact person.

ALTERNATE HOME PHONE NUMBER
Enter the alternate 10-digit phone number where the family can be reached.
APPENDICES

APPENDIX A  CCS HRIF PROGRAM MEDICAL ELIGIBILITY CRITERIA
APPENDIX B  REPORTING SYSTEM FORMS
  Referral/Registration (RR) Form
  Standard Visit (SV) Form
  Additional Visit (AV) Form
  Client Not Seen/Discharge (CNSD) Form
APPENDIX C  OSHPD FACILITY CODES
  Other Codes – Sorted by OSHPD
  Sorted by Facility
  Sorted by City
APPENDIX D  CCS HRIF Program Billing Codes
  Listed by Provider
APPENDIX E  CPQCC NICU ELIGIBILITITY CRITERIA
APPENDIX A  CCS HRIF PROGRAM MEDICAL ELIGIBILITY CRITERIA
1. pH less than 7.0 on an umbilical blood sample or a blood gas obtained within one hour of life) or an Apgar score of less than or equal to three at five minutes or an Apgar score less than 5 at 10 minutes.

2. An unstable infant manifested by hypoxia, acidemia, hypoglycemia and/or hypotension requiring pressor support.

3. Persistent apnea which required caffeine or other simulant medication for the treatment of apnea at discharge.

4. Required oxygen for more than 28 days of hospital stay and had radiographic finding consistent with chronic lung disease (CLD).

5. Infants placed on extracorporeal membrane oxygenation (ECMO).

6. Infants who received inhaled nitric oxide greater than four hours, and/or treatment during hospitalization with sildenafil or other pulmonary vasodilatory medications for pulmonary hypertension.

7. Congenital heart disease requiring surgery or minimally invasive intervention.

8. History of observed clinical or electroencephalographic (EEG) seizure activity or receiving antiepileptic medication(s) at time of discharge.

9. Evidence of intracranial pathology, including but not limited to, intracranial hemorrhage (grade II or worse), white matter injury including periventricular leukomalacia (PVL), cerebral thrombosis, cerebral infarction or stroke, congenital structural central nervous system (CNS) abnormality or other CNS problems associated with adverse neurologic outcome.

10. Clinical history and/or physical exam findings consistent with neonatal encephalopathy.

11. Other documented problems that could result in neurologic abnormality, such as: history of CNS infection, documented sepsis, bilirubin at excessive levels concerning for brain injury as determined by NICU medical staff, history of cardiovascular instability as determined by NICU medical staff due to: sepsis, congenital heart disease, patent ductus arteriosus (PDA), necrotizing enterocolitis, other documented conditions.

Had a CCS Program-eligible medical condition in a CCS Program-approved NICU, regardless of length of stay, even if they were never a CCS client, (as per California Code of Regulations, Title 22, Section 41515.1 through 41518.9, CCS Program Medical Eligibility Regulations).

AND MET ONE OF THE FOLLOWING:

- Birth weight ≤ 1500 grams or the gestational age at birth < 32 weeks.
- Birth weight > 1500 grams and the gestational age at birth ≥ 32 weeks and one of the following criteria was met during the NICU stay:
  1. pH less than 7.0 on an umbilical blood sample or a blood gas obtained within one hour of life) or an Apgar score of less than or equal to three at five minutes or an Apgar score less than 5 at 10 minutes.
  2. An unstable infant manifested by hypoxia, acidemia, hypoglycemia and/or hypotension requiring pressor support.
  3. Persistent apnea which required caffeine or other simulant medication for the treatment of apnea at discharge.
  4. Required oxygen for more than 28 days of hospital stay and had radiographic finding consistent with chronic lung disease (CLD).
  5. Infants placed on extracorporeal membrane oxygenation (ECMO).
  6. Infants who received inhaled nitric oxide greater than four hours, and/or treatment during hospitalization with sildenafil or other pulmonary vasodilatory medications for pulmonary hypertension.
  7. Congenital heart disease requiring surgery or minimally invasive intervention.
  8. History of observed clinical or electroencephalographic (EEG) seizure activity or receiving antiepileptic medication(s) at time of discharge.
  9. Evidence of intracranial pathology, including but not limited to, intracranial hemorrhage (grade II or worse), white matter injury including periventricular leukomalacia (PVL), cerebral thrombosis, cerebral infarction or stroke, congenital structural central nervous system (CNS) abnormality or other CNS problems associated with adverse neurologic outcome.

Medical eligibility for the HRIF Program is determined by the County CCS Program or Regional Office staff. The CCS Program is also required to determine residential eligibility. As the HRIF Program is a diagnostic service, there is no financial eligibility determination performed at the time of referral to CCS. However, insurance information shall be obtained by CCS. An infant or child is eligible for the HRIF Program from birth up to 3 years of age.
APPENDIX B

REPORTING SYSTEM FORMS

- Referral/Registration (RR) Form
- Standard Visit (SV) Form
- Additional Visit (AV) Form
- Client Not Seen/Discharge (CNSD) Form
## Referral/Registration (RR) Form

### High Risk Infant Follow-Up Quality of Care Initiative

**HRIF I.D. #**

<table>
<thead>
<tr>
<th>Hospital/Center Information (Optional)</th>
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<tbody>
<tr>
<td>Hospital Specific Medical I.D. #</td>
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<tr>
<td>Infant’s First Name:</td>
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<tr>
<td>Infant’s Last Name:</td>
</tr>
<tr>
<td>Infant’s AKA-1 Last Name:</td>
</tr>
<tr>
<td>Infant’s AKA-2 Last Name:</td>
</tr>
<tr>
<td>Primary Caregiver’s First Name:</td>
</tr>
<tr>
<td>Primary Caregiver’s Last Name:</td>
</tr>
<tr>
<td>Street Address:</td>
</tr>
<tr>
<td>City:</td>
</tr>
<tr>
<td>State/Country: CA</td>
</tr>
<tr>
<td>Zip Code:</td>
</tr>
<tr>
<td>Home Phone Number: ( )</td>
</tr>
<tr>
<td>Alternate Street Address:</td>
</tr>
<tr>
<td>City:</td>
</tr>
<tr>
<td>State/Country: CA</td>
</tr>
<tr>
<td>Zip Code:</td>
</tr>
<tr>
<td>Alternate Phone Number: ( )</td>
</tr>
</tbody>
</table>

### Program Registration Information

- Infant enrolled in a CCS clinic other than the HRIF Program:  
  - **No**  
  - **Yes**  
  - **Unknown**

- CCS #: [ ]

- **CPQCC Reference #**

- **Date of Birth:** [ ] [ ] [ ] [ ] [ ] [ ] (MM-DD-YYYY)

- **Birth Hospital:**

- **Birth Weight:** [ ] [ ] [ ] Grams  

- **Singleton/Multiple:**  
  - **Singleton**  
  - **Multiple:** (ex: 2A)

- **Infant’s Gender:**  
  - **Male**  
  - **Female**  
  - **Unknown**  

- **Infant’s Race:**  
  - **Black or African American**  
  - **Asian**  
  - **Native Hawaiian or Other Pacific Islander**  
  - **American (North, South or Central) Indian or Alaskan Native**  
  - **White**  
  - **Other**  
  - **Unknown**  
  - **Declined**

- **Infant’s Ethnicity:**  
  - **Hispanic / Latino**  
  - **Non-Hispanic**  
  - **Unknown**  
  - **Declined**

- **Hospital Discharging to Home:**

- **Date of Discharge to Home:** [ ] [ ] [ ] [ ] [ ] [ ] (MM-DD-YYYY)

- **Referring CCS NICU:**

- **Date of Discharge to Home:** [ ] [ ] [ ] [ ] [ ] [ ] (MM-DD-YYYY)

- **Infant Still in Hospital**

---

*Required Field*
**REFERRAL/REGISTRATION (RR) FORM**
HIGH RISK INFANT FOLLOW-UP QUALITY OF CARE INITIATIVE

*Required Field

**PROGRAM REGISTRATION INFORMATION - continue**

<table>
<thead>
<tr>
<th>Birth Mother’s Date of Birth</th>
<th>Birth Mother’s Ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td>[MM-DD-YYYY]</td>
<td>Hispanic / Latino</td>
</tr>
</tbody>
</table>

Birth Mother’s Race

- Single:
- Multiracial:
- Declined

**Insurance** (Check all that apply)

- CCS
- Point of Service/EPO
- Commercial HMO
- Commercial PPO
- No Insurance/Self Pay
- Other
- Medi-Cal
- Unknown

**Primary Caregiver**

- Mother
- Father
- Both Parents
- Other Relatives/Not Parents
- Foster/Family/CPS
- Pediatric Subacute Facility
- Other

**Zip Code of Pediatric Subacute Facility, if Checked:**

**Zip Code of Primary Caregiver Residence:**

<table>
<thead>
<tr>
<th>Education of Primary Caregiver</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;9th Grade</td>
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<tr>
<td>Some College</td>
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<tr>
<td>High School Degree/GED</td>
</tr>
<tr>
<td>Some College</td>
</tr>
<tr>
<td>College Degree</td>
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<td>Graduate School or Degree</td>
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<tr>
<td>Other</td>
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<td>Declined</td>
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<table>
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<tr>
<th>Caregiver Employment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full-Time</td>
</tr>
<tr>
<td>Part-Time</td>
</tr>
<tr>
<td>Temporary</td>
</tr>
<tr>
<td>Multiple Jobs</td>
</tr>
<tr>
<td>Work From Home</td>
</tr>
<tr>
<td>Not Currently Employed</td>
</tr>
<tr>
<td>Arabic</td>
</tr>
<tr>
<td>Cantonese</td>
</tr>
<tr>
<td>Korean</td>
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<tr>
<td>Sign Language</td>
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<tr>
<td>Other</td>
</tr>
<tr>
<td>Unknown</td>
</tr>
<tr>
<td>Declined</td>
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</tbody>
</table>

**Primary Language Spoken at Home**

(Check only ONE)

- English
- Armenian
- Farsi/Persian
- Mandarin
- Tagalog
- Unknown
- Spanish
- Cambodian/Khmer
- Hmong/Miao
- Russian
- Vietnamese
- Declined

**Secondary Language Spoken at Home**

(Optional – Check only ONE)

- N/A
- Arabic
- Cantonese
- Korean
- Sign Language
- Other
- English
- Armenian
- Farsi/Persian
- Mandarin
- Tagalog
- Unknown
- Spanish
- Cambodian/Khmer
- Hmong/Miao
- Russian
- Vietnamese
- Declined

**MEDICAL ELIGIBILITY PROFILE** (Check all that apply)

- Birth Weight ≤ 1500 Grams
- Gestational age at Birth < 32 Weeks
- Persistent Apnea
- Seizure Activity / Anti-Seizure Meds
- Oxygen > 28 Days and CLD
- Neonatal Encephalopathy
- INO > 4 Hours / Meds for PPHN
- ECMO
- CHD Requiring Surgery / Intervention:
  - Was the Norwood or a single ventricle palliation procedure performed?
  - No
  - Yes
- Cardiorespiratory Depression:
  - Apgar Score ≤ 3 at 5 Minutes
  - Apgar Score < 5 at 10 Minutes
  - pH < 7.0 on an Umbilical Blood Sample
  - pH < 7.0 on Blood Gas at < 1 Hour of Age
- Other Problems that Could Result in Neurologic Abnormality:
  - CNS Infection
  - Documented Sepsis
  - Bilirubin
  - Cardiovascular Instability
  - HIE
  - Other

Persistently Unstable Infant:

- Hypoxia
- Acidemia
- Hypoglycemia
- Hypotension Requiring Pressors

Intracranial Pathology with Potential for Adverse Neurologic Outcome:

- Intracranial Hemorrhage
- PVL
- Cerebral Thrombosis
- Cerebral Infarction
- Developmental CNS Abnormality
- Other
STANDARD VISIT (SV) FORM
HIGH RISK INFANT FOLLOW-UP QUALITY OF CARE INITIATIVE

NAME: ______________________ (Last, First)  HRIF I.D. # ______________________

*Required Field

*Date of Visit: __________-________-________ (MM-DD-YYYY)

VISIT ASSESSMENT

*Core Visit (1)☐ #1 (4-8 months) ☐ #2 (12-16 months) ☐ #3 (18-36 months)

Infant enrolled in a CCS clinic other than the HRIF Program: ☐ No ☐ Yes ☐ Unknown

