CHILDREN WITH DISABILITIES COMMUNITY SERVICES PROGRAM (CDCSP)

You have received an application packet for the **Children with Disabilities Community Services Program**. This is a program which provides a medical card to children from birth through age 18 who would otherwise be denied a medical card due to their parent's income exceeding allowed limits. You may reference the CDCSP policy manual on the Bureau for Medical Services website at the following link: https://dhhr.wv.gov/bms/Provider/Documents/Manuals/bms-manual-Chapter_526_CDCSP%202015.pdf

*CDCSP 1: **Information Sheet**-To be completed by parent, guardian, legal representative or service coordinator.

*CDCSP-2A: **ICF/IID Level of Care Evaluation**-This is to be completed by the child's treating physician. **must be completed by a licensed physician** (MD or DO). This document must contain eligible diagnoses and the physician's certification that the individual requires an **ICF/IID Level of Care.**

*CDCSP-2B: **Acute Care Hospital/Nursing Facility Level of Care Evaluation-This must be completed by a licensed physician** (MD or DO) when **Nursing Level of Care** or **Acute Hospital Level of Care** is the level of care required. The physician must indicate which level of care he/she believes is appropriate.

*CDCSP-3: **Comprehensive Psychological Evaluation**-This is to be completed by a **licensed psychologist** using the format provided. (ICF/IID Level of Care only). For individuals who are on the IDD Waiver Wait List, the Independent Psychological Evaluation may be used for their first year of CDCSP eligibility.

*CDCSP-4: **Cost Estimate Worksheet**-This is to include all medical costs for 12 months prior to application. **Costs must be totaled**. This is to be completed by the parent, legal guardian, or legal representative. You may also submit private insurance Explanation of Benefits in place of completing the form but signature is still required.

***Social Security Denial Notice**: must apply for SSI benefits for your child and be dated within the last 12 months.

Psychological Consultation & Assessment Inc./CDCSP
ATTN: CDCSP
202 Glass Drive
Cross Lanes, WV 25313
Phone (304) 776-7230
Fax (304) 776-7247
cdcsp@pcasolutions.com

You will receive notification of eligibility determination by mail.

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

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: ☐☐ ☐☐ ☐☐☐☐ Age: ☐☐ Gender ☐M ☐F
Month Day Year

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

WV Department of Health and Human Resources
Bureau for Medical Services
Children with Disabilities Community Services Program (CDCSP)

COST ESTIMATE WORKSHEET

Child's Full Name	**Date of Birth**

☐ **INITIAL** ☐ **RENEWAL**

LEVEL OF CARE

☐ **ICF/IID** ☐ **NURSING FACILITY** ☐ **ACUTE HOSPITAL**

12 MONTH TIME PERIOD

FROM _____ TO _____

Please either provide Explanation of Benefits from the Private Insurance or a Summary of Charges/Allowed Amounts/Patient Responsibility
OR
Complete the following attachment

Please sign

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

_____ _____ _____
Parent Printed Name **Parent Signature** **Date**

Child's Full Name	Date of Birth

MEDICAL SERVICES

Date	Physician/Facility	Charges that are Patient Responsibility/Deductible Co-pays
		$

PHARMACY

Date	Medication	Charges that are Patient Responsibility/Deductible Co-pays
		$

DURABLE MEDICAL EQUIPMENT/SUPPLIES

List Medical Equipment/Supplies	Amount that is patient responsibility
	$