CHAPTER 526

COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR CHILDREN WITH DISABILITIES COMMUNITY SERVICES PROGRAM (CDCSP)

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CHAPTER 526 CHILDREN WITH DISABILITIES COMMUNITY SERVICES PROGRAM (CDCSP)

INTRODUCTION

The West Virginia (WV) Medicaid Program offers a comprehensive scope of medically necessary medical and mental health services to diagnose and treat eligible members. Covered and authorized services must be rendered by enrolled providers within the scope of their license and in accordance with all state and federal requirements. Any service, procedure, item, or situation not discussed in the manual must be presumed non-covered unless informed, otherwise in writing, by the Bureau for Medical Services (BMS).

This chapter sets forth the BMS eligibility and reimbursement requirements for services provided to eligible WV Medicaid members under the Children with Disabilities Community Services Program (CDCSP).

The policies and procedures set forth herein are the regulations governing the provision of services under the Children with Disabilities Community Services Program of the Medicaid Program administered by the Department of Health and Human Resources (DHHR) under the provisions of Title XIX of the Social Security Act and Chapter 9 of the WV Code. The Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 allowed the State of West Virginia to elect the option of providing CDCSP (Federal Title "Disabled Child In-Home Care Program" otherwise known as Katie Beckett) under Medicaid.

The CDCSP allows a child with a severe disability who is eligible to receive the level of care provided in a medical institution (i.e., nursing facility, ICF/MR, hospital) to receive Medical Assistance, i.e., the child will receive a West Virginia Medical card. Medicaid may pay the premiums, deductibles, coinsurance and other cost sharing obligations for eligible members who have primary insurance. The member will remain eligible for CDCSP State plan services. CDCSP applicants are encouraged to inquire about the guidelines for this program.

To be eligible for the CDCSP, the child must (a) live at home with his/her biological or adoptive parents and (b) have a program of community services developed by a health care provider. The level of services provided in the community must serve the child as well as or better than comparable services in a medical institution and must cost less than the same services delivered in a comparable medical institution (nursing facility, ICF/MR, hospital).

526.1 DEFINITIONS

Definitions governing the provision of all WV Medicaid services will apply pursuant to Chapter 200 Definitions of the Provider Manual. In addition, the following definitions also apply to the requirements for payment of the services in the **CDCSP** described in this chapter.

Complex medication regimen means the child must have a complex range of new medications (including medications by mouth) following a hospitalization where there is a high probability of adverse reactions and/or a need for changes in the dosage or type of medication

to maintain stability; and documentation must include the child's unstable condition, medication changes, continuing probability of complications and need for monitoring by skilled personnel.

Complex teaching services to the child and/or family requiring 24-hour skilled nursing facility setting vs. intermittent home health setting means the teaching itself is the skilled service that must be provided by the appropriate professional. The activity being taught may or may not be considered skilled; documentation should include the reasons why the teaching was not completed in the hospital, as well as the child's or family's capability of compliance.

Cost Effectiveness means the cost of care for the child in the home cannot exceed the cost of care in an institution.

Children with Disabilities Community Services Program (CDCSP) is a West Virginia optional program that provides Medicaid benefits to severely disabled children who meet the program's eligibility requirements. It is administered by the Bureau for Medical Services (BMS) and approved by the Centers for Medicare and Medicaid Services (CMS), the federal agency responsible for Title XIX. The CDCSP is an alternative to institutionalization and provides medically necessary services that are community-based and costs less than institutional services.

Developmental Disability: This term is used to describe a child who has not attained normal development when compared with the standard population. It may be attributable to mental retardation, cerebral palsy or epilepsy; or any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons. It is manifested before the person reaches age 22; it is likely to continue indefinitely; it results in substantial functional limitations in three or more of the following areas of major life activity: (1) self-care, (2) understanding and use of language, (3) learning (functional academics), (4) mobility, (5) self-direction and (6) capacity for independent living. (Code of Federal Regulations 42, 435.1010).

Disability for CDCSP means that the child must be disabled according to the SSI definition of disability.

Forms:

- DD1: CDCSP Information Sheet
- DD2A: Medical Evaluation (ICF/MR Level of Care)
- DD2B: Medical Evaluation (Acute Hospital/Nursing Home Level of Care)
- DD3: Comprehensive Psychological Evaluation
- DD4: Social History
- DD6: Cost Estimate Worksheet Instructions

Level of Care for CDCSP references the medical eligibility criteria for level of care provided in a hospital, nursing facility, and ICF/MR facility.

Mental Retardation means significantly sub-average intellectual functioning which manifests itself in a person during his/her developmental period and which is characterized by inadequacy in adaptive behavior. West Virginia Code § 27-1-3.

Observation, assessment and monitoring of a complicated or unstable condition means unstable condition of the child must require the skills of a licensed nurse or rehabilitation personnel in order to identify and evaluate the child's need for possible modification of the treatment plan or initiation of additional medical procedures; there must be a high likelihood of a change in a child's condition due to complications or further exacerbations; Daily nursing notes must give evidence of the child's condition and indicate the results of monitoring; Documentation must indicate the child's condition and indicate the results of monitoring.

Wound care [including decubitus ulcers] Skilled nursing facility services solely for the purpose of wound care should be rare. **All** of the following criteria must be met:

- Wound care must be ordered by a physician,
- The child must require extensive wound care that consists of packing, debridement and/or irrigation.

526.2 MEMBER ELIGIBILITY AND ENROLLMENT PROCESS

Targeted Population includes:

- A child from newborn up through the age of 18 [Soc. Sec. Act, Sect. 1902(e)(3)(A)], who lives with his/her adoptive or biological family, and;
- who has a disability that qualifies him/her to receive Supplemental Security Income (SSI), but who is denied SSI because his/her parents' income or assets exceeds the Social Security Administration guidelines;
- whose care is provided in his/her home and community setting at the same level of quality and does not exceed the cost of care in a medical institution, and:
- whose care requires the level of services provided in one of the following medical facilities:

Acute Care Hospital: A child with a significant need for medical services and/or nursing services who is at risk of hospitalization in an acute care hospital setting. Inpatient services are defined as services ordinarily furnished in a hospital for care and treatment of inpatients and are furnished under the direction of a physician. CFR §440.10.

- Hospital level of care is appropriate for individuals who continuously require the type of care ordinarily provided in a hospital, and who, without these services, would require frequent hospitalizations. This level of care is highly skilled and provided by professionals in amounts not normally available in a skilled nursing facility but available in a hospital.

Intermediate Care Facility for Individuals with Mental Retardation and/or Related Conditions (ICF/MR): A child with mental retardation and/or related conditions (e.g., cerebral palsy, autism, traumatic brain injury) who is at risk of being placed in an ICF/MR facility. CFR §440.50.

- An ICF/MR level of care is appropriate for individuals who require the type of active treatment typically provided by a facility whose primary purpose is to furnish health and habilitation services to persons with mental retardation or related conditions.

Nursing facility (NF): A child with a significant need for medical services and/or nursing services who is at risk of hospitalization or placement in a nursing facility.

