APPLICATION FOR UTAH'S MEDICALLY COMPLEX CHILDREN'S WAIVER

Medically Complex Children's Waiver Application Instructions

(Please read the following information carefully)

The Medically Complex Children's Waiver (the program) was authorized by the Utah State Legislature as a pilot program (HB199, 2015 General Session) that will run through June 30, 2018. Authorized funding for the program will allow approximately 165 children to be served on an ongoing basis during the pilot period. Children enrolled in this program will have access to respite services, as well as traditional Medicaid services.

In order to qualify a child must meet the following criteria:

- Be 18 years old or younger (the individual is eligible until turning 19)
- Have 3 or more specialty physicians in addition to their primary care physician
- Show medical complexity involving 3 or more organ systems
- Demonstrate a level of medical complexity based on a combination of need for device-based supports, high utilization of medical therapies, and treatments and frequent need for medical intervention
- Have a level of disability determined by the Social Security Administration or the State Medical Review Board

To be considered for participation, this application must be complete and include a copy of the most recent history and physical or Well Child Check from the child's physician. This documentation must include past medical and surgical history, problem or diagnosis list, active medication list, allergies, vital signs, physical exam and a plan of care.

The information submitted must be for the 24 month period immediately preceding the month of program application (or less if the applicant is less than 24 months old). All healthcare information will be verified through medical documentation by Medicaid's clinical staff.

If you have multiple children in your family for whom you are applying, you will need to complete a separate application for each child.

Please read all application instructions thoroughly and carefully.

In addition to this application you will be required to provide additional supporting documentation. Without the supporting documentation your application will NOT be considered complete.

Your supporting documentation must include:

- **a copy of the history and physical or Well Child Check completed within the last 24 months;**
- **a completed *Authorization to Release Information* form found at http://health.utah.gov/ltc/mccw/Files/114AR.pdf**
- **and ONE of the following:**
  - **a copy of the SSI designation of disability (if you already have the disability designation); or**
  - **a completed *Medicaid Disability Addendum* form found at http://health.utah.gov/ltc/mccw/Files/354.pdf**

To be considered for participation, applications must be complete. INCOMPLETE APPLICATIONS WILL NOT BE ACCEPTED. Applications will be accepted by mail or fax using the following contact information:

FAX: 801-323-1593

MAIL: Utah Department of Health
Medically Complex Children's Waiver
Division of Medicaid and Health Financing
Bureau of Authorization and Community Based Services
PO Box 143112
Salt Lake City, Utah 84114-3112

Please be aware that the application for this program is a two-step process. The purpose of this application is to determine if your child meets specific program requirements. To determine if your child meets financial eligibility you will be required to complete a Medicaid application with the Department of Workforce Services (DWS). Only the child's income and assets will be used to make the financial eligibility determination.

If you have not yet completed the financial eligibility portion of the application, it can be completed at this point, or you can complete it later if your child is selected for participation in the program. Please see the following link for financial eligibility application information.
https://medicaid.utah.gov/apply-medicaid

For more information, please contact the Utah Department of Health.
Toll-free Phone: 1-800-662-9651, option 5
Email: mccw@utah.gov

Applications WILL NOT be accepted via email. Please do not submit any private health information to this email address.

Website: http://health.utah.gov/ltc/mccw

Applicant Information

Please fill out as much of this section as possible so that we can identify and contact you regarding the status of your application.

Child's Name: _____
Last *First* *M.I.*

Parent's Name: _____
Last *First* *M.I.*

Child's Date of Birth: _____ Child's Gender: ☐ Male ☐ Female

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Home Phone: ( ) _____ Alternate Phone Number: _____

Email Address: _____

Frequent Medical Intervention and Consultation

Please provide a list of your child's specialty physicians below (these are physicians who are in addition to your primary care physician). If additional lines are required please attach a separate sheet:

Physician Name: _____
Specialty *Phone Number*

Physician Name: _____
Specialty *Phone Number*

Physician Name: _____
Specialty *Phone Number*

Physician Name: _____
Specialty *Phone Number*

Physician Name: _____
Specialty *Phone Number*

Please provide a list of your child's conditions/diagnoses below. If additional lines are required please attach a separate sheet:

Condition/Diagnosis _____

Condition/Diagnosis _____

Condition/Diagnosis _____

_____

Condition/Diagnosis _____

Condition/Diagnosis _____

If your child has experienced any of the following in the past 24 months, please indicate below.