Zip Code of Primary Caregiver: __________

Chronological Age: __________ Months __________ Days

Adjusted Age: __________ Months __________ Days

Interpreter Used
☐ No ☐ Yes:
☐ Spanish ☐ Arabic ☐ Armenian
☐ Cambodian/Khmer ☐ Cantonese ☐ Farsi/Persian
☐ Hmong/Miao ☐ Korean ☐ Mandarin
☐ Russian ☐ Sign Language ☐ Tagalog
☐ Vietnamese ☐ Other ☐ Vietnamese
☐ Declined ☐ Vietnamese Unknown

Insurance (Check all that apply)
☐ CCS ☐ Commercial HMO ☐ Commercial PPO
☐ Point of Service/EPO ☐ No Insurance/Self Pay ☐ Other
☐ Commercial HMO ☐ Commercial PPO ☐ Other
☐ Medi-Cal ☐ Unknown

PATIENT ASSESSMENT

Weight:
☐ ________ kg ☐ ________ lbs ☐ ________ oz

Length:
☐ ________ cm ☐ ________ in

Head Circumference:
☐ ________ cm ☐ ________ in

Reason NOT Collected:
☐ Not Routinely Done ☐ Unable to Obtain ☐ Other

GENERAL ASSESSMENT

Is the Child Currently Receiving Breastmilk?
☐ Exclusively ☐ Some ☐ None

Living Arrangement of the Child
☐ Both Parents ☐ One Parent ☐ One Parent/Other Relatives
☐ Other Relatives/Not Parents ☐ Non Relative ☐ Foster/Adoptive Family
☐ Foster Family/CPS ☐ Pediatric Subacute Facility ☐ Other
☐ Unknown

Education of Primary Caregiver
☐ <9th Grade ☐ Some College ☐ Other
☐ Some High School ☐ College Degree ☐ Unknown
☐ High School Degree/GED ☐ Graduate School or Degree ☐ Declined
☐ Full-Time ☐ Multiple Jobs ☐ Unknown
☐ Part-Time ☐ Work From Home ☐ Declined
☐ Temporary ☐ Not Currently Employed ☐ Declined

Caregiver Employment
☐ None ☐ Yes ☐ Unknown

Routine Child Care
☐ None ☐ Yes ☐ Unknown
If Yes, Check all that apply:
☐ Child Care Outside of Home ☐ Home Babysitter/Nanny ☐ Not Used Routinely
☐ Specialized Medical Setting ☐ Other

Caregiver Concerns of the Child
☐ None ☐ Yes ☐ Unknown
If Yes, Check all that apply:
☐ Behavioral ☐ Calming/Crying ☐ Feeding & Growth
☐ Frequent Illness ☐ Gastrointestinal/Stooling/Spitting-up ☐ Hearing
☐ Medications ☐ Motor Skills, Movement ☐ Pain
☐ Sensory Processing ☐ Speech & Language ☐ Stress
☐ Sleeping/Napping ☐ Vision ☐ Other

[1] Core Visits: The HRIF Program has three core visits that take place during the following recommended time periods: Visit #1 (4-8 months), Visit #2 (12-16 months) and Visit #3 (18-36 months). NOTE: Core Visit #1 is the initial first visit to the follow-up program, even if the patient is older than 8 months corrected age, HRIF-QCI: Manual of Definitions.
## INTERVAL MEDICAL ASSESSMENT

### Does the Child have a Primary Care Provider?
- [ ] No
- [ ] Yes
- [ ] Unknown

### Does the Primary Care Provider Act as the Child’s Medical Home?
- [ ] No
- [ ] Yes
- [ ] Unknown

#### Hospitalizations Since Last Visit

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<td>Nutrition/Inadequate Growth</td>
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</tr>
</tbody>
</table>

#### Surgeries Since Last Visit

- [ ] No
- [ ] Yes: [ ] Number of Surgeries
- [ ] Unknown

If Yes, Check all that apply:
- Cardiac Surgery
- Inguinal Hernia Repair
- Tracheostomy
- Other Gastrointestinal Surgical Procedures
- Other Surgical Procedures

#### Medications Since Last Visit

- [ ] No
- [ ] Yes
- [ ] Unknown

If Yes, Check all that apply:
- Actigall (or a similar medication)
- Antibiotics/Antifungal
- Cardiac Medications
- Diuretics
- Inhalated Steroids (daily)
- Nutrition Supplements (make selection): [ ] Enteral Nutrition
- Oral Steroids
- Oxygen (if discontinued also enter chronologic post-natal age: ________ months ________ days)
- Viagra (Pulmonary Hypertension)
- Unknown
# STANDARD VISIT (SV) FORM
HIGH RISK INFANT FOLLOW-UP QUALITY OF CARE INITIATIVE

**NAME:** ____________________________ (Last, First)  **HRIF I.D. #**

## INTERVAL MEDICAL ASSESSMENT - continue

<table>
<thead>
<tr>
<th>Equipment Since Last Visit</th>
<th>No</th>
<th>Yes</th>
<th>Unknown</th>
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</thead>
<tbody>
<tr>
<td>Apnea/CR Monitor</td>
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<td></td>
</tr>
<tr>
<td>Helmet</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Tracheostomy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Braces/Castings/Orthotics</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Nebulizer</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Ventilator/CPAP/BiPAP</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Unknown</td>
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</tr>
<tr>
<td>Enteral Feeding Equipment</td>
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<td></td>
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</tr>
<tr>
<td>Ostomy Supplies</td>
<td></td>
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</tr>
<tr>
<td>Wheelchair</td>
<td></td>
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</tbody>
</table>

## MEDICAL SERVICES REVIEW

**Is the Child Receiving or Being Referred for Medical Services?**

- [ ] No (Skip to Neurosensory Assessment)
- [ ] Yes (Complete below)
- [ ] Unknown (Skip to Neurosensory Assessment)

**Audiology**

- [ ] Does Not Need
- [ ] Receiving
- [ ] Complete
- [ ] Referred at Time of Visit

- **Referred, but Not Receiving** [check reason]
  - [ ] Missed Appointment
  - [ ] Re-Referred
  - [ ] Parent Declined/Refused Service
  - [ ] Other/Unknown Reason

**Cardiology**

- [ ] Does Not Need
- [ ] Receiving
- [ ] Complete
- [ ] Referred at Time of Visit

- **Referred, but Not Receiving** [check reason]
  - [ ] Missed Appointment
  - [ ] Re-Referred
  - [ ] Parent Declined/Refused Service
  - [ ] Other/Unknown Reason

**Craniofacial**

- [ ] Does Not Need
- [ ] Receiving
- [ ] Complete
- [ ] Referred at Time of Visit

- **Referred, but Not Receiving** [check reason]
  - [ ] Missed Appointment
  - [ ] Re-Referred
  - [ ] Parent Declined/Refused Service
  - [ ] Other/Unknown Reason

**Endocrinology**

- [ ] Does Not Need
- [ ] Receiving
- [ ] Complete
- [ ] Referred at Time of Visit

- **Referred, but Not Receiving** [check reason]
  - [ ] Missed Appointment
  - [ ] Re-Referred
  - [ ] Parent Declined/Refused Service
  - [ ] Other/Unknown Reason

**Gastroenterology**

- [ ] Does Not Need
- [ ] Receiving
- [ ] Complete
- [ ] Referred at Time of Visit

- **Referred, but Not Receiving** [check reason]
  - [ ] Missed Appointment
  - [ ] Re-Referred
  - [ ] Parent Declined/Refused Service
  - [ ] Other/Unknown Reason

**Hematology/Oncology**

- [ ] Does Not Need
- [ ] Receiving
- [ ] Complete
- [ ] Referred at Time of Visit

- **Referred, but Not Receiving** [check reason]
  - [ ] Missed Appointment
  - [ ] Re-Referred
  - [ ] Parent Declined/Refused Service
  - [ ] Other/Unknown Reason

**Metabolic/Genetics**

- [ ] Does Not Need
- [ ] Receiving
- [ ] Complete
- [ ] Referred at Time of Visit

- **Referred, but Not Receiving** [check reason]
  - [ ] Missed Appointment
  - [ ] Re-Referred
  - [ ] Parent Declined/Refused Service
  - [ ] Other/Unknown Reason

**Nephrology**

- [ ] Does Not Need
- [ ] Receiving
- [ ] Complete
- [ ] Referred at Time of Visit

- **Referred, but Not Receiving** [check reason]
  - [ ] Missed Appointment
  - [ ] Re-Referred
  - [ ] Parent Declined/Refused Service
  - [ ] Other/Unknown Reason

**Neurology**

- [ ] Does Not Need
- [ ] Receiving
- [ ] Complete
- [ ] Referred at Time of Visit

- **Referred, but Not Receiving** [check reason]
  - [ ] Missed Appointment
  - [ ] Re-Referred
  - [ ] Parent Declined/Refused Service
  - [ ] Other/Unknown Reason
**STANDARD VISIT (SV) FORM**
HIGH RISK INFANT FOLLOW-UP QUALITY OF CARE INITIATIVE

NAME: ____________________  (Last, First)  HRIF I.D. #

### MEDICAL SERVICES REVIEW - continue

<table>
<thead>
<tr>
<th>Service</th>
<th>Does Not Need</th>
<th>Receiving</th>
<th>Complete</th>
<th>Referred at Time of Visit</th>
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<tbody>
<tr>
<td>Neurosurgery</td>
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<tr>
<td>Ophthalmology</td>
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<tr>
<td>Orthopedic</td>
<td></td>
<td></td>
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<tr>
<td>Otolaryngology (ENT)</td>
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<tr>
<td>Pulmonology</td>
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<tr>
<td>Surgery</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Urology</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**Referral, but Not Receiving** (check reason):
- Missed Appointment
- Re-Referred
- Parent Declined/Refused Service
- Other/Unknown Reason
- Visit Pending
- Insurance/HMO Denied
- Service Not Available

### NEUROSENSORY ASSESSMENT

**Vision Assessment History**

Does the Child Have History of Retinopathy of Prematurity (ROP)?  
- No  
- Yes

Eye Surgery and/or Treatment with Anti-VEGF [i.e. Avastin]?  
- No  
- Yes

Location of ROP:  
- Unilateral  
- Bilateral  
- Unknown

Does the Child Have Visual Impairment?  
- No (Skip to Hearing Assessment History)  
- Yes

**A. Impairment Due To:** (check all that apply)

<table>
<thead>
<tr>
<th>Impairment</th>
<th>Eye Surgery?</th>
<th>No</th>
<th>Yes</th>
<th>Scheduled</th>
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</thead>
<tbody>
<tr>
<td>Strabismus:</td>
<td>No</td>
<td></td>
<td>Yes</td>
<td>Scheduled</td>
</tr>
<tr>
<td>Cataract:</td>
<td>No</td>
<td></td>
<td>Yes</td>
<td>Scheduled</td>
</tr>
<tr>
<td>Retinoblastoma:</td>
<td>No</td>
<td></td>
<td>Yes</td>
<td>Scheduled</td>
</tr>
</tbody>
</table>

- Cortical Visual Impairment
- Nystagmus
- Other

**B. Location of Impairment:**  
- Unilateral  
- Bilateral  
- Unknown

**C. Corrective Lens(es) Recommended:**  
- No  
- Yes  
- Unknown

**D. Corrective Lens(es) Used:**  
- No  
- Yes  
- Unknown

**E. Is There Functional Vision?**  
- Yes  
- No (complete below)

Location of “Blindness”  
- Unilateral  
- Bilateral  
- Unknown
STANDARD VISIT (SV) FORM
HIGH RISK INFANT FOLLOW-UP QUALITY OF CARE INITIATIVE

NAME: ___________________(Last, First)  HRIF I.D. #________________

*Required Field

NEUROSENSORY ASSESSMENT - continue

☐ Unknown Visual Impairment

Why is Visual Impairment Unknown?
☐ Exam Results Unknown  ☐ No Ophthalmology Exam Performed
☐ Needs Referral for Exam  ☐ Referred for Exam, Not Received
☐ Referred, but Service Not Available  ☐ Referred, but Parent Declines/Refuses Services
☐ Referred, but Insurance/HMO Denied Services  ☐ Referred, but Missed Appointment
☐ Referred for Functional Vision Assessment  ☐ Functional Vision Assessment in Progress

Hearing Assessment History

Does the Child Have a Hearing Loss (HL)?
☐ No (Skip to Neurologic Assessment)

