West Virginia Department of Health and Human Resources

Children with Disabilities Community Services Program (CDCSP) Information Sheet

Initial ☐	Annual Renewal ☐

ICF/IID ☐	Acute Care Hospital ☐	Nursing Facility ☐

Name: _____

Address: _____

_____

DATE OF BIRTH: _____

SSN: _____

MEDICAID #:_____

STATE THAT ISSUED MEDICAID CARD:

PARENTS' NAMES: _____

TELEPHONE(S) #: _____

E-MAIL ADDRESSES: _____

COUNTY: (CHILD RESIDES) _____

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

West Virginia Department of Health and Human Resources
Children with Disabilities Community Services Program (CDCSP)
Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)
Level of Care Evaluation

__ **Initial** ___**Annual Renewal**

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 #

11. List Current Medications

Name of Medication Dosage Frequency

_____
_____
_____
_____
_____
_____
_____
_____

13. Living Arrangement ___ Natural Family ___ Adoptive Family ____Foster 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)

_____
_____
_____
_____
_____
_____
_____

Name of Applicant/Member: _____ Date: _____

II**. MEDICAL ASSESSMENT** (Must be Completed by Physician):

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

Code: V= Normal N=Not Done (Please explain why) NA=Not applicable X=Abnormal (Please describe)

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

Name of Applicant/Member: _____ 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	____
Ambulatory w/mechanical help	____	Not toilet trained	_____	Needs to be fed	____
Wheelchair self-propelled	____	Catheter	_____	Gastric/J tube	____
Wheelchair w/assistance	____	Ileostomy	_____	Special diet	____
Immobile	____	Colostomy	_____		

PERSONAL HYGIENE/SELF CARE		**MENTAL/BEHAVIOR 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/IID.

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

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

FOR DEPARTMENT OF HEALTH AND HUMAN RESOURCES USE ONLY

West Virginia Department of Health and Human Resources
Children with Disabilities Community Services Program (CDCSP)
Acute Care Hospital OR Nursing Facility
Level of Care Evaluation

I. DEMOGRAPHIC INFORMATION (COMPLETED BY PARENT OR GUARDIAN)

1. Individual's Full Name (Last, first, middle)	2. Sex F □ M □	3. Medicaid Member □ Yes (give number) □ No	4. Medicare Number □ Yes (give number) □ No
5. Address (including Street/Box, City, State and Zip)			
6. Private Insurance __ Yes (give information including policy number)__No			

7. County	8. Social Security No.	9. Birth date (M/D/YY)	10. Age	11. Phone Number

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? __ Yes ___ 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/Member Relationship Date

Name of Person completing the form: _____

Telephone No. of person completing form: _____

Name of Applicant/Member: _____ Date: _____

II. MEDICAL ASSESSMENT

DIAGNOSIS:	
Primary Diagnosis:	**Secondary Diagnosis:**

NORMAL VITAL SIGNS FOR THE INDIVIDUAL:					
a. Height	**b. Weight**	**c. Blood Pressure**	**d. Temperature**	**3. Pulse**	**f. Respiratory Rate**

PHYSICAL EXAMINATION:
RESULTS: v-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		
Coordination		
Gait		
Muscle Tone		
Reflexes		

AREAS REQUIRING SPECIAL CARE	
RESULTS: v=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 (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**	
Urogenital	**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)		
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 individual's medical conditions 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 __**	
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.	**Yes__ (explain) No __**	
The individual's medical condition is stabilized.	**Yes __(explain) No__**	
The individual's care is ordered and delegated by the physician to an RN or LPN and/or RN or LPN oversight according to a plan to treatment with short 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 ___**	

Name of Applicant/Member: _____ Date: _____

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 professional in amounts not normally available in a skilled nursing facility but available in a hospital.

-OR-

_____**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 service, 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 OF 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.

West Virginia Department of Health and Human Resources

Children with Disabilities Community Services Program (CDCSP)
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. Mobility:
2. Self-Care:
3. Language (Receptive and Expressive):

4. Learning:

5. Self-direction:

6. Capacity for Independent Living:

7. Mental Status:

8. Other:

III. Current Evaluation

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

B. Adaptive Behavior
   1. Instruments used: ABAS II
   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 associated 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 settings 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 & 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

West Virginia Department of Health and Human Resources

Children with Disabilities Community Services Program (CDCSP)
Cost Estimate Worksheet

INSTRUCTIONS:

1. COMPLETE DEMOGRAPHIC INFORMATION.

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

3. LIST ALL SERVICES THE CHILD HAD RECEIVED IN THE TWELVE (12) MONTHS PRIOR TO SUBMISSION OF THE PACKET, ON THE FORM "HISTORY OF MEDICAL TREATMENT 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 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/IID ___Nursing Facility ___Acute Care Hospital

HISTORY OF MEDICAL TREATMENT PRIOR 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

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 (IP)	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.			
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)			