



SED Attachments

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- Attachment E : Request for Exception to Minimum Age Criteria
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**Home and Community Based Services – SED Waiver
 (HCBS/SED)
 Initial Clinical Eligibility**

Member Name _____ Date of Birth _____
 Address _____ City _____ Zip _____
 Telephone (____) _____ County of Residence _____ Sex _____
 Education/Vocation Status _____
 Primary Language of Communication _____ SRS Custody? Y N

Parent/Guardian Name _____
 Address _____ City _____ State _____ Zip _____
 Telephone (____) _____ County of Residence _____
 Primary Language of Communication _____

Assessment Information

1. Is the member at least 4 years old?
 _____ No. The member does not meet HCBS/SED minimum age criterion. (Go to number 9)
 _____ Yes. (Go to number 2)

2. Is the member under 18 years of age?
 _____ No. The member does not meet HCBS/SED age 18 criterions. (Go to number 9)
 _____ Yes. (Go to number 3)

3. Does the member have a KHS qualifying DSM-IV TR, Axis I diagnosis?
 _____ No. The member does not meet HCBS/SED criteria. (Go to number 9)
 _____ Yes. Diagnosis is _____ (Go to number 4)
 Name/Discipline/Agency/Telephone of QMHP making the diagnosis:

 _____ Date of diagnosis _____

4. Does the member meet Severe Emotional Disturbance (SED) criteria? Complete Attachment B.
 _____ No. The member does not meet HCBS/SED criteria. (Go to number 10)
 _____ Yes. Date of determination of SED was _____ (Go to number 5)
 Name/Discipline/Agency/Telephone of QMHP making the SED determination:

5. Is the member currently admitted to a state mental health hospital per Mental Health Reform procedures and receiving hospital treatment services?
 _____ No. (Go to number 6)
 _____ Yes. Attach copy of hospital service plan. Complete Attachment C (Summary of CMHC Clinical Assessment). (Go to number 11).



- 6. Has the member been screened as appropriate for admission to a state mental health hospital per Mental Health Reform procedures?
 No. (Go to number 7)
 Yes. Attach a copy of the most recent Mental Health Reform screening document, if other screens took place, attach a copy if possible. If screening documents are not available, describe the date, location, and name of agency of the screener.

_____ (Go to number 8)

- 7. Is the member likely to need the level of care provided in a state mental health hospital in absence of HCBS/SED services?
 No. Member does not meet HCBS/SED criteria (Go to number 10)
 Yes. Complete Attachment D. (Go to number 8)

- 8. HCBS/SED eligibility requires minimum scores on both Child Behavior Check List (CBCL), and the Child and Adolescent Functional Assessment Scale (CAFAS) or Preschool and Early Childhood Functional Assessment Scale (PECFAS) as applicable. Record results the CBCL, and CAFAS or PECFAS.

CBCL. Indicate Scores and version used, as applicable.

	CBCL	TRF	YSR	Date of CBCL_____
Total Problems	_____	_____	_____	
Externalizing	_____	_____	_____	
Internalizing	_____	_____	_____	

(Note: HCBS/SED eligibility requires a minimum score of 70 on at least one scale.)

Did the member score at least 70 on any scale?

No. The member does not meet HCBS/SED criteria. If an exception to CBCL criteria will be requested, go to number 9. If an exception will not be requested, go to number 10.

Yes. Complete the CAFAS or PECFAS, and record results below.

CAFAS or PECFAS, as applicable.

Subscales/Scores:

School/Work Role Performance	_____	Moods/Emotions	_____
Home Role Performance	_____	Self Harm	_____
Community Role Performance	_____	Substance Abuse	_____

Behavior Towards Others _____ Thinking _____

Completion Date _____ Total Score (sum of all sub-scales) _____

(Note: HCBS/SED eligibility criteria require a minimum Total Score of 100, or a minimum score of 30 on each of any two sub-scales.)

Did the member score 100 on Total Score, or 30 on each of two subscales?

No. The member does not meet HCBS/SED criteria. (Go to number 10).