- Nursing facility services are skilled services that are needed on a daily basis that must be provided on an inpatient basis and ordered by, and provided under the direction of a physician. (42 CFR)
- Nursing facility level of care is appropriate for individuals who do not require acute hospital care, but, on a regular basis, require nursing services, or other health-related services ordinarily provided in an institution. With respect to an individual who has a mental illness or mental retardation, nursing facility level of care services are usually inappropriate unless that individual's mental health needs are secondary to needs associated with a more acute physical disorder.

526.3 MEMBER MEDICAL AND FINANCIAL ELIGIBILITY

The member must have a determination of Medical Eligibility. Medical eligibility is comprised of two components:

1. The applicant must meet the level of care stated in the application; and
2. All medical costs [billed charges] the child incurred in the 12 months prior to application are less than the costs that would have been incurred in the institution for the distinct level of care during the same period. The child's proposed costs for the forthcoming year are also compared to the costs in the institution and may not exceed the 'ceiling' for the specific level of care. Please refer to Appendix A.

The member must have a determination of Financial Eligibility. Once medical eligibility is established, members make application at the local Department of Health & Human Resource (DHHR) office for assessment of financial eligibility. A child will be assessed as an individual applicant regardless of his/her family's income. Income and assets of the child will be used in determining his/her financial eligibility for the program.

Financial eligibility will be determined by the local Department of Health and Human Resources (DHHR) Economic Services (ES) Worker. Financial Eligibility will be based on:

- INCOME: Only the applicant's income is considered available to him/her. The parents' income is not considered available to the child. The child's income will be established as a single applicant with eligibility determined independently of other members of his/her family.
- ASSETS: An individual's assets, excluding residence and furnishings, may not exceed $2,000 for Medicaid eligibility under CDCSP.

Once medical and financial eligibility is determined, the member is eligible for a West Virginia Medicaid card under CDCSP for a period of one year or until the cost exceeds that which can be provided in an institution. The member must be a resident of the State of West Virginia.

Medicaid may pay the premiums, deductibles, coinsurance and other cost sharing obligations for eligible members who have primary insurance. The member will remain eligible for CDCSP

State plan services. CDCSP applicants are encouraged to inquire about the guidelines for this program.

526.4 APPLICATION PROCESS

1. Parent applies at Social Security Administration (SSA) for Supplemental Security Income (SSI).
    i. If the child is eligible for SSI, he or she receives a Medicaid Card.
    ii. If the child is ineligible for SSI due to parents' income or assets exceeding the Social Security Administration guidelines, then the application process for CDCSP should be initiated.
2. A member (family) may obtain an application for CDCSP and information packet from: the Bureau for Medical Services, the local Behavioral Health Centers, or the local/county DHHR Offices. An application and information packet is also available at www.wvdhhr.org/bms/manuals/bms_manuals_main.htm.
3. The Application packet must be **fully** completed. The family may select a Service Coordination Agency to support the applicant and/or legal representative to ensure processing without delay or may complete the application packet on their own.
4. The Service Coordinator/Case Manager or Parent/Guardian takes the child and the Annual Medical Evaluation [DD2A/CDCSP (for ICF/MR Level of Care)] or the Medical Evaluation [DD-2B/CDCSP (for acute hospital/nursing home level of care)] form to a physician.
    i. Physician completes assessment documenting on the DD2A or DD2B form. The assessment must indicate that child requires **one** of the institutional levels of care to allow for review to determine medical eligibility to be established and returns it to the Service Coordinator/Case Manager or Parent. **Only one** institutional level of care is to be selected.
    ii. Other pertinent information may also be obtained and submitted for review.
5. The Service Coordinator/Case Manager or Parent completes or may provide the following:
    - DD-6/CDCSP, "Cost Estimate Sheet"
    - DD-4/CDCSP, "Social History"
    - Obtains the Individualized Education Plan (IEP) for school-age children
    - Obtains the West Virginia Birth to Three, Individual Family Service Plan (IFSP), for children three and below
    - Obtains the DD-2A/CDCSP or DD-2B/CDCSP, "Medical Evaluation"
    - DD-3/CDCSP, "Psychological Evaluation" (for ICF/MR Level of Care only)
    - Other documentation if required and/or pertinent to apply for the institutional level of care the individual is seeking

- The packet of information is to be submitted directly to the contracted agency (vendor), dated and logged. Applications will be reviewed in the order received.

Applications should be addressed to Attention: CDCSP, Psychological Consultation and Assessment (contractual agency), 202 Glass Drive, Cross Lanes, West Virginia 25313.

6. The Bureau for Medical Services (BMS) or its agent reviews the documentation to determine medical eligibility. Additional information may be requested to support application.
   - If the documentation does not support medical or cost eligibility, BMS informs the Service Coordinator/Case Manager, or parent and the local DHHR office. The parent/applicant is notified of the appeals process.
   - If the documentation substantiates medical eligibility, the local DHHR office, Service Coordinator/Case Manager or parent, is informed.

8. The parent applies at the local Department of Health and Human Resources (DHHR) office to determine financial eligibility after medical eligibility has been determined.
   - If child is financially ineligible - Child has income and/or resources in excess of limits. Parents are informed of ineligibility and appeals decisions.
   - If child is financially eligible – the Medicaid card will be provided.

9. Medical and financial eligibility must be re-established annually, following the same guidelines.

526.5 MEDICAL ELIGIBILITY FOR ACUTE CARE HOSPITAL LEVEL OF CARE

Hospital level of care is appropriate for children who require the type of care ordinarily provided in a hospital, and who, without these services, would require frequent, continuous, or prolonged hospitalizations. This level of care is highly skilled, provided by professionals, and is not normally available in a skilled nursing facility, but available only in an inpatient hospital setting. This level of care is appropriate when a child requires throughout the day an extensive array of services furnished either directly by, or under the direct supervision of, a physician. This daily skilled medical treatment is more complex than nursing facility level of care due to an unstable medical condition.

526.5.1 Medical Necessity for Acute Care Hospital Level of Care

The child meets hospital level of care when:

1. Skilled assessment and intervention multiple times during a 24 hour period, on a daily basis, is required to maintain stability and prevent deterioration including:
   - Medical monitoring, assessment, and intensive medication administration for the medical condition;
   - Monitoring changes in the child's condition that require prompt interventions to avert complications;

- Provision of physician-supervised, hands-on, comprehensive medical interventions and treatments;
- Modifications of treatment plans throughout the day based on the child's condition;
- The child requires comprehensive medical treatments and skilled services on a daily basis; AND

2. As a practical matter, the daily comprehensive medical services can be provided only on an
   inpatient basis in a hospital setting; AND
3. The child requires acute care services that must be performed by, or under the supervision of, professional or technical personnel and directed by a physician and directed by a treatment plan; AND
4. The treatment of the child's illness substantially interferes with the ability to engage in everyday age appropriate activities of daily living at home and in the community, including but not limited to bathing, dressing, toileting, feeding, and walking/mobility; AND
5. The child's daily routine is substantially altered by the need to complete these specialized, complex and time consuming treatments and medical interventions or self-care activities; AND
6. The child requires specialized professional training and monitoring beyond those ordinarily expected of parents; AND
7. The child's condition meets criteria for an inpatient level of care. Hospital level of care must be furnished pursuant to a physician's orders and be reasonable and necessary for the treatment of an individual's illness or injury and must be consistent with the nature and severity of the child's illness or injury, his/her particular medical needs and accepted standards of medical practice.

