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based on the degree of mental impairment and any resulting limitation on the individual's activities, interests, personal habits and ability to relate to others. The "Psychiatric Review Technique Form" (LDSS-3818) may be used and where appropriate the "Mental Residual Functional Capacity Assessment Form" (LDSS-3817) may be completed. (These forms can be found in CentraPort and the DOH intranet library.)

Once the RFC has been established, the evaluation of the individual's ability to do past relevant work or other work in the national economy should be determined by following the procedures outlined in this manual.

### 3. Pain and Medical Improvement

Medical improvement is any decrease in the medical severity of the individual's impairment(s) since the time of the most recent favorable decision. Where medical improvement is an issue, the signs, symptoms and laboratory findings at the time of the most recent favorable decision must be compared with the current signs, symptoms and lab findings.

A lessening of symptoms such as pain reported by the individual can be the basis for a finding that medical improvement has occurred even if there is no corresponding improvement in signs or laboratory findings. However, if such signs or laboratory findings have worsened, these would have to be considered in assessing medical improvement.

If medical improvement has occurred, it must be determined whether the medical improvement is related to the individual's ability to work and if so, whether the individual is currently able to engage in substantial gainful employment.

## **M. Evaluation of Children from Birth to Attainment of Age 18**

### 1. General

A child is considered disabled if he/she has a medically determinable physical or mental impairment or combination of impairments that causes marked and severe functional limitations and that can be expected to cause death or that has lasted or can be expected to last for a continuous period of not less than 12 months. To be determined disabled, the impairment must meet, medically equal, or functionally equal the requirements of the medical listings of impairments found in Appendix I, Part B. If the medical criteria in the children's listings do not apply, then the adult listings in Appendix I, Part A may be used. Generally a child may be found disabled if the impairment causes a marked limitation in two broad areas of function or an extreme limitation in one area.

### 2. Sequential Evaluation Process

As is the case for adults, the sequential evaluation process must be followed. (Please see the sequential evaluation flow chart for children which follows Section M.6.)

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The steps of the sequential evaluation process for children's cases are:

- Step 1 - determining if the child is engaged in substantial gainful activity;
- Step 2 - determining if the child has a severe impairment(s); and
- Step 3 - determining if the child's impairment(s) meets or medically equals a listing, or functionally equals the listings and meets the duration requirement.

- (a) Substantial Gainful Activity - Is the child engaging in substantial gainful activity?

The basic statutory definition of disability requires an inability to engage in substantial gainful activity. The same rules for determining whether an adult is engaging in substantial gainful activity also apply to children. (Please refer to Section E. 1.) Except for some older children who may be employed, most children will not be engaged in substantial gainful activity, and it will be necessary to continue with the sequential process.

If a child is at least 16 years of age and engaging in substantial gainful activity, eligibility for the Medicaid Buy-In Program for Working People with Disabilities must be considered, and the case sent to the State DRT for disability determination. If the child is not engaging in SGA, the sequential evaluation process will proceed to the next step.

- (b) Severity of Impairment - Does the child have a "severe" impairment or combination of impairments?

The child must have a medically determinable impairment that is severe. If the impairment is severe, the case will be reviewed further to see if the impairment(s) meets or medically equals a listing, or functionally equals the listings. If the child does not have a medically determinable impairment or his/her impairment(s) is a slight abnormality or combination of slight abnormalities that causes no more than minimal functional limitations, the child will be found not to have a severe impairment and will, therefore, be determined not disabled.

- (c) Meeting or Equaling the Listings - Does the child have a medically determinable impairment(s) that meets or equals the severity of a listing? An impairment causes marked and severe functional limitations if it meets or medically equals the severity of a set of criteria for an impairment in the listings, or if it functionally equals the listings.

- (1) Therefore, if the child has an impairment(s) that meets or medically equals the requirements of a listing or that functionally equals the listings, and that meets the duration requirement, the child will be found disabled.
- (2) If the child's impairment(s) does not meet the duration requirement or does not meet or medically equal a listing, or functionally equal the listings, the child will be found not disabled.

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## 3. Considerations in Determining Disability for Children

(a) Basic considerations. All relevant evidence in the case record is considered. The evidence in the case record may include information from medical sources, such as the child's pediatrician, other physicians, psychologist, or qualified speech-language pathologist; other medical sources such as physical, occupational, and rehabilitation therapists; and non-medical sources such as the child's parents, teachers, and other people who know the child.

### (1) Medical evidence

(i) General. Medical evidence of the child's impairment(s) must describe symptoms, signs, and laboratory findings. The medical evidence may include, but is not limited to, formal testing that provides information about the child's development or functioning in terms of standard deviations, percentiles, percentages of delay, or age or grade equivalents. It may also include opinions from medical sources about the nature and severity of the child's impairment.

(ii) Test scores. All of the relevant information in the case record will be considered. Consideration should not be given to any single piece of evidence in isolation. Therefore, test scores alone should not be relied on when deciding whether the child is disabled. See Section 6. (e) (3) for more information about how test scores are considered.

(iii) Medical sources. Medical sources should report their findings and observations on clinical examination and the results of any formal testing. A medical source's report should note and resolve any material inconsistencies between formal test results, other medical findings, and the child's usual functioning. Whenever possible and appropriate, the interpretation of findings by the medical source should reflect consideration of information from the child's parents or other people who know the child, including teachers and therapists. When a medical source has accepted and relied on such information to reach a diagnosis, this information may be considered a clinical sign.

(2) Information from other people. Every child is unique, so the effects of the child's impairment(s) on his/her functioning may be very different from the effects that the same impairment(s) might have on another child. Therefore, whenever possible and appropriate, attempts will be made to get information from people who can tell what the effects of the child's impairment(s) is on his/her activities and how the child functions on a day-to-day basis. These other people may include, but are not limited to:

(i) The child's parents and other caregivers. The child's parents and other caregivers can be important sources of information because they usually see the child every day. In addition to the child's parents, other caregivers may include a childcare provider who takes care of the child while his/her parent(s) works or an adult who looks after the child in a before-or after-school program.

(ii) Early intervention and preschool programs. If the child has been identified

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for early intervention services (in the home or elsewhere) because of his/her impairment(s), or if the child attends a preschool program (e.g., Headstart or a public school kindergarten for children with special needs), these programs are also important sources of information about the child's functioning. Reports should be requested from the agency and individuals who provide the child with services or from the child's teachers about how the child typically functions when compared to other children the same age who do not have impairments.

(iii) School. If the child goes to school, information should be requested from his/her teachers and other school personnel about how the child is functioning there on a day-to-day basis compared to other children the same age who do not have impairments. A request should be made for any reports that the school may have that show the results of formal testing or that describe any special education instruction or services, including home-based instruction, or any accommodations provided in a regular classroom.

(b) Factors to be considered when evaluating the effects of the child's impairment(s) on his/her functioning.

(1) General. The child's functioning must be considered when deciding whether his/her impairment(s) is "severe" and when deciding whether his/her impairment(s) functionally equals the listings. The child's functioning must also be considered when deciding whether his/her impairment(s) meets or medically equals a listing if the listing being considered includes functioning among its criteria.

(2) Factors to be considered when evaluating the child's functioning. The child's limitations in functioning must result from his/her medically determinable impairment(s). The information obtained from the child's medical and non-medical sources can help in understanding how the child's impairment(s) affects his/her functioning. Any factors that are relevant to how the child functions will be considered when evaluating the child's impairment or combination of impairments. For example, the child's symptoms (such as pain, fatigue, decreased energy, or anxiety) may limit his/her functioning. Some other factors that may be considered when evaluating the child's functioning are explained in paragraphs (b) (3) - (b) (9) of this section.

(3) How the child's functioning compares to the functioning of children the same age who do not have impairments.

(i) General. When the child's functioning is evaluated, consider whether the child does the things that other children the same age typically do or whether the child has limitations and restrictions because of his/her medically determinable impairment(s). Also, consider how well the child does the activities and how much help he/she needs from family, teachers and others. Information about what the child can and cannot do, and how the child

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functions on a day to day basis at home, at school and in the community, allows a comparison of the child's activities to the activities of children the same age who do not have impairments.