☐ Yes  A. Is There Loss in One or Both Ears?  ☐ One  ☐ Both  ☐ Assessment in Progress  ☐ Unknown

B. Does the Child Use an Assistive Listening Device (ALD):
☐ No  ☐ Yes, ALD Recommended, but Not Received  ☐ Unknown
☐ Yes, ALD Recommended and Received

C. Type of ALD(s) Used (check all that apply)
☐ BAHA  ☐ Cochlear Implant  ☐ FM System
☐ Hearing Aid  ☐ Other  ☐ Unknown

☐ Unknown Hearing Loss

Why is Hearing Loss Unknown?
☐ Exam Results Unknown  ☐ No Audiology Exam Performed
☐ Needs Referral for Exam  ☐ Referred for Exam, Not Received
☐ Referred, but Service Not Available  ☐ Referred, but Parent Declines/Refuses Services
☐ Referred, but Insurance/HMO Denied Services  ☐ Referred, but Missed Appointment

☐ Hearing Assessment in Progress (Skip to Neurologic Assessment)

NEUROLOGIC ASSESSMENT

*Was a Neurologic Exam Performed During this Core Visit?
☐ Yes
☐ No  Reason Why

Date Performed: ______-____-____ (MM-DD-YYYY)

Exam NOT Performed:
☐ Acute Illness  ☐ Behavior Problems  ☐ Examiner Not Available
☐ Known SEVERE Developmental Disability  ☐ Primary Caregiver Refused  ☐ Primary Language
☐ Significant Sensory Impairment/Loss  ☐ Other Medical Condition  ☐ Other

Summary of Neurologic Assessment
☐ Normal (skip to Developmental Assessment)

☐ Abnormal
☐ Suspect

A. Oral Motor Function – Age Appropriate Responses for the Following:

Feeding:
☐ Normal  ☐ Abnormal  ☐ Suspect  ☐ Unable to Determine

Swallowing:
☐ Normal  ☐ Abnormal  ☐ Suspect  ☐ Unable to Determine

Management of Secretions:
☐ Normal  ☐ Abnormal  ☐ Suspect  ☐ Unable to Determine

B. Muscle Tone

Neck
☐ Normal  ☐ Increased  ☐ Decreased  ☐ Suspect  ☐ Unable to Determine

Trunk
☐ Normal  ☐ Increased  ☐ Decreased  ☐ Suspect  ☐ Unable to Determine

Right Upper Limb:
☐ Normal  ☐ Increased  ☐ Decreased  ☐ Suspect  ☐ Unable to Determine

Left Upper Limb:
☐ Normal  ☐ Increased  ☐ Decreased  ☐ Suspect  ☐ Unable to Determine

Right Lower Limb:
☐ Normal  ☐ Increased  ☐ Decreased  ☐ Suspect  ☐ Unable to Determine

Left Lower Limb:
☐ Normal  ☐ Increased  ☐ Decreased  ☐ Suspect  ☐ Unable to Determine

HRIF-QC: Standard Visit (SV) Form  v01.18  5 of 11
**STANDARD VISIT (SV) FORM**  
HIGH RISK INFANT FOLLOW-UP QUALITY OF CARE INITIATIVE

**NAME:** ___________________________ (Last, First)  
HRIF I.D. # ____________

*Required Field

### NEUROLOGIC ASSESSMENT - continue

#### C. Is There Scissoring of the Legs on Vertical Suspension?
- [ ] No  
- [ ] Yes

#### D. Deep Tendon Reflexes:

<table>
<thead>
<tr>
<th></th>
<th>Normal</th>
<th>Increased</th>
<th>Decreased</th>
<th>Suspect</th>
<th>Unable to Determine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right Upper Limb</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Left Upper Limb</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Right Lower Limb</td>
<td></td>
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</tr>
<tr>
<td>Left Lower Limb</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

#### E. Are Persistent Primitive Reflexes Present?
- [ ] No  
- [ ] Yes

#### F. Are Abnormal Involuntary Movements Present?
- [ ] No  
- [ ] Yes (check all that apply)
  - Ataxia  
  - Choreaathetoid  
  - Tremors

#### G. Quality of Movement and Posture:
- [ ] Normal  
- [ ] Abnormal  
- [ ] Suspect  
- [ ] Unable to Determine

### Functional Assessment

#### A. Bimanual Function
- [ ] Normal  
- [ ] Abnormal  
- [ ] Suspect  
- [ ] Unable to Determine

*Only Complete if the Child is ≥ 15 Months Adjusted Age*

#### B. Right Pincer Grasp
- [ ] Normal  
- [ ] Abnormal  
- [ ] Suspect  
- [ ] Unable to Determine

#### C. Left Pincer Grasp
- [ ] Normal  
- [ ] Abnormal  
- [ ] Suspect  
- [ ] Unable to Determine

---

**CEREBRAL PALSY (CP)**

**Does the Child Have Cerebral Palsy (CP)?**
- [ ] No (skip to Developmental Assessment)  
- [ ] Yes  
- [ ] Suspect

**Gross Motor Function Classification System (GMFCS) Adjusted Age:** (check only one)

<table>
<thead>
<tr>
<th>Child 18 - 24 months of age adjusted for prematurity</th>
<th>Child ≥ 24 - 36 months of age adjusted for prematurity</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Level I</td>
<td>[ ] Level I</td>
</tr>
<tr>
<td>[ ] Level II</td>
<td>[ ] Level II</td>
</tr>
<tr>
<td>[ ] Level III</td>
<td>[ ] Level III</td>
</tr>
<tr>
<td>[ ] Unable to Determine</td>
<td>[ ] Unable to Determine</td>
</tr>
</tbody>
</table>

- [ ] Unable to Determine

---

**DEVELOPMENTAL CORE VISIT ASSESSMENT**

*Was a Developmental Assessment Screener or Test Performed During this Core Visit?*

- [ ] Yes  
  **Date Performed:** [ ]-[ ]-[ ]-(MM-DD-YYYY)

- [ ] No  
  **Reason Why Assessment NOT Performed:**
  - Acute Illness  
  - Known SEVERE Developmental Disability  
  - Significant Sensory Impairment/Loss  
  - Behavior Problems  
  - Primary Caregiver Refused  
  - Other Medical Condition  
  - Other  
  - Primary Language  
  - Other

---

**DEVELOPMENTAL SCREENERS**

**Bayley Infant Neurodevelopmental Screener (BINS) – check appropriate range**

<table>
<thead>
<tr>
<th>Overall Classification</th>
<th>Low Risk</th>
<th>Medium Risk</th>
<th>High Risk</th>
<th>Unable to Assess</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Battelle Developmental Inventory Screening Test, 2nd Edition (BDIST) - check appropriate range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adaptive Domain: Pass Refer Unable to Assess Did Not Assess</td>
</tr>
<tr>
<td>Personal-Social Domain: Pass Refer Unable to Assess Did Not Assess</td>
</tr>
<tr>
<td>Communication: Pass Refer Unable to Assess Did Not Assess</td>
</tr>
<tr>
<td>Motor Domain: Pass Refer Unable to Assess Did Not Assess</td>
</tr>
<tr>
<td>Cognitive Domain: Pass Refer Unable to Assess Did Not Assess</td>
</tr>
</tbody>
</table>
**STANDARD VISIT (SV) FORM**
HIGH RISK INFANT FOLLOW-UP QUALITY OF CARE INITIATIVE

**NAME: ___________________________** (Last, First) **HRIF I.D. #**

### DEVELOPMENTAL SCREENERS - continue

**Bayley Scales of Infant and Toddler Development Screening Test, 3rd Edition (Bayley-III Screener) - check appropriate range**

<table>
<thead>
<tr>
<th>Category</th>
<th>Competent</th>
<th>Emerging</th>
<th>At Risk</th>
<th>Unable to Assess</th>
<th>Did Not Assess</th>
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<tbody>
<tr>
<td>Cognitive</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Receptive Language</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expressive Language</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Fine Motor</td>
<td></td>
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<tr>
<td>Gross Motor</td>
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</tbody>
</table>

**The Capute Scales/The Cognitive Adaptive Test/Clinical Linguistic and Auditory Milestone Scale Screener (CAT-CLAMS) - enter score**

<table>
<thead>
<tr>
<th>Category</th>
<th>Score:</th>
<th>Unable to Assess</th>
<th>Did Not Assess</th>
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</thead>
<tbody>
<tr>
<td>Language Auditory (CLAMS)</td>
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</tr>
<tr>
<td>Cognitive Adaptive (CAT)</td>
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<tr>
<td>Full Scale Capute</td>
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</table>

**Other/Not Listed Screener: - check appropriate range**

<table>
<thead>
<tr>
<th>Category</th>
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<th>Mild/Moderate</th>
<th>Significant</th>
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<tbody>
<tr>
<td>Cognitive</td>
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<td></td>
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<td></td>
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<td>Receptive Language</td>
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<td>Expressive Language</td>
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<tr>
<td>Language</td>
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</tr>
<tr>
<td>Motor Composite</td>
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<tr>
<td>Personal-Social</td>
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<tr>
<td>Adaptive</td>
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<tr>
<td>Other</td>
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</table>

### DEVELOPMENTAL TESTS

**Bayley Scales of Infant and Toddler Development, 3rd Edition (Bayley-III) "Hardcopy" - enter score**

<table>
<thead>
<tr>
<th>Category</th>
<th>Score:</th>
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<th>Did Not Assess</th>
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</thead>
<tbody>
<tr>
<td>Cognitive Composite</td>
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<tr>
<td>Receptive Language Scaled Score</td>
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<tr>
<td>Expressive Language Scaled Score</td>
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<tr>
<td>Language Composite</td>
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<td>Fine Motor Scaled Score</td>
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<td>Gross Motor Scaled Score</td>
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<tr>
<td>Motor Composite</td>
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<td>Social-Emotional Composite</td>
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<td>Adaptive- Behavior Composite</td>
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</table>

**Bayley Scales of Infant and Toddler Development, 3rd Edition (Bayley-III) "Computer" - enter score**

<table>
<thead>
<tr>
<th>Category</th>
<th>Score:</th>
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<th>Did Not Assess</th>
</tr>
</thead>
<tbody>
<tr>
<td>Receptive Language Scaled Score</td>
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<tr>
<td>Expressive Language Scaled Score</td>
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<tr>
<td>Fine Motor Scaled Score</td>
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<tr>
<td>Gross Motor Scaled Score</td>
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<tr>
<td>Cognitive Composite</td>
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<tr>
<td>Motor Composite</td>
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### DEVELOPMENTAL TESTS – continue

**Battelle Developmental Inventory, 2nd Edition (BDI-2) - enter score**

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<tr>
<td>Personal-Social Domain</td>
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<td>Expressive Language Scale</td>
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<tr>
<td>Communication Domain</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gross Motor Scale</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fine Motor Scale</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Motor Domain</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Cognitive Domain</td>
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**Revised Gesell and Amatruda Developmental and Neurologic Examination (Gesell) - enter score**

<table>
<thead>
<tr>
<th>Test</th>
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<th>Did Not Assess</th>
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</thead>
<tbody>
<tr>
<td>Language Development</td>
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<tr>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Gross Motor</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Personal-Social</td>
<td></td>
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<tr>
<td>Adaptive</td>
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</table>

**Mullen Scales of Early Learning - AGS Edition (Mullen) - enter score**

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<tbody>
<tr>
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<td>Early Learning Composite</td>
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**Other/Not Listed Test: - check appropriate range**

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<tr>
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<th>Significant</th>
<th>Unable to Assess</th>
<th>Did Not Assess</th>
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<tbody>
<tr>
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<td>Significant</td>
<td>Unable to Assess</td>
<td>Did Not Assess</td>
</tr>
<tr>
<td>Expressive Language:</td>
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<td>Mild/Moderate</td>
<td>Significant</td>
<td>Unable to Assess</td>
<td>Did Not Assess</td>
</tr>
<tr>
<td>Language Composite:</td>
<td>Normal</td>
<td>Mild/Moderate</td>
<td>Significant</td>
<td>Unable to Assess</td>
<td>Did Not Assess</td>
</tr>
<tr>
<td>Gross Motor:</td>
<td>Normal</td>
<td>Mild/Moderate</td>
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<td>Did Not Assess</td>
</tr>
<tr>
<td>Fine Motor:</td>
<td>Normal</td>
<td>Mild/Moderate</td>
<td>Significant</td>
<td>Unable to Assess</td>
<td>Did Not Assess</td>
</tr>
<tr>
<td>Motor Composite:</td>
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<td>Mild/Moderate</td>
<td>Significant</td>
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<td>Did Not Assess</td>
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<tr>
<td>Personal-Social:</td>
<td>Normal</td>
<td>Mild/Moderate</td>
<td>Significant</td>
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<td>Did Not Assess</td>
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<td>Did Not Assess</td>
</tr>
<tr>
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<td>Mild/Moderate</td>
<td>Significant</td>
<td>Unable to Assess</td>
<td>Did Not Assess</td>
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**AUTISM SPECTRUM SCREEN (Optional)**

