Utah Department of Health & Human Services
Integrated Healthcare

Medically Complex Children's Waiver Application Instructions

The Utah State Legislature authorized the Medically Complex Children's Waiver (the program) as an ongoing program (HB100, 2018 General Session). Children enrolled in this program will have access to traditional Medicaid benefits as well as respite services. Applications will be accepted on an ongoing basis. Once open spots are filled, applicants will be moved to a waitlist.

To qualify a child must meet all the following criteria:

- Be 18 years old or younger
- Have 3 or more separate specialty physicians in addition to their primary care provider; Seen within the last 24 months. (Example: Neurologist, Cardiologist, Pulmonologist, etc.) **Multiple providers within the same specialty will count as one specialty
- Have medical complexity that involves 3 or more organ systems
- Children who are not meeting age-appropriate milestones for their activities of daily living; this includes eating, toileting, dressing, bathing, and mobility
- Meet minimum medical score by demonstrating 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
- Children who have a SSI Disability Designation through the SSA or a disability determination by the State Medical Review Board, this will be coordinated as part of the MCCW application process

To be considered for participation, this application must be complete and include required attachments. We will be requesting a copy of the most recent history and physical or Well Child Check from the child's physicians. 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. We will also be having the Primary Care Provider fill out a certification form.

The information submitted must be no later than 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.

In addition to this application, you will be required to provide additional supporting documentation. This documentation must be sufficient to validate the information in this application. Without the supporting documentation your application will NOT be considered complete.

Your supporting documentation must include:

1. Authorization to Disclose Health Information

2. You must provide a copy of the child's most recent history and physical from a MD/DO licensed provider completed within the last 24 months. Clinical notes should support application
3. If the applicant has an Individualized Education Program (IEP) please include the IEP

To be considered for participation, applications must be complete. INCOMPLETE APPLICATIONS WILL NOT BE ACCEPTED. Applications will be accepted online, by mail or fax.

WEBSITE: https://medicaid.utah.gov/ltc-2/mccw/

FAX: 801-323-1593

*MAIL: Utah Department of Health and Human Services
Medically Complex Children's Waiver
Office of Long Term Services and Supports
PO Box 143112
Salt Lake City, Utah 84114-3112

* If you submit this application via USPS mail, it must be postmarked with the date it was mailed. Please be aware that this will require you to go the post office and request that the envelope be postmarked.

Please be aware that determining eligibility for this program is a two-step process that includes: 1) Program eligibility and 2) Financial eligibility. 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 your child is selected for participation in the program, you will be contacted by the Department about completing the financial eligibility portion of the application.

Additional information on financial eligibility can also be found at:
https://medicaid.utah.gov/apply-medicaid

For more information, please contact the Utah Department of Health and Human Services 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.

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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:		
Email Address:				

Medical Intervention, Consultation, and Conditions

Who is your child's Primary Medical Provider? _____

When was the last time your child saw this Provider: _____

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Please provide a list of your child's care team that your child has seen in the past 24 months. (These are in addition to your primary care provider). If additional lines are required, please attach a separate sheet:

Doctor's Name	*Specialty*	*Condition or Diagnosis*	*Date Last Seen*
Doctor's Name	*Specialty*	*Condition or Diagnosis*	*Date Last Seen*
Doctor's Name	*Specialty*	*Condition or Diagnosis*	*Date Last Seen*
Doctor's Name	*Specialty*	*Condition or Diagnosis*	*Date Last Seen*
Doctor's Name	*Specialty*	*Condition or Diagnosis*	*Date Last Seen*
Doctor's Name	*Specialty*	*Condition or Diagnosis*	*Date Last Seen*
Doctor's Name	*Specialty*	*Condition or Diagnosis*	*Date Last Seen*

Please list any additional diagnoses:

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Please indicate if your child has prolonged dependence for Medical Devices, Treatments, Therapies, or Subspecialty Services

- *Please indicate if your child has prolonged dependence (more than 3 months) using medical devices or treatments to support adequate organ function.*
- *Please do not include periods of increased illness in your response as it is anticipated that such needs will be temporary (less than 3 months).*

☐ Tracheostomy with or without humidification

☐ Implantable technology; shunts, pumps (e.g. insulin, baclofen, vagal nerve stimulator, etc.)

**(Devices not considered implantable technology: Tympanostomy tubes (ear tubes) or balloon dilation of the ear tubes to treat Eustachian Tube Dysfunction. IUD or other types of implantable birth control, regardless of what the IUD is treating.)*

☐ Daily ventilation; invasive (through a tracheostomy) or noninvasive (cpap, bipap, etc.)