Yes. If member meets CBCL criteria (without a need to request an exception to CBCL criteria), go to number 11.



9. The member does not meet HCBS/SED criteria. Is an exception requested for:

Minimum Age? No____(Go to number 10) Yes____(Complete Attachment E)
 Age 18 Criteria? No____(Go to number 10) Yes____(Complete Attachment F)
 CBCL Score? No____(Go to number 10) Yes____(Complete Attachment G)

A request for an exception must include the completed Initial Clinical Eligibility form and applicable attachments, mailed to: SRS Waiver Manager, Division of Disability and Behavioral Health Services, Docking State Office Building, 915 SW Harrison, 9th Floor South, Topeka, KS 66612-1570.

10. The member is not eligible for the HCBS/SED waiver.

Has the member and family/caretaker been made aware of the appeal process? _____
 What date was the Notice of Action delivered, informing the member and family/caretaker the member does not meet HCBS/SED Functional (i.e. Clinical) requirements? _____

11. The member is eligible for the HCBS/SED waiver.

What date was the Notice of Action delivered, informing the member and family/caretaker the member meets HCBS/SED Functional (i.e. Clinical) requirements? _____

Prepared by:

_____ Date _____
 (Please type/print name/credentials)

_____ Phone (____) _____

_____ Agency Address Zip



Criteria for Serious Emotional Disturbance (SED)

The term “serious emotional disturbance” refers to a diagnosed mental health problem that substantially disrupts a child's ability to function socially, academically, and/or emotionally.

Complete the following checklist to determine if the youth has SED:

Name of Youth: _____

Name of Agency: _____

Evaluator Signature: _____

Date: _____

Check yes or no on #1 - 3 to determine if the youth has SED:

1. AGE: YES NO

The youth is under age 18, or under the age of 22 and has been receiving community based mental health services prior to the age of 18 that must be continued for optimal benefit.

2. DURATION and DIAGNOSIS: YES NO

The youth currently has a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the diagnostic criteria specified within the most current DSM.

Disorders include those listed in the most current DSM or the ICD-9 equivalent with the exception of DSM "V" codes, substance abuse or dependence, and developmental disorders, unless they co-occur with another diagnosable disorder that is accepted within this definition.

3. FUNCTIONAL IMPAIRMENT: YES NO

The disorder must have resulted in functional impairment which substantially interferes with or limits the youth's role or functioning in family, school, or community activities.

Functional impairment is defined as difficulties (internalizing and externalizing) that substantially interfere with or limit a youth from achieving or maintaining one or more developmentally-appropriate social, behavioral, cognitive, communicative, or adaptive skills. Functional impairments of episodic, recurrent and continuous duration are included.

Youth that would have met functional impairment criteria without the benefit of treatment or other support services are included in this definition.



SED Attachment B-2

Which of the following functional areas has been disrupted as a direct result of the child's mental health condition? (Examples are not intended to be all inclusive and more than one can be marked).

- School (for example: exhibiting behaviors that interfere with the child's ability to perform, such as inattentive in class, unable to sit in one place, unable to concentrate, withdrawn at school to the point that the child's ability to function at school is impacted, accumulating sick days as a result of being overwhelmed/depressed which places the student at risk for truancy, in-school suspension, out-of-school suspension).

Describe:

- Family (for example: at risk of out of home placement, physical aggression at home, suicidal, isolative and withdrawn to the point that youth is not engaging in day to day family activities).

Describe:

- Community (for example: impairment necessitates law enforcement contact such as youth is running away due to delusional symptoms; unable to or serious difficulty participating in regular community and/or peer activities due to behavior, isolating from peers).

Describe:

EXCLUSIONS: Functional impairment does not qualify if it is a temporary response to stressful events in the youth's environment. Functional impairment also does not qualify if it can be attributed solely to intellectual, physical, or sensory deficits.



REQUEST FOR EXCEPTION TO MINIMUM AGE CRITERIA – SED Waiver

(Use additional pages as necessary)

Member Name _____ Date _____

(Note: to request an exception, complete the sections below, then continue with numbers 3 through 8 (CBCL only in number 8) and send the eligibility form and attachments, with a cover letter, to: SRS Waiver Manager, Division of Disability and Behavioral Health Services, Docking State Office Building, 915 SW Harrison, 9th Floor South, Topeka, KS 66612-1570.)