526.5.2 Documentation Evidence Required for Acute Care Hospital Level of Care

- DD1/ CDCSP Cover Sheet
- DD2B/CDCSP Medical Evaluation
- DD4/ CDCSP Social History
- DD6/CDCSP Cost Estimate
- Evidence of Physician directed medical care
- History of recurrent emergency room visits for acute episodes over the last year **AND** history of recurrent hospitalizations over the last year
- Ongoing visits with specialists in an effort to prevent an acute episode
- Medical condition is not stabilized, requiring frequent interventions
- Substantial impairment of daily living activities within the child's developmental level for age due to recurrent acute illnesses requiring hospitalization
- Documentation of frequent need to stabilize in an inpatient setting using medication, surgery, and/or other procedures.

526.5.3 Factors Not Considered Medically Necessary for Acute Hospital Level of Care

A hospital setting is not considered medically necessary when ANY ONE of the following is present:

- Services do not meet the medically necessary criteria above; OR

- The child's condition has changed such that hospital care is no longer needed; OR
- Medical monitoring, assessment, frequent medical intervention, comprehensive medical treatment and intensive medication regimen is no longer required and there is no improvement in the level of functioning within a reasonable period of time; OR
- Services that are solely performed to preserve the present level of function or prevent regression of functions for an illness, injury or condition that is resolved or stable; OR
- The child or his/her family refuses to participate in the recommended treatment plan; OR
- The care has become custodial; OR
- The services are provided by a family member or another non-medical person; OR
- When a service can be safely and effectively performed (or self-administered) by the average non-medical person without the direct supervision of a nurse; OR
- The service cannot be regarded as an acute hospital service.

526.6 MEDICAL ELIGIBILITY FOR ICF/MR LEVEL OF CARE

In order to be eligible to receive ICF/MR Level of Care, an applicant must meet the following medical eligibility criteria:

526.6.1 Diagnostic

- Have a diagnosis of mental retardation and/or a related condition.
- Require the level of care and services provided in an ICF/MR (Intermediate Care Facility for the Mentally Retarded) as evidenced by required evaluations and corroborated by narrative descriptions of functioning and reported history. An ICF/MR provides services in an institutional setting for persons with mental retardation or related condition. An ICF/MR facility provides monitoring, supervision, training, and supports.
    - Level of care (medical eligibility) is based on the Annual Medical Evaluation (DD-2A/CDCSP), the Psychological Evaluation (DD-3/CDCSP) and verification if not indicated in the DD-2B/CDCSPand DD-3/CDCSP, that documents that the mental retardation and/or related conditions with associated concurrent adaptive deficits, are severe, and are likely to continue indefinitely. Other documents, if applicable and available, that can be utilized include the Social History, IEP for school age children and Birth to Three assessments.

The evaluations must demonstrate that an applicant has a diagnosis of mental retardation and/or a related developmental condition, which constitutes a severe and chronic disability. For this program individuals must meet the diagnostic criteria for medical eligibility not only by relevant test scores, but also be supported by the narrative descriptions contained in the documentation.

- Must have a diagnosis of mental retardation, with concurrent substantial deficits (substantial limitations associated with the presence of mental retardation), and/or
- Must have a related developmental condition which constitutes a severe and chronic disability with concurrent substantial deficits. Examples of related conditions which, if severe and chronic in nature, may make an individual eligible for the CDCSP (ICF/MR Level of Care) include, but are not limited to, the following:

- Autism
- Traumatic brain injury
- Cerebral Palsy
- Spina Bifida
- Tuberous Sclerosis

- Any condition, other than mental illness, found to be closely related to mental retardation that results in an impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires services similar to those required for persons with mental retardation. Additionally, mental retardation and/or related conditions with associated concurrent adaptive deficits that are likely to continue indefinitely.

- Must result in the presence of a least three (3) substantial deficits as that term is defined in Title 42, Chapter IV, Part 435.1010 of the Code of Federal Regulations (CFR). Substantial deficits associated with a diagnosis other than mental retardation or a related condition do not meet eligibility criteria. Additionally, any individual needing only personal care services does not meet the eligibility criteria for ICF/MR level of care

526.6.2 Functionality

Substantially limited functioning in three (3) or more of the following major life areas; ("substantially limited" is defined on standardized measures of adaptive behavior scores as three (3) standard deviations below the mean or less than (1) one percentile when derived from non MR normative populations (when mental retardation has not been diagnosed) or in the average range or equal to or below the seventy-fifth (75) percentile when derived from MR normative populations. The presence of substantial deficits must be supported by not only the relevant test scores, but also the narrative descriptions contained in the documentation submitted for review, i.e., psychological, the IEP, Occupational Therapy evaluation, narrative descriptions, etc.)

- **Self-care** refers to such basic activities such as age appropriate grooming, dressing, toileting, feeding, bathing, and simple meal preparation.
- **Receptive or expressive language** (communication) refers to the age appropriate ability to communicate by any means whether verbal, nonverbal/gestures, or with assistive devices.
- **Functional Learning** (age appropriate functional academics)
- **Mobility (motor skills)** refers to the age appropriate ability to move one's person from one place to another with or without mechanical aids.
- **Self-direction** refers to the age appropriate ability to make choices and initiate activities, the ability to choose an active lifestyle or remain passive, and the ability to engage in or demonstrate an interest in preferred activities.
- **Capacity for independent living** encompasses sub-components that are age appropriate for home living, socialization, leisure skills, community use and health and safety.

526.6.3 Active Treatment

The applicant would benefit from continuous active treatment typically provided by a facility whose primary purpose is to furnish health and habilitation services to persons with mental retardation or related conditions.

526.6.4 Child Determined Medically Eligible for Title XIX Home and Community Based Waiver

If the child has been determined medically eligible for the Title MR/DD XIX Home and Community Based Waiver program and is on the wait list, the medical eligibility will be accepted for the CDCSP. An updated CDCSP Cover Sheet (DD-1/CDCSP), an updated social history (DD- 4/CDCSP) that is signed and dated, and the Cost Estimate (DD-6/CDCSP) will need to be submitted for review.

526.7 MEDICAL ELIGIBILITY FOR NURSING FACILTY LEVEL OF CARE

Nursing facility level of care is appropriate for children who do not require acute hospital care, but who, on a regular basis, require skilled nursing services, complex rehabilitation services, and other health-related services ordinarily provided in an institution.

Skilled nursing services are provided to children living at home who have significant medical needs and require complex nursing treatments, personal care, specialized therapy, and medical equipment to enhance or sustain their lives. The child's daily routine is substantially altered by the need to complete specialized, complex, and time consuming treatments.