Please Check ALL that Apply

☐ **10 or more days in an inpatient facility**
This can include any days spent in an inpatient hospital, or skilled nursing facility during the past 24 months where the stay was related to the child's complex medical condition.

☐ **8 or more emergency department or outpatient visits**
This can include any visits to the emergency room as well as any outpatient procedures performed during the last 24 months where the visit was related to the child's complex medical condition.

☐ **20 or more physician visits or phone calls**
This can include office visits to any physician (including primary care and specialists) and also include visits to the urgent care in the last 24 months where the visit was related to the child's complex medical condition.

Device Based Supports

Prolonged dependence (more than 3 months) on medical devices to compensate for inadequate organ function. Please do not respond to these based on periods of increased illness as it is anticipated that all applicant's needs will temporarily increase during these periods.

Please Check ALL that Apply

☐ **Tracheostomy – including humidification**

☐ **Daily non-invasive ventilation; or pressure support through tracheostomy (BiPAP, CPAP, etc.)**

☐ **Daily oxygen use**

☐ **Nasal, oral, pharyngeal, or tracheal suctioning 4 or more times per day**

☐ **Nasal, oral, pharyngeal, or tracheal suctioning 3 or fewer times per day**

☐ **Daily cough assist, or daily CPT vest or manual CPT treatments**

☐ **Shunts, pumps (e.g. insulin, baclofen, etc.), VNS, etc.**

☐ **Monitors – cardiorespiratory, pulse oximeter, apnea, glucose, etc.**

High Utilization of Medical Therapies, Treatments or Sub-specialty Services

Prolonged dependence (more than 3 months) on any of the following.

Please Check ALL that Apply

☐ **Central Venous Catheter (PICC Line, Hickman, etc.)**

☐ **Urinary Catheter (vesicostomy, indwelling or intermittent)**

☐ **Colostomy or complex bowel program**

☐ **Daily bowel or bladder incontinence (child must be greater than 3 years of age)**

☐ **Daily wound care or sterile dressing changes (does not include trach, IV, stoma or feeding tube sites)**

☐ **Tube Feeding (bolus OR continuous)**

☐ **Severe seizures requiring at least minimal intervention one or more times per month**

☐ **Occupational Therapy at least monthly**

☐ **Physical Therapy at least monthly**

☐ **Speech Therapy at least monthly**

☐ **My child is deaf and/or blind**

☐ **Daily prolonged oral feedings lasting more than 30 minutes**

Daily prolonged oral feeding includes not able to self-feed, arching or stiffening during feeding, refusal of feeding, texture aversion, difficulty chewing, coughing or gagging, frequent spitting or vomiting, excessive food drooling, etc.

If you select the checkbox below indicating that your child is administered 5 or more routine medications, please list the medications and frequency. If additional lines are required please attach a separate sheet:

☐ **Daily administration of 5 or more routine medications**

Daily administration of medication does not include any medications that are PRN or medications prescribed to be taken "as needed" and should include all administration routes.

Medication Name: _____

Times Per Day

Medication Name: _____

Times Per Day

Medication Name: _____

Times Per Day

Medication Name: _____

Times Per Day

Medication Name: _____

Times Per Day

If you select the checkbox below indicating that your child relies on additional devices for functional supports, please list the devices. If additional lines are required please attach a separate sheet:

☐ **Daily use of braces, AFO's, wheelchairs, shower chairs, gait belts, or other mobility related devices**

Daily use of other devices includes any device not already specified in the application.