1. Describe the member's functioning that indicate the need for a state mental hospital level of care (e.g. harmful behavior to self or others, psychotic or organic symptoms, aggression, et. al.)

2. Describe the member's behavior in the home/caretaker environment that indicate the member is at risk (e.g. extensive management/supervision by others is needed due to potentially dangerous behaviors; constant clinging behavior; extreme temper tantrums, stealing.)

3. Describe the member's behavior toward others that indicates risk (e.g. bizarre and disruptive behavior, deliberate cruelty to animals, lack of age-appropriate peer interactions, threat, stealing.)

4. Describe the member's moods/emotions that indicate risk (e.g. anxiety, depression, panic, fear, etc.) as demonstrated by odd behavior, marked distress, excessive crying, sadness accompanied by suicidal wish, stealing.



REQUEST FOR EXCEPTION TO AGE 18 CRITERIA – SED Waiver
 (Use additional pages as necessary)

Member Name _____ Date _____

Member Date of Birth _____ Date of Clinical Eligibility Assessment _____

Note: Community Based Services (CBS) are defined as any one or combination of the following CMHC provided services: Targeted Case Management, Community Psychiatric Supportive Treatment, Psychosocial Rehabilitation - Group, Psychosocial Rehabilitation – Individual, or Home Based Therapy.

1. On what date did CBS begin? _____

2. Services provided were:

<u>Service</u>	<u>Start Date</u>	<u>Frequency</u>
----------------	-------------------	------------------

Comments:

3. Has the member been identified as SED and received specialized rehabilitative community based services any time for the six months prior to turning age 18, or would have accessed community based services during that time period but were unable due to their institutional or residential status, provided they continue to meet functional and financial eligibility criteria?

_____No. Member does not meet waiver criteria. Go to number 10.

_____Yes. Go to number 3 and continue.



SED Attachment G

REQUEST FOR EXCEPTION TO CBCL CRITERIA – SED Waiver

(Use additional pages as necessary)

Member Name _____

Date _____

1. A minimum score of 70 on any applicable version of the CBCL was not attained. **Was a score of 63-69 attained for the member on Total Problems, or on the Externalizing or Internalizing sub-scale?**

_____ No. The member does not meet HCBS/SED criteria. Go to number 10.

_____ Yes. Document reasons for CBCL exception (below). Complete the CAFAS (or PECFAS, as appropriate) and record results in number 8. Forward request for exception.

(Note: A request for an exception must include the completed Initial Clinical Eligibility form and applicable attachments, mailed to: SRS Waiver Manager, Division of Disability and Behavioral Health Services, Docking State Office Building, 915 SW Harrison, 9th Floor South, Topeka, KS 66612-1570.)

2. Explain why the CBCL minimum score criteria should be excepted. For example, describe circumstances that interfere with attaining the minimum CBCL score, or clinical observations that support exception of the minimum score.

3. Has there been CBCL in the 6 months previous to this current clinical assessment that did attain a score of 70 or higher?

_____ No.

_____ Yes. Date completed : _____

QMHP reviewer was _____



Notice of Action

SED Attachment H

From: (CMHC Name/Address)

Three horizontal lines for address input

To: (Recipient of Action: Name and Address)

(Parent/Guardian: Name and Address)

Two columns of three horizontal lines each for recipient and guardian addresses

Explanation of Action: In order for Medicaid to pay for your waiver services, you need to meet both the Financial (Medicaid) and Clinical Eligibility requirements. This Notice of Action is to advise you of your status with Clinical Eligibility requirements only.

This Notice of Action is to advise you that:

- Checkboxes for Clinical Eligibility requirements and reasons for waiver termination (e.g., Loss of clinical eligibility, Move out of CMHC Catchments area, etc.)

You will be contacted by your SRS Economic and Employment Support (EES) Specialist regarding how this Action affects your eligibility for Medicaid.