A nursing facility level of care is appropriate when the child requires complex skilled nursing care or comprehensive rehabilitative interventions throughout the day including **ALL** of the following:

1. The child requires skilled nursing or skilled rehabilitation services that must be performed by, or under the supervision of professional or technical personnel; AND
2. The child requires specialized professional training and monitoring beyond the capability of, and those ordinarily expected of parents; AND
3. The child requires skilled observation and assessment several times daily due to significant health needs; AND
4. The child requires these skilled services on a daily basis; AND
5. A skilled nursing facility setting must be furnished pursuant to a physician's order and be reasonable and necessary for the treatment of a child's illness or injury (i.e.,, be consistent with the nature and severity of the individual's injury or illness, his particular medical needs and accepted standards of medical practice); AND
6. The child has unstable health, functional limitations, complicating conditions, or is medically fragile such that there is a need for active care management; AND
7. The child's impairment substantially interferes with the ability to engage in everyday activities of daily living at home and in the community, including but not limited to bathing, dressing, toileting, feeding, and walking/mobility; AND
8. The child's daily routine is substantially altered by the need to complete these specialized, complex and time consuming treatments and medical interventions or self-care activities; AND

9. The child needs complex care management and/or hands on care that substantially exceeds age appropriate assistance; AND
10. The child needs complex restorative, rehabilitative and other special treatment of a chronic nature that can be provided only in a skilled nursing facility. In other words, institutionalization in a nursing facility would be necessary in the absence of these services provided in the community setting; AND
11. In addition to the general requirements above, the child's condition must require one or more of the following defined settings below on a daily basis:

    - Observation, assessment and monitoring of a complicated or unstable condition; OR
    - Complex teaching services to the child and/or family requiring 24-hour skilled nursing facility (SNF) setting vs. intermittent home health setting; OR
    - Complex medication regimen other than oral medication or medication otherwise deemed self administered, such as insulin or growth hormone; OR
    - *Initiation* of tube feedings; OR
    - Active weaning of ventilator dependent children requiring changing and monitoring of ventilator setting; OR
    - Wound care (including decubitus ulcers) requiring more than just superficial dressing changes, i.e. packing, debridement, etc.

526.7.1 Documentation - Evidence Required for Nursing Level of Care

Documentation required:

- DD1/ CDCSP Cover Sheet
- DD2B/CDCSP Medical Evaluation
- DD4/CDCSP Social History
- DD6/CSCSP Cost Estimate
- Evidence that Complex rehabilitative services (therapies), wound care, and other intense skilled nursing care of a chronic nature is medically necessary
- The medical condition is stabilized
- Substantial impairment of daily living activities which are not within the child's developmental level for age
- Care is ordered and delegated by the physician to an RN or LPN and/or RN or LPN oversight according to a plan of treatment with short and long term goals
- Medical care can be managed in setting that is less than a acute care setting
- Skilled nursing care is medically necessary.

526.7.2 Factors Not Considered Medically Necessary for Nursing Facility Level of Care

A skilled nursing facility setting is considered not medically necessary when ANY ONE of the following is present:

- Services do not meet the medically necessary criteria above; OR
- The child's condition has changed such that skilled medical or rehabilitative care is no longer needed; OR
- Physical medicine therapy or rehabilitation services that will not result in improvement in the level of functioning within a reasonable period of time; OR

- Services that are solely performed to preserve the present level of function or prevent regression of functions for an illness, injury or condition that is resolved or stable; OR
- The child and or family refuses to participate in the recommended treatment plan; OR
- The care has become custodial; OR
- The services are provided by a family member or another non-medical person. When a service can be safely and effectively performed (or self-administered) by the average non-medical person without the direct supervision of a nurse, the service cannot be regarded as a skilled service.

526.7.2.1 Examples of Services Not Medically Necessary for Nursing Facility Level of Care

- Routine or maintenance medication administration, including oral medication and other agents deemed by CMS to be 'self-administered drugs'
- Routine enteral feedings
- Medically stable ventilator care that can be safely provided in an alternative setting
- Monitoring of home oxygen therapy
- Routine tracheostomy care
- Routine gastrostomy, jejunostomy or ileostomy care
- CPAP or BiPAP administration or monitoring
- Inhalation care. **The need for respiratory therapy, either by a nurse or by a respiratory therapist, DOES not alone qualify a child for skilled nursing facility care.**
- Personal care services such as bathing.

526.8 CASE MANAGEMENT/SERVICE COORDINATOR FOR THOSE APPLYING FOR ICF/MR LEVEL OF CARE--RECERTIFICATION

The Case Management/Service Coordinator Agency, if utilized, must:

- o Accept referrals of children who are included in the disability group(s) which the agency serves;
- o Ensure that the parents or legal representative establish or re-establish their child's financial eligibility at the county DHHR office on an annual basis and report any changes in the child's finances to the county DHHR office;
- o Ensure that the child has completed all assessments necessary for initial certification and annually thereafter for recertification; Coordinate and obtain appropriate assessments and evaluations (this should include a discharge plan if the child has been recently discharged from a medical facility) to be used in development of the Individual Program Plan (IPP).
- o Convene an Interdisciplinary Team (IDT), consisting of the child, family or legal representative, service providers, advocate, professionals, paraprofessionals and other stakeholders needed to ensure the delivery of the necessary level of services and care, to develop an annual comprehensive IPP in accordance with Medicaid and Office of Health Facility Licensure and Certification (OHFLAC) policies;
- o Complete the Cost Estimate Worksheet (DD-6/CDCSP) on an annual basis;

- Monitor the implementation of the IPP to assure the quality of services and to ensure that the services are delivered in accordance with the relevant State Medicaid manual (e.g., Targeted Case Management, Personal Care, and Clinic Services Manuals) and policies;
- Communicate with the family via home visits, telephone calls and letters to monitor its satisfaction with and the effectiveness of services. The frequency of home visits and other contacts will be determined by the IDT;
- Monitor the service cost to ensure that the community service costs do not exceed the comparable institutional cost and notify the county DHHR office and BMS if the community service costs exceed the comparable institutional cost;
- Ensure that all providers of service and the parent are made aware of the cost effective nature of the program and that all community service providers must participate in the development of the IPP and be part of the cost estimate for services;
- Review and update the IPP as required by Medicaid and OHFLAC policies, to ensure the quality, appropriateness and cost effectiveness of the community services. Substantial changes in the IPP and DD-6/CDCSP will require submission of a new DD-6/CDCSP to BMS.
- Maintain the required documentation for Medicaid services in the child's record, and provide State level staff with necessary information to establish or maintain eligibility and meet reporting requirements.

526.9 RE-DETERMINATION OF MEDICAL ELIGIBILITY

Re-determination of medical eligibility must be completed annually for each member, pursuant to federal law. An individual must qualify for recertification at least annually. Eligibility determination must be made on current eligibility criteria, not on past CDCSP eligibility. The fact that a recipient had previously received CDCSP services shall have no bearing on continued eligibility for this program. The date of the member's medical re-eligibility is the date the annual medical evaluation (DD 2A or DD-2B/CDCSP) was signed.

526.10 SERVICES

Covered Medicaid Services that are appropriate and medically necessary for the individual.

526.11 SERVICE LIMITATIONS

Services are restricted by limits as set in the Medicaid State Plan/policies/procedures. Services do not include Waiver program services.

526.12 RIGHT TO APPEAL

If an applicant/member is determined not to be medically eligible by BMS, a Notice of Decision and a Request for Hearing form will be issued to the applicant/member. The decision/denial may be appealed directly through the fair hearing process.