- (ii) How to consider reports of the child's functioning. When considering the evidence in the child's case record about the quality of his/her activities, consider the standards used by the person who gave the information. Also, consider the characteristics of the group to whom the child is being compared. For example, if the way the child does his/her class work is compared to other children in a special education class, consider that the child is being compared to children who do have impairments.
- (4) Combined effects of multiple impairments. If the child has more than one impairment, consider whether the child has a "severe" impairment or an impairment that meets or medically equals a listing, or functionally equals the listings by looking at each of the child's impairments separately. If each separate impairment does not meet or equal the listings, consider comprehensively the combined effects of all the child's impairments on his/her day to day functioning instead of considering the limitations resulting from each impairment separately. (See Section 6. (c) for more information on how to consider the interactive and cumulative effects of the child's impairments on functioning.)
- (5) How well can the child initiate, sustain, and complete his/her activities, including the amount of help or adaptations he/she needs, and the effects of structured or supportive settings.
  - (i) Initiating, sustaining, and completing activities. Consider how effectively the child functions by examining how independently the child is able to initiate, sustain, and complete his/her activities despite his/her impairment(s) compared to other children the same age who do not have impairments. Consider:
    - (A) The child's range of activities;
    - (B) The child's ability to do them independently, including any prompting that the child may need to begin, carry through, and complete his/her activities;
    - (C) The pace at which the child does his/her activities;
    - (D) How much effort the child needs to make in order to do his/her activities; and
    - (E) How long the child is able to sustain his/her activities.
  - (ii) Extra help. Consider how independently the child is able to function compared to other children the same age who do not have impairments. Consider whether the child needs help from other people, or whether the child needs special equipment, devices, or medications to perform his/her

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day-to-day activities. For example, consider how much supervision the child needs to keep from hurting him/herself, how much help the child needs every day to get dressed or, in the case of an infant, how long it takes the parents or other caregivers to feed the infant. Children are often able to do things and complete tasks when given help, but may not be able to do these same things by themselves. Therefore, consider how much extra help the child needs, what special equipment or devices the child uses, and the medication the child takes that enable him/her to participate in activities like other children the same age who do not have impairments.

- (iii) Adaptations. Consider the nature and extent of any adaptations used by the child to enable him/her to function. Such adaptations may include assistive devices or appliances. Some adaptations may enable the child to function normally or almost normally (e.g., eyeglasses). Others may increase the child's functioning, even though the child may still have functional limitations (e.g., ankle-foot orthosis, hand or foot splints, and specially adapted or custom-made tools, utensils, or devices for self-care activities such as bathing, feeding, toileting and dressing). When evaluating the functioning of a child with an adaptation, consider the degree to which the adaptation enables the child to function compared to other children the same age who do not have impairments. Consider the child's ability to use the adaptation effectively on a sustained basis and any functional limitations that nevertheless persist.
- (iv) Structured or supportive settings.
  - (A) If the child has a serious impairment(s), the child may spend some or all of his/her time in a structured or supportive setting, beyond what a child who does not have an impairment typically needs.
  - (B) A structured or supportive setting may be the child's own home in which family members or other people (e.g., visiting nurses or home health workers) make adjustments to accommodate the child's impairment(s). A structured or supportive setting may also be the child's classroom at school, whether it is a regular classroom in which the child is accommodated or a special classroom. It may also be a residential facility or school where the child lives for a period of time.
  - (C) A structured or supportive setting may minimize signs and symptoms of the child's impairment(s) and help to improve his/her functioning while the child is in it, but the child's signs, symptoms, and functional limitations may worsen outside this type of setting. Therefore, consider the child's need for a structured setting and the degree of limitation in functioning the child has or would have outside the structured setting. Even if the child is able to function adequately in the structured or supportive setting, consider how the child functions in other settings and whether the child would continue to function at an adequate level without the structured or supportive setting.

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- (D) If the child has a chronic impairment(s), the child may have his/her activities structured in such a way as to minimize stress and reduce the symptoms or signs of the impairment(s). The child may continue to have persistent pain, fatigue, decreased energy, or other symptoms or signs, although at a lesser level of severity. Consider whether the child is more limited in functioning than his/her symptoms and signs would indicate.
  - (E) Therefore, if the child's symptoms or signs are controlled or reduced in a structured setting, consider how well the child is functioning in the setting and the nature of the setting in which the child is functioning (e.g., home or a special class). Consider the amount of help the child needs from his/her parents, teachers or others to function as well as he/she does; adjustments the child makes to structure his/her environment; and how the child would function without the structured or supportive setting.
- (6) Unusual settings. Children may function differently in unfamiliar or one-to-one settings than they do in their usual settings at home, at school, in childcare or in the community. The child may appear more or less impaired on a single examination (such as a consultative examination) than indicated by the information covering a longer period. Therefore, apply the guidance in paragraph (b) (5) of this section when considering how the child functions in an unusual or one-to-one situation. Look at the child's performance in a special situation and at the child's typical day-to-day functioning in routine situations. Inferences should not be drawn about the child's functioning in other situations based only on how the child functions in a one-to-one, new, or unusual situation.
- (7) Early intervention and school programs.
- (i) General. If the child is very young and has been identified for early intervention services, or if the child attends school (including preschool), the records of people who know the child or who have examined the child are important sources of information about the child's impairment(s) and its effects on the child's functioning. Records from physicians, teachers and school psychologists, or physical, occupational, or speech-language therapists are examples of what information may be considered. If the child receives early intervention services or goes to school or preschool, consider this information when it is relevant and available.
  - (ii) School evidence. If the child goes to school or preschool, try to obtain information from the child's teacher(s) about his/her performance in activities throughout the school day. Consider all of the evidence received from the child's school, including teacher questionnaires, teacher checklists, group achievement testing, and report cards.
  - (iii) Early intervention and special education programs. If the child has had a comprehensive assessment for early intervention services or special education services, consider information used by the assessment team to make

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its recommendations. Consider the information in the child's Individualized Family Service Plan, his/her Individualized Education Program, or his/her plan for transition services to help understand the child's functioning. Examine the goals and objectives of the child's plan or program as further indicators of the child's functioning, as well as statements regarding related services, supplementary aids, program modifications, and other accommodations recommended to help the child function together with the other relevant information in the child's case record.

- (iv) Special education or accommodations. Consider the fact that the child attends school, that the child may be placed in a special education setting, or that the child receives special accommodations because of his/her impairments along with the other information in the case record. The fact that the child attends school does not mean that the child is not disabled. The fact that the child does or does not receive special education services does not, in itself, establish the child's actual limitations or abilities. Children are placed in special education settings, or are included in regular classrooms (with or without accommodation), for many reasons that may or may not be related to the level of their impairments. For example, the child may receive one-to-one assistance from an aide throughout the day in a regular classroom, or be placed in a special classroom. Consider the circumstances of the child's school attendance, such as his/her ability to function in a regular classroom or preschool setting with children the same age who do not have impairments. Similarly, consider that good performance in a special education setting does not mean that the child is functioning at the same level as other children the same age who do not have impairments.
- (v) Attendance and participation. Consider factors affecting the child's ability to participate in his/her education program. The child may be unable to participate on a regular basis because of the chronic or episodic nature of his/her impairment(s) or his/her need for therapy or treatment. If a child has more than one impairment, consider whether the effects of the child's impairments taken together make the child unable to participate on a regular basis. Consider how the child's temporary removal or absence from the program affects his/her ability to function compared to other children the same age who do not have impairments.
- (8) The impact of chronic illness and limitations that interfere with the child's activities over time. If the child has a chronic impairment(s) that is characterized by episodes of exacerbation (worsening) and remission (improvement), consider the frequency and severity of the episodes of exacerbation as factors that may be limiting the child's functioning. The child's level of functioning may vary considerably over time. Proper evaluation of the child's ability to function in any domain requires taking into account any variations in the child's level of functioning to determine the impact of the child's chronic illness on his/her ability to function over time. If the child requires frequent treatment, consider it as explained in paragraph (b) (9) (ii) of this section.