☐ Daily oxygen use

☐ Daily suctioning: nasal, oral, pharyngeal, or tracheal *(Bulb syringe is not a form of suction.)*

☐ Daily airway clearance; cough assist, vest or manual chest physiotherapy

☐ Daily monitoring; cardiorespiratory, pulse oximeter, apnea, glucose, etc.

☐ Daily use of urinary catheter; vesicostomy, indwelling or intermittent

☐ Daily use of colostomy or complex bowel program *(Daily laxative, Miralax, Exlax or enema use does not qualify as a complex bowel program.)*

☐ Daily bowel or bladder incontinence – (child must be greater than 3 years of age) **diagnosis of incontinence, neurogenic bladder, bowel incontinence, or other medical diagnosis that requires use of diaper/incontinence brief daily.*

☐ Nightly nocturnal enuresis (child must be greater than 5 years of age) or daily urge incontinence, stress incontinence, overflow incontinence, or functional incontinence.

☐ Daily wound care or sterile dressing changes (NOT including trach, IV, stoma or feeding tube sites)

☐ Daily tube feeding; bolus or continuous, gastric or jejunal

☐ Severe seizures requiring at least minimal medical intervention at least monthly

☐ Infusions through a central venous catheter (e.g., PICC, Broviac, Port-a-Cath, etc.) at least monthly

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Please indicate if your child has dependence on at least five (5) daily scheduled medications

☐ Daily administration of five (5) or more routine medications.

Medication Name:	Medication Schedule:
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

Please indicate whether your child has any of the following functional or developmental limitations and/or prolonged dependence on supportive or mobility-related devices (e.g., braces, AFOs, wheelchairs, shower chairs, gait belts, etc.) Adaptive bicycles, tricycles, etc. do not count if used for recreation and not required for daily ADLs. Child must be dependent on a device for daily mobility.

Please list devices:

1.
2.
3.
4.
5.

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Please check all that apply:

- ☐ Daily prolonged oral feedings lasting more than 30 minutes

  (*Daily prolonged oral feeding includes not being 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.)*

- ☐ Occupational Therapy at least monthly
- ☐ Physical Therapy at least monthly
- ☐ Speech Therapy at least monthly
- ☐ ABA Therapy at least monthly
- ☐ Child is legally deaf and/or blind

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

- ☐ **The child is completely immobile**
  Non-ambulatory and is not able to make changes in positioning without assistance. Maintains lying position when not secured into chair.

- ☐ **The child's mobility is very limited**
  Able to make slight changes in body or extremity position. Cannot bear weight and needs assistance into chair or wheelchair. Requires a wheelchair for daily mobility.

- ☐ **The child's mobility is slightly limited**
  Makes frequent though slight changes in body or extremity position independently. Is able to walk with assistance or crawl independently.

- ☐ **The child's mobility is not limited**
  Walks independently without assistance.

Please indicate with an "X" in the appropriate column your child's ability to perform age-appropriate self-care tasks.

Self-Care Skills	*Independent* or Age-Appropriate	*Needs Help* (Supervision or Minimal Physical Assistance)	*Dependent* (Full Assistance by Another) Please list diagnosis that will prevent development of this self-care skill, as appropriate
Bathing	☐	☐	☐
Dressing	☐	☐	☐
Toileting	☐	☐	☐
Transferring from Bed to Chair	☐	☐	☐
Walking	☐	☐	☐
Climbing Stairs	☐	☐	☐
Eating/Self-Feeding	☐	☐	☐
Walking	☐	☐	☐
Climbing Stairs	☐	☐	☐
Eating/Self-Feeding	☐	☐	☐

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 12 months.

Please select the most applicable answers from the items below:

1. How often does your 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 that support their own health and well-being as primary care giver?

- ☐ Often (1 or more times per week)
- ☐ Sometimes (2 or more times per month)
- ☐ Seldom or Never (less than 1 time per month)

3. How often do others (family members, volunteers, school, etc.) assist in caregiving of your medically complex child?

- ☐ Often (1 or more times per week)
- ☐ Sometimes (2 or more times per month)
- ☐ Seldom or Never (1 or fewer times per week)

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

☐ 4. I have additional children served on the Medically Complex Children's Waiver or I am applying for multiple children.

Please list the names of the additional children:

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5. The ANNUAL out-of-pocket medical expense for my Medically Complex Child is:
*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.

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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.

- ☐ 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 Name: _____

SUBMISSION

By submitting this application, I certify that the information provided is accurate to the best of my knowledge. I understand that intentional misstatements 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 to be considered, and that if my application is not complete, it will be rejected.

_____ _____

Date *Signature*