526.13 MOUNTAIN HEALTH TRUST—MANAGED CARE

Recipients eligible for this program are not eligible for enrollment in a managed care organization.

526.14 MOUNTAIN HEALTH CHOICES

Recipients eligible for this program are not eligible to participate in Mountain Health Choices.

CHAPTER 526

CHILDREN WITH DISABILITIES COMMUNITY SERVICE PROGRAM

(CDCSP)

JULY 1, 2008

APPENDIX A

FINANCIAL LIMITATIONS

APPENDIX A

FINANCIAL LIMITATIONS:

Services in a community setting must be cost-effective when compared to the cost of facility-based care.	
FACILITY	**COST**
Hospital	$3,951 per stay
Nursing Facility	$4,934/month
ICF/MR Facility	$9,696/month

CHAPTER 526

CHILDREN WITH DISABILITIES COMMUNITY SERVICE PROGRAM

(CDCSP)

JULY 1, 2008

APPENDIX B

CDCSP INFORMATION SHEET

DD1

PAGE 1 OF 2

CDCSP INFORMATION SHEET

□ **Initial** □ **Annual Renewal**

□ **ICF/MR** □ **Acute Care Hospital** □ **Nursing Facility**

NAME: _____

ADDRESS: _____

_____

DATE OF BIRTH: _____

SSN: _____

MEDICAID #: _____

PARENTS' NAMES: _____

TELEPHONE (s)#: _____

E-MAIL ADDRESS:_____

COUNTY: (CHILD RESIDES) _____

CASE MANAGER / SERVICE COORDINATOR (if applicable):

NAME: _____

AGENCY: _____

ADDRESS: _____

_____

TELEPHONE #:_____

DATE COMPLETED: _____ **COMPLETED BY:** _____

Revised September 2008

CHAPTER 526

CHILDREN WITH DISABILITIES COMMUNITY SERVICE PROGRAM

(CDCSP)

JULY 1, 2008

APPENDIX C

MEDICAL EVALUATION (ICF/MR LEVEL OF CARE)

DD2A

West Virginia Department of Health and Human Resources
CDCSP Level of Care Evaluation

□ **Initial** □ **Annual Renewal**
□ **ICF/MR Facility**

Service Coordination Agency: _____
Address: _____
Service Coordinator: _____
Contact Person: _____
Date: _____

I. DEMOGRAPHIC INFORMATION (MAY BE COMPLETED BY SERVICE COORDINATOR OR FAMILY MEMBER)

1. Individual's Full Name	2. Sex: ☐ F ☐ M	3. Medicaid # (Required)
4. Address (including Street/Box, City, State & Zip) _____ _____ Phone: ( )		

5. County	6. Social Security #	7. Birthday (MM/DD/YY)	8. Age	9. Phone

10. Parents' Name	11. Children with Special Needs #

12. List Current Medications

Name of Medication	**Dosage**	**Frequency**

13. Living Arrangement □ Natural Family □ Adoptive Family

14. Private Insurance □ Yes □ No
Name of Company _____

15. Significant Health history – (include recent hospitalization(s) and/or surgery(ies) with dates, history of infectious disease)

II. MEDICAL ASSESSMENT (MUST BE COMPLETED BY PHYSICIAN)

NAME: _____

DATE: _____

16. Height	Weight	BP	P	R	T
17. Allergies:					

CODE: √ **= NORMAL** **N** = **NOT DONE** (PLEASE EXPLAIN WHY) **NA = NOT APPLICABLE** **X = ABNORMAL** (PLEASE DESCRIBE**)**

SKIN		
EYES/VISION		
NOSE		
THROAT		
MOUTH		
SWALLOWING		
LYMPH NODES		
THYROID		
HEART		
LUNGS		
BREAST		
ABDOMEN		
EXTREMETIES		
SPINE		
GENITALIA		
RECTAL (MALES INCLUDE PROSTATE)		
BI-MANUAL VAGINAL		
VISION		
DENTAL		
HEARING		
NEUROLOGICAL		
ALERTNESS		
COHERENCE		
ATTENTION SPAN		
SPEECH		
SENSATION		
COORDINATION		
GAIT		
MUSCLE TONE		
REFLEXES		

NAME _____ DATE _____

II . MEDICAL ASSESSMENT (CONTINUED)

Problems requiring Special Care (check all appropriate blanks)

MOBILITY		CONTINENCE STATUS		MEAL TIMES	
Ambulatory	_____	Continent	_____	Eats independently	_____
Ambulatory w/human help	_____	Incontinent	_____	Needs Assistance	_____
Ambul. w/mechanical help	_____	Not Toilet trained	_____	Needs to be fed	_____
Wheelchair self propelled	_____	Catheter	_____	Gastric/J tube	_____
Wheelchair w/assistance	_____	Ileostomy	_____	Special Diet	_____
Transfer w/assistance	_____	Colostomy	_____		
Immobile	_____				

PERSONAL HYGIENE/SELF CARE		MENTAL/BEHAVIORAL DIFFICULTIES		COMMUNICATION	
Independent	_____	Alert	_____	Communicates verbally	_____
Needs assistance	_____	Confused/Disoriented	_____	Communicates with sign	_____
Needs total care	_____	Irrational behavior	_____	Communicates/assistive device	_____
		Needs close supervision	_____	Communicates/hearing aid	_____
		Self-injurious behavior	_____	Communicates/gestures	_____
		EPS/Tardive Dyskinesia	_____	Limited communication	_____

CURRENT THERAPEUTIC MODALITIES

VISION THERAPY	_____	TRACTION, CASTS	_____	SOAKS, DRESSINGS	_____
SPEECH THERAPY	_____	OXYGEN THERAPY	_____	IV FLUIDS	_____
OCCUPATIONAL THERAPY	_____	SUCTIONING	_____	VENTILATOR	_____
PHYSICAL THERAPY	_____	TRACHEOSTOMY	_____	DIAGNOSTIC SERVICES	_____

ADD ADDITIONAL SHEET IF NECESSARY.

PLEASE COMPLETE ALL SECTIONS BELOW TO ENSURE CERTIFICATION FOR THE PROGRAM

DIAGNOSTIC SECTION:

AXIS I: (List all Emotional and/or Psychiatric conditions)

AXIS II: (List all Cognitive, Developmental conditions and Personality disorders)

AXIS III: (List all Medical conditions)

PROGNOSIS AND RECOMMENDATIONS FOR FURTHER CARE:

I CERTIFY THAT THIS INDIVIDUAL'S DEVELOPMENTAL DISABILITY, MEDICAL CONDITION AND/OR RELATED HEALTH NEEDS ARE AS DOCUMENTED ABOVE AND HE/SHE REQUIRES THE LEVEL OF CARE PROVIDED IN AN ICF/MR.