Right to Appeal: You have the right to appeal this decision to the Executive Director at the mental health center. You may also appeal the Executive Director’s decision concerning your case by requesting a fair hearing. If the Member/family wishes to appeal a decision or request a fair hearing, the Member or family can contact the State directly using a written, taped, or other alternative format, to request an appeal within 30 days of the notice of the “Action” to:

The Kansas Department of Administration
Office of Administrative Hearings
1020 S. Kansas Avenue
Topeka, KS 66612

For questions about this Notice of Action, contact: _____

Two horizontal lines for contact information



SED Attachment I-1

HOME AND COMMUNITY-BASED SERVICES WAIVERS
FAMILY CHOICE ASSURANCE DOCUMENT

Child Name

Family Name

I understand that my child is eligible for:

HCBS-SED Waiver services in lieu of state hospitalization

I have been informed that my child may receive services in my home and/or community. I have been given a copy of the SED Waiver informational brochure which explains the home and community-based services waiver program for children with severe emotional disturbance. I understand that services provided under the SED Waiver may be used as an alternative to pursuing admission to a State Hospital.

* * * *

HCBS-PRTF Waiver services as an alternative to services in a Psychiatric Residential Treatment Facility (PRTF)

HCBS-PRTF Waiver services when my child is discharged from a PRTF

Date of discharge: _____

I have been informed that my child may receive services in my home and/or community. I have been given a copy of the PRTF informational brochure which explains the home and community-based services waiver program for children with severe emotional disturbance. I understand that services provided under the PRTF Waiver may be used as an alternative to pursuing admission to a PRTF or as part of the discharge plan from a PRTF.

My signature below indicates I have been informed of the options available for my child.

My choice is to: (check one)

- 1. Meet with a parent support worker at this time to receive further explanation of my choices and my responsibilities.
- 2. Keep my child at home with home and community-based services waiver program and request a Wrap-Around Facilitator to work with me to develop a Plan of Care for my child.
- 3. Bring my child home after being discharged from a PRTF placement and request a Wrap-Around Facilitator to work with me to develop a Plan of Care for my child.
- 4. Pursue PRTF treatment for my child through the screening process.
- 5. Pursue State Hospitalization for my child through the screening process.
- 6. Refuse all services.

Signature:

Date:

Parent/Legal Guardian

Approved Mental Health Professional

Agency Name

For more information about family choice, contact the Department of Social and Rehabilitation Services, Division of Disability and Behavioral Health Services, Docking State Office Building, 915 SW Harrison, 9th Floor South, Topeka, Kansas 66612-1570, or call 1-785-296-7272



Family Choice Assurance Document Instructions

The Family Choice Assurance Document (FCAD) is used for both the SED and PRTF Waivers.

- Complete the child's name and family name.
- If SED Waiver has been considered, mark the line next to the appropriate SED Waiver option (first two options).
- If PRTF Waiver has been considered, mark the line next to the appropriate PRTF Waiver option (the next three options).
- After indicating the Waiver option chosen by the family, indicate which choice the family has made (numbers 1 through 6) regarding Waiver services.
- Ensure the parent/guardian and the Mental Health Professional have signed and dated the form.
- This document remains in the CMHC member chart.

For SED Waiver, the start date of waiver eligibility is the date this FCAD is signed by the family.

For PRTF Waiver, the start date of waiver eligibility is the date the child is discharged from the PRTF if the waiver is chosen upon discharge. If the child has not been in a PRTF prior to qualifying for the waiver, the start date is the date this FCAD is signed by the family.



Kansas Health Solutions
SED/PRTF Waiver Interim Budget

*** This Interim Budget will be adjusted after the Plan of Care Wrap-Around meeting has occurred. This dollar amount will be used to calculate the "Monthly Cost" on Form 3160 Section III.

Please check the box next to the Waiver Service that you anticipate will be provided in the next 30 days. Calculate the cost per service and place the amount on the line provided. Calculate the total for all services except the Community Transition Supports and place the amount on the "Total Budget Amount" line.