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- (9) The effects of treatment (including medications and other treatment). Evaluation of the effects of the child's treatment is done to determine its effect on the child's functioning in his/her particular case.
- (i) Effects of medication. Consider the effects of medication on the child's symptoms, signs, laboratory findings, and functioning. Although medications may control the most obvious manifestations of the child's impairment(s), they may or may not affect the functional limitations imposed by the child's impairment(s). If the child's symptoms or signs are reduced by medications, consider:
    - (A) Any of the child's functional limitations that may nevertheless persist, even if there is improvement from the medications;
    - (B) Whether the child's medications create any side effects that cause or contribute to the child's functional limitations;
    - (C) The frequency of the child's need for medication;
    - (D) Change in the child's medication or the way the child's medication is prescribed; and
    - (E) Any evidence over time of how medication helps or does not help the child to function compared to other children the same age who do not have impairments.
  - (ii) Other treatment. Consider also the level and frequency of treatment other than medications that the child gets for his/her impairment(s). The child may need frequent and ongoing therapy from one or more medical sources to maintain or improve his/her functional status. (Examples of therapy include occupational, physical, or speech and language therapy, nursing or home health services, psychotherapy, or psychosocial counseling.) Frequent therapy, although intended to improve the child's functioning in some ways, may also interfere with the child's functioning in other ways. Therefore, consider the frequency of any therapy the child must have and how long the child has received or will need it. Also, consider whether the therapy interferes with the child's participation in activities typical of other children the same age who do not have impairments, such as attending school or classes and socializing with peers. If the child's activities at school or at home are frequently interrupted for therapy, consider whether these interruptions interfere with the child's functioning. Also, consider the length and frequency of the child's hospitalization.
  - (iii) Treatment and intervention, in general. With treatment or intervention, the child may not only have his/her symptoms or signs reduced, but may also maintain, return to, or achieve a level of functioning that is not disabling. Treatment or intervention may prevent, eliminate, or reduce functional limitations.

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## 4. Age as a Factor in the Sequential Evaluation Process for Children

- (a) Age may or may not be a factor in determining whether a child's impairment(s) meets or medically equals a listing. This depends on the listing used for comparison. Age, however, is an important factor used in deciding whether a child's impairment(s) is severe and whether it functionally equals the listings. Except in the case of certain premature infants, as described in paragraph (b) of this section, age means chronological age.
  - (1) When determining whether a child has an impairment or combination of impairments that is severe, the child's functioning is compared to that of other children the same age who do not have impairments.
  - (2) When determining whether a child's impairment meets a listing, the child's age may or may not need to be considered. The listings describe impairments that are considered to be of such significance that they are presumed to cause marked and severe functional limitations.
    - (i) If the listing appropriate for evaluating the child's impairment is divided into specific age categories, the child's impairment will be evaluated according to his/her age when it is determined that the child's impairment meets that listing.
    - (ii) If the listing appropriate for evaluating the child's impairment does not include specific age categories, a decision as to whether the child's impairment meets the listing will be made without giving consideration to age.
  - (3) When comparing an unlisted impairment or a combination of impairments with the listings to determine whether the impairment(s) medically equals the severity of a listing, consideration of the child's age will depend on the listing used for comparison. The same principles for considering age will be used as in paragraphs (a) (2) (i) and (a) (2) (ii) of this section; that is, we will consider the child's age only if we are comparing the child's impairment(s) to a listing that includes specific age categories.
  - (4) Consideration will also be given to a child's age and whether it affects his/her ability to be tested. If the child's impairment is not amenable to formal testing because of his/her age, all information in the child's case record must be considered in determining whether the child is disabled. In order to help evaluate the existence and severity of the child's impairment(s), consideration will be given to other generally acceptable methods consistent with the prevailing state of medical knowledge and clinical practice.
- (b) **Correcting chronological age of premature infants.** Chronological age (that is, a child's age based on birth date) is generally used when deciding whether, or the extent to which, a physical or mental impairment or combination of impairments causes functional limitations. However, if a child was born prematurely, the child may be

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considered younger than his/her chronological age. When evaluating the development or linear growth of a child born prematurely, a "corrected" chronological age may be used; that is, the chronological age adjusted by a period of gestational prematurity. An infant born at less than 37 weeks gestation is considered to be born prematurely.

- (1) A corrected chronological age is applied in the following situations:
  - (i) When evaluating developmental delay in premature children until the child's prematurity is no longer a relevant factor; generally no later than about chronological age 2 (see paragraph (b) (2) of this section);
  - (ii) When evaluating an impairment of linear growth, such as under the listings in 100.00 in Appendix I, Part B, until the child is 12 months old. In this situation, refer to the neonatal growth charts which have been developed to evaluate growth in premature infants (see paragraph (b) (2) of this section).
- (2) A corrected chronological age is computed as follows:
  - (i) If the child has not attained age 1, the child's chronological age will be corrected. The corrected chronological age is computed by subtracting the number of weeks of prematurity (i.e., the difference between 40 weeks of full-term gestation and the number of actual weeks of gestation) from the child's chronological age. The result is the child's corrected chronological age.
  - (ii) If the child is over age 1, has a developmental delay, and prematurity is still a relevant factor in the case (generally no later than about chronological age 2), a decision whether to correct the child's chronological age must be made. The decision should be based on judgment and all the facts in the child's case. If a decision is made to correct the child's chronological age, it may be corrected by subtracting the full number of weeks of prematurity or a lesser number of weeks. A decision may also be made not to correct the child's chronological age if it can be determined from the evidence that that the child's developmental delay is the result of the child's medically determinable impairment(s) and is not attributable to the child's prematurity.
- (3) Notwithstanding the provisions in paragraph (b) (1) of this section, a corrected chronological age will not be computed if the medical evidence shows that the child's treating source or other medical source has already taken the child's prematurity into consideration in his or her assessment of the child's development. Also, a corrected chronological age is not required to satisfy listing 100.04.

## 5. Medical Equivalence

- (a) How medical equivalence is determined. A decision will be made that the child's impairment is medically equivalent to a listed impairment in Appendix I if the medical findings are at least equal in severity and duration to the listed findings. The signs, symptoms and laboratory findings related to the child's impairment(s), as found in the medical evidence, are compared with the corresponding medical criteria shown for

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any listed impairment. When making a finding of medical equivalence, all relevant evidence in the case record should be considered. Medical equivalence can be found in two ways:

- (1) If the child has a listed impairment but does not exhibit one or more of the medical findings specified in the listing, or exhibits all of the medical findings but one or more of the findings is not as severe as specified in the listing, the child may be found to equal the listing if there are other medical findings related to the impairment that are at least of equal medical significance.
  - (2) If the child has an unlisted impairment or a combination of impairments no one of which meets or equals a listing, the medical findings are compared to medical findings for a closely related impairment. If the medical findings are at least of equal significance to a closely analogous listed impairment, the child may be found to equal the listings.
- (b) If the impairment meets or medically equals the severity of a listed impairment, and also meets the duration requirement, the impairment will be found to cause marked and severe limitations, and the child will be determined disabled. (Note: If the medical criteria in the children's criteria do not apply, the adult medical listings should be used.)
- (c) If the impairment does not meet or medically equal the severity of a listed impairment, proceed to determine whether the impairment(s) functionally equals the listings.

## 6. Functional Equivalence for Children

- (a) General. If the child has a severe impairment or combination of impairments that does not meet or medically equal any listing, a decision must be made as to whether the impairment(s) results in limitations that functionally equal the listings. "Functionally equaling the listings" means that the child's impairment(s) is of listing-level severity; i.e., it must result in "marked" limitations in two domains of functioning or an "extreme" limitation in one domain, as explained in this section. An assessment of the functional limitations caused by the child's impairment(s) must be done; i.e. what the child cannot do, has difficulty doing, needs help doing, or is restricted from doing because of his/her impairment(s). When making a finding regarding functional equivalence, assess the interactive and cumulative effects of all of the impairments for which there is evidence, including any impairments the child has that are not "severe". When assessing the child's functional equivalence, consider all relevant factors including, but not limited to:
- (1) How well the child can initiate and sustain activities, how much extra help the child needs, and the effects of structured or supportive settings (see Section 3. (b) (5) );
  - (2) How the child functions in school (see Section 3. (b) (7)); and
  - (3) The effects of the child's medication or other treatment (see Section 3. (b) (9)).

