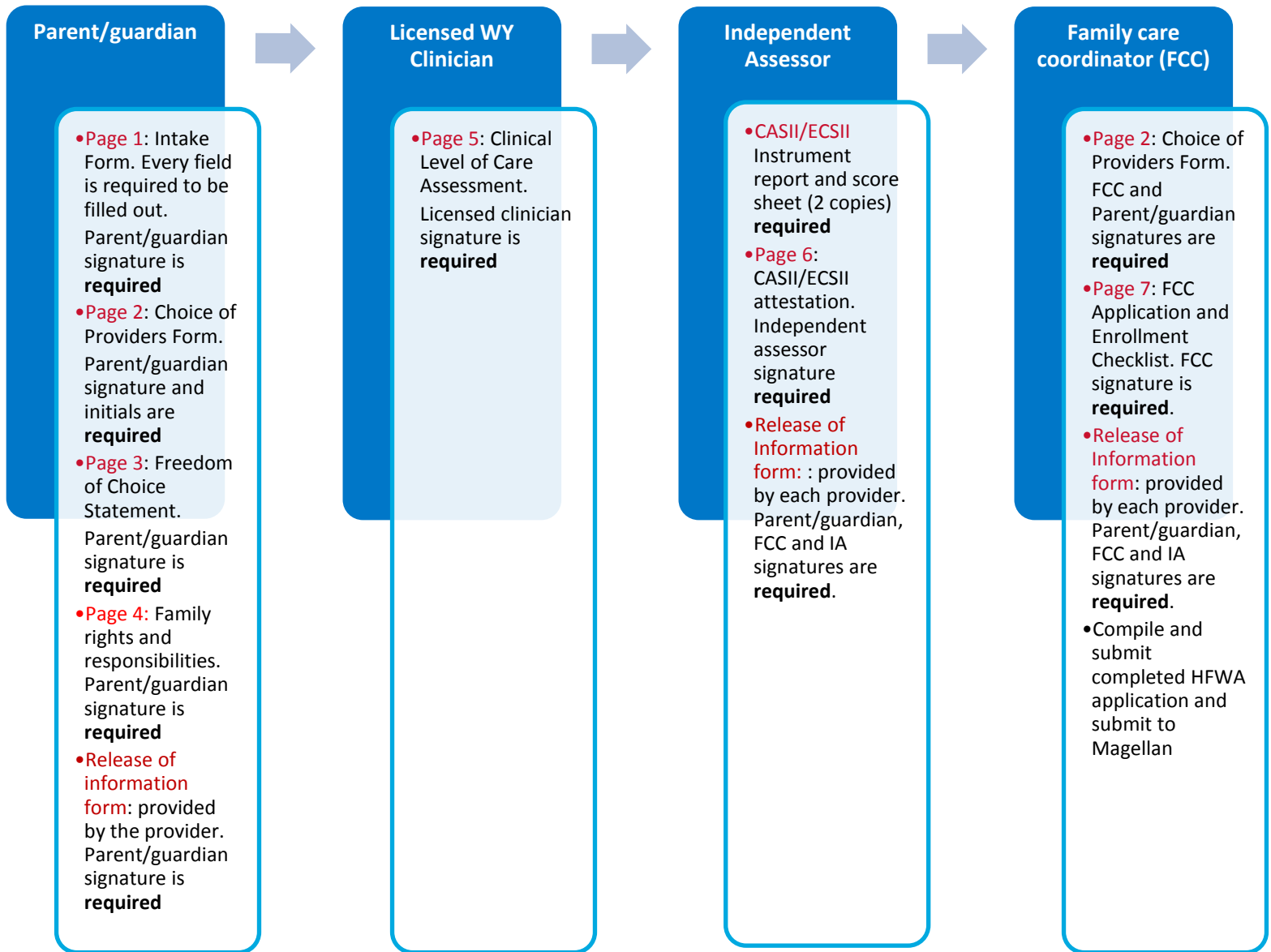


HIGH FIDELITY WRAPAROUND APPLICATION

A Medicaid home and community-based waiver - 1915(b) and 1915(c)



This section for Magellan Providers ONLY: A complete application equals **EVERYTHING** listed above (use the checklist on page 7 for further instructions).