<table>
<thead>
<tr>
<th>Was an Autism Spectrum Screen Performed During this Visit?</th>
<th>No</th>
<th>Yes</th>
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<tbody>
<tr>
<td>Screening Tool Used:</td>
<td>M-CHAT</td>
<td>CSBS-DP</td>
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<td>Screening Results:</td>
<td>Pass</td>
<td>Did Not Pass</td>
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<tr>
<td>Was the Infant Referred for Further Autism Spectrum Assessment?</td>
<td>No</td>
<td>Yes</td>
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</tbody>
</table>
# STANDARD VISIT (SV) FORM
HIGH RISK INFANT FOLLOW-UP QUALITY OF CARE INITIATIVE

**NAME:** ___________________________ (Last, First)  **HRIF I.D. #**

## EARLY START (ES) PROGRAM

Is the Child Currently Receiving Early Intervention Services Through Early Start (Regional Center and/or LEA)? (check only one)
- [ ] Yes
- [ ] No, Not Required
- [ ] No, Referred at Visit
- [ ] No, Parent Refused Service
- [ ] No, Determined Ineligible by ES
- [ ] Unknown

## MEDICAL THERAPY PROGRAM (MTP)

Is the Child Currently Receiving Services Through CCS Medical Therapy Program (MTP)? (check only one)
- [ ] Yes
- [ ] No, Not Required
- [ ] No, Referred at Visit
- [ ] No, Parent Refused Service
- [ ] No, Determined Ineligible by ES
- [ ] Unknown

## SPECIAL SERVICES REVIEW

Is the Child Receiving or Being Referred for Special Services?
- [ ] No (Skip to Resources and Social Concerns)
- [ ] Yes (Complete below)
- [ ] Unknown

### Behavior Intervention

- [ ] Does Not Need
- [ ] Receiving
- [ ] Complete
- [ ] Referred at Time of Visit

**Service Provider:**
- [ ] Early Intervention Specialist
- [ ] Occupational Therapist
- [ ] Registered Dietitian
- [ ] Other

**Referred, but Not Receiving (check reason):**
- [ ] Missed Appointment
- [ ] Re-Referred
- [ ] Service Not Available
- [ ] Parent Declined/Refused Service

**Other/Unknown Reason:**
- [ ] Waiting List / Visit Pending
- [ ] Insurance/HMO Denied
- [ ] Service Cancelled

### Feeding Therapy

- [ ] Does Not Need
- [ ] Receiving
- [ ] Complete
- [ ] Referred at Time of Visit

**Service Provider:**
- [ ] Early Intervention Specialist
- [ ] Occupational Therapist
- [ ] Registered Dietitian
- [ ] Other

**Referred, but Not Receiving (check reason):**
- [ ] Missed Appointment
- [ ] Re-Referred
- [ ] Service Not Available
- [ ] Parent Declined/Refused Service

**Other/Unknown Reason:**
- [ ] Waiting List / Visit Pending
- [ ] Insurance/HMO Denied
- [ ] Service Cancelled

### Infant Development Services

- [ ] Does Not Need
- [ ] Receiving
- [ ] Complete
- [ ] Referred at Time of Visit

**Service Provider:**
- [ ] Early Intervention Specialist
- [ ] Physical Therapist
- [ ] Registered Nurse
- [ ] Unknown

**Referred, but Not Receiving (check reason):**
- [ ] Missed Appointment
- [ ] Re-Referred
- [ ] Service Not Available
- [ ] Parent Declined/Refused Service

**Other/Unknown Reason:**
- [ ] Waiting List / Visit Pending
- [ ] Insurance/HMO Denied
- [ ] Service Cancelled

### Hearing Services

- [ ] Does Not Need
- [ ] Receiving
- [ ] Complete
- [ ] Referred at Time of Visit

**Service Provider:**
- [ ] Audiologist
- [ ] Speech/Language Pathologist
- [ ] Unknown

**Referred, but Not Receiving (check reason):**
- [ ] Missed Appointment
- [ ] Re-Referred
- [ ] Service Not Available
- [ ] Parent Declined/Refused Service

**Other/Unknown Reason:**
- [ ] Waiting List / Visit Pending
- [ ] Insurance/HMO Denied
- [ ] Service Cancelled

### Nutritional Therapy

- [ ] Does Not Need
- [ ] Receiving
- [ ] Complete
- [ ] Referred at Time of Visit

**Service Provider:**
- [ ] Certified Lactation Consultant
- [ ] Registered Dietitian
- [ ] Unknown

**Referred, but Not Receiving (check reason):**
- [ ] Missed Appointment
- [ ] Re-Referred
- [ ] Service Not Available
- [ ] Parent Declined/Refused Service

**Other/Unknown Reason:**
- [ ] Waiting List / Visit Pending
- [ ] Insurance/HMO Denied
- [ ] Service Cancelled

**Physician**
- [ ] Unknown
# STANDARD VISIT (SV) FORM

## HIGH RISK INFANT FOLLOW-UP QUALITY OF CARE INITIATIVE

| Name: _____________________________ | (Last, First) | HRIF I.D. # __________ |

## SPECIAL SERVICES REVIEW - continue

### Occupational Therapy (OT)
- **Does Not Need**
- **Referred, but Not Receiving** (check reason)
  - Missed Appointment
  - Re-Referred
  - Service Not Available
  - Parent Declined/Refused Service
  - Waiting List / Visit Pending
  - Insurance/HMO Denied
  - Service Cancelled
  - Other/Unknown Reason

<table>
<thead>
<tr>
<th>Service Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Occupational Therapist</td>
</tr>
<tr>
<td>☐ Other</td>
</tr>
<tr>
<td>☐ Unknown</td>
</tr>
</tbody>
</table>

### Physical Therapy (PT)
- **Does Not Need**
- **Referred, but Not Receiving** (check reason)
  - Missed Appointment
  - Re-Referred
  - Service Not Available
  - Parent Declined/Refused Service
  - Waiting List / Visit Pending
  - Insurance/HMO Denied
  - Service Cancelled
  - Other/Unknown Reason

<table>
<thead>
<tr>
<th>Service Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Physical Therapist</td>
</tr>
<tr>
<td>☐ Other</td>
</tr>
<tr>
<td>☐ Unknown</td>
</tr>
</tbody>
</table>

### Speech/Language Communication
- **Does Not Need**
- **Referred, but Not Receiving** (check reason)
  - Missed Appointment
  - Re-Referred
  - Service Not Available
  - Parent Declined/Refused Service
  - Waiting List / Visit Pending
  - Insurance/HMO Denied
  - Service Cancelled
  - Other/Unknown Reason

<table>
<thead>
<tr>
<th>Service Provider:</th>
</tr>
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<tbody>
<tr>
<td>☐ American Sign Language</td>
</tr>
<tr>
<td>☐ Early Intervention Specialist</td>
</tr>
<tr>
<td>☐ Speech/Language Pathologist</td>
</tr>
<tr>
<td>☐ Teacher of the Deaf</td>
</tr>
<tr>
<td>☐ Unknown</td>
</tr>
</tbody>
</table>

### Social Work Intervention
- **Does Not Need**
- **Referred, but Not Receiving** (check reason)
  - Missed Appointment
  - Re-Referred
  - Service Not Available
  - Parent Declined/Refused Service
  - Waiting List / Visit Pending
  - Insurance/HMO Denied
  - Service Cancelled
  - Other/Unknown Reason

<table>
<thead>
<tr>
<th>Service Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Licensed Clinical Social Worker</td>
</tr>
<tr>
<td>☐ Marriage &amp; Family Therapist</td>
</tr>
<tr>
<td>☐ MSW</td>
</tr>
<tr>
<td>☐ Psychologist</td>
</tr>
<tr>
<td>☐ Other</td>
</tr>
<tr>
<td>☐ Unknown</td>
</tr>
</tbody>
</table>

### Visiting, Public Health, and/or Home Nursing
- **Does Not Need**
- **Referred, but Not Receiving** (check reason)
  - Missed Appointment
  - Re-Referred
  - Service Not Available
  - Parent Declined/Refused Service
  - Waiting List / Visit Pending
  - Insurance/HMO Denied
  - Service Cancelled
  - Other/Unknown Reason

<table>
<thead>
<tr>
<th>Service Provider:</th>
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</thead>
<tbody>
<tr>
<td>☐ Licensed Vocational Nurse</td>
</tr>
<tr>
<td>☐ Registered Nurse</td>
</tr>
<tr>
<td>☐ Physician</td>
</tr>
<tr>
<td>☐ Other</td>
</tr>
<tr>
<td>☐ Public Health Nurse</td>
</tr>
<tr>
<td>☐ Unknown</td>
</tr>
</tbody>
</table>

### Vision Services
- **Does Not Need**
- **Referred, but Not Receiving** (check reason)
  - Missed Appointment
  - Re-Referred
  - Service Not Available
  - Parent Declined/Refused Service
  - Waiting List / Visit Pending
  - Insurance/HMO Denied
  - Service Cancelled
  - Other/Unknown Reason

<table>
<thead>
<tr>
<th>Service Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Low Vision Specialist (Optometrist)</td>
</tr>
<tr>
<td>☐ Orientation &amp; Mobility Specialist</td>
</tr>
<tr>
<td>☐ Other</td>
</tr>
<tr>
<td>☐ Low Vision Specialist (Ophthalmologist)</td>
</tr>
<tr>
<td>☐ Physical Therapist</td>
</tr>
<tr>
<td>☐ Teacher of the Visually Impaired</td>
</tr>
<tr>
<td>☐ Occupational Therapist</td>
</tr>
<tr>
<td>☐ Unknown</td>
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</table>
### Social Concerns and Resources

<table>
<thead>
<tr>
<th>Concerns</th>
<th>Response Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caregiver-Child Disruptions or Concerns</td>
<td>Yes, Referral Not Necessary</td>
</tr>
<tr>
<td></td>
<td>Yes, Referred to Social Worker</td>
</tr>
<tr>
<td></td>
<td>Yes, Referred to Other Community Resources</td>
</tr>
<tr>
<td>Economic/Environmental Concerns/Stressors</td>
<td>Yes, Referral Not Necessary</td>
</tr>
<tr>
<td></td>
<td>Yes, Referred to Social Worker</td>
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<tr>
<td></td>
<td>Yes, Referred to Other Community Resources</td>
</tr>
<tr>
<td>Community &amp; Relationship Concerns</td>
<td>Yes, Referral Not Necessary</td>
</tr>
<tr>
<td></td>
<td>Yes, Referred to Social Worker</td>
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<tr>
<td></td>
<td>Yes, Referred to Other Community Resources</td>
</tr>
<tr>
<td>Parent-Child Concerns</td>
<td>Yes, Referral Not Necessary</td>
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<tr>
<td></td>
<td>Yes, Referred to Social Worker</td>
</tr>
<tr>
<td></td>
<td>Yes, Referred to Other Community Resources</td>
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</tbody>
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### Child Protective Services (CPS)

**Is a Child Protective Services Case Currently Opened?**
- No
- Yes
- Referred at Time of Visit

### Other Medical Conditions

**Were there Additional Medical Conditions Identified that may Impact the Child’s Outcome?**
- Yes (complete below)

- Cardiovascular and Circulatory:
- Endocrine and Metabolic:
- Eye, Ear, Nose:
- Gastrointestinal and Hepatobiliary:
- Genetic:
- Hematologic, Immunologic, or Oncologic/Neoplasm:
- Infectious Diseases:
- Injuries, Accident, Poisoning:
- Renal and Genitourinary Tract:
- Respiratory System:
- Nervous System:
- Other:

### Disposition (Required Field)

- Scheduled to Return
- Completed HRIF Core Visits, Scheduled to Return
- Will be Followed by Another CCS HRIF Program (1)

### Discharged:

- Graduated
- Family Moving Out of State/Country
- Will be Followed Elsewhere
- Closed Out of Program
- Family Withdrew Prior To Completion
- Completed HRIF Core Visits, Referred for Additional Resources

---

(1) Submit a Help Ticket at: https://www.cpqcchelp.org/, to request to transfer the patient record to another CCS HRIF Program. Include in the ticket request the patient’s “HRIF ID Number”, “Birth Weight or Gestational Age” and the “CCS HRIF Program, where the patient will be transferred for follow-up services”. 