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- (b) How the child's functioning is considered. Look at the information contained in the child's case record about how the child's functioning is affected during all of his/her activities when deciding whether the child's impairment or combination of impairments functionally equals the listings. The child's activities are everything he/she does at home, at school, and in his/her community. Review how appropriately, effectively, and independently the child performs his/her activities compared to the performance of other children the same age who do not have impairments.
- (1) How the child functions in his/her activities will be considered in terms of six domains. These domains are broad areas of functioning intended to capture all of what a child can or cannot do. In paragraphs (g) through (l), each domain is described in general terms. For most of the domains, examples are also provided of activities that illustrate the typical functioning of children in different age groups. For all of the domains, examples are provided of limitations within the domains. However, it is recognized that there is a range of development and functioning, and that not all children within an age category are expected to be able to do all of the activities in the examples of typical functioning. It is also recognized that limitations of any of the activities in the examples do not necessarily mean that a child has a "marked" or "extreme" limitation as defined in paragraph (e) of this section. The domains that are used are:
- (i) Acquiring and using information;
  - (ii) Attending and completing tasks;
  - (iii) Interacting and relating with others;
  - (iv) Moving about and manipulating objects;
  - (v) Caring for oneself; and
  - (vi) Health and physical well-being.
- (2) When evaluating the child's ability to function in each domain, ask for and consider information that will help answer the following questions about whether the child's impairment(s) affects his/her functioning and whether the child's activities are typical of other children the same age who do not have impairments.
- (i) What activities is the child able to perform?
  - (ii) What activities is the child not able to perform?
  - (iii) Which of the child's activities are limited or restricted compared to other children the same age who do not have impairments?
  - (iv) Where does the child have difficulty with his/her activities - at home, in childcare, at school, or in the community?
  - (v) Does the child have difficulty independently initiating, sustaining, or completing activities?
  - (vi) What kind of help does the child need to do his/her activities, how much help does the child need, and how often does he/she need it?
- (3) Try to get information from sources who can tell about the effects of the child's impairment(s) and how the child functions. Try to obtain information from the

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child's treating and other medical sources who have seen the child and can give their medical finding and opinions about the child's limitations and restrictions. Also, obtain information from the child's parents and teachers and others who see the child often and can describe the child's functioning at home, in childcare, at school, and in the community.

- (c) The interactive and cumulative effects of an impairment or multiple impairments. When evaluating the child's functioning and deciding which domains may be affected by the child's impairment(s), consider first the child's activities and his/her limitations and restrictions. Any given activity may involve the integrated use of many abilities and skills; therefore, any single limitation may be the result of the interactive and cumulative effects of one or more impairments. And any given impairment may have effects in more than one domain; therefore, evaluate the limitations from the child's impairment(s) in any affected domain(s).
- (d) How to decide if the child's impairment(s) functionally equals the listings. The child's impairment(s) will be found to functionally equal the listings if it is of listing level severity. The child's impairment is of listing-level severity if the child has "marked" limitations in two of the domains in paragraph (b) (1) of this section, or an "extreme" limitation in one domain. The child's functioning should not be compared to the requirements of any specific listing. The terms "marked" and "extreme" are explained in paragraph (e) of this section. An explanation of how to use the domains is found in paragraph (f) of this section, and a description of each domain can be found in paragraphs (g) - (l). The duration requirement must also be met.
- (e) How "marked" and "extreme" limitations are defined.
  - (1) General.
    - (i) When deciding whether the child has a "marked" or an "extreme" limitation, consider the functional limitations resulting from all of the child's impairments, including their interactive and cumulative effects. Consider all of the relevant information in the child's case record that will help in determining the child's functioning, including the child's signs, symptoms, and laboratory findings, the descriptions provided about the child's functioning from his/her parents, teachers, and other people who know the child, and the relevant factors explained in the previous sections.
    - (ii) The medical evidence may include formal testing that provides information about the child's development or functioning in terms of percentiles, percentages of delay, or age or grade equivalents. Standard scores (e.g., percentiles) can be converted to standard deviations. When such scores are available, consider them together with the information obtained about the child's functioning to determine whether the child has a "marked" or "extreme" limitation in a domain.

- (2) Marked limitation.

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- (i) The child will be found to have a "marked" limitation in a domain when his/her impairment(s) interferes seriously with his/her ability to initiate, sustain, or complete activities. The child's day-to-day functioning may be seriously limited when his/her impairment(s) limits only one activity or when the interactive and cumulative effects of the child's impairment(s) limit several activities. "Marked" limitation also means a limitation that is "more than moderate" but "less than extreme." It is the equivalent of the functioning that would be expected to be found on standardized testing with scores that are at least two, but less than three, standard deviations below the mean.
  - (ii) If the child has not attained age 3, it will generally be found that the child has a "marked" limitation if he/she is functioning at a level that is more than one-half but not more than two-thirds of his/her chronological age when there are no standard scores from standardized tests in the child's case record.
  - (iii) A child of any age (birth to the attainment of age 18) will be found to have a "marked" limitation when the child has a valid score that is two standard deviations or more below the mean, but less than three standard deviations, on a comprehensive standardized test designed to measure ability or functioning in that domain, and when the child's day-to-day functioning in domain-related activities is consistent with that score. (See paragraph (e) (4) of this section.)
  - (iv) For the sixth domain of functioning, "Health and physical well-being", the child may be considered to have a "marked" limitation if he/she is frequently ill because of his/her impairment(s) or has frequent exacerbations of his/her impairment(s) that result in significant, documented symptoms or signs. For the purposes of this domain, "frequent" means that the child has episodes of illness or exacerbations that occur on an average of 3 times a year, or once every 4 months, each lasting 2 weeks or more. A "marked" limitation may also be found if the child has episodes that occur more often than 3 times in a year or once every 4 months but do not last for 2 weeks, or occur less often than an average of 3 times a year or once every 4 months but last longer than 2 weeks, if the overall effect (based on the length of the episode(s) or its frequency) is equivalent in severity.
- (3) Extreme limitation.
- (i) The child will be found to have an "extreme" limitation in a domain when the child's impairment(s) interferes very seriously with his/her ability to independently initiate, sustain, or complete activities. The child's day-to-day functioning may be very seriously limited when his/her impairment(s) limits only one activity or when the interactive and cumulative effects of the child's impairment(s) limit several activities. "Extreme" limitation also means a limitation that is "more than marked" and is the rating given to the worst limitations. However, "extreme" limitation does not necessarily mean a total lack or loss of ability to function. It is the equivalent of the functioning expected to be found on standardized testing with scores that are at least three standard deviations below the mean.

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- (ii) If the child has not attained age 3, it will generally be found that the child has an "extreme" limitation if he/she is functioning at a level that is one-half of his/her chronological age or less when there are no standard scores from standardized tests in the child's case record.
  - (iii) A child of any age (birth to the attainment of age 18) will be found to have an "extreme" limitation when he/she has a valid score that is three standard deviations or more below the mean on a comprehensive standardized test designed to measure ability or functioning in that domain, and when the child's day-to-day functioning in domain-related activities is consistent with that score. (See paragraph (e) (4) of this section.)
  - (iv) For the sixth domain of functioning, "Health and physical well-being", the child may be considered to have an "extreme" limitation if he/she is frequently ill because of his/her impairment(s) or has frequent exacerbations of his/her impairment(s) that result in significant, documented symptoms or signs substantially in excess of the requirements for showing a "marked" limitation in paragraph (e) (2) (iv) of this section. However, if the child has episodes of illness or exacerbations of his/her impairment(s) that would be rated as "extreme" under this definition, the child's impairment(s) should meet or medically equal the requirements of a listing in most cases.
- (4) How test scores are considered.
- (i) As indicated in Section 3. (a) (1) (ii), any test scores alone should not be relied on. No single piece of information taken in isolation can establish whether a child has a "marked" or an "extreme" limitation in a domain.
  - (ii) The child's test scores should be considered together with the other information obtained about the child's functioning, including reports of classroom performance and the observation of school personnel and others.
    - (A) It may be found that the child has a "marked" or "extreme" limitation when he/she has a test score that is slightly higher than the level provided in paragraph (e) (2) or (e) (3) of this section, if other information in the child's case record shows that his/her functioning in day-to-day activities is seriously or very seriously limited because of his/her impairment(s). For example, the child may have IQ scores above the level in paragraph (e) (2), but other evidence shows that the child's impairment(s) causes him/her to function in school, home, and community far below his/her expected level of functioning based on this score.
    - (B) On the other hand, it may be found that the child does not have a "marked" or "extreme" limitation, even if the child's test scores are at the level provided in paragraph (e) (2) or (e) (3) of this section, if other information in the child's case record shows that his/her functioning in day-to-day activities is not seriously or very seriously limited by

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his/her impairment(s). For example, the child may have a valid IQ score below the level in paragraph (e) (2), but other evidence shows that the child has learned to drive a car, shop independently, and read books near his/her expected grade level.