Submit an application for High Fidelity Wraparound:

- If the youth has an active Medicaid number: Submit the completed application packet through Magellan's Provider Portal, www.MagellanProvider.com
- If the youth does not have an active Medicaid number: Submit the completed application packet to WYClinical@MagellanHealth.com

Name of Applicant		Date of Birth	Age
Applicants Home and/or Mailing Address <u>Physical Address</u> <u>Mailing Address (if different)</u>		Social Security Number	
		Email Address (Adult or Participant if 18 or older without guardian)	
Preferred Language of Communication __ English __ Spanish __ Other _____		Phone Information Home: () ____ - ____ Mobile: () ____ - ____ Work: () ____ - ____ Other: () ____ - ____	Gender __ Male __ Female
Primary Health Care Provider Name: _____ Address: _____ City, State, ZIP code: _____ Phone Number: () ____ - ____		Disability Does applicant have a disability? Yes No Is the applicant deaf or hard of hearing? Yes No Is the applicant blind? Yes No	
Race (check all that apply) __ American Indian or Alaska Native __ Hispanic __ Asian __ Black/African American __ White/Caucasian __ Native Hawaiian/Pacific Islander __ Other _____ __ Not Reported/Unknown			
Applicant's location at time of application (if not at home, please list complete address) __ Home __ Residential treatment center _____		__ In-state mental health facility _____ __ Acute care hospital _____ __ Juvenile detention/correction facility _____ __ Other _____	
Medicaid Information Is applicant currently enrolled in Medicaid? Yes No If Yes, Medicaid Recipient Number: _____ Effective Date: _____ Is applicant currently enrolled in Kid Care CHIP? Yes No If Yes, Kid Care CHIP Number: _____ Effective Date: _____			<i>Please note that if an applicant has Kid Care CHIP and is accepted to the waiver, the family must choose one coverage type. If eligible for the waiver, staff will outline the differences.</i>
Name of Responsible Adult		Is applicant currently receiving wraparound services? Yes No	
Relationship to Applicant (if guardian, include a copy of the guardianship order/court documents) __ Parent __ Guardian __ Grandparent __ Other Family Member __ DFS Custody __ Other _____			
Adult Home and/or Mailing Address (if different than applicant) <u>Physical Address</u> <u>Mailing Address</u>		Adult Phone Information Home: () ____ - ____ Mobile: () ____ - ____ Work: () ____ - ____ Other: () ____ - ____	
<ul style="list-style-type: none"> I agree to participate in assessments/screenings to determine eligibility and the need for Care Management Entity (CME) services. I authorize the release of information by my physician, hospital, community mental health center, other social service providers, school, health service providers and family members to and among State agencies and their agents on my child's medical condition and other relevant information necessary to determine appropriate home and community-based services for the CME. I understand I may revoke this release of information in writing at any time. 			
Signature of Applicant/Parent/Guardian/Responsible Person		Date (month/day/year)	Time (a.m. /p.m.)
Signature of Witness (required ONLY if the signature of applicant is an "X")			
Signature/Title of Individual Assisting in Completing Application			
For Internal Use Only __ 1915 (b) waiver __ 1915 (c) waiver			

CHOICE OF PROVIDERS FORM

Date	
Youth Name	Guardian Name
Reason for Completing This Form <input type="checkbox"/> New Member <input type="checkbox"/> Adding a provider <input type="checkbox"/> Changing a provider	
Guardian initials: <input type="checkbox"/> Providers and services available through Magellan have been explained to me. <input type="checkbox"/> I understand that I can make the decisions about what High Fidelity Wraparound services will be provided to me or my youth. I can make the decisions about which providers will work with my youth while he/she is a member of Magellan. <input type="checkbox"/> I understand that I/my youth have/has a right to change my provider(s) at any time for any reason. Magellan providers also have a right to stop providing services. But they must give a 30- day written notice to me/my youth. <input type="checkbox"/> I understand that I/my youth have/has the right to ask for informal dispute resolution or an administrative hearing if we are not given the choice of services or providers.	
Provider Chosen: A list of Magellan providers has been shared with me and my questions have been answered. I have chosen to work with the following:	
Provider:	
Family care coordinator (FCC)-required:	
Optional team members:	
*Family support partner (FSP):	
*Youth support partner (YSP):	
*Can add youth and family training (YFT) at enrollment	
Potential team members:	
Mental health professional:	
School representative:	
Other (please specify):	
Signatures	
Signature of applicant/parent/guardian/legally responsible representative:	Date
Signature of witness (ONLY IF SIGNATURE IS AN "X"):	Date
Signature of Family Care Coordinator (FCC):	Date

