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		

Name of Applicant/Member: _____ Date: _____

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.)		

Name of Applicant/Member: _____ Date: _____

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

Name of Applicant/Member: _____ Date: _____

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.

Psychological Evaluation Template
CDCSP

Evaluation Date ☐

Please ensure the following sections are covered in the submitted psychological evaluation for CDCSP.

Name of applicant	Service Coordination Agency (SCA)

Current location of applicant: ☐Residential ☐Home ☐Nursing Facility ☐Psychiatric Unit ☐Acute Hospital ☐Other:_____

Reason for evaluation:

Previous IPE I/DD ☐Yes ☐No If yes, Date of Evaluation:_____

Demographics

Date of Birth: ☐☐ (Month) ☐☐ (Day) ☐☐☐☐ (Year) Age: ☐☐ Gender ☐M ☐F

Per documentation does the individual have a Legal Guardian? ☐Yes ☐No

If yes complete the following:

a. Contact Name

Last	First	MI

b. Contact Address

c. Contact Phone Number ☐☐☐-☐☐☐-☐☐☐☐

d. Relationship: ☐Parent ☐Child ☐Sibling ☐Spouse ☐ Friend Other:_____

I. Relevant History:

A. Developmental Hx:
Infants and Toddlers: Will consist of a through descriptor of mother's pregnancy and delivery, health problems during infancy, review of developmental milestones, and services received.

B. Medical Hx:
Any medical conditions; medication and response to treatment, head injuries, seizure activity, hospitalizations.

C. Mental Health Hx:
Past evaluations, onset of diagnoses and response to treatment. Establishing a time line with records to support is critical.

D. Results of previous Psychological Evaluations:
The previous psychological evaluations can be summarized here and/or attached to the evaluation. You must supply this information so that a timeline of diagnoses can be established.

II. Current Status:

A. Physical/Sensory Deficits
Summarize the individual's ability physically and with respect to vision, hearing, and sensory issues. Please note any corrective aids and therapies.

B. Medications
Please note current medications and reason for prescription.

C. Current Behaviors **(A narrative description of an individual's activities and abilities per guardian/informant report, behavioral observations, and information from additional sources. NOT a summary of ABAS-3 Scores**

1. **Self-care** refers to such basic activities such as age appropriate grooming, dressing, toileting, feeding, bathing, and simple meal preparation.
   Focus on what is age appropriate for the individual. A 4 year old would not be expected to assist with food preparation, but should be able to drink from a cup. A 2 year old may or may not have toileting abilities.
2. **Receptive or expressive language** (communication) refers to the age appropriate ability to communicate by any means whether verbal, nonverbal/gestures, or with assistive devices.
   Note the onset of speech, if speech therapy was/is necessary, and the individual's ability to convey his/her needs. Articulation difficulties are not considered a language deficit. If other modes of communication are needed, please note this as well. Also include if the individual understands what is being stated, but not the compliance with said statements.
3. **Functional Learning** (age appropriate functional academics)
   For children, discuss the individual's school placement and any services they receive through the school system or in the community. Include the IEP and psychoeducational testing if appropriate.
4. **Mobility (motor skills)** refers to the age appropriate ability to move one's person from one place to another with or without mechanical aids.
   This refers to both gross motor skills and fine motor skills. Please note if the individual can ambulate, ascend and descend stairs, write, cut with scissors. Note if mechanical aids are needed. In the case of an infant or toddler, note head control, crawling, walking, grasping, self feeding.
5. **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.
   This addresses an individual's ability to initiate activities and make choices, but does not address whether they are appropriate. Note the individual's daily activities, if he/she attempts to assert control over the environment, and if he/she makes choices with respect to food, activities, preferences, etc.
6. **Capacity for independent living** encompasses sub-components that are age appropriate for home living, socialization, leisure skills, community use, health and safety, and employment.
   Addressing each area of capacity is preferred. Note the individual's ability to utilize his/her community resources, choice of leisure skills, ability to socialize and have friends, activities in the home, awareness of health and safety, and if employed. Again, this will be very age dependent. A 4 year old is not expected to know how to cross the street, but could alert a caregiver if injured.

III. Mental Status Evaluation

Please complete as thorough a mental status as possible given the verbal skills and capacity of the individual. In very young children, this may be behavioral observations only. Attempts should be made to secure as much information as possible.

IV. Current Evaluation

A. Intellectual/Cognitive: **A full battery test of intellect should always be attempted. If one has been completed in the past 6 months and is believed to be accurate, a brief IQ test may be administered. In very young children who are unable to participate in IQ testing, a developmental inventory such as the DP-3 or ELAP may be administered as they measure cognitive abilities. If an adult is unable to complete in a full battery, a Slosson and PPVT can be administered. Please include all scores.**

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

B. Adaptive Behavior: **The ABAS-3 should be administered. It has a parent and teacher version. For school aged children, both are helpful. If deemed necessary, an additional adaptive behavior instrument can be administered.**
   1. Instruments used:
   2. Results:
   3. Discussion:

C. Achievement: **A brief achievement test should be administered in order to assess learning if the individual will participate.**
   1. Instruments used:
   2. Results:
   3. Discussion:

D. Autism Screening (when warranted)

E. Developmental Summary: **Please summarize the history and test results.**

F. Findings/Conclusions: **Please note the individual's limitations and strengths.**

V. Diagnosis: Please include all medical diagnoses as well as developmental disorders.

VI. Prognosis: A brief statement regarding prognosis.

VII. Recommendation: Note any recommendations for services.

Supervised Psychologist

Signature/Date | Printed Name

Licensed Psychologist

Signature/Date | Printed Name

West Virginia Department of Health and Human Resources

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

INSTRUCTIONS:

1. COMPLETE DEMOGRAPHIC INFORMATION PAGE AND SIGN THE FORM

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

3. **EITHER**
   A. List all services that child has received in the twelve (12) month prior to submission of the packet on the from entitled "History of Medical Treatment Prior to Submission of the Packet". Complete all information including billed charges. Be sure to include the following categories:
      a. Outpatient Services including: 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 including: all hospital stays (include number of times and days), surgeries, physician visits, anesthesia, tests, medications, procedures, therapies, etc.
      c. School based Services: services provided by the school system, e.g., physical, occupational and speech therapies, aids, transportation, monthly case management, etc.
      d. Birth to Three Services
      e. Pharmacy: medications that have been dispensed by a pharmacist, prescribed nutritional supplements, etc.
      f. Durable Medical Equipment including: diapers, assistive technology, wheelchairs, orthotics, dressings, etc.

   OR

   B. **Provide copies** of the Explanation of Benefits (EOBs) from the private commercial insurance company.

Children with Disabilities Community Services Program (CDCSP)
Demographic Information

Individual's Full Name	Date of Birth

☐ INITIAL ☐ RENEWAL

LEVEL OF CARE

☐ ICF/IID ☐ NURSING FACILITY ☐ ACUTE HOSPITAL

12 Month Time Period

From _____ **To** _____

The estimate cost for the upcoming year and/or EOBs are accurate to the best of my knowledge:

_____ _____

Signature Date

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 ***TO BE COMPLETED WHEN EOBs ARE NOT BEING SUBMITTED***

Child'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 or Physician	Type of Visit: OP-Outpatient or IP-Inpatient	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
Outpatient 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 the 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.			