- Formula : Number of units (15 minutes unless otherwise specified) multiplied by the cost per unit.

Wrap-Around Facilitation (mandatory) Code H2021

_____ units x \$20.00 = \$_____

Parent Support and Training

Individual Code S5110

_____ units x \$10.00 = \$_____

Group Code S5110 Tj

_____ units x \$3.00 = \$_____

Attendant Care Code T1019 HK

_____ units x \$6.00 = \$_____

Short-Term Respite Care Code S5150

_____ units x \$6.00 = \$_____

Independent Living/Skills Building Code T2038

_____ Hour(s) x \$40.00 = \$_____

Professional Resource Family Care (Crisis Stabilization) Code S9485

_____ Day(s) x \$138.00 = \$_____

Employment Preparation/Support Code H2025 – **PRTF Waiver Only**

_____ units x \$10.00 = \$_____

Total Budget Amount for all above services = \$_____

Community Transition Supports Code T2038-U1 – **PRTF Waiver Only**

* Not to be included in the Total Monthly Budget



SED Attachment J

(Agency Letterhead)

Date: _____

To: To: SRS Waiver Manager
SRS - Division of Disability and Behavioral Health Services
Docking State Office Building
915 SW Harrison St., 9th Floor South
Topeka, KS 66612-1570
(785)296-3471 Fax:(785)296-5507

Re: SED Waiver Exception Request for

_____ (Name of Youth) _____ DOB _____

Exception Reason:

Minimum Age _____
Age 18 Criteria _____
CBCL Score _____

From: (Whom to contact with additional questions regarding this waiver exception)

Name: _____ Date: _____
Agency: _____
Address: _____
Telephone #: _____
Fax #: _____
E-mail: _____

Attachments Included:

- Attachment A: Initial Clinical Eligibility _____
- Attachment D: Current Evidence Supporting Member's Need for Level of Care
Provided in a State Mental Health Hospital _____
- Attachment E: Request for Exception to Minimum Age Criteria _____
- Attachment F: Request for Exception to Age 18 Criteria _____
- Attachment G: Request for Exception to CBCL Criteria _____
- _____
- _____
- _____



**NOTIFICATION OF MEDICAID/HCBS/WORKING HEALTHY SERVICES
 CHANGES / UPDATES**

ES-3161
 Rev. 7-02

TO: _____ **FROM:** _____
ADDRESS: _____ **ADDRESS:** _____

I. CONSUMER INFORMATION:

Name: _____
 Case Number (If Known): _____ Medicaid ID #: _____
 Address Change: _____ Date: _____
 Responsible Person or Alternate Contact Change: _____ Date: _____

II. SRS MEDICAID INFORMATION CHANGES: (to be completed by EES Specialist or Social Worker)

Review Complete: Approved / Denied Working Healthy - Temporary Unemployment Plan Needed.
 Eff Date: _____ Next Review: _____ Date Last Employed _____

HCBS Obligation Change: \$ _____ Eff: _____ Reason for Unemployment _____
 \$ _____ Eff: _____

Medicaid Case Close Eff _____ Reason: _____

HCBS Client Employed (possible Working Healthy eligible): _____

Other: _____

Comments: _____

III. HCBS SERVICE CHANGES: (to be completed by Case Manager/IL Counselor)

HCBS Services Review: Approved / Denied _____ Effective Date: _____

Level of Care Waiver Change To: _____ Effective Date: _____

Monthly Cost of Services Change To: \$ _____ Effective Date: _____

HCBS Services Terminated - Effective Date: _____ Reason: _____

Medical Bills for Obligation (Bills Attached)

NF Entrance: Date Entered: _____ Facility: _____ Anticipated Length of Stay _____

