

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://bms.wv.gov/index%2Ephp/media/40936/download?inline>

*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

317 5th Avenue

South Charleston, WV 25303

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

Ambulatory _____
Ambulatory w/human help _____
Ambulatory w/mechanical help _____
Wheelchair self-propelled _____
Wheelchair w/assistance _____
Immobile _____

CONTINENCE STATUS

Continent _____
Incontinent _____
Not toilet trained _____
Catheter _____
Ileostomy _____
Colostomy _____

MEAL TIMES

Eats independently _____
Needs Assistance _____
Needs to be fed _____
Gastric/J tube _____
Special diet _____

PERSONAL HYGIENE/SELF CARE

Independent _____
Needs assistance _____
Needs total care _____

MENTAL/BEHAVIOR DIFFICULTIES

Alert _____
Confused/Disoriented _____
Irrational behavior _____
Needs close supervision _____
Self-injurious behavior _____
EPS/Tardive Dyskinesia _____

COMMUNICATION

Communicates verbally _____
Communicates with sign _____
Communicates/assistive device _____
Communicates/hearing aid _____
Communicates/gestures _____
Limited Communication _____

CURRENT THERAPEUTIC MODALITIES

VISION THERAPY _____
SPEECH THERAPY _____
OCCUPATIONAL THERAPY _____
PHYSICAL THERAPY _____

TRACTION, CASTS _____
OXYGEN THERAPY _____
SUCTIONING _____
TRACHEOSTOMY _____

SOAKS, DRESSINGS _____
IV FLUIDS _____
VENTILATOR _____
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.	

**Psychological Evaluation Template
CDCSP**

Evaluation Date

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. The psychologist must recommend an ICF level of care.	
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
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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

--

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[illegible][illegible]

PHARMACY

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

DURABLE MEDICAL EQUIPMENT/SUPPLIES

List Medical Equipment/Supplies	Amount that is patient responsibility
	\$