FREEDOM OF CHOICE STATEMENT

Date	
Youth Name	
<p>Services Available I/my youth have been given the choice to: Access State Amendment Waiver services in our home and in community-based settings (HFWA) OR for my youth to be admitted to the hospital (PRTF, RTC or other) I understand that the cost of home and community-based waiver services must meet the waiver requirement of being cost-effective.</p>	
<p>Choice of Service ____ State Amendment Waiver. I/my youth have chosen to receive State Amendment Waiver services (HFWA) rather than services in a hospital setting. I have been told of my right to choose any certified waiver provider for these services.</p> <p>or</p> <p>____ Hospital. I/my youth have chosen to receive services in a hospital setting.</p>	
Signatures	
<i>*I received training on my rights, and understand the process for instances of abuse, neglect, and exploitation.</i>	
Signature of participants/parent/guardian/legally authorized representative:	Date
Signature of witness (ONLY IF SIGNATURE IS AN X):	Date

FAMILY RIGHTS AND RESPONSIBILITIES

Your family has rights and responsibilities under the HFWA program. In particular, as a member of HFWA, your child or youth's rights are very important. Family care coordinators must explain your child's rights at the first visit.

Youth Name	Date
<p>Your rights As an enrollee in the program, your child or youth has the right to:</p> <ul style="list-style-type: none"> • Be treated with respect, dignity and privacy. • Be treated fairly, whatever his/her: <ul style="list-style-type: none"> ○ Race, religion, gender, sexual orientation, ethnic background and disability. • Have your child's treatment and other information kept private. The only time we may share treatment records is when required. (The Confidentiality section in the family and youth handbook provides more details). • Have access to care. • Learn about treatment in a way that: <ul style="list-style-type: none"> ○ Respects your culture, you can understand and fits your needs. • Take part in making your child's plan of care. • Get information in a language your family can understand. Also, get things translated for free. • Get information in other ways if you ask for it. • Get information about Magellan and its: <ul style="list-style-type: none"> ○ Providers, programs and services. ○ Role in the treatment process. • Be informed about the clinical rules followed in your child's care. • Ask providers and others on the child and family team (CFT) about their work history and training. • Not to be forced to do something you're not comfortable with (this is based on a federal law). • Give your thoughts on the Rights and Responsibilities policy. • Ask for a specific certified provider in our network. • Have your child's team make decisions based on your youths' needs. • Get healthcare services that obey Wyoming and federal laws. • Help make decisions about your youth's healthcare. This includes the right: <ul style="list-style-type: none"> ○ To get a second medical opinion. ○ To say no to treatment. This is your right unless the court says otherwise. • File a complaint or grievance about: <ul style="list-style-type: none"> ○ Magellan, a HFWA provider or the care your youth receives. • File an appeal about a Magellan action or decision. • Get a copy of your youth's records. You can ask that they be changed or corrected. • Use your rights. This will not affect the way Magellan and its providers treat you. 	<ul style="list-style-type: none"> • Talk with your child and family team about what strategies are right for your child. • Ask for information in a way that you can get to it easily. This applies if you have a visual, hearing or physical disability. This will help you know about the benefits and services you can get. • Receive training on my rights, and understand the process for instances of abuse, neglect, and exploitation. <p>Your responsibilities As the parent or guardian of a child or youth, you have the responsibility to:</p> <ul style="list-style-type: none"> • Fully participate with the FCC and team in developing and carrying out your Plan of Care (POC). • Ensure Medicaid benefits are current. • Ensure safety of your child and anyone providing care in your home Give Magellan the information they need. This helps support quality care and getting the right services. • Ask questions about your child's care. This helps everyone understand your child's condition. It helps create goals and plans you agree on. • Follow your child's Plan of Care. This plan is agreed upon by the whole team and it is the responsibility of everyone to make sure it is completed. If you encounter barriers, you can contact your family care coordinator. • Attend all team meetings. You should call the family care coordinator as soon as you know you need to reschedule a meeting. • Tell the child and family team if the plan of care does not seem to be working. • Complete and help your child complete a survey from Magellan about your experience in our program. This will be asked of you after you've been enrolled in HFWA for 6 months. You will get a call from Magellan's Family Support Specialist to complete this at your convenience, but must be done. • Share worries about the quality of your child's care. • Tell someone if you suspect abuse or fraud. (This is someone not being honest.) If you suspect abuse or fraud, call Magellan's Corporate Compliance Hotline. You can reach this number 24 hours a day, seven days a week. <ul style="list-style-type: none"> • This hotline is run by an outside company. • You do not have to give your name when you call. • You can also send an email. • Magellan will look into all calls and emails. <p>The calls and emails will stay private.</p>
Parent/guardian signature:	Date