---

**HRIF-QCI: Standard Visit (SV) Form v01.18 | 11 of 11**
# ADDITIONAL VISIT (AV) FORM
## HIGH RISK INFANT FOLLOW-UP QUALITY OF CARE INITIATIVE

**NAME:** ______________________ (Last, First)  **HRIF I.D.#** ______________________

- **Required Field**

- **DATE OF ADDITIONAL VISIT:** ____-____-____ (MM-DD-YYYY)

## *REASON FOR ADDITIONAL VISIT (Required Field)*

- □ Social Risk
- □ Case Management
- □ Concern With Neuro/Developmental Course
- □ Other: ______________________

## *DISPOSITION (Required Field)*

- □ Scheduled To Return
- □ Will Be Followed by Another CCS HRIF Program (1)

- **DISCHARGED:**
  - □ Graduated
  - □ Closed Out of Program
  - □ Family Moving Out of State/Country
  - □ Family Withdrew Prior To Completion
  - □ Will be Followed Elsewhere
  - □ Completed HRIF Core Visits, Referred For Additional Resources

## HOSPITAL/CENTER INFORMATION (Optional)

- **Hospital Specific Medical I.D. #** ______________________
- **Infant’s First Name:** ______________________
- **Infant’s Last Name:** ______________________
- **Infant’s AKA-1 Last Name:** ______________________
- **Infant’s AKA-2 Last Name:** ______________________
- **Primary Caregiver’s First Name:** ______________________
- **Primary Caregiver’s Last Name:** ______________________
- **Street Address:** ______________________
- **City:** ______________________  **State:** CA  **Zip Code:** ______________________
- **Home Phone Number:** (____) ______-____
- **Alternate Street Address:** ______________________
- **Alternate City:** ______________________  **State:** CA  **Zip Code:** ______________________
- **Alternate Phone Number:** (____) ______-____

---

(1) Submit a Help Ticket at: [https://www.cpqcchelp.org/](https://www.cpqcchelp.org/), to request to transfer the patient record to another CCS HRIF Program. Include in the ticket request the patient’s “HRIF ID Number”, “Birth Weight or Gestational Age” and the “CCS HRIF Program, where the patient will be transferred for follow-up services”.
**CLIENT NOT SEEN/DISCHARGE (CNSD) FORM**

**HIGH RISK INFANT FOLLOW-UP QUALITY OF CARE INITIATIVE**

**NAME:** ___________________________ (Last, First)  
**HRIF I.D.#** ______________________

*Required Field

*DATE CLIENT NOT SEEN/DISCHARGE: [ ]-[ ]-[ ] (MM-DD-YYYY)

**CATEGORY (Required Field)**

- [ ] No Appointment Scheduled  
- [ ] Core Visit Appointment Scheduled  
- [ ] Discharged

**REASON FOR CLIENT NOT SEEN / DISCHARGE (Required Field)**

- [ ] Infant Illness  
- [ ] Infant Hospitalized  
- [ ] Infant Referred to Another HRIF Program  
- [ ] Infant/Family Moved Within California  
- [ ] Infant/Family Moved Out of State  
- [ ] Infant Expired  
- [ ] Parent Illness  
- [ ] Parent Refused  
- [ ] Parent Competing Priorities  
- [ ] Parent Declines Due to Cost  
- [ ] Insurance Authorization Problems  
- [ ] CCS Denied  
- [ ] Lack of Transportation  
- [ ] Lost to Follow-up  
- [ ] Unable to Contact  
- [ ] Other: ____________________

**DISPOSITION (Required Field)**

- [ ] Scheduled Appointment  
- [ ] Will Schedule Appointment  
- [ ] Will Be Followed by Another CCS HRIF Program (1)

**DISCHARGED:**  
- [ ] Family Moving Out of State/Country  
- [ ] Will be Followed Elsewhere  
- [ ] Closed Out of Program

**HOSPITAL/CENTER INFORMATION (Optional)**

- Hospital Specific Medical I.D. #: ______________________
- Infant’s First Name: ______________________
- Infant’s Last Name: ______________________
- Infant’s AKA-1 Last Name: ______________________
- Infant’s AKA-2 Last Name: ______________________
- Primary Caregiver’s First Name: ______________________
- Primary Caregiver’s Last Name: ______________________
- Street Address: ______________________
- City: ______________________  
- State: CA  
- Zip Code: ______________________
- Home Phone Number: ( )-______________
- Alternate Street Address: ______________________
- Alternate City: ______________________  
- State: CA  
- Zip Code: ______________________
- Alternate Phone Number: ( )-______________

---

[1] Submit a Help Ticket at: [https://www.cpqcchelp.org/](https://www.cpqcchelp.org/), to request to transfer the patient record to another CCS HRIF Program. Include in the ticket request the patient’s “HRIF ID Number”, “Birth Weight or Gestational Age” and the “CCS HRIF Program, where the patient will be transferred for follow-up services”.

---

**cpqcc**
### APPENDIX C

#### OSHPD FACILITY CODES

- Other Codes – Sorted by OSHPD
- Sorted by Facility
- Sorted by City
<table>
<thead>
<tr>
<th>OSHPD #</th>
<th>HOSPITAL NAME</th>
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<tbody>
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<td>NOT APPLICABLE</td>
</tr>
<tr>
<td>880000</td>
<td>OUT OF STATE - HOME BIRTH</td>
</tr>
<tr>
<td>880094</td>
<td>OUT OF STATE - OTHER OUT/PATIENT SETTING</td>
</tr>
<tr>
<td>880095</td>
<td>OUT OF STATE - MD OFFICE</td>
</tr>
<tr>
<td>880096</td>
<td>OUT OF STATE - CLINIC</td>
</tr>
<tr>
<td>880097</td>
<td>OUT OF STATE - EMERGENCY ROOM</td>
</tr>
<tr>
<td>880099</td>
<td>OUT OF STATE - OTHER IN/PATIENT SETTING</td>
</tr>
<tr>
<td>890000</td>
<td>CALIFORNIA - HOME BIRTH</td>
</tr>
<tr>
<td>890094</td>
<td>CALIFORNIA - OTHER OUT/PATIENT SETTING</td>
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<tr>
<td>890095</td>
<td>CALIFORNIA - MD OFFICE</td>
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<td>890096</td>
<td>CALIFORNIA - CLINIC</td>
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<td>890097</td>
<td>CALIFORNIA - EMERGENCY ROOM</td>
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<tr>
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<td>CALIFORNIA - OTHER IN/PATIENT SETTING</td>
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<td>SAFE SURRENDER</td>
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<td>OSHPD #</td>
<td>HOSPITAL NAME</td>
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</tr>
<tr>
<td>700564</td>
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<tr>
<td>700431</td>
<td>722ND MEDICAL GROUP</td>
</tr>
<tr>
<td>700103</td>
<td>95TH MEDICAL GROUP - EDWARDS AIR FORCE BASE</td>
</tr>
<tr>
<td>150808</td>
<td>ADVENTIST HEALTH MEDICAL CENTER TEHACHI VALLEY</td>
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<td>164029</td>
<td>ADVENTIST MEDICAL CENTER</td>
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<tr>
<td>100797</td>
<td>ADVENTIST MEDICAL CENTER - REEDLEY</td>
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<tr>
<td>010735</td>
<td>ALAMEDA HOSPITAL</td>
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<td>291053</td>
<td>TAHOE FOREST HOSPITAL</td>
</tr>
<tr>
<td>334564</td>
<td>TEMECULA VALLEY HOSPITAL</td>
</tr>
<tr>
<td>190422</td>
<td>TORRANCE MEMORIAL MEDICAL CENTER</td>
</tr>
<tr>
<td>370780</td>
<td>TRI-CITY MEDICAL CENTER</td>
</tr>
<tr>
<td>531059</td>
<td>TRINITY HOSPITAL</td>
</tr>
<tr>
<td>540816</td>
<td>TULARE REGIONAL MEDICAL CENTER</td>
</tr>
<tr>
<td>400548</td>
<td>TWIN CITIES COMMUNITY HOSPITAL</td>
</tr>
<tr>
<td>190796</td>
<td>UCLA MATTEL CHILDREN'S HOSPITAL</td>
</tr>
<tr>
<td>374141</td>
<td>UCSD-LA JOLLA, JOHN M/SALLY B THORNTON HOSP &amp; SULPICO CARDIO</td>
</tr>
<tr>
<td>010776</td>
<td>UCSF BENIOFF CHILDREN'S HOSPITAL - OAKLAND</td>
</tr>
<tr>
<td>384200</td>
<td>UCSF BENIOFF CHILDREN'S HOSPITAL - SAN FRANCISCO</td>
</tr>
<tr>
<td>231396</td>
<td>UKIAH VALLEY MEDICAL CENTER</td>
</tr>
<tr>
<td>341006</td>
<td>UNIVERSITY OF CALIFORNIA, DAVIS CHILDREN'S HOSPITAL (UCD)</td>
</tr>
<tr>
<td>301279</td>
<td>UNIVERSITY OF CALIFORNIA, IRVINE MEDICAL CENTER (UCI)</td>
</tr>
<tr>
<td>370782</td>
<td>UNIVERSITY OF CALIFORNIA, SAN DIEGO MEDICAL CENTER (UCSD)</td>
</tr>
<tr>
<td>999999</td>
<td>UNKNOWN</td>
</tr>
<tr>
<td>700330</td>
<td>US ARMY AIR FORCE HOSPITAL</td>
</tr>
<tr>
<td>700333</td>
<td>US LEWIS MEMORIAL HOSPITAL</td>
</tr>
<tr>
<td>700664</td>
<td>USAF HOSPITAL - MARYSVILLE</td>
</tr>
<tr>
<td>700475</td>
<td>USAF HOSPITAL: 83RD MEDICAL GRO</td>
</tr>
<tr>
<td>700350</td>
<td>USAF HOSPITAL: 93RD STRATEGIC</td>
</tr>
<tr>
<td>700444</td>
<td>USAF HOSPITAL: MATHER</td>
</tr>
<tr>
<td>190818</td>
<td>USC VERDUGO HILLS HOSPITAL</td>
</tr>
<tr>
<td>204019</td>
<td>VALLEY CHILDREN'S HOSPITAL</td>
</tr>
<tr>
<td>100899</td>
<td>VALLEY CHILDREN'S HOSPITAL - ST. AGNES HOSPITAL</td>
</tr>
<tr>
<td>OSHPD #</td>
<td>HOSPITAL NAME</td>
</tr>
<tr>
<td>----------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td>010983</td>
<td>VALLEY MEMORIAL HOSPITAL</td>
</tr>
<tr>
<td>190812</td>
<td>VALLEY PRESBYTERIAN HOSPITAL</td>
</tr>
<tr>
<td>014050</td>
<td>VALLEYCARE MEDICAL CENTER</td>
</tr>
<tr>
<td>560521</td>
<td>VENTURA COUNTY MEDICAL CENTER - SANTA PAULA HOSPITAL</td>
</tr>
<tr>
<td>560481</td>
<td>VENTURA COUNTY MEDICAL CENTER (VCMC)</td>
</tr>
<tr>
<td>454012</td>
<td>VIBRA HOSPITAL OF NORTHERN CALIFORNIA</td>
</tr>
<tr>
<td>344035</td>
<td>VIBRA HOSPITAL OF SACRAMENTO</td>
</tr>
<tr>
<td>374094</td>
<td>VIBRA HOSPITAL OF SAN DIEGO</td>
</tr>
<tr>
<td>361370</td>
<td>VICTOR VALLEY GLOBAL MEDICAL CENTER</td>
</tr>
<tr>
<td>010987</td>
<td>WASHINGTON HOSPITAL HEALTHCARE SYSTEM - FREMONT</td>
</tr>
<tr>
<td>444013</td>
<td>WATSONVILLE COMMUNITY HOSPITAL</td>
</tr>
<tr>
<td>700693</td>
<td>WEED ARMY COMMUNITY HOSPITAL</td>
</tr>
<tr>
<td>301379</td>
<td>WEST ANAHEIM MEDICAL CENTER</td>
</tr>
<tr>
<td>190857</td>
<td>WEST COVINA MEDICAL CENTER</td>
</tr>
<tr>
<td>190859</td>
<td>WEST HILLS HOSPITAL AND MEDICAL CENTER</td>
</tr>
<tr>
<td>301188</td>
<td>WESTERN MEDICAL CENTER ANAHEIM</td>
</tr>
<tr>
<td>190878</td>
<td>WHITE MEMORIAL MEDICAL CENTER</td>
</tr>
<tr>
<td>190883</td>
<td>WHITTEY HOSPITAL MEDICAL CENTER</td>
</tr>
<tr>
<td>571086</td>
<td>WOODLAND MEMORIAL HOSPITAL</td>
</tr>
<tr>
<td>380939</td>
<td>ZUCKERBERG SAN FRANCISCO GENERAL HOSPITAL AND TRAUMA CENTER</td>
</tr>
</tbody>
</table>
APPENDIX D