- (iii) If there is a material inconsistency between the child's test scores and other information in the child's case record, try to resolve it. The interpretation of the test is primarily the responsibility of the psychologist or other professional who administered the test. But it is also the reviewer's responsibility to ensure that the evidence in the child's case record is complete and consistent or that any material inconsistencies have been resolved. Therefore, the following guidelines will be used to resolve concerns about the child's test scores:
  - (A) The inconsistencies may be able to be resolved with the information on hand. It may be necessary to obtain additional information; e.g., by recontact with the child's medical source(s), by recontact with a medical source who provided a consultative exam, or by questioning individuals familiar with the child's day-to-day functioning.
  - (B) Generally, a test score should not be relied on as a measurement of the child's functioning within a domain when the information obtained about the child's functioning is the kind of information typically used by medical professionals to determine that the test results are not the best measure of the child's day-to-day functioning. When test scores are not relied on, an explanation of the reasons for doing so should be documented on the "Disability Review Team Certificate" (LDSS 639).
- (f) How domains are used to help evaluate the child's functioning.
  - (1) When considering whether the child has a "marked" or "extreme" limitation in any domain, examine all the information in the child's case record about how the child's functioning is limited because of his/her impairment(s). Compare the child's functioning to the typical functioning of children the same age who do not have impairments.
  - (2) The general descriptions of each domain in paragraphs (g) - (l) will help in deciding whether the child has limitations in any given domain and whether these limitations are "marked" or "extreme".
  - (3) The domain descriptions also include examples of some activities typical of children in each age group and some functional limitations that may be considered. These examples also help in deciding whether the child has limitations in a domain because of his/her impairment(s). The examples are not all-inclusive, and developing evidence about each specific example is not required. When the child has limitations in a given activity or activities in the examples, a decision may or may not be made that the child has a "marked" or "extreme" limitation in that domain. Consider the activities in which the child is limited because of his/her

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impairment(s) and the extent of the child's limitations under the rules in paragraph (e) of this section.

- (g) *Acquiring and using information.* In this domain, consideration is given to how well the child acquires or learns information, and how well the child uses the information he/she has learned.

(1) General.

- (i) Learning and thinking begin at birth. A child learns as he/she explores the world through sight, sound, taste, touch, and smell. As a child plays, he/she acquires concepts and learns that people, things, and activities have names. This lets the child understand symbols, which prepares him/her to use language for learning. Using the concepts and symbols acquired through play and learning experiences, the child should be able to learn to read, write, do arithmetic, and understand and use new information.
- (ii) Thinking is the application or use of information the child has learned. It involves being able to perceive relationships, reason, and make logical choices. People think in different ways. When a child thinks in pictures, he/she may solve a problem by watching and imitating what another person does. When a child thinks in words, he/she may solve a problem by using language to talk his/her way through it. A child must also use language to think about the world and to understand others and express him/herself; e.g., to follow directions, ask for information, or explain something.

(2) Age group descriptors.

- (i) Newborns and young infants (birth to attainment of age 1). At this age, a child should show interest in and explore his/her environment. At first, a child's actions are random; for example, when the child accidentally touches the mobile over his/her crib. Eventually, the child's actions should become deliberate and purposeful, such as when he/she shakes noisemaking toys like a bell or rattle. The child should begin to recognize, and then anticipate, routine situations and events, such as when he/she grins at the sight of his/her stroller. The child should also recognize and gradually attach meaning to everyday sounds, such as when he/she hears the telephone or his/her name. Eventually, the child should recognize and respond to familiar words, including family names and what his/her favorite toys and activities are called.
- (ii) Older infants and toddlers (age 1 to attainment of age 3). At this age, the child is learning about the world around him/her. When the child plays, he/she should learn how objects go together in different ways. The child should learn that by pretending, his/her actions can represent real things. This helps the child understand that words represent things, and that words are simply symbols or names for toys, people, places, and activities. The child should refer to him/herself and the things around him/her by pointing and eventually naming. The child should form concepts and solve simple problems through purposeful experimentation (e.g., taking toys apart), imitation, constructive play (e.g.,

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building with blocks), and pretend play activities. The child should begin to respond to increasingly complex instructions and questions, and to produce an increasing number of words and grammatically correct simple sentences and questions.

- (iii) Preschool children (age 3 to attainment of age 6). When the child is old enough to go to preschool or kindergarten, the child should begin to learn and use the skills that will help him/her to read and write and do arithmetic when he/she is older. For example, listening to stories, rhyming words, and matching letters are skills needed for learning to read. Counting, sorting shapes, and building with blocks are skills needed to learn math. Painting, coloring, copying shapes, and using scissors are some of the skills needed in learning to write. Using words to ask questions, give answers, follow directions, describe things, explain what he/she means, and tell stories allows the child to acquire and share knowledge and experience of the world around him/her. All of these are called "readiness skills", and the child should have them by the time he/she begins first grade.
  - (iv) School-age children (age 6 to attainment of age 12). When the child is old enough to go to elementary and middle school, he/she should be able to learn to read, write, do math, and discuss history and science. The child will need to use these skills in academic situations to demonstrate what he/she has learned; e.g., by reading about various subjects and producing oral and written projects, solving mathematical problems, taking achievement tests, doing group work, and entering into class discussions. The child will also need to use these skills in daily living situations at home and in the community (e.g., reading street signs, telling time, and making change). The child should be able to use increasingly complex language (vocabulary and grammar) to share information and ideas with individuals or groups, by asking questions and expressing his/her own ideas, and by understanding and responding to the opinions of others.
  - (v) Adolescents (age 12 to attainment of age 18). In middle and high school, the child should continue to demonstrate what he/she has learned in academic assignments (e.g., composition, classroom discussion, and laboratory experiments). The child should also be able to use what he/she has learned in daily living situations without assistance (e.g., going to the store, using the library, and using public transportation). The child should be able to comprehend and express both simple and complex ideas, using increasingly complex language (vocabulary and grammar) in learning and daily living situations (e.g., to obtain and convey information and ideas). The child should also learn to apply these skills in practical ways that will help him/her enter the workplace after he/she finishes school (e.g., carrying out instructions, preparing a job application, or being interviewed by a potential employer).
- (3) Examples of limited functioning in acquiring and using information. The following examples describe some limitations found in this domain. The child's limitations may be different from the ones listed here. Also, the examples do not necessarily

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describe a "marked" or "extreme" limitation. Whether an example applies in a child's case may depend on the child's age and developmental stage; e.g., an example below may describe a limitation in an older child, but not a limitation in a younger one. As in any case, the child's limitation must result from his/her medically determinable impairment(s). However, all of the relevant information in the child's case record should be considered when deciding whether the child's medically determinable impairment(s) results in a "marked" or "extreme" limitation in this domain.

