



SED Attachments

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SED Attachment A-1

**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 criteria. (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).



SED Attachment A-2

- 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).



SED Attachment A-3

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



SFD Attachment B-1

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.



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.



SED Attachment E

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.



SED Attachment F

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.



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 address

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, waiver status, and reasons for action (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

CMHC Waiver Manager

Date



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.

[X] 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 _____
- _____



SED Attachment N

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.)

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 Attachment O

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 _____