Check one: HCBS-Covered Respite Temporary Care Permanent/Undetermined

Other: _____

Comments: _____

IV. WORKING HEALTHY INFORMATION (to be completed by Benefits Specialist)

Temporary Unemployment Plan Info: Client Failed to Comply, Reason Plan Developed

Premium Repayment: Agreement Signed, Date Received _____

Other: _____

Comments: _____

_____ YES NO
 EES SPECIALIST/SOCIAL WORKER SIGNATURE DATE ATTACHMENTS:

_____ DATE

CASE MANAGER/IL COUNSELOR/BENEFITS SPECIALIST SIGNATURE



**KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
 HOME AND COMMUNITY BASED SERVICES
 CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE (HCBS/SED)
 PLAN OF CARE**

SECTION I. IDENTIFICATION INFORMATION

Client Name: _____ **Medicaid I.D.#** _____ **SSN:** _____

Birth Date __/__/__ **Gender:** _____ **Date of KanBe Healthy Screen** __/__/__ **Clinical Eligibility Date:** __/__/__

Address: _____ **Phone#:** () _____

Guardian: _____ **Address:** _____ **Phone#:** () _____

Approved Mental Health Provider: _____ **Phone#:** () _____

CMHC Contact Person (=Case Manager on electronic POC) _____ **Phone#:** () _____

Wraparound Facilitator: _____ **Phone#:** () _____

Diagnosis: **Axis I:** _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____ **GAF:** _____

Prognosis _____

SECTION II. PARTICIPATANTS (List participants in the development of the plan)

<u>Involvement</u>	<u>Name</u>	<u>Relationship to Child or Family</u>	<u>Telephone</u>
C <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> R <input type="checkbox"/>			
C <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> R <input type="checkbox"/>			
C <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> R <input type="checkbox"/>			
C <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> R <input type="checkbox"/>			
C <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> R <input type="checkbox"/>			
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C <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> R <input type="checkbox"/>			
C <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> R <input type="checkbox"/>			

Codes: C – contacted prior to plan development, A – completed assessment prior to plan development, P – Present at the planning meeting, and R – Reviewed the completed plan

SECTION III. DOMAINS/NEEDS STRENGTHS (describe the client's and / or family's caretaker's problems, issues and needs. Include strengths/assets which are relevant to meeting the needs).

➤ **All services will be provided directly to the eligible client for the benefit of the Medicaid eligible client**

DOMAINS	STRENGTHS	NEEDS
<u>Home</u>		
<u>Community</u>		
<u>Financial/Economic</u>		
<u>Health</u>		
<u>Legal</u>		
<u>Leisure/Recreation</u>		
<u>Vocational/Educational</u>		
<u>Socialization</u>		
<u>Other</u>		

SECTION IV. TERMINATION PLAN;

PRESENTING PROBLEM: (This should describe the child's problems/needs prior to the plan of care)

STATEMENT OF GOALS/OUTCOMES REQUIRED FOR TERMINATION OF THE PLAN OF CARE:

(This should describe how the child will function when all the objectives are met. (This statement of goals/outcomes is to be written at the time the Plan Of Care is being developed).

Example: (Child's name) will have no evidence of suicidal thoughts or gestures and will attend a full day of school without running away.

I.D. LETTER	GOAL/OUTCOME

Date Plan of Care Terminated: _____

Was the cost of the POC contained? Yes ___ No ___

SECTION V. OBJECTIVES: List objectives and action steps needed to reach goals. Include a target date to reach objective

Goal ID Letter _____ Objective: Projected date for meeting objective:				
Measurement Strategy (what, who, and when) 				
Action Step	Responsible Person	Target Date	Date Done	Progress Notes (date)
1. 2. 3. 4. 5.				
Services and Supports needed for Objective(s)	Type of Support	Duration and Frequency	Total Units	

SECTION VI. CRISIS PLAN:

Potential Crisis	Action Steps	Person(s) Responsible	
Services and Supports needed for Objective(s)	Type of Support	Duration and Frequency	Total Units

SECTION VII. INDIVIDUALIZED CARE PLAN THREE MONTH BUDGET

Waiver and Non-Waiver /Services Supports	Provider	Provider I.D.	Procedure Code	Effective Date	Unit of Service	Frequency & Duration Totals	Rate	Waiver Cost or Other Source of Pymt.