CLINICAL LEVEL OF CARE ASSESSMENT

Name of Youth: _____	
1. Is the applicant between the ages of 4 and 20 years old?	Yes No
2. Is the applicant Medicaid eligible or currently have Medicaid?	Yes No
3. Does the applicant have a current version DSM 5 or ICD-10 <i>mental, behavioral, or emotional disorder</i> ? Code number(s) and primary mental health diagnosis: _____ Date of most recent <i>mental health</i> evaluation: _____	Yes No
4. For applicants ages 4 through 17, does the disorder result in functional impairment within the last year which substantially interferes with or limits the child's role in functioning in family, school, or community activities? OR For applicants ages 18 and over, does the disorder result in functional impairment within the last year which substantially interferes with or limits one or more life activities?	Yes No Yes No
5. Does the applicant display one or more of the following below Medicaid Criteria that may put them at risk for placement out of their home at a residential, detention or psychiatric residential treatment facility: <input type="checkbox"/> Persistent, pervasive and frequently occurring oppositional/defiant behavior <input type="checkbox"/> Reckless and/or impulsive behavior, which represents a disregard for the well-being and/or safety of self/others <input type="checkbox"/> Aggressiveness and/or explosive behavior <input type="checkbox"/> Gestures with intent to injure self/others, which have not resulted in serious injury, without evidence that such gestures are immediately progressing to life threatening behavior <input type="checkbox"/> Self-induced vomiting, use of laxative/diuretics, strict dieting, fasting and/or vigorous exercise <input type="checkbox"/> Extreme phobic/avoidant behavior <input type="checkbox"/> Extreme social isolation <input type="checkbox"/> History of repeated life threatening injury to self/others, resulting in acute care admissions within the past 12 months	
6. Does the applicant meet at least one Medicaid Criteria (above) If ONE of the items above is checked, then YES is the appropriate answer for this question. <i>Note: The Children's Mental Health Waiver is a home and community-based service waiver, not a hospital authorization program. The information provided in this application is not used to support hospitalization.</i>	Yes No
7. Is it reasonable to expect the applicant could be safely served in his/her home, school and community with access to intensive, community based, behavioral health and care coordination services (including evolving crisis plans) that are individualized to the youth and family's particular needs? If the answer is no above because youth is currently in an out of home placement: Is it reasonable to expect this youth be safely served in the community upon discharge, with intensive, community-based services individualized to youth and family needs in place? <i>See Application Cover Page for additional guidance on this question</i>	Yes No Yes No
8. Is the applicant currently enrolled in any other Medicaid waivers, or on any other waiver waitlists?	Yes No
CLEARLY PRINT the required information of the documenting QMHP-C Name and Credentials: _____ License Number: _____ Agency Name: _____ Contact Telephone Number: () _____ - _____ Contact Fax Number: () _____ - _____	

CASII score _____
or
ECSII score _____

Name of Applicant	Date
--------------------------	-------------

How to submit the CASII/ECSII score sheet and report:

If this is an initial evaluation – return to the chosen FCC for this youth. If it’s an annual re-evaluation or return to community evaluation, please submit following instructions below:

If the youth has an active Medicaid number: Submit the completed application packet through Magellan’s Provider Portal, www.MagellanProvider.com

If the youth does not have an active Medicaid number: Submit the completed application packet to WYClinical@MagellanHealth.com

CASII/ECSII assessment, report and score sheet completed by: Independent Assessor Name (printed)	Date
--	-------------

Independent Assessor Signature

Agency: _____ Street Address: _____ City, State and ZIP Code: _____ Telephone Number: () _____ - _____

Medicaid Provider ID or NPI (if billing for additional modifier to providing application assistance)

How was the family referred to HFWA? <input type="checkbox"/> Provider Agency <i>Name of Agency:</i> _____ <input type="checkbox"/> Conduent <input type="checkbox"/> Department of Family Services <input type="checkbox"/> Child Protective Services <input type="checkbox"/> Juvenile probation <input type="checkbox"/> Primary Care Physician <input type="checkbox"/> Therapist <input type="checkbox"/> Family self-referred/Magellan Clinical staff coordinated <input type="checkbox"/> School <i>Name of School:</i> _____ <input type="checkbox"/> Other <i>Specify:</i> _____
--

FCC APPLICATION AND ENROLLMENT CHECKLIST

Magellan must receive a youth **referral before the 14 day** application period can begin. Everything on this page is required, to successfully submit a complete application to Magellan and for the FCC to bill for application period.

Name of Applicant	Date of Birth
___ Verify Medicaid Eligibility – verify number with legal guardian and on application	Date
REQUIRED documents and steps for application processing:	
___ *Pages 1-4: completed and signed by parent/guardian. Every single block must be filled out and answered. If it doesn't apply, enter NA (not applicable). Explain HFWA is home and community based and not for out of home (OOH) placement (ex. cannot sign up for a home and community based program for Medicaid to pay for OOH).	CASII score
___ *Level of Care (LOC) form (page 5): completed and signed by a qualified mental health professional, licensed in Wyoming – See LOC for list of QMHPs in Wyoming.	___
___ > Make sure the LOC is qualifying – this means all questions are answered yes and youth can be safely served at home and in the community – there are no exceptions for this.	___
___ > In the event of non-qualifying LOC, stop the process and explain to the family the disqualification. Send Magellan the disqualifying LOC with explanation via secured email to WYClinical@MagellanHealth.com .	or
___ Contact Magellan's Care worker at 307-459-6162 to help family select an approved Independent Assessor to do the CASII/ECSII.	ECSII score
___ *Independent Assessor form (page 6): Must be signed by the IA. This is part of the application packet, along with the *CASII/ECSII tool and Scoring sheet (IA).	___
___ > Be present when the IA talks to the family for the CASII so you can utilize the information to begin filling out the ACE survey and the CANS assessment.	___
___ Keep a copy of the CASII/ECSII for SNCD and POC/Crisis planning and discussions with the family.	
___ The family has a copy of the CASII/ECSII – help them talk to the IA about any questions they have.	
___ Release of information (2 needed for the CASII evaluator): One for family to get a copy and one for FCC. This form is provided by the provider.	
___ Review each page of the application and required documents; a signature and/or initials are required on each page- follow instructions on the cover page	
___ *FCC Attestation of completed application (page 7): Follow this checklist and sign below	
___ Reviewed family rights and responsibilities (page 4) for enrollment in the CME and participation in HFWA, including the need for both caregiver and age appropriate youth to complete WFI-EZ survey in 6 months.	
___ Upload completed application packet (*everything in red) to Magellan within 14 days of application period authorization	
___ > If youth <i>has an active Medicaid number</i>: Submit the completed application packet with this form through Magellan's Provider Portal at www.MagellanProvider.com	
___ > If youth <i>does not have an active Medicaid number</i>: Submit the completed application packet with this form via secured email to WYClinical@MagellanHealth.com	
Agency:	
Street Address:	
City, State and ZIP Code:	
Telephone Number:	
Email address:	
FCC attestation: All the above was completed on time	Date
FCC signature _____ (<i>required for payment</i>) FCC printed name _____	