

CLINICAL LEVEL OF CARE ASSESSMENT COVER SHEET

Information and Directions for this Form

This form is used to verify an appropriate level of care for enrollment into a home and community-based Medicaid waiver program. It is not used for hospital authorization. The information provided helps confirm the youth's diagnosis and any risk factors that may meet eligibility criteria for this program. Some information may be based on statements from individuals other than the signing clinician.

Thank you for completing the Level of Care Assessment for a Wyoming youth in your community. This assessment plays a critical role in determining eligibility for services. All required fields must be completed fully and accurately.

Completion of this form must be done by a Qualified Mental Health Professional (QMHP) or a Qualified Healthcare Professional (QHP) as defined by the Wyoming Department of Health. A QMHP or QHP includes a physician (MD, DO), PA, nurse practitioner, psychologist (PsyD, PhD), LCSW, LPC, LMFT, LMHC, or other mental health professional actively licensed.

Important note: Qualified Healthcare Professionals (QHPs) and Qualified Mental Health Professionals (QMHPs) may bill for reimbursement from Wyoming Medicaid for the Level of Care using CPT code 96127, in accordance with applicable billing and payer guidelines.

Descriptions for the Level of Care form are provided on the following pages.

1. Print the youth's full name.

2. This box collects demographics of the youth. For youth to qualify for the Wraparound Program, they must fall within the ages of 4 and 20 (before a youth's 21st birthday).

3. As the QMHP or QHP denote the identified diagnosis and list the correct corresponding F code number(s). Youth must have a current DSM 5 or ICD-10 *mental, behavioral, or emotional disorder diagnosis* that meets federal qualifying criteria for a youth with serious emotional disturbance (SED). This information is utilized to determine the youth's eligibility and to also inform services provided under Wraparound. You will list the primary diagnosis code for the youth first followed by any secondary diagnosis that the youth might have. If a youth has a diagnosis of Autism Spectrum Disorder (ASD) or another developmental disability, please also include an applicable Serious Emotional Disturbance (SED) diagnosis when one exists.

Acceptable Serious Emotional Disturbance (SED) criteria:

- Disorders usually first diagnosed in infancy, childhood, or adolescence (excluding intellectual disability)
- Delirium, dementia, amnestic and other cognitive disorders
- Mental disorders due to a general medical condition
- Substance-related disorders, Schizophrenia, and other psychotic disorders
- Mood disorders
- Anxiety disorders
- Somatoform disorders
- Factitious disorders
- Dissociative disorders
- Sexual and gender identity disorders
- Eating disorders
- Sleep disorders
- Impulse-control disorders not elsewhere classified
- Adjustment disorders
- Other conditions that may be a focus of clinical attention

4. Please list the most recent date you evaluated the youth. This might be a formal psychiatric evaluation, or it might be the last time you saw the youth and checked in on their mental status.

5. Please fill out the questions section based on the youth's age (only one part will be completed).

Youth Ages 4-17: The first part of this question applies to youth under the age of 18 and is used to determine whether the youth is experiencing difficulties functioning in one or more areas of their life, which may indicate a Serious Emotional Disturbance (SED).

Youth Ages 18-20: The second part of the question concerns if youth above 18 have difficulties functioning in at least one life activity. For either of these questions, you as the QMHP or QHP are looking to see if the youth is experiencing extreme enough difficulties that more help is needed to help that youth succeed in one or more areas of their life, which may indicate a Serious Persistent Mental Illness (SPMI).

6. Wraparound is a home and community-based program. It is crucial that the youth you are completing this form for can be served safely in the community. Safety of the potential youth that are looking to be enrolled in the Wraparound Program will always be priority. If the youth is currently at home and can safely be served at home or in the community, then it would be appropriate to mark “Yes” and then skip the next question. If the youth is in out of home placement and you have selected “No” to the first part of the question, you then can document if it is safe to serve the youth in a community setting when they return home.

Note: Wraparound can begin to aid transition to home planning when a youth is in Out-of-Home Placement. This can be as far as 90 days in advance of the youth’s planned return to home date.

7. Section six is about the youth’s Medicaid criteria. To qualify for services, a youth must meet at least one of the Medicaid criteria in this section.

8. Finally, please complete all the information in the signature section. This includes your name, credentials, license number, agency, fax, and phone number. Once this information is all complete, please sign and date the form. A Level of Care will be good for six (6) months while the youth is in the application process. Once enrolled, the Level of Care is good for one (1) year after the signed date. Provisionally licensed individuals may sign with their supervisors' signature and license information included.

Important note: Qualified Healthcare Professionals (QHPs) and Qualified Mental Health Professionals (QMHPs) may bill for reimbursement from Wyoming Medicaid for the Level of Care using CPT code 96127, in accordance with applicable billing and payer guidelines.

Thank you again for your help in serving Wyoming communities and youth. If you have any questions or concerns regarding this form, please reach out to the Magellan Customer Service Line at 1-855-883-8470.

CLINICAL LEVEL OF CARE

NOTE TO SIGNING PROVIDER:

This form is used for the purpose of enrollment into a home and community-based Medicaid waiver program, not for hospital authorization. This form is used to verify an appropriate level of care at the time this form is completed. Some of the information provided may be based on statements given by others, not you as the signing clinician. The information provided in this application is to verify diagnosis and risk(s) present that may meet eligibility criteria for this program.

1. Name of Youth _____

2. Is the applicant between the ages of 4 and 20 years old?

___ Yes ___ No

3. Does the applicant have a current DSM 5 or ICD-10 *mental, behavioral, or emotional disorder* that meets federally qualifying criteria for a youth with a serious emotional disturbance (SED)?

___ Yes ___ No

Primary Mental Health Dx Code _____ Secondary Dx Code _____

4. Date of most recent Mental Health Evaluation.

Date: _____

5. For applicants ages 4 through 17, does the applicant's serious emotional disturbance result in functional impairment that, within the past 12 months, has substantially interfered with or limited their ability to function in family, school, or community activities?

___ Yes ___ No

OR

For applicants ages 18 and over, does the applicant's serious and persistent mental illness result in functional impairment that, within the past 12 months, has substantially interfered with or limited one or more major life activities?

___ Yes ___ No

6. Is it reasonable to expect the applicant to 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?

___ Yes ___ No

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's needs in place?

___ Yes ___ No

7. Does the applicant meet at least one Medicaid criteria (below). Please select the appropriate option(s).

- ___ Persistent, pervasive, and frequently occurring oppositional/defiant behavior.
- ___ Reckless and/or impulsive behavior, which represents a disregard for the well-being and/or safety of self/others.
- ___ 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.
- ___ Self-induced vomiting, use of laxatives, strict dieting, fasting, and/or vigorous exercise.
- ___ Aggressiveness and/or explosive behavior.
- ___ History of repeating life-threatening injury to self/others, resulting in acute care admissions within the past 12 months.
- ___ Extreme social isolation.
- ___ None apply. (Selecting this option indicates that the youth does not meet the requirements for service eligibility.)

8. Please clearly print the name and required information of the documenting QMHP or QHP.

Name and Credentials: _____

If applicable, include supervisor information. Please sign below as well.

Agency Name: _____

Supervisor Name: _____

Contact Telephone Number: _____

Credentials of Supervisor: _____

License Number: _____

License Number of Supervisor: _____

***QMHP or QHP Signature** _____

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Date _____

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