AS AN ALTERNATIVE, THIS CHILD CAN BE SERVED BY:
CHILDREN WITH DISABILITIES COMMUNITY SERVICES PROGRAM _____ Yes _____ No

_____ _____ _____

DATE **PHYSICIAN'S SIGNATURE** **LICENSE #**

FOR DEPARTMENT OF HEALTH AND HUMAN RESOURCES USE ONLY

Approved for Children with Disabilities Community Services Program _____ Yes _____ No
Name of Reviewer: _____ Date:_____

DD-2A CDCSP – Revised September 2008

CHAPTER 526

CHILDREN WITH DISABILITIES COMMUNITY SERVICE PROGRAM

(CDCSP)

JULY 1, 2008

APPENDIX D

MEDICAL EVALUATION (ACUTE HOSPITAL/NURSING HOME LEVEL OF CARE)

DD2B

PAGE 1 OF 6

INSTRUCTIONS:

- Initial Application –must be completed by the physician within ninety (90) days of submission.
- Re-determination Application – must be completed by the physician ninety (90) days of submission.
- Physician completes assessment documenting on the DD-2B/CDCSP form. (must indicate that child requires **one** of the institutional levels of care to allow medical eligibility to be established) and returns it to the Service Coordinator/Case Manager or Parent. **Only one** institutional level of care can be selected. The capabilities of the children will be compared to other children his/her own age. Note: the recommendation that the child requires one of the institutional levels of care is only one piece of information that will be taken into consideration. The process of defining the institutional level of care takes into account all pieces of information submitted in the packet.

West Virginia Department of Health and Human Resources

MEDICAL EVALUATION

Children With Disabilities Community Services Program (CDCSP)

I. DEMOGRAPHIC INFORMATION (can be completed by Parent/Guardian or Case Manager)

1. Individual's Full Name (Last, First, Middle)	2. Sex		3. Medicaid Number	4. Medicare Number
	F	M	□ Yes (give number) □ No	□ Yes (give number) □ no
5. Address (Including Street/Box, City, State & Zip)				6. Private Insurance □ Yes (give information including policy number) □ No
7. County	8. Social Security Number	9. Birth date (M/D/YY)	10. Age	11. Phone Number(s)
12. Parent/Guardian Name:		13. Address (If different from above)		

14. Current living arrangements, including formal and informal support (i.e., family, friends, other services)_____

_____

15. Name and Address of Provider, if applicable_____

_____

16. Medicaid Waiver Wait List A. □ Yes B. □ No

17. Has the option of Medicaid Waiver been explained to the applicant? A. □ Yes B. □ No

18. For the purpose of determining my need for appropriate services, I authorize the release of any medical information by the physician to the Department of Health and Human Resources or its representative.

_____ / _____ / _____

SIGNATURE – Parent or Legal Guardian for Applicant Relationship Date

19. Check if Applicant has any of the following:

a. □ **Guardian**
b. □ **Committee**
c. □ **Medical Power of Attorney**
d. □ **Power of Attorney**
e. □ **Durable Power of Attorney**
f. □ **Living Will**
g. □ **Other** _____

Name and Address of the Representative_____

_____

Phone: (_____) _____ - _____

Name of Person completing the form **Telephone number of person completing form**

_____ _____

DATE: _____

NAME: _____

II. MEDICAL ASSESSMENT

DIAGNOSIS:	
Primary Diagnosis	**Secondary Diagnosis**

NORMAL VITAL SIGNS FOR THE INDIVIDUAL:					
a. Height	**b. Weight**	**c. Blood Pressure**	**d. Temperature**	**e. Pulse**	**f. Respiratory Rate**

PHYSICAL EXAMINATION:

RESULTS: √ **=**Normal **NC =** Not completed (explain) **N/A =**not applicable **X =**Abnormal (explain)

AREA	RESULTS	EXPLANATION
Eyes/Vision		
Nose		
Throat		
Mouth		
Swallowing		
Lymph Nodes		
Thyroid		
Heart		
Lungs		
Breast		
Abdomen		
Extremities		
Spine		
Genitalia		
Rectal		
Prostrate (Males)		
Bi-Manual Vaginal		
Vision		
Dental		
Hearing		
NEUROLOGICAL		
Alertness		
Coherence		
Attention Span		
Speech		
Sensation		
Coordination		
Gait		
Muscle Tone		
Reflexes		

DATE: _____

NAME: _____

AREAS REQUIRING SPECIAL CARE

RESULTS: √ = within developmental limits AD= Age Appropriate Dependent X =Problems Requiring Special Care (Explain below)

AREA	RESULTS	PLEASE PROVIDE A DESCRIPTIVE – SPECIFIC EXPLANATION
Grooming / Hygiene		
Dressing		
Bathing		
Toileting		
Eating/ Feeding		
Simple Meal Preparation		
Communication (communication) refers to the age appropriate ability to communicate by any means whether verbal, nonverbal/gestures, or with assistive devices.		
Mobility – Motor Skills refers to the age appropriate ability to move one's person from one place to another with or without mechanical aids.		–
Self Direction: refers to the age appropriate ability to make choices and initiate activities, the ability to choose an active life style or remain passive, and the ability to engage in or demonstrate an interest in preferred activities.		
Household Skills (cleaning laundry, dishes, etc)		
Health and safety		

CURRENT TREATMENT		
	EXAMPLES	PLEASE PROVIDE A DESCRIPTIVE- SPECIFIC EXPLANATION OF TREATMENT
Nutrition	Tube feeding, N/G Tube, IV use, Medications, Special diets, etc.	
Bowel	Colostomy	
Urogential	Dialysis in the home, Ostomy, Catheterization	
Cardiopulmonary	CPAP/Bi-PAP, CP Monitor, Home Vent, Tracheostomy, Inhalation Therapy, Continuous Oxygen, Suctioning	
Integument System	Sterile Dressing, Decubiti, Bedridden, Special Skin Care	
Neurological Status	Seizures, Paralysis	
Other		

MEDICATION(s) INDIVIDUAL IS CURRENTLY BEING PRESCRIBED				
Medication	**Dosage/Route**	**Frequency**	**Reason Prescribed**	**Diagnosis**

III. HOSPITAL LEVEL OF CARE ASSESSMENT **(only required for Hospital Level of Care)**

Skilled Assessment (ONLY REQUIRED FOR HOSPITAL LEVEL OF CARE) (See Section IV)		
		Specific Description and frequency of intervention
The individual requires acute care services that must be performed by, or under the supervision of professional or technical personnel and directed by a physician.	□ Yes (explain) □ No	
The individual requires specialized professional training and monitoring beyond those ordinarily expected of parents.	□ Yes (explain) □ No	
Individual has a history of recurrent emergency room visits for acute episodes over the last year AND/OR history of recurrent hospitalizations over the last year	□ Yes (explain) □ No	
Individual has had ongoing visits with specialists in an effort to prevent an acute episode	□ Yes (explain) □ No	
The Individuals' medical condition is not stabilized, requiring frequent interventions	□ Yes (explain) □ No	
Individual has had a history in the past year of a need to frequently stabilize in an inpatient setting using medication, surgery, and/or other procedures	□ Yes (explain) □ No	