CCS HRIF PROGRAM BILLING CODES

Listed by provider
**HOSPITAL HRIF PROGRAM FACILITY**

The following codes are included in SCG 06 for authorization of facility related costs.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z7500</td>
<td>USE OF HOSP, EXAM. OR TREAT.RM.</td>
</tr>
<tr>
<td></td>
<td>Utilized by the hospital HRIF program facility, the hospital facility for the audiologist, or the hospital facility for the ophthalmologist for the examining room charge per patient per date of service.</td>
</tr>
<tr>
<td>Z7610</td>
<td>MISC DRUGS AND MED SUPPLIES, ADMIN STAT</td>
</tr>
<tr>
<td></td>
<td>Utilized by the hospital HRIF program facility, the hospital facility for the audiologist, or the hospital facility for the ophthalmologist for any miscellaneous medical supplies per patient per date of service.</td>
</tr>
</tbody>
</table>

**AUDIOLOGIST**

The following codes are included in SCG 06 for authorization of services provided by an audiologist for a diagnostic audiology evaluation.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>X4300</td>
<td>SP THER LANGUAGE EVAL</td>
</tr>
<tr>
<td>X4301</td>
<td>SP THER-SPEECH EVALUATION</td>
</tr>
<tr>
<td>X4500</td>
<td>SP HR HR DIAG AUDILOG EVALUATION</td>
</tr>
<tr>
<td>X4501</td>
<td>SP HR HR PURE TONE AUDIOMETRY</td>
</tr>
<tr>
<td>X4506</td>
<td>PEDIATRIC EVAL 0-7 YRS FIRST VISIT</td>
</tr>
<tr>
<td>X4508</td>
<td>PEDIATRIC EVAL 0-7 YRS FIRST DIAG FOLLOW</td>
</tr>
<tr>
<td>X4510</td>
<td>PEDIATRIC EVAL 0-7 YRS SECOND DIAG FOLLO</td>
</tr>
<tr>
<td>X4522</td>
<td>EVOKED RESP AUDIOMET TEST PHYSICIAN EVAL</td>
</tr>
<tr>
<td>X4530</td>
<td>IMPED AUD (BILAT) PRT COMP AUD EVAL AUDI</td>
</tr>
<tr>
<td>X4536</td>
<td>WEBER TEST</td>
</tr>
<tr>
<td>X4538</td>
<td>IMPED AUDIO (UNLIA) PRT COMP AUD EVAL AUD</td>
</tr>
<tr>
<td>X4540</td>
<td>TY (IMP TST) PRT COMP AUD EVAL AUDIOLOGI</td>
</tr>
<tr>
<td>Z0316</td>
<td>TY (IMP TST) COMP AUDIO EVAL NON-SPE PHY</td>
</tr>
<tr>
<td>Z5900</td>
<td>EPSDT-AUDIO EVAL LESS THAN 2 YRS</td>
</tr>
<tr>
<td>Z5902</td>
<td>EPSDT-AUDIO EVAL 2-5 YRS</td>
</tr>
<tr>
<td>Z5906</td>
<td>EPSDT-SUBSEQUENT AUDIO EVAL UNDER 2 YRS</td>
</tr>
<tr>
<td>Z5908</td>
<td>EPSDT-SUBSEQUENT AUDIO EVAL 2-5 YRS</td>
</tr>
<tr>
<td>Z5912</td>
<td>EPSDT-EVAL DIFFICULT TEST PT UNDER 7 YRS</td>
</tr>
<tr>
<td>Z5914</td>
<td>EPSDT-AUDITORY BRAINSTEM RESPONSE (ABR)</td>
</tr>
<tr>
<td>Z5916</td>
<td>AUDIOMETRY/BEHAVIORAL OBSERVATIONAUDIO</td>
</tr>
<tr>
<td>Z5918</td>
<td>EPSDT-SPEECH THRESHOLD TEST</td>
</tr>
<tr>
<td>Z5920</td>
<td>SPEECH DISCRIMINATION/WORD RECOGNITION TEST</td>
</tr>
<tr>
<td>Z5922</td>
<td>EPSDT-ACOUSTIC IMMITANCE TST, MONAURAL</td>
</tr>
<tr>
<td>Z5924</td>
<td>EPSDT-ACOUSTIC IMMITANCE TST, BINAURAL</td>
</tr>
<tr>
<td>Z5934</td>
<td>EPSDT-EVOKED OTOACOUSTIC EMISSION, LTD</td>
</tr>
<tr>
<td>Z5936</td>
<td>EVOKED OTOACOUSTIC EMISSION CMPSNV/DGNTC</td>
</tr>
<tr>
<td>92550</td>
<td>TYPANOMETRY &amp; REFLEX THRESH</td>
</tr>
<tr>
<td>92551</td>
<td>PURE TONE HEARING TEST, AIR</td>
</tr>
</tbody>
</table>
### AUDIOLOGIST - continue

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>92552</td>
<td>PURE TONE AUDIOMETRY, AIR</td>
</tr>
<tr>
<td>92553</td>
<td>AUDIOMETRY, AIR &amp; BONE</td>
</tr>
<tr>
<td>92555</td>
<td>SPEECH AUDIOMETRY THRESHOLD</td>
</tr>
<tr>
<td>92556</td>
<td>SPEECH AUDIOMETRY THRESH, W/SPEECH REC</td>
</tr>
<tr>
<td>92557</td>
<td>COMPREHENSIVE AUDIOMETRY THRESHOLD EVAL</td>
</tr>
<tr>
<td>92567</td>
<td>TYMPANOMETRY, IMPEDANCE TESTING</td>
</tr>
<tr>
<td>92568</td>
<td>ACOUSTIC REFLEX THRESHOLD TESTING</td>
</tr>
<tr>
<td>92570</td>
<td>ACOUSTIC IMMITANCE TESTING</td>
</tr>
<tr>
<td>92571</td>
<td>FILTERED SPEECH HEARING TEST</td>
</tr>
<tr>
<td>92572</td>
<td>STAGGERED SPONDAIC WORD TEST</td>
</tr>
<tr>
<td>92575</td>
<td>SENSORINEURAL ACUITY TEST</td>
</tr>
<tr>
<td>92576</td>
<td>SYNTHETIC SENTENCE TEST</td>
</tr>
<tr>
<td>92577</td>
<td>STENGER TEST, SPEECH</td>
</tr>
<tr>
<td>92579</td>
<td>VISUAL REINFORCEMENT AUDIOMETRY (VRA)</td>
</tr>
<tr>
<td>92582</td>
<td>CONDITIONING PLAY AUDIOMETRY</td>
</tr>
<tr>
<td>92585</td>
<td>AUDITOR EVOKE POTENT, COMPRE</td>
</tr>
<tr>
<td>92586</td>
<td>AUDITOR EVOKE POTENT, LIMIT</td>
</tr>
<tr>
<td>92587</td>
<td>EVOKED AUDITORY TEST LIMITED</td>
</tr>
<tr>
<td>92588</td>
<td>COMPREHENSIVE OR DIAGNOSTIC EVAL</td>
</tr>
</tbody>
</table>

### NURSE SPECIALIST
The following codes are included in SCG 06 for authorization of services provided by a nurse specialist.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z4300</td>
<td>CENTER COORDINATOR</td>
</tr>
<tr>
<td></td>
<td>Utilized for non-physician coordinating activities for the HRIF program per patient per date of service (including coordinating multidisciplinary team case conference discussion and recommendations after team member evaluations and case reporting). An HRIF clinic can only bill for the time of one coordinator per patient per date of service (i.e., either Z4300 or Z4305). Also, a nurse specialist cannot bill for both serving as the case conference coordinator and as a conference participant (i.e., Z4300 and Z4310).</td>
</tr>
<tr>
<td>Z4301</td>
<td>ASSESSMENT, NURSE-PER HALF HOUR</td>
</tr>
<tr>
<td></td>
<td>Utilized for nursing assessment per patient and family (per 0.5 hrs), and instruction/education following any team recommendations.</td>
</tr>
<tr>
<td>Z4304</td>
<td>EPSDT: CCS PATIENT RPT-COMPLEX/COMPREHEN</td>
</tr>
<tr>
<td></td>
<td>Utilized for development of an &quot;extensive, comprehensive level&quot; chart review (inpatient/outpatient) and preparation of the HRIF multidisciplinary team visit report per patient. An HRIF clinic can only bill for one report (from either the Physician or Nurse Specialist) per patient multidisciplinary team visit or case conference.</td>
</tr>
<tr>
<td>Z4310</td>
<td>MEDICAL CASE CONF, NURSE-PER 1/4 HR</td>
</tr>
<tr>
<td></td>
<td>Utilized for nurse specialist participation in the HRIF comprehensive team case conference per patient (per 0.25hrs). Z4300 cannot be claimed in addition to Z4310 for the same patient on the same date of service.</td>
</tr>
</tbody>
</table>
## CCS High Risk Infant Follow Up (HRIF) Program Billing Codes

Expanded Descriptions and Guidelines for Billing Service Code Grouping (SCG) 06

Sorted by Provider Type

### NURSE SPECIALIST - continue

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z5406</td>
<td>ALLIED PROF. NEC-TELEP CONSULT -15 MIN</td>
</tr>
<tr>
<td></td>
<td>Utilized for telephone consultation(s) for case management and coordination of care per patient per date of service (per 0.25hrs). This code is not to be utilized for scheduling appointments or appointment-reminder notifications.</td>
</tr>
<tr>
<td>96110</td>
<td>DEVELOPMENTAL TESTING</td>
</tr>
<tr>
<td>96111</td>
<td>DEVELOPMENTAL TESTING; LIMITED (EG, DEVE)</td>
</tr>
<tr>
<td></td>
<td>DEVELOPMENTAL TESTING; EXTENDED (INCLUDE)</td>
</tr>
</tbody>
</table>