Device Name: _____

Device Name: _____

Device Name: _____

Device Name: _____

Device Name: _____

Please select the item below that best describes your child's mobility.

☐ **My child is completely immobile**
Non-ambulatory and is not able to make slight changes in positioning without assistance, cannot transfer to a chair and maintains a lying position.

☐ **My child's mobility is very limited**
Able to make slight changes in body or extremity position but unable to make frequent or significant changes without assistance. Cannot bear own weight and/or must be assisted into the chair or wheelchair.

☐ **My child's mobility is slightly limited**
Makes frequent though slight changes in body or extremity position independently. Walks or crawls occasionally during the day, but for very short distances, with or without assistance.

☐ **My child's mobility is not limited**
Walks or crawls frequently (at least every 2 hours) and is able to reposition without assistance.

Care Giver Impact

Please answer the questions below to provide information regarding how your child's complex medical conditions have impacted family caregivers and finances in the past 24 months.

Please select the most applicable answers from the items below:

1. How often does the child sleep 6 hours or more, without requiring care?

☐ **Often (4 or more times per week)**

☐ **Sometimes (2 or more times per week)**

☐ **Seldom or Never (1 or fewer times per week)**

2. How often does the primary care giver engage in activities outside of the home without the applicant?

☐ **Often (1 or more times per week)**

☐ **Sometimes (2 or more times per month)**

☐ **Seldom or Never (less than 1 time per month)**

If you are applying for multiple children in your family please indicate below:

3. I am applying for multiple children in my family ☐

Please list the names of the additional children for whom you are applying:

_____

_____

The next question relates to the out-of-pocket medical expenses incurred by the applicant during the last 24 months.

Out-of-pocket medical expenses are defined as expenses for medical care incurred by the applicant.

Expenses include: insurance premiums, deductibles, coinsurance and copayments for covered services, plus costs for services that aren't covered by a primary insurance or all medical costs if the applicant does not have medical insurance. This may include the costs for medical equipment and supplies that aren't covered by insurance.

Examples include but are not limited to: cost of nutritional formula for applicants more than 2 years old, cost of incontinence supplies for applicants more than 3 years old and cost of other medically necessary medical equipment and supplies. Out-of-pocket expenses should not include the cost of home or vehicle modifications or items such as child car seats that would otherwise be required for the general safety of any child.

Self-attestation of out-of-pocket expenses may be subject to post-payment review and audit. In the event of an audit, applicants must be prepared to provide evidence to support the amount of out-of-pocket expenses claimed.

4. The ANNUAL out-of-pocket medical expenses for the children for whom I am applying are:

☐ **Less than $7,500**

☐ **Between $7,501 and $10,000**

☐ **Between $10,001 and $15,000**

☐ **Between $15,001 and $20,000**

☐ **Between $20,001 and $25,000**

☐ **More than $25,001**

The next questions are related to how your child's complex medical conditions have impacted your family's employment experience.

Please Check ALL that Apply

☐ **A parent or guardian has had to decrease the number of hours worked to care for the applicant**

☐ **A parent or guardian had to change jobs with reduced hours or pay to care for the applicant**

☐ **A parent or guardian had to quit a job to care for the applicant**

The next question is used to identify the medical service coverage resources available to your child.

Please check the box below if your child has medical insurance coverage. If your child has medical insurance coverage please list the insurance providers below.

☐ **My child has medical insurance coverage**

This can include coverage by publicly funded programs such as Medicaid, CHIP, Medicare, etc.

Insurance Provider: _____

Insurance Provider: _____

Insurance Provider: _____

Application Submission

By submitting this application I certify that the information provided is accurate to the best of my knowledge. I understand that intentional mis-statements may be grounds for rejection of my application, or termination of my enrollment in the program. I also understand that my application must be complete in order to be considered, and that if my application is not complete it will be rejected.

Signature _____