IV. NURSING FACILITY LEVEL OF CARE ASSESSMENT (only required for Nursing Facility Level of Care)

Skilled Assessment (ONLY REQUIRED FOR HOSPITAL LEVEL OF CARE) (See Section IV)		
		Specific Description and frequency of intervention
The individual requires rehabilitative services (therapies), wound care, and other intense nursing care of a chronic nature that is medically necessary and must be performed by, or under the supervision of professional or technical personnel.	□ Yes (explain) □ No	
The individual requires specialized professional training and monitoring beyond the capability of, and those ordinarily expected of parents.		
The individual's medical condition is stabilized.	□ Yes (explain) □ No	
The individual's care is order and delegated by the physician to an RN or LPN and/or RN or LPN oversight according to a plan to treatment with sort and long term goals.	□ Yes (explain) □ No	
The individual's medical care can be managed in a setting that is less than an acute care setting.	□ Yes (explain) □ No	

DATE: _____
NAME: _____

IV. PHYSICIAN RECOMMENDATION (recommendation by physician necessary)

Recommendation for the following level of Care for the Children with Disabilities Community Services Program **(only one can be checked).**

- Acute Care Hospital: A child with a high need for medical services and/or nursing services who is at risk of hospitalization in an acute care hospital setting. Inpatient services are defined as services ordinarily furnished in a hospital for care and treatment of inpatients and are furnished under the direction of a physician. Hospital level of care is appropriate for individuals who continuously require the type of care ordinarily provided in a hospital, and who, without these services, would require frequent hospitalizations. This level of care is highly skilled and provided by professionals in amounts not normally available in a skilled nursing facility but available in a hospital.
- Intermediate Care Facility for Individuals with Mental Retardation and/or Related Conditions (ICF/MR): A child with *mental retardation and/or related conditions* (e.g., cerebral palsy, autism, traumatic brain injury) and ***substantial*** deficits in self-care (age appropriate grooming, dressing, toileting, feeding, bathing, and simple meal preparation), receptive or expressive language functional learning (age appropriate functional academics), mobility (motor skills—age appropriate ability to move one's person from one place to another with or without mechanical aids, self-direction (age appropriate ability to make choices and initiate activities, the ability to choose an active life style or remain passive, and the ability to engage in or demonstrate an interest in preferred activities), and capacity for independent living (age appropriate for home living, socialization, leisure skills, community use and health and safety); and who is at risk of being placed in an ICF/MR facility An ICF/MR level of care is appropriate for individuals who require the type of active treatment typically provided by a facility whose primary purpose is to furnish health and habilitation services to persons with mental retardation or related conditions.
- Nursing facility (NF): A child with a high need for medical services and/or nursing services who is at risk of hospitalization or placement in nursing facility. Nursing facility services are services that are needed on a daily basis that must be provided on an inpatient basis and that ordered by and provided under the direction of a physician. Nursing level of care is appropriate for individuals who do not require acute hospital care, but, on a regular basis, require licensed nursing services, or other health-related services ordinarily provided in an institution. With respect to an individual who has a mental illness or mental retardation, nursing facility level of care services are usually inappropriate unless that individual's mental health needs are secondary to needs associated with a more acute physical disorder.

I RECOMMEND THAT THIS INDIVIDUAL'S DEVELOPMENTAL DISABILITY, MEDICAL CONDITION AND/OR RELATED HEALTH NEEDS ARE AS DOCUMENTED ABOVE AND HE/SHE REQUIRES THE LEVEL OF CARE PROVIDED IN ONE OF THE ABOVE CHECKED FACILITIES:	
_____ **Physician's Signature** **MD/DO** _____ **Physician's License Number** _____ **Date This Assessment Completed**	**TYPE OR PRINT Physician's name/address below:** _____ _____ _____ _____ _____

DISCLAIMER: Approval of this form does not guarantee eligibility for payment under the State Medicaid Plan.

NOTE: Information gathered from this form may be utilized for statistical/data collection.

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CHILDREN WITH DISABILITIES COMMUNITY SERVICE PROGRAM

(CDCSP)

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APPENDIX E

COMPREHENSIVE PSYCHOLOGICAL EVALUATION

DD3

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INSTRUCTIONS:

- Initial Application –must be completed by the psychologist within ninety (90) days of submission.
- Re-determination Application – must be completed by the psychologist within ninety (90) days of submission.
- MR/DD Waiver Wait List – will accept verification of established medical eligibility for the MR/DD Waiver Program for ICF/MR Level of Care

West Virginia Department of Health and Human Resources

Comprehensive Psychological Evaluation

Name: _____

Evaluation Date: _____/_____/_____

Birth Date:_____/_____/_____

Agency/Facility: _____

Reason for Evaluation:

_____

_____

_____

I. Relevant History:

A. Prior Hospitalization/Institutionalization:

B. Prior Psychological Testing:

C. Behavioral History:

II. Current Status:

A. Physical/Sensory Deficits:

B. Medications (type, frequency and dosage):

C. Current Behaviors:

1. Psychomotor:
2. Self-help:
3. Language:
4. Affective:
5. Mental Status:
6. Other (social interaction, use of time, leisure activities)

III. Current Evaluation:

A. Intellectual/Cognitive
   1. Instruments used:
   2. Results:
   3. Discussion:

B. Adaptive Behavior
   1. Instruments used: ABS I & II Other (list)
   2. Results:
   3. Discussion

C. Other
   1. Instruments used:
   2. Results:
   3. Discussion

D. Indicate the individual's level of acquisition of these skills commonly associate with needs for active treatment.
   1. Able to take care of most personal care needs Yes_____No_____
   2. Able to understand simple commands Yes_____No_____
   3. Able to communicate basic needs and wants Yes_____No_____
   4. Able to be employed at a productive wage level without systematic long-term supervision or support Yes_____No_____
   5. Able to learn new skills without aggression and consistent training Yes_____No_____
   6. Able to apply skills learned in a training situation to other environments or setting without aggressive and consistent training Yes_____No_____
   7. Able to demonstrate behavior appropriate to the time, situation or place without direct supervision Yes_____No_____
   8. Demonstrates severe maladaptive behavior(s) which place the person or others in jeopardy to health and safety Yes_____No_____
   9. Able to make decisions requiring informed consent without extreme difficulty Yes_____No_____
   10. Identify other skill deficits or specialized training needs which necessitates the availability of trained NR personnel, 24 hours per day, to teach the person to learn functional skills Yes_____No_____

E. Developmental Findings/Conclusions:

IV. Recommendations:

A. Training:
B. Activities:
C. Therapy/Counseling/Behavioral Intervention:

V. Diagnosis:

VI. Prognosis:

VII. Placement Recommendations:

_____
Signature of Supervised Psychologist Date

_____
Title

_____
Signature of Licensed Psychologist Date

_____
License#/Title

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APPENDIX F

SOCIAL HISTORY

DD4

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The Social History is the DD-4/CDCSP. It is not necessary for a social worker to complete the social history if the family is completing the application without the assistance of the case management service coordinator. The family may complete the social history.