### OPHTHALMOLOGIST

The following codes are included in SCG 06 for authorization of services provided by an ophthalmologist.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>92002, 92004</td>
<td>NEW PATIENT EYE EXAM</td>
</tr>
<tr>
<td></td>
<td>One of these codes is utilized for an eye examination and evaluation for a new patient per date of service depending on whether the visit is intermediate or comprehensive.</td>
</tr>
<tr>
<td>92002</td>
<td>EYE EXAM NEW PATIENT INTERM</td>
</tr>
<tr>
<td>92004</td>
<td>EYE EXAM NEW PATIENT COMPRE</td>
</tr>
<tr>
<td>92012, 92014</td>
<td>ESTABLISHED PATIENT EYE EXAM</td>
</tr>
<tr>
<td></td>
<td>One of these codes is utilized for an eye examination and evaluation for an established patient per date of service depending on whether the visit is intermediate or comprehensive.</td>
</tr>
<tr>
<td>92012</td>
<td>EYE EXAM ESTABLISHED PAT INTERM</td>
</tr>
<tr>
<td>92014</td>
<td>EYE EXAM &amp; TREATMENT ESTAB PT 1/&gt; VST</td>
</tr>
<tr>
<td>92081-92083</td>
<td>VISUAL FIELD EXAM</td>
</tr>
<tr>
<td></td>
<td>One of these codes is utilized for a visual field examination, unilateral or bilateral, that is limited, intermediate or extended per patient per date of service.</td>
</tr>
<tr>
<td>92081</td>
<td>VISUAL FIELD EXAM, UNILAT OR BILAT; LIMI</td>
</tr>
<tr>
<td>92082</td>
<td>VISUAL FIELD EXAM; INTERMEDIATE</td>
</tr>
<tr>
<td>92083</td>
<td>VISUAL FIELD EXAM; EXTENDED</td>
</tr>
<tr>
<td>92225-92226</td>
<td>EXTEND OPHTHALMOSCOPY, RETINAL DRAWING</td>
</tr>
<tr>
<td></td>
<td>One of these codes is utilized for either an initial or a subsequent visit for extended ophthalmoscopy with retinal drawing, with interpretation and report per patient per date of service.</td>
</tr>
<tr>
<td>92225</td>
<td>OPHTHALMOSCOPY, EXTEND, RETINAL DRAWING</td>
</tr>
<tr>
<td>92226</td>
<td>EXTENDED OPHTHALMOSCOPY SUBSEQUENT</td>
</tr>
<tr>
<td>92250</td>
<td>FUNDUS PHOTOGRAPHY WITH INTERPRETATION</td>
</tr>
<tr>
<td></td>
<td>Utilized for fundus photography with interpretation and report per patient per date of service.</td>
</tr>
<tr>
<td>92499</td>
<td>OPHTHALMOLOGIC PROCEDURE-UNLISTED PROCEDURE</td>
</tr>
<tr>
<td></td>
<td>Utilized for an unlisted diagnostic ophthalmologic service / procedure per patient per date of service.</td>
</tr>
</tbody>
</table>
**OPHTHALMOLOGIST - continue**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
</table>
| 99241-99245 | OFFICE CONSULTATION  
One of these codes is utilized for an office consultation for a new or established patient per date of service. The comprehensiveness and length of time spent determine the code billed. |
| 99241   | OFFICE CONSULTATION, LEVEL 1                                                |
| 99242   | OFFICE CONSULTATION, LEVEL 2                                                |
| 99243   | OFFICE CONSULTATION, LEVEL 3                                                |
| 99244   | OFFICE CONSULTATION, LEVEL 4                                                |
| 99245   | OFFICE CONSULTATION, LEVEL 5                                                |

**PHYSICAL THERAPIST (PT) / OCCUPATIONAL THERAPIST (OT)**
The following codes are included in SCG 06 for authorization of services provided by a Physical or Occupational Therapist.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
</table>
| Z4300  | CENTER COORDINATOR  
Utilized for non-physician coordinating activities for the HRIF program per patient (including coordinating multidisciplinary team case conference discussion and recommendations after team member evaluations and case reporting). An HRIF clinic can only bill for the time of one coordinator per patient per date of service (i.e., either Z4300 or Z4305). Also, a PT/OT cannot bill for both serving as the case conference coordinator and as a conference participant (i.e., Z4300 and Z4302).                                                                                                                                                                                                                                                                 |
| Z4302  | CASE CONF-ALLIED HEALTH-PER QT HR  
Utilized for PT/OT participation in the HRIF comprehensive team case conference (per 0.25hrs). Z4300 cannot be claimed in addition to Z4302 for the same patient on the same date of service.                                                                                                                                                                                                                                                                                                                                 |
| Z4309  | ASSESS/INTERVEN, ALLD PROF-PER HALF HOUR  
Utilized by the PT/OT for a PT/OT assessment as clinically indicated per patient and family per date of service (per 0.5hrs).                                                                                                                                                                                                                                                                                                                                                           |
| 96110-96111 | DEVELOPMENTAL TESTING  
One of these codes can be utilized by a PT/OT per patient for one of the standardized developmental tests. These codes include interpretation and reporting and are billed based on testing being limited or extended. The PT/OT must have been trained in the developmental test administered.                                                                                                                                                                                                                       |
| 96110   | DEVELOPMENTAL TESTING; LIMITED (EG, DEVE)                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| 96111   | DEVELOPMENTAL TESTING; EXTENDED (INCLUDE)                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| Z5406  | ALLIED PROF. NEC-TELEP CONSULT - 15 MIN  
Utilized for telephone consultations for case management and coordination of care per patient per date of service (per 0.25hrs). This code is not to be utilized for scheduling appointments or appointment reminders.                                                                                                                                                                                                                                               |
## PHYSICIAN

The following codes are included in SCG 06 for authorization of services provided by a physician.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z4304</td>
<td><strong>EPSDT: CCS PATIENT RPT-COMPLEX/COMPREHEN</strong>&lt;br/&gt;Development of an “extensive, comprehensive level” chart review (inpatient/outpatient) and preparation of the HRIF multidisciplinary team visit report per patient. <strong>An HRIF clinic can only bill for one report (from either the Physician or Nurse Specialist) per patient multidisciplinary team visit or case conference.</strong></td>
</tr>
<tr>
<td>Z4305</td>
<td><strong>EPSDT SVS: CENTER COORDINATION, PHYS</strong>&lt;br/&gt;Physician coordinating activities of the HRIF program per patient per date of service (including coordinating multidisciplinary team case conference discussion and recommendations after team member evaluations and case reporting). <strong>An HRIF clinic can only bill for the time of one coordinator per patient per date of service</strong> (i.e., either Z4300 or Z4305). Also, a physician cannot bill for both serving as the coordinator for a patient and as a case conference participant (i.e., Z4305 and Z4306) per date of service.</td>
</tr>
<tr>
<td>Z4306</td>
<td><strong>EPSDT: CASE CONF, PHYS-PER .5 HR</strong>&lt;br/&gt;Physician participation in the HRIF comprehensive case conference per patient (per 0.5hrs). <strong>Z4305 cannot be claimed in addition to Z4306 for the same patient on the same date of service.</strong></td>
</tr>
<tr>
<td>99201</td>
<td><strong>NEW PATIENTS</strong> - The physician or nurse practitioner can utilize one of these codes for new patients, per patient visit, for the history and physical, including neurologic assessment. The comprehensiveness and length of time spent determine the code billed.</td>
</tr>
<tr>
<td>99202</td>
<td>OFFICE VISIT, NEW, LEVEL 1</td>
</tr>
<tr>
<td>99203</td>
<td>OFFICE VISIT, NEW, LEVEL 2</td>
</tr>
<tr>
<td>99204</td>
<td>OFFICE VISIT, NEW, LEVEL 3</td>
</tr>
<tr>
<td>99205</td>
<td>OFFICE VISIT, NEW, LEVEL 5</td>
</tr>
<tr>
<td>99211</td>
<td><strong>ESTABLISHED PATIENTS</strong>&lt;br/&gt;The physician or nurse practitioner can utilize one of these codes for established patients, per patient visit, for the history and physical, including neurologic assessment. The comprehensiveness and length of time spent determine the code billed.</td>
</tr>
<tr>
<td>99211</td>
<td>OFFICE VISIT, EST., LEVEL 1</td>
</tr>
<tr>
<td>99212</td>
<td>OFFICE VISIT, EST., LEVEL 2</td>
</tr>
<tr>
<td>99213</td>
<td>OFFICE VISIT, EST., LEVEL 3</td>
</tr>
<tr>
<td>99214</td>
<td>OFFICE VISIT, EST., LEVEL 4</td>
</tr>
<tr>
<td>99215</td>
<td>OFFICE VISIT, EST., LEVEL 5</td>
</tr>
<tr>
<td>96110</td>
<td><strong>DEVELOPMENTAL TEST</strong>&lt;br/&gt;One of these codes can be utilized by a physician per patient for one of the standardized developmental tests. These codes include interpretation and reporting, and are billed based on testing being limited or extended.</td>
</tr>
<tr>
<td>96110</td>
<td>DEVELOPMENTAL TESTING; LIMITED (EG, DEVE)</td>
</tr>
<tr>
<td>96111</td>
<td>DEVELOPMENTAL TESTING; EXTENDED (INCLUDE)</td>
</tr>
</tbody>
</table>
### PSYCHOLOGIST
The following codes are included in SCG 06 for authorization of services provided by a psychologist.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z4300</td>
<td>CENTER COORDINATOR</td>
</tr>
<tr>
<td></td>
<td>Utilized for non-physician coordinating activities for the HRIF program per</td>
</tr>
<tr>
<td></td>
<td>patient (including coordinating multidisciplinary team case conference</td>
</tr>
<tr>
<td></td>
<td>discussion and recommendations after team member evaluations and case</td>
</tr>
<tr>
<td></td>
<td>reporting). **An HRIF clinic can only bill for the time of one coordinator</td>
</tr>
<tr>
<td></td>
<td>per patient per date of service** (i.e., either Z4300 or Z4305). **Also, a</td>
</tr>
<tr>
<td></td>
<td>psychologist cannot bill for both serving as the case conference coordinator</td>
</tr>
<tr>
<td></td>
<td>and as a conference participant** (i.e., Z4300 and Z4302). **</td>
</tr>
<tr>
<td>Z4302</td>
<td>CASE CONF-ALLIED HEALTH-PER QT HR</td>
</tr>
<tr>
<td></td>
<td>Utilized for psychologist participation in the HRIF comprehensive team case</td>
</tr>
<tr>
<td></td>
<td>conference (per 0.25hrs). **Z4300 cannot be claimed in addition to Z4302</td>
</tr>
<tr>
<td></td>
<td>for the same patient on the same date of service.</td>
</tr>
<tr>
<td>X9514,</td>
<td>DEVELOPMENTAL TEST</td>
</tr>
<tr>
<td>X9534,</td>
<td>Utilized for psychologist billing for one of the standardized development</td>
</tr>
<tr>
<td>&amp; X9542</td>
<td>al tests per patient per visit. The 3 codes together include test</td>
</tr>
<tr>
<td></td>
<td>administration, scoring, and written report.</td>
</tr>
<tr>
<td></td>
<td>X9514 TEST ADMIN., INCLUDES PRETEST INTERVIEW-ON</td>
</tr>
<tr>
<td>X9534</td>
<td>TEST SCORING-PARTIAL HOUR-EACH 15 MINUTE</td>
</tr>
<tr>
<td>X9542</td>
<td>WRITTEN REPORT-PARTIAL HOUR-EACH 15 MINU</td>
</tr>
<tr>
<td>Z5406</td>
<td>ALLIED PROF. NEC-TELEP CONSULT - 15 MIN</td>
</tr>
<tr>
<td></td>
<td>Utilized for telephone consultations for case management and coordination</td>
</tr>
<tr>
<td></td>
<td>of care per patient per date of service (per 0.25hrs). **This code is not</td>
</tr>
<tr>
<td></td>
<td>to be utilized for scheduling appointments or appointment reminders.</td>
</tr>
</tbody>
</table>

### SOCIAL WORKER
The following codes are included in SCG 06 for authorization of services provided by a social worker.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z4300</td>
<td>CENTER COORDINATOR</td>
</tr>
<tr>
<td></td>
<td>Utilized for non-physician coordinating activities for the HRIF program per</td>
</tr>
<tr>
<td></td>
<td>patient (including coordinating multidisciplinary team case conference</td>
</tr>
<tr>
<td></td>
<td>discussion and recommendations after team member evaluations and case</td>
</tr>
<tr>
<td></td>
<td>reporting). **An HRIF clinic can only bill for the time of one coordinator</td>
</tr>
<tr>
<td></td>
<td>per patient per date of service** (i.e., either Z4300 or Z4305). **Also, a</td>
</tr>
<tr>
<td></td>
<td>social worker cannot bill for both serving as the coordinator (which</td>
</tr>
<tr>
<td></td>
<td>included coordinating the case conference) and as a case conference</td>
</tr>
<tr>
<td></td>
<td>participant** (i.e., Z4300 and Z4311).</td>
</tr>
<tr>
<td>Z4307</td>
<td>EVAL/INTERVEN, SOC WK-PER HALF HOUR</td>
</tr>
<tr>
<td></td>
<td>Utilized for social worker assessment, evaluation, counseling and/or referral</td>
</tr>
<tr>
<td></td>
<td>per patient and family per date of service (per 0.5hrs).</td>
</tr>
<tr>
<td>Z4311</td>
<td>MEDICAL CASE, SOCIAL WK-PER 1/4 HOUR</td>
</tr>
<tr>
<td></td>
<td>Utilized for social worker participation in the HRIF comprehensive team</td>
</tr>
<tr>
<td></td>
<td>case conference (per 0.25hrs). **Z4300 cannot be claimed in addition to Z4311</td>
</tr>
<tr>
<td>Z5406</td>
<td>ALLIED PROF. NEC-TELEP CONSULT - 15 MIN</td>
</tr>
<tr>
<td></td>
<td>Utilized for telephone consultations for case management and coordination</td>
</tr>
<tr>
<td></td>
<td>of care per patient per date of service (per 0.25hrs). **This code is not</td>
</tr>
<tr>
<td></td>
<td>to be utilized for scheduling appointments or appointment reminders.</td>
</tr>
</tbody>
</table>
APPENDIX E  CPQCC NICU ELIGIBILITY CRITERIA
CPQCC NICU ELIGIBILITY CRITERIA

2017 CPQCC Network Database, Manual of Definitions: For Infants Born in 2017

An infant is eligible for inclusion in the database upon meeting both the Population Criteria and the Selection Criteria as described below.