Total Waiver Cost \$ _____

Plan of Care Start Date: _____

Total Non-Waiver Cost \$ _____

Plan of Care End Date: _____

Total Plan of Care Cost \$ _____

Monthly Cost:

\$ _____
MM/YY

\$ _____
MM/YY

\$ _____ \$ _____
MM/YY

Crisis

SECTION VIII. SIGNATURES

Client: _____

Date: _____

Parent/Guardian: _____

Date: _____

Wraparound Facilitator: _____

Date: _____

Mental Health Center QMHP: _____

Date: _____

Mental Health Center Physician: _____

Date: _____

SECTION IX. APPROVAL- MHDD

() Yes. This plan of care is approved as written

() No. This plan of care requires revision(s) in the following areas.

Specify _____

Signature, Title

Date of Decision _____



HCBS/SED Waiver Annual Evaluation of Level of Care

Requirements of the HCBS/SED waiver for annual evaluation of the need for HCBS level of care:

- This evaluation must be conducted by a Qualified Mental Health Professional.
- The date for annual review is established by the date of initial clinical eligibility.
- This form needs to be completed by the clinician responsible for the waiver Plan of Care and filed in the member's clinical chart with other waiver
- Eligibility information - Persons who have reached their 22nd birthday are not eligible for the waiver.

Name of Member: _____

Original Family Choice Date: _____

Complete the following:

1) Does the member have a KHS qualifying Axis 1, DSM-IV TR diagnosis? - [] Yes, go to #2 [] No, go to #4

2) Does the member meet criteria for SED Criteria? - [] Yes, go to #3 [] No, go to #4

3) Does the member continue to need a HCBS/SED waiver plan in order to maintain the member in the community and avoid state hospitalization?

[] No, go to Number #4.

[] Yes, describe below current evidence which supports the member's need for HCBS/SED Waiver services. This should include a description of services and supports the member has received that have contributed to community placement and stability as well as continuing factors that would prevent the member from remaining in their community without HCBS services. Go to Number 5.) (Use additional page(s) as needed.)

Blank lines for providing evidence and details for question 3.

4) The member is not eligible for the HCBS/SED waiver. Notify local SRS staff (1M 3161). Terminate waiver plan of care. Deliver the Notice of Action.

5) Member remains eligible for the HCBS/SED waiver. Notify local SRS staff (1M 3161). Deliver the Notice of Action.

Date the Member and/or Family/Caretaker Notified of Evaluation Findings: _____

Clinician Signature: _____ Date: _____



SED Waiver Registration Form

Family Choice Date: _____

Monthly Budget for SED Waiver Services

Service	Monthly Units	Service Budget
Wrap-Around Facilitation (mandatory)- H2021-\$20		
Parent Support and Training Individual-S511-\$10		
Parent Support and Training Group-S5110 Tj -\$3		
Attendant Care-T1019 HK-\$6		
Short-Term Respite Care-S5150-\$6		
Independent Living/Skills Building-T2038 -\$40 (per hour)		
Professional Resource Family Care-S9485- \$138 (per day)		

Total Monthly Budget for Waiver

services: _____

Effective date for these service units: _____

CBCL

Date Administered _____

Total Competency Scale _____

Total Problem Scale _____

Total Internalizing Scale _____

Total Externalizing Scale _____

Registration Completed By _____

Phone Number _____



SED Attachment P

Kansas Health Solutions

Exception Request for SED Waiver Services Which Exceed the Limits of Initial Authorization

Member Name: _____ **Date of Birth:** _____

_____ Last First Middle mm/dd/yy

Medicaid Number: _____ **Social Security Number:** _____

Provider Agency:

Check the box corresponding to the service for which the initial authorization limits have been met.

Service	Units Requested	Service	Units Requested
<input type="checkbox"/> SED Short Term Respite Care		<input type="checkbox"/> SED Professional Family Resource Care	

Timeframe of Request: Start Date: _____ (mm/dd/yy) End Date: _____ (mm/dd/yy)

Provide in detail the reason for this request (i.e., why are additional units medically necessary?)

Completed By: _____ Date: _____
(mm/dd/yy)

Please Print Name

Contact Number: _____