West Virginia Department of Health and Human Resources

Social History

Participant Name: _____ Date: _____

I. <u>Developmental History:</u> Provide information summarizing personal growth from infancy through adolescence with attention to the development of his/her physical, social, and emotional competencies. As outlined below, if developmental is delayed, describe the circumstances or conditions associated with the delay and date of onset. If more space is needed, use back of this sheet and identify information by Roman Numeral and Letter.

a. Physical

b. Social

c. Emotional

II. <u>Family:</u> List parents, spouse, children, siblings, significant other, and type of relationships, i.e., are they an available source of support and/or resources. Include description of family's socioeconomic circumstances, and family composition. Past and current living arrangements, special problems, such as alcohol, substance abuse, and mental illness should be included.

III. Education/Training: Describe education and training experiences. Identify schools and programs attended, relationships with peers and teachers, any adjustment problems, levels of accomplishment and any other pertinent information.

IV. Functional Status: Describe levels of functioning relevant to the activities of daily living and self-care skills. Indicate level of care recommendations.

V. Recreation/Leisure Activities: Identify and describe recreational and leisure time activities, frequencies, accessibility and degree of involvement.

VI. Hospitalizations: List all hospitalization dates and reason for admissions.

VII. Family Medical History (identify relationship to the participant):

_____	MR/DD	_____	Heart Disease	_____	Cerebral Palsy
_____	Autism	_____	Diabetes	_____	Tuberculosis
_____	Hepatitis	_____	Mental Illness	_____	Kidney Disease
_____	Cancer	_____	Hypertension	_____	Metabolic Disease
_____	Allergies	_____	Thyroid Disease	_____	Muscular Dystrophy
_____	Epilepsy	_____	Other	_____	Other

Deceased Siblings (cause of death):

_____

_____

VIII. Legal Status: (guardianship, committee, custody)

IX. Other Relevant Information: (family medical history; religious preference or significant events or circumstances not covered in other sections)

_____	_____
Date	Date
_____	_____
Signature of Temporary LSW	Signature/Co-Sign of Degree/LSW
_____	_____
License #/Degree	License #/Degree
_____	_____
Parent Signature	Date

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APPENDIX G

COST ESTIMATE WORKSHEET INSTRUCTIONS

DD6

PAGE 1 OF 6

All medical costs [billed charges] the child incurred in the twelve [12] months prior to application are less than the costs that would have been incurred in/out of the institution for the distinct level of care during the same period. The child's proposed costs for the forthcoming year are also compared to the costs in/out of the institution and may not exceed the 'ceiling' for the specific level of care.

Cost Estimate Worksheet Instructions

1. **COMPLETE DEMOGRAPHIC INFORMATION.**

2. **INDICATE THE SPECIFIC PERIOD OF TIME: FROM _____ TO _____.**

3. **LIST ALL SERVICES THE CHILD HAS RECEIVED IN THE TWELVE (12) MONTHS PRIOR TO SUBMISSION OF THE PACKET. ON THE FORM "HISTORY OF MEDICALTREATMENT PRIOR TO SUBMISSION OF THE PACKET". COMPLETE ALL INFORMATION REQUESTED INCLUDING BILLED CHARGES**.**

   a. **Out-patient Services Include: physician, dental, behavioral health, specialized tests, lab work, Children with Special Health Care Needs services, home health, private duty nursing, therapies, etc.**

   b. **In-hospital Services Include: all hospital stays (include number of times and days), surgeries, physician visits, anesthesia, tests, medications, procedures, therapies, etc.**

   c. **School-Based Services: provided by the school system, e.g., physical, occupational, speech, aide, transportation, monthly case management, etc.**

   d. **Birth to Three Services: provided by the Birth to Three Program**

   e. **Pharmacy Includes: medications that have been dispensed by a pharmacist***, prescribed nutritional supplements, etc.**

   f. **Durable Medical Equipment Includes: diapers, assistive technology, wheelchairs, orthotics, dressings, etc.**

4. **ON The FORM "SERVICES THE CHILD IS EXPECTED TO RECEIVE IN THE UPCOMING TWELVE (12) MONTHS" LIST ALL SERVICES THE CHILD IS EXPECTED TO RECEIVE IN THE NEXT TWELVE (12) MONTHS. SEE ABOVE CATEGORIES.**

* IF YOUR CHILD HAS PRIVATE INSURANCE IN LIEU OF THE ABOVE LISTING, PROVIDE COPIES OF THE EXPLANATION OF BENEFITS (EOBs) FROM YOUR INSURANCE COMPANY. ASSURE THAT ALL ABOVE CATEGORIES ARE INCLUDED.
** BILLED CHARGES ARE THE CHARGES THE PROVIDER CHARGES NOT WHAT YOU HAVE PAID OUT OF POCKET.
*** A PRINT-OUT FROM THE PHARMACY SHOULD INCLUDE TOTAL BILLED CHARGES.

□ **Initial** □ **Annual Review**

(check only one) □ **ICF-MR** □ **Nursing Facility Hospital** □ **Acute Care Hospital**

`HISTORY OF MEDICAL TREATMENT PRIOR TO SUBMISSION OF THE PACKET

(can be completed by Parent/Guardian, Nurse and/or Case Manager)

West Virginia Department of Health and Human Resources

BUREAU FOR MEDICAL SERVICES- CHILDREN WITH DISABILITIES COMMUNITY SERVICES PROGRAM

COST ESTIMATE WORKSHEET

Demographic Information (may be completed by Service Coordinator or family member)

Individual's Full Name:

12 Month Period from _____ to _____

PHYSICIAN AND INPATIENT VISITS DURING THE PAST YEAR

Admission and/or Date seen	**Discharge Date** (if applicable)	**Name of Medical Facility and/or Physician**	**Type of Visit** Outpatient (OP) Inpatient (I P)	**Purpose of Medical Treatment**	**BILLED CHARGES (EOB)**

SCHOOL BASED SERVICES - BIRTH TO THREE SERVICES (if applicable)		
SERVICE	FREQUENCY	BILLED CHARGES
PHARMACY		
MEDICATION	COST OF MEDICATION	
DURABLE MEDICAL EQUIPMENT / SUPPLIES		
MEDICATION	BILLED CHARGES	

SERVICES THE CHILD IS EXPECTED TO RECEIVE IN THE UPCOMING TWELVE (12) MONTHS			
TYPE OF SERVICES	**ANTICIPATED SERVICE (s)**	**ANTICIPATED FREQUENCY OF SERVICE**	**ESTIMATED COST**
Out-patient Services Include: *physician, dental, behavioral health,, specialized tests, lab work, Children with Special Health Care Needs services, home health, private duty nursing, ,therapies, etc.*			
In-hospital Services Include: *all hospital stays (include number of times and days), surgeries, physician visits, anesthesia, tests, medications, procedures, therapies, etc.*			
School-Based Services: provided by the school system, *e.g., physical, occupational, speech, aide, transportation, monthly case management, etc.*			
School-Based Services: *e.g., physical, occupational, speech, case management, etc.*			

Durable Medical Equipment Includes: *diapers, assistive technology, wheelchairs, orthotics, dressings, etc*			
Pharmacy Includes: *medications that have been dispensed by a pharmacist***, prescribed nutritional supplements, etc.*			
TOTAL ESTIMATED COST FOR THE YEAR:			

The estimated cost for the upcoming year is accurate to the best of my knowledge:

Signature: _____

NOTE: REMEMBER TO INCLUDE EXPLANATION OF BENEFITS (EOBs)