POPULATION CRITERIA:
The population under consideration consists of all live born infants who either (1) die in the delivery room (or initial resuscitation area) within 12 hours of birth and prior to NICU admission, or (2) are admitted as a NICU infant on or before day 28 of life. **NOTE:** Any infant (inborn or outborn) whose birth weight is between 401 and 1,500 grams OR whose gestational age is between 22 weeks 0 days and 31 weeks 6 days (inclusive) is eligible, regardless of where in your hospital the infant receives care.

**Live Born Infant**
**NOTE:** Since 2011, the definition of live born was updated to use the standard terminology recommendation of The Committee on Fetus and Newborn of the American Academy of Pediatrics: “A live born infant is one who breathes or has any evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscle, regardless of whether the umbilical has been cut or the placenta is attached. Heartbeats are to be distinguished from transient cardiac contractions; respirations are to be distinguished from fleeting respiratory efforts or gasps.”

**Delivery Room Death**
Any eligible inborn infant who dies in the delivery room or at any other location in your hospital within 12 hours after birth and prior to admission to your NICU is defined as a “Delivery Room Death.” These other locations may include the mother's room or resuscitation rooms, or any location other than the NICU in your hospital.

**NOTE:** Outborn infants and infants who are admitted to the NICU should not be classified as Delivery Room Deaths. Do not use a Delivery Room Death Booklet for these infants, regardless of when or where death occurs.

**NICU Infant**
A NICU infant is any baby cared for by the neonatology service in your NICU or other unit in your Center, other than the delivery room.

**NOTE:** Use the calendar date of birth as Day 1 regardless of the time of birth. Thus for an infant born at 23:59 PM on September 1, Day 28 occurs on September 28. If this infant were transported to your NICU at 12:01 am on September 29 (the 29th day), the infant would not satisfy the Population criteria as defined. The Population criteria must be satisfied on or before day 28.

SELECTION CRITERIA:
The selection criteria in the 2017 CPQCC dataset is as follows:

A. Any infant who is born at your hospital and whose birth weight is between 401 and 1,500 grams OR whose gestational age is between 22 weeks 0 days and 31 6 days (inclusive) is eligible, regardless of where in your hospital the infant receives care.

B. Any outborn infant who is admitted to any location in your hospital within 28 days, and whose birth weight is between 401 and 1,500 grams OR whose gestational age is between 22 weeks 0 days and 31 6 days (inclusive) is eligible, regardless of where in your hospital the infant receives care.

**In summary, any Small Baby infant is automatically eligible into the CPQCC database. However,**
any Small Baby infant who was previously discharged home from a hospital will not be forwarded to VON.

C. Any infant who is born at or admitted to your hospital within 28 days of birth, with a birth weight that is greater than 1500 grams MUST also meet one of the following 10 criteria: 1) Death, 2) Acute Transport-In, 3) Nasal IMV/SIMV (or any other form of non-intubated assisted ventilation) for greater than four continuous hours (for 2009 and later), 4) Intubated Assisted Ventilation for greater than four continuous hours, 5) Early Bacterial Sepsis, 6) Major surgery requiring anesthesia, 7) Previously Discharged Home and Readmitted to your hospital for Total Serum Bilirubin => 25 mg/dL (427 micromols/Liter) and/or exchange transfusion, 8) Acute Transport-Out of your NICU, 9) Suspected Encephalopathy or suspected perinatal asphyxia, 10) Active therapeutic hypothermia.

NOTE: Any Big Baby infant is eligible into the CPQCC database if the infant is admitted to your NICU within 28 days of birth, and then fulfill one of the 8 above criteria during the episode of care in your NICU. For criteria 7 (hyperbilirubinemia/ exchange transfusion), the infant may or may not be admitted to your NICU.

1. **Death** Check Yes if the infant died in your Center. Check No if the infant did not die in your center. If the infant died in the delivery room or resuscitation room, do not fill out an Admission / Discharge Form, fill out a Delivery Room Death Form.

2. **Acute Transport-In** Check Yes if the infant was an acute transport-in to your facility for this admission. If not, check No.

   **Acute:** An acute transport is movement of an infant from one in-patient setting to another in-patient setting for a higher level of care on or before Day 28 of life (i.e. medical, diagnostic, or surgical therapy that is not provided, or that cannot be provided due to temporary staffing/census issues, or due to insurance restrictions at the referring hospital).

   **Non-Acute:** A non-acute transport is a transport of an infant at any age for any category other than a need of acute care (i.e back transport or transport to a lower level of care).

   **NOTE:** Infants moved from one unit to another within your hospital are not considered to have been transported or discharged.

   **NOTE:** In 2008, we clarified that an infant born in the host facility and then admitted to imbedded NICUs (e.g., a NICU-owned and managed by another hospital) is not considered a CPeTS Acute Inter-facility Transport-In and does not require submission of the (TRS form) for the purpose of the Transport Data System for the Second Quarter systems upgrade. However, this infant may be CPQCC-eligible because of meeting one of the 10 criteria, requiring submission of the Admission/Discharge form.

3. **Nasal IMV/SIMV (or any other form of non-intubated assisted ventilation) for greater than four hours (for 2009 or later):** Starting in 2009, we have added a new High Acuity Criterion for eligibility in the Big Baby database - Nasal IMV/SIMV for greater than four continuous hours. In 2010 this modality was updated to “Nasal IMV/SIMV (or any other form of non-intubated assisted ventilation)” for greater than four continuous hours.

   **NOTE:** The time that an infant is on this modality should not be recorded as ventilation time in Item 25b.

   **NOTE:** Non-intubated assisted ventilation is defined as a mechanically produced breath. CPAP alone doesn’t qualify as non-intubated assisted ventilation. However,
CPAP with a back-up rate whether administered through the nose, face mask, etc., that is triggered as a back-up rate or intermittently would qualify. Check Yes to Nasal IMV/SIMV in Item 23e, but do not include these hours in calculating the duration of intubated assisted ventilation (Item 25b.)

**NOTE:** If a Big Baby infant is on CPAP with a back-up rate for greater than four continuous hours, then this infant qualifies under the Big Baby selection criteria of nasal IMV/SIMV (or any other form of non-intubated assisted ventilation) greater than four continuous hours.

4. **Intubated Assisted Ventilation > 4 hrs** Check Yes if an infant requires intubated assisted ventilation, using a cycled or triggered mechanical ventilator, via an endotracheal tube or other interface (such as nasal prongs or a secured face mask), for greater than four continuous hours (including duration of ventilation during transport or surgery). Check No if the infant did not require ventilation. CPAP alone via endotracheal tube or any other delivery system does not qualify regardless of oxygen concentration.

**Important Note:** We have clarified the definition for Item 25b. Use of Intubated Assisted Ventilation. If Greater than four continuous hours, specify ventilation time. Starting in 2009, for an infant treated with intubated conventional ventilation or intubated HIFI ventilation for greater than four continuous hours, record infant’s initial episode of ventilation, during the initial stay at your hospital for any reason (surgery or the need for controlled sedation to perform imaging studies are included. However, for those infants who are ventilated for more than four continuous hours, then transported out, and then readmitted while still ventilated, include the days and hours at the transported to hospital as well. However, if this same infant is transported out and never readmitted, you only include the days/hours at your hospital. Nasal IMV/SIMV (or any other form of non-intubated assisted ventilation) should not be included in the length of time on ventilation for Item 25b. CPAP alone should also not be included in the length of time on ventilation for Item 25b.

Conventional Ventilation (Con Vent) is defined for any infant given intermittent positive pressure ventilation through an endotracheal tube with a conventional ventilator (IMV rate <240/minute). Note: Intermittent positive pressure ventilation (IPPV) via nasal prongs is not considered conventional ventilation. Synchronized intermittent positive pressure ventilation (SIMV) via nasal prongs is not considered conventional ventilation.

High Frequency Ventilation (HIFI Vent) is defined for any infant given high frequency ventilation (IMV rate >=240/minute). Note: High frequency ventilation via nasal prongs is not considered high frequency ventilation.

5. **Early Bacterial Sepsis** Check Yes if the infant had a positive blood or CSF culture obtained on day 1, 2 or 3 of life, which grew out a bacterial pathogen. Check No if the infant did not.

**NOTE:** If an infant who was transported into your center, is being treated for early bacterial sepsis because of a positive culture drawn at the referring hospital, this infant qualifies, even if a repeat culture drawn at your center is negative. However, if an infant who was transported into your center was diagnosed with early sepsis but is no longer septic (due to treatment at the referring hospital), this infant does not qualify.

6. **Major Surgery Requiring Anesthesia.** Check Yes if the infant had major invasive surgery (requiring general anesthesia, or its equivalent) during this admission. Check No if the infant did not.

**NOTE:** The following surgeries are not considered surgical procedures for eligibility
purposes: Pyloromyotomy, unilateral or bilateral inguinal hernia repair, central line placement or circumcision. If you are not sure whether a procedure qualifies, please consult our FAQ, found on the Data Center page of our website (www.cpqcc.org). If you are still undecided, please e-mail the Data Center staff with your question.

**NOTE:** Only conditions that require general anesthesia or anesthesia techniques felt by your neonatologist to be equivalent to general anesthesia qualify. Most of these procedures involve opening a cavity (head, chest, abdomen, etc.). A hernia or insertion of a central line may or may not qualify depending on the use of general anesthesia or anesthesia techniques felt by your neonatologist to be equivalent to general anesthesia. Circumcision is not a qualifying surgery for Big Babies.

7. **Acute Transport-Out** Check Yes if the infant was an acute transport from your facility upon discharge. If the infant was not an acute transport-out, check No.

   **Acute:** An acute transport is movement of an infant from one in-patient setting to another in-patient setting for a higher level of care on or before Day 28 of life. (i.e. medical, diagnostic, or surgical therapy that is not provided, or that cannot be provided due to temporary staffing/census issues, or due to insurance restrictions at the referring hospital).

   **Non-Acute:** A non-acute transport is a transport of an infant at any age for any category other than a need of acute care (i.e. back transport or transport to a lower level of care).

   **NOTE:** Infants moved from one unit to another within your hospital are not considered to have been transported or discharged.

8. **Hyperbilirubinemia** Starting in 2007, check Yes if the infant was previously discharged home and readmitted to any location in your hospital on or before Day 28 of life for Total Serum Bilirubin => 25 mg/dL (427 micromols/Liter) and/or exchange transfusion.

   **NOTE:** This is the only Big Baby selection criterion where an infant does NOT have to be under the care of a neonatologist or the NICU service

9. **Suspected encephalopathy or suspected perinatal asphyxia** Starting in 2013, check Yes if the infant had suspected encephalopathy or suspected perinatal asphyxia, defined by cardiorespiratory depression at birth signified by any one (or more) of the following: (1) pH less than 7.0 on an umbilical blood sample or a blood gas obtained within one hour of life, (2) 5-minute Apgar score of less than or equal to 3, or (3) 10-minute Apgar score of less than or equal to 4. Check No if the infant does not meet any of the above criteria.

   **NOTE:** This definition of suspected encephalopathy or suspected perinatal asphyxia is different from the criteria for hypoxic ischemic encephalopathy (HIE), defined later in Item 48 (i.e., not all patients meeting eligibility criteria under suspected encephalopathy or suspected perinatal asphyxia will have HIE according to the HIE definition).

10. **Active therapeutic hypothermia** Check Yes if the infant was actively cooled (received hypothermia therapy) during the admission to your NICU. Active cooling includes selective head cooling or whole body cooling. Check No if the infant was not actively cooled.

   **NOTE:** Passive exposure to environmental temperature or intentionally withholding standard temperature maintenance does not qualify as active cooling.