HIGH FIDELITY WRAPAROUND APPLICATION

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

Parent/guardian

- Page 1: Intake Form. Every field is required to be filled out. Parent/guardian signature is **required**
- Page 2: Choice of Providers Form. Parent/guardian signature and initials are **required**
- Page 3: Freedom of Choice Statement. Parent/guardian signature is **required**
- Page 4: Family rights and responsibilities. Parent/guardian signature is **required**
- Release of information form: provided by the provider. Parent/guardian signature is **required**

Licensed WY Clinician

- Page 5: Clinical Level of Care Assessment. Licensed clinician signature is **required**

Independent Assessor

- CASII/ESCII Instrument report and score sheet (2 copies) **required**
- Page 6: CASII/ECSII attestation. Independent assessor signature **required**
- Release of Information form: : provided by each provider. Parent/guardian, FCC and IA signatures are **required**.

Family care coordinator (FCC)

- Page 2: Choice of Providers Form. FCC and Parent/guardian signatures are **required**
- Page 7: FCC Application and Enrollment Checklist. FCC signature is **required**.
- Release of Information form: provided by each provider. Parent/guardian, FCC and IA signatures are **required**.
- Compile and submit completed HFWA application and submit to Magellan

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

INTAKE FORM

Name of Applicant	**Date of Birth**	**Age**
Applicants Home and/or Mailing Address Physical Address Mailing Address *(if different)*	**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 <u>at time of application</u> *(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: _____		*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.*
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)* Physical Address Mailing Address	**Adult Phone Information** Home: ( ) ___ - _____ Mobile: ( )___ - _____ Work: ( )___ - _____ Other: ( )___ - _____	

- 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		

Magellan HEALTHCARE

Wyoming Department of Health

CHOICE OF PROVIDERS FORM

Date	
Youth Name	**Guardian Name**
Reason for Completing This Form ___New Member ___Adding a provider ___Changing a provider	
Guardian initials: ___Providers and services available through Magellan have been explained to me. ___ 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. ___ 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. ___ 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 (required):	
Optional team members:	
Family support partner:	
Youth support partner:	
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	
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.	
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. or ____ Hospital. I/my youth have chosen to receive services in a hospital setting.	
Signatures	
**I received training on my rights, and understand the process for instances of abuse, neglect, and exploitation.*	
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

Your rights

As an enrollee in the program, your child or youth has the right to:

- Be treated with respect, dignity and privacy.
- Be treated fairly, whatever his/her:
  - 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:
  - 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:
  - 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:
  - 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:
  - 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.
- 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.

Your responsibilities

As the parent or guardian of a child or youth, you have the responsibility to:

- 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.
  - 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.

The calls and emails will stay private.

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?** **2. Is the applicant Medicaid eligible or currently have Medicaid?**	 Yes No Yes No
3. Does the applicant have a current version DSM 5 or ICD-10 *mental, behavioral, or emotional disorder?* Code number(s) **and** primary mental health diagnosis: _____ Date of most recent *mental health* 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: __ 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 __ Aggressiveness and/or explosive behavior __ 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 laxative/diuretics, strict dieting, fasting and/or vigorous exercise __ Extreme phobic/avoidant behavior __ Extreme social isolation __ History of repeated life threatening injury to self/others, resulting in acute care admissions within the past 12 months **Does the applicant meet at least one Medicaid Criteria (above) Yes No** If ONE of the items above is checked, then YES is the appropriate answer for this question. *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.*	
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? *See Application Cover Page for additional guidance on this question*	Yes No Yes No
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: ( ) ____ - _____	
***QMHP-C Signature _____** ***A Qualified Mental Health Professional –Child (QMHP-C) is any person able to diagnose and treat behavioral health disorders with children and is limited to a physician (MD, DO, PA), psychiatrist, nurse practitioner, psychologist/neuropsychologist, licensed mental health professional (including provisionally licensed).Must be actively/provisionally licensed in WY.**	**Date**

CASII/ECSII ATTESTATION

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 this is for 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 and one day add form 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?
___Provider Agency *Name of Agency:*_____
___WYHealth
___Department of Family Services
___Child Protective Services
___Juvenile probation
___Primary Care Physician
___Therapist
___ Family self-referred/Magellan Clinical staff coordinated
___School *Name of School:* _____
___Other *Specify:*_____

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). ___*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. ___Contact Magellan's Care worker at 307-459-6162 to help family select an approved Independent Assessor to do the CASII/ECSII. ___*Independent Assessor form (page 6): Must be signed by the IA. This is part of the application packet, along with the *CASII/ESCII 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 ***has an active Medicaid number*:** Submit the completed application packet with this form through Magellan's Provider Portal at www.MagellanProvider.com ➢ If youth ***does not have an active Medicaid number***: Submit the completed application packet with this form via secured email to WYClinical@MagellanHealth.com	CASII score _____ or ECSII score _____
Agency:	
Street Address:	
City, State and ZIP Code:	
Telephone Number:	
Email address:	
FCC attestation: All the above was completed on time FCC signature_____ (*required for payment*) FCC printed name_____	**Date**