- (i) The child does not demonstrate understanding of words about space, size, or time; e.g., in/under, big/little, morning/night.
  - (ii) The child cannot rhyme words or the sounds in words.
  - (iii) The child has difficulty recalling important things he/she has learned in school yesterday.
  - (iv) The child has difficulty solving mathematics questions or computing arithmetic answers.
  - (v) The child talks only in short, simple sentences and has difficulty explaining what he/she means.
- (h) Attending and completing tasks. In this domain, consideration is given to how well the child is able to focus and maintain attention, and how well the child begins, carries through, and finishes his/her activities, including the pace at which he/she performs activities and the ease with which he/she changes them.
- (1) General.
    - (i) Attention involves regulating levels of alertness and initiating and maintaining concentration. It involves the ability to filter out distractions and to remain focused on an activity or task at a consistent level of performance. This means focusing long enough to initiate and complete an activity or task and changing focus once it is completed. It also means that if the child loses or changes focus in the middle of a task, he/she is able to return to the task without other people having to remind him/her frequently to finish it.
    - (ii) Adequate attention is needed to maintain physical and mental effort and concentration on an activity or task. Adequate attention permits the child to think and reflect before starting or deciding to stop an activity. In other words, the child is able to look ahead and predict the possible outcomes of his/her actions before acting. Focusing attention allows the child to attempt tasks at an appropriate pace. It also helps the child determine the time needed to finish a task within an appropriate timeframe.
  - (2) Age group descriptors.
    - (i) Newborns and young infants (birth to attainment of age 1). The child should

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begin at birth to show sensitivity to his/her environment by responding to various stimuli (e.g., light, touch, temperature, movement). Very soon, the child should be able to fix his/her gaze on a human face. The child should stop his/her activity when he/she hears voices or sounds. Next, the child should begin to attend to and follow various moving objects with his/her gaze, including people and toys. The child should be listening to his/her family's conversations for longer and longer periods of time. Eventually, as the child is able to move around and explore his/her environment, he/she should begin to play with people and toys for longer periods of time. The child will still want to change activities frequently, but his/her interest in continuing interaction or a game should gradually expand.

- (ii) Older infants and toddlers (age 1 to attainment of age 3). At this age, the child should be able to attend to things that interest him/her and have adequate attention to complete some tasks by him/herself. As a toddler, the child should demonstrate sustained attention, such as when looking at picture books, listening to stories, or building with blocks, and when helping to put on his/her clothes.
- (iii) Preschool children (age 3 to attainment of age 6). As a preschooler, the child should be able to pay attention when he/she is spoken to directly, sustain attention to play and learning activities, and concentrate on activities like putting puzzles together or completing art projects. The child should also be able to focus long enough to do more things by him/herself, such as getting his/her clothes together, dressing him/herself, feeding him/herself, or putting away his/her toys. The child should be able to wait his/her turn or to change his/her activity when a caregiver or teacher says it is time to do something else.
- (iv) School-age children (age 6 to attainment of age 12). When the child is of school age, he/she should be able to focus his/her attention in a variety of situations in order to follow directions, remember and organize his/her school materials, and complete classroom and homework assignments. He/she should be able to concentrate on details and not make careless mistakes in his/her work (beyond what would be expected in other children the same age who do not have impairments). The child should be able to change his/her activities or routines without distracting him/herself or others, and stay on task and in place when appropriate. The child should be able to sustain his/her attention well enough to participate in group sports, read by him/herself, and complete family chores. The child should also be able to complete a transition task (e.g., be ready for the school bus, change clothes after gym, change classrooms) without extra reminders and accommodation.
- (v) Adolescents (age 12 to attainment of age 18). In the child's later years of school, he/she should be able to pay attention to increasingly longer presentations and discussions, maintain his/her concentration while reading textbooks, and independently plan and complete long-range academic projects. The child should also be able to organize his/her materials and to plan his/her

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time in order to complete school tasks and assignments. In anticipation of entering the workplace, the child should be able to maintain his/her attention on a task for extended periods of time, and not be unduly distracted by his/her peers or unduly distracting to them in a school or work setting.

(3) Examples of limited functioning in attending and completing tasks.

The following examples describe some limitations that may be considered in this domain. The child's limitations may be different from the ones listed here. Also, the examples do not necessarily describe a "marked" or "extreme" limitation. Whether an example applies in a child's case may depend on the child's age and developmental stage; e.g., an example below may describe a limitation in an older child, but not a limitation in a younger one. As in any case, the child's limitations must result from his/her medically determinable impairment(s). However, all of the relevant information in the child's case record will be considered when deciding whether the child's medically determinable impairment(s) results in a "marked" or "extreme" limitation in this domain.

- (i) The child is easily startled, distracted, or over-reactive to sounds, sights, movements, or touch.
  - (ii) The child is slow to focus on, or fails to complete activities of interest to him/her, e.g., games or art projects.
  - (iii) The child repeatedly becomes sidetracked from his/her activities or he/she frequently interrupts others.
  - (iv) The child is easily frustrated and gives up on tasks, including ones that he/she is capable of completing.
  - (v) The child requires extra supervision to keep him/her engaged in an activity.
- (i) Interacting and relating with others. In this domain, consideration is given to how well the child initiates and sustains emotional connections with others, develops and uses the language of his/her community, cooperates with others, complies with the rules, responds to criticism, and respects and takes care of the possessions of others.

(1) General.

- (i) Interacting means initiating and responding to exchanges with other people, for practical or social purposes. A child interacts with others by using facial expressions, gestures, actions, or words. The child may interact with another person only once, as when asking a stranger for directions, or many times, as when describing his/her day at school to his/her parents. The child may interact with people one at a time, as when he/she is listening to another student in the hallway at school, or in groups, as when he/she plays with others.
- (ii) Relating to other people means forming intimate relationships with family members and with friends who are the child's age, and sustaining them over time. The child may relate to individuals, such as his/her siblings, parents or best friend, or to groups, such as other children in childcare, his/her

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friends in school, teammates in sports activities, or people in his/her neighborhood.

- (iii) Interacting and relating requires the child to respond appropriately to a variety of emotional and behavioral cues. The child may be able to speak intelligibly and fluently so that others can understand him/her; participate in verbal turn-taking and nonverbal exchanges; consider others' feelings and points of view; follow social rules for interaction and conversation; and respond to others appropriately and meaningfully.
  - (iv) The child's activities at home, school or in his/her community may involve playing, learning, and working cooperatively with other children, one at a time or in groups; joining voluntarily in activities with the other children in his/her school or community; and responding to persons (e.g., a parent, teacher, bus driver, coach, or employer).
- (2) Age group descriptors.
- (i) Newborns and young infants (birth to the attainment of age 1). The child should begin to form intimate relationships at birth by gradually responding visually and vocally to his/her caregiver(s), through mutual gaze and vocal exchanges, and by physically molding his/her body to the caregiver's while being held. The child should eventually initiate give-and-take games (such as pat-a-cake, peek-a-boo) with his/her caregivers, and begin to affect others through his/her own purposeful behavior (e.g., gestures and vocalizations). The child should be able to respond to a variety of emotions (e.g., facial expressions and vocal tone changes). The child should begin to develop speech by using vowel sounds and later consonants, first alone, and then in babbling.
  - (ii) Older infants and toddlers (age 1 to attainment of age 3). At this age, the child is dependent upon his/her caregivers, but should begin to separate from them. The child should be able to express emotions and respond to the feelings of others. The child should begin initiating and maintaining interactions with adults, but also show interest in, then play alongside, and eventually interact with other children his/her age. The child should be able to spontaneously communicate his/her wishes or needs, first by using gestures, and eventually by speaking words clearly enough that people who know him/her can understand what he/she says most of the time.
  - (iii) Preschool children (age 3 to attainment of age 6). At this age, the child should be able to socialize with children as well as adults. The child should begin to prefer playmates his/her own age and start to develop friendships with children who are the same age. The child should be able to use words instead of actions to express him/herself, and also be better able to share, show affection, and offer to help. The child should be able to relate to caregivers with increasing independence, choose his/her own friends, and play cooperatively with other children, one at a time or in a group, without continual

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adult supervision. The child should be able to initiate and participate in conversations, using increasingly complex vocabulary and grammar, and speak clearly enough that both familiar and unfamiliar listeners can understand what he/she says most of the time.

- (iv) School-age children (age 6 to attainment of age 12). When the child enters school, he/she should be able to develop more lasting friendships with children who are the same age. The child should begin to understand how to work in groups to create projects and solve problems. He/she should have an increasing ability to understand another's point of view and to tolerate differences. The child should be able to talk to people of all ages, to share ideas, tell stories, and to speak in a manner that both familiar and unfamiliar listeners readily understand.
  - (v) Adolescents (age 12 to attainment of age 18). By the time the child reaches adolescence, he/she should be able to initiate and develop friendships with children who are the same age and to relate appropriately to other children and adults, both individually and in groups. The child should begin to be able to solve conflicts between him/herself and peers or family members or adults outside his/her family. The child should recognize that there are different social rules for him/her and for his/her friends and for acquaintances or adults. The child should be able to intelligibly express his/her feelings, ask for assistance in getting his/her needs met, seek information, describe events, and tell stories, in all kinds of environments (e.g., home, classroom, sports, extra-curricular activities, or part-time job), and with all types of people (e.g., parents, siblings, friends, classmates, teachers, employers, and strangers).
- (3) Examples of limited functioning in interacting and relating with others.

The following examples describe some limitations that may be considered in this domain. The child's limitations may be different from the ones listed here. Also, the examples do not necessarily describe a "marked" or an "extreme" limitation. Whether an example applies in the child's case may depend on the child's age and developmental stage; e.g., an example below may describe a limitation in an older child, but not a limitation in a younger one. As in any case, the child's limitations must result from his/her medically determinable impairment(s). However, all of the relevant information in the child's case record should be considered when deciding whether the child's medically determinable impairment(s) results in a "marked" or "extreme" limitation in this domain.

- (i) The child does not reach out to be picked up and held by his/her caregiver.
- (ii) The child has no close friends, or his/her friends are all older or younger than him/her.
- (iii) The child avoids or withdraws from people he/she knows, or he/she is overly anxious or fearful of meeting new people or trying new experiences.

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- (iv) The child has difficulty playing games or sports within the rules.
  - (v) The child has difficulty communicating with others; e.g., in using verbal and nonverbal skills to express him/herself, carrying on a conversation, or in asking others for assistance.
  - (vi) The child has difficulty speaking intelligibly or with adequate fluency.
- (j) *Moving about and manipulating objects.* In this domain, consider how the child moves his/her body from one place to another and how the child moves and manipulates things. These are called gross and fine motor skills.
- (1) General.
    - (i) Moving the body involves several different kinds of actions: rolling; rising or pulling from a sitting to a standing position; pushing up; raising one's head, legs, and twisting one's hands and feet; balancing one's weight on the legs and feet; shifting one's weight while sitting or standing; transferring oneself from one surface to another; lowering oneself to or toward the floor as when bending, kneeling, stooping, or crouching; moving oneself forward and backward in space as when crawling, walking, or running, and negotiating different terrains (e.g., curbs, steps, and hills).
    - (ii) Moving and manipulating things involves several different kinds of actions: engaging one's upper and lower body to push, pull, lift, carry objects from one place to another; controlling shoulders, arms, and hands to hold or transfer objects; coordinating one's eyes and hands to manipulate small objects or parts of objects.
    - (iii) These objects require varying degrees of strength, coordination, dexterity, pace, and physical ability to persist at the task. They also require a sense of where one's body is and how it moves in space; the integration of sensory input with motor output; and the capacity to plan, remember and execute controlled motor movements.
  - (2) Age group descriptors.
    - (i) Newborns and infants (birth to attainment of age 1). At birth, a child should begin to explore his/her world by moving his/her body and by using his/her limbs. The child should learn to hold his/her head up, sit, crawl, and stand, and sometimes hold onto a stable object and stand actively for brief periods. The child should begin to practice his/her developing eye-hand control by reaching for objects or picking up small objects and dropping them into containers.
    - (ii) Older infants and toddlers (age 1 to attainment of age 3). At this age, the child should begin to explore actively a wide area of his/her physical environment, using his/her body with steadily increasing control and independence from others. The child should begin to walk and run without assistance and climb with increasing skill. The child should frequently try to

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manipulate small objects and to use his/her hands to do or get something that he/she wants or needs. The child's improved motor skills should enable him/her to play with small blocks, scribble with crayons, and feed him/herself.

- (iii) Preschool children (age 3 to attainment of age 6). As a preschooler, the child should be able to walk and run with ease. The child's gross motor skills should let him/her climb stairs and playground equipment with little supervision, and let him/her play more independently; e.g., the child should be able to swing by him/herself and may start learning to ride a tricycle. The child's fine motor skills should also be developing. The child should be able to complete puzzles easily, string beads, and build with an assortment of blocks. The child should be showing increasing control of crayons, markers, and small pieces in board games, and should be able to cut with scissors independently and manipulate buttons and other fasteners.
- (iv) School-age children (age 6 to attainment of age 12). As a school age child, the child's developing gross motor skills should let him/her move at an efficient pace about his/her school, home and neighborhood. The child's increasing strength and coordination should expand his/her ability to enjoy a variety of physical activities, such as running and jumping, and throwing, kicking, catching and hitting balls in informal play or at organized sports. The child's developing fine motor skills should enable him/her to do things like use many kitchen and household tools independently, use scissors, and write.
- (v) Adolescents (age 12 to attainment of age 18). As an adolescent, the child should be able to use his/her motor skills freely and easily to get about his/her school, the neighborhood, and the community. The child should be able to participate in a full range of individual and group physical fitness activities. The child should show mature skills in activities requiring eye-hand coordination, and should have the fine motor skills needed to write efficiently or type on a keyboard.

(3) Examples of limited functioning in moving about and manipulating objects.

The following examples describe some limitations that may be considered in this domain. The child's limitations may be different from the ones listed here. Also, the examples do not necessarily describe a "marked" or "extreme" limitation. Whether an example applies in the child's case may depend on the child's age and developmental stage; e.g., an example below may describe a limitation in an older child, but not a limitation in a younger one. As in any case, the child's limitations must result from his/her medically determinable impairment(s). However, all of the relevant information in the child's case record should be considered when deciding whether the child's medically determinable impairment(s) results in a "marked" or "extreme" limitation in this domain.

- (i) The child experiences muscle weakness, joint stiffness, or sensory loss (e.g., spasticity, hypotonia, neuropathy, or paresthesia) that interferes with

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- his/her motor activities (e.g., the child unintentionally drops things).
- (ii) The child has trouble climbing up and down stairs, or has jerky or disorganized locomotion or difficulty with his/her balance.
  - (iii) The child has difficulty coordinating gross motor movements (e.g., bending, kneeling, crawling, and running, jumping rope, or riding a bike).
  - (iv) The child has difficulty with sequencing hand or finger movements.
  - (v) The child has difficulty with fine motor movement (e.g., gripping or grasping objects).
  - (vi) The child has poor eye-hand coordination when using a pencil or scissors.
- (k) Caring for oneself. In this domain, consideration is given to how well the child maintains a healthy emotional and physical state, including how well the child gets his/her physical and emotional needs met in appropriate ways; how well the child copes with stress and changes in his/her environment; and whether he/she takes care of his/her own health, possessions, and living area.
- (1) General.
    - (i) Caring for oneself effectively, which includes regulating oneself, depends upon the child's ability to respond to changes in his/her emotions and the daily demands of his/her environment to help him/herself and cooperate with others in taking care of his/her personal needs, health and safety. It is characterized by a sense of independence and competence. The effort to become independent and competent should be observable throughout childhood.
    - (ii) Caring for oneself effectively means becoming increasingly independent in making and following one's own decisions. This entails that the child rely on his/her own abilities and skills, and display consistent judgment about the consequences of caring for him/herself. As the child matures, using and testing his/her own judgment helps him/her develop confidence in his/her independence and competence. Caring for oneself includes using one's independence and competence to meet one's physical needs, such as feeding, dressing, toileting, and bathing, appropriately for one's age.
    - (iii) Caring for oneself effectively requires the child to have a basic understanding of his/her body, including its normal functioning, and of his/her emotional needs. To meet these needs successfully, the child must employ effective coping strategies, appropriate for his/her age, to identify and regulate his/her feelings, thoughts, urges, and intentions. Such strategies are based on taking responsibility for getting one's needs met in an appropriate and satisfactory manner.

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(iv) Caring for oneself means recognizing when one is ill, following the recommended treatment, taking medication as prescribed, following safety rules, responding to circumstances in safe and appropriate ways, making decisions that do not endanger oneself, and knowing when to ask for help from others.

(2) Age group descriptors.

(i) Newborns and infants (birth to attainment of age 1). The child's sense of independence and competence begins by being able to recognize his/her body's signals (e.g., hunger, pain, discomfort), to alert a caregiver to his/her needs (e.g., by crying), and to console him/herself (e.g., by sucking on his/her hand) until help comes. As the child matures, his/her capacity for self-consolation should expand to include rhythmic behaviors (e.g., rocking). The child's need for a sense of competence also emerges in things he/she tries to do for him/herself, perhaps before he/she is ready to do them, as when insisting on putting food in his/her own mouth and refusing a caregiver's help.

(ii) Older infants and toddlers (age 1 to attainment of age 3). As the child grows, the child should be trying to do more things for him/herself that increase his/her sense of independence and competence in his/her environment. The child might try to console him/herself by carrying a favorite blanket everywhere. The child should be learning to cooperate with his/her caregivers when they take care of the child's physical needs, but the child should also want to show what he/she can do (e.g., pointing to the bathroom, pulling off his/her coat). The child should be experimenting with his/her independence by showing some degree of contrariness (e.g., "No! No!") and identity (e.g., hoarding his/her toys).

(iii) Preschool children (age 3 to attainment of age 6). The child should want to take care of many of his/her physical needs by him/herself (e.g., putting on shoes, getting a snack), and also want to try doing some things that he/she cannot do fully (e.g., tying his/her shoes, climbing on a chair to reach something up high, taking a bath). Early in this age range, it may be easy for the child to do what a caregiver asks. Later, that may be difficult for the child because he/she wants to do things his/her way or not at all. These changes usually mean that the child is more confident about his/her ideas and what he/she is able to do. The child should also begin to understand how to control behaviors that are not good for him/her (e.g., crossing the street without an adult).

(iv) School-age children (age 6 to attainment of age 12). The child should be independent in most day-to-day activities (e.g., dressing him/herself, bathing him/herself), although he/she may still need to be reminded sometimes to do these routinely. The child should begin to recognize that he/she is competent in doing some activities and that he/she has difficulty with others. The child should be able to identify those circumstances when he/she feels good about

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him/herself and when he/she feels bad. The child should begin to develop understanding of what is right and wrong, and what is acceptable and unacceptable behavior. The child should begin to demonstrate consistent control over his/her behavior, and should be able to avoid behaviors that are unsafe or otherwise not good for him/her. The child should begin to imitate more of the behavior of adults he/she knows.

- (v) Adolescents (age 12 to attainment of age 18). The child should feel more independent from others and should be increasingly independent in all of his/her day-to-day activities. The child may sometimes experience confusion in the way he/she feels about him/herself. The child should begin to notice significant changes in his/her body's development, and this could result in anxiety or worrying about him/herself and his/her body. Sometimes these worries may make the child angry or frustrated. The child should begin to discover appropriate ways to express his/her feelings, both good and bad (e.g., keeping a diary to sort out angry feelings or listening to music to calm down). The child should begin to think seriously about his/her future plans, and what he/she will do when school is finished.

(3) Examples of limited functioning in caring for oneself.

The following examples describe some limitations that may be considered in this domain. The child's limitations may be different from the ones listed here. Also, the examples do not necessarily describe a "marked" or "extreme" limitation. Whether an example applies in a child's case may depend on the child's age and developmental stage; e.g., an example below may describe a limitation in an older child, but not a limitation in a younger one. As in any case, the child's limitations must result from his/her medically determinable impairment(s). However, consider all of the relevant information in the child's case record when deciding whether the child's medically determinable impairment(s) results in a "marked" or "extreme" limitation in this domain.

- (i) The child continues to place non-nutritive or inedible objects in his/her mouth. The child often uses self-soothing activities showing developmental regression (e.g., thumb-sucking, re-chewing food), or he/she has restrictive or stereotyped mannerisms (e.g., body rocking, head banging).
- (ii) The child does not dress or bathe him/herself appropriately for his/her age because he/she has an impairment that affects this domain.
- (iii) The child engages in self-injurious behavior (e.g., suicidal thoughts or actions, self-inflicted injury, or refusal to take his/her medication), or he/she ignores safety rules.
- (iv) The child does not spontaneously pursue enjoyable activities or interests.
- (v) The child has a disturbance in eating or sleeping patterns.

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- (l) Health and physical well-being. In this domain, consideration is given to the cumulative physical effects of physical or mental impairments and their associated treatments or therapies on the child's functioning that were not considered in paragraph (j) of this section. When the child's physical impairment(s), mental impairment(s), or combination of physical and mental impairments has physical effects that cause "extreme" limitations in the child's functioning, the child will generally have an impairment(s) that "meets" or "medically equals" a listing.
- (1) A physical or mental disorder may have physical effects that vary in kind and intensity, and make it difficult for the child to perform his/her activities independently or effectively. The child may experience problems such as generalized weakness, dizziness, shortness of breath, reduced stamina, fatigue, psychomotor retardation, allergic reactions, recurrent infection, poor growth, bladder or bowel incontinence, or local or generalized pain.
  - (2) In addition, the medications that the child takes (e.g., for asthma or depression) or the treatments the child receives (e.g., chemotherapy or multiple surgeries) may have physical effects that also limit the child's performance of activities.
  - (3) The child's illness may be chronic with stable symptoms, or episodic with periods of worsening and improvement. Consider how the child functions during periods of worsening and how often and for how long these periods occur. The child may be medically fragile and need intensive medical care to maintain his/her level of health and physical well-being. In any case, as a result of the illness itself, the medications or treatment the child receives, or both, the child may experience physical effects that interfere with his/her functioning in any or all of his/her activities.
  - (4) Examples of limitations in health and physical well-being. The following examples describe some limitations we may consider in this domain. The child's limitations may be different from the ones listed here. Also, the examples do not necessarily describe a "marked" or "extreme" limitation. Whether an example applies in the child's case may depend on the child's age or developmental stage; e.g., an example below may describe a limitation in an older child, but not a limitation in a younger one. As in any case, the child's limitations must result from his/her medically determinable impairment(s). However, consider all of the relevant information in the child's case record when deciding whether the child's medically determinable impairment(s) results in a "marked" or "extreme" limitation in this domain.
    - (i) The child has generalized symptoms, such as weakness, dizziness, agitation (e.g., excitability), lethargy (i.e., fatigue or loss of energy or stamina), or psychomotor retardation because of his/her impairment(s).
    - (ii) The child has somatic complaints related to his/her impairment (e.g., seizure or convulsive activity, headaches, incontinence, recurrent infections, allergies, changes in weight or eating habits, stomach discomfort, nausea, headaches, or insomnia).

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- (iii) The child has limitations in his/her physical functioning because of his/her treatment (e.g., chemotherapy, multiple surgeries, chelation, pulmonary cleansing, or nebulizer treatments).
  - (iv) The child has exacerbations from one impairment or a combination of impairments that interfere with his/her physical functioning.
  - (v) The child is medically fragile and needs intensive medical care to maintain his/her level of health and physical well-being.
- (m) *Examples of impairments that functionally equal the listings.* The following are some examples of impairments and limitations that functionally equal the listings. Findings of equivalence based on the disabling functional limitations of a child's impairment(s) are not limited to the examples in this paragraph, because these examples do not describe all possible effects of impairments that might be found to functionally equal the listings. As with any disabling impairment, the duration requirement must also be met.
- (1) Documented need for major organ transplant (e.g., liver).
  - (2) Any condition that is disabling at the time of onset, requiring continuing surgical management within 12 months after onset as a life-saving measure, or for salvage or restoration of function, and such major function is not restored or is not expected to be restored within 12 months after onset of the condition.
  - (3) Effective ambulation possible only with obligatory bilateral upper limb assistance.
  - (4) Any physical impairment(s) or combination of physical and mental impairments causing complete inability to function independently outside the area of one's home within age-appropriate norms.
  - (5) Requirement for 24-hour-a-day supervision for medical (including psychological) reasons.
  - (6) Major congenital organ dysfunction which could be expected to result in death within the first year of life without surgical correction, and the impairment is expected to be disabling (because of residual impairment following surgery, or the recovery time required, or both) until attainment of 1 year of age.