Wyoming Department of Health
Commit to your health.

BEHAVIORAL HEALTH DIVISION
APPLICATION FOR CHILDREN'S MENTAL HEALTH WAIVER (CMHW)
A Medicaid home & community-based waiver

Please type or print CLEARLY. ***All shaded sections are required.***

Date Recieved _____ Initials _____
Demographics complete? ☐ Y ☐ N
Clinical LOC complete? ☐ Y ☐ N
CASII included? ☐ Y ☐ N
CHIPRA/CME? ☐ Y ☐ N
∘ FOR OFFICE USE ONLY ∘ FOR OFFICE USE ONLY ∘

Name of Applicant	**Date of Birth**	**Age**
Applicant's Home and/or Mailing Address, City, State, Zip Physical Address Mailing Address	**Social Security Number**	

Preferred Language of Communication	**Gender**	**Phone Information**
☐ English ☐ Spanish ☐ Other	☐ Male ☐ Female	Home: ( ) Mobile/Cell: ( ) Work: ( ) Other: ( )

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: _____

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 Program? _____

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 Telephone Number** Home: ( ) Mobile/Cell: ( ) Work: ( ) Other: ( )

EMAIL Address (Participant, ***if 18 and older without guardian or*** **Adult)**

☐ **I agree to participate in assessments/screenings to determine eligibility and the need for Children's Mental Health Waiver 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 waiver.**
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** ☐ **AM** ☐ **PM**

Signature of Witness *(required ONLY if the signature of applicant is an "X")*

Signature/Title of Individual Assisting in Completing Application *(see page 3; part 4)*

Part 2 – Clinical Level of Care Assessment – PRINT CLEARLY

MUST be completed by a Qualified Mental Health Professional (QMHP)

1. **Is the applicant between the ages of 4 and 21 years old?** ☐ **Yes** ☐ **No**

2. **Does the applicant have a current version DSM Axis I or ICD *mental health* diagnosis?** ☐ **Yes** ☐ **No**

   Code number(s) and primary *mental health* diagnosis: _____
   Date of most recent *mental health* evaluation: _____

3. **Does the applicant (ages 4 through 17) meet the definition of Serious Emotional Disturbance (SED)?** ☐ **Yes** ☐ **No**

   OR

   Does the applicant (ages 18 and over) meet the definition of Serious and Persistent Mental Illness (SPMI)? ☐ **Yes** ☐ **No**

4. ***Review and mark any/all that apply to the applicant:***

   ☐ Behavior likely to lead to injury or circumstances in which they are likely to be injured (such as habitual running away and/or exposing themselves to physical and sexual abuse or danger) without control by caregiver

   ☐ Perceived as genuine danger by caregivers

   ☐ Serious damage to the home of their caregivers or fire setting which has the potential of endangering others (within past 72 hours)

   ☐ Child/adolescent can no longer be managed in their customary domestic setting as far as peer and family relations are concerned and/or school and training

   ☐ Certain psychiatric diagnostic procedures which require 24-hour supervision

   ☐ Anticipated severe side-effects of medications or treatments where there is a high probability of medical complications or severe cognitive impairments or where there exists a concomitant medical disorder, requiring 24-hour medical supervision

   ☐ Psychiatric symptoms in the course of treatment of a medical disorder that is being treated on an inpatient basis that interferes with the treatment of that disorder

   ☐ Weight loss below 85% of ideal weight that appears to be progressive and with significant medical complications

Does the applicant meet the *level of care equivalent criteria* for inpatient psychiatric hospitalization?

IF one of the items above is checked, THEN YES is the appropriate answer for this question. ☐ **Yes** ☐ **No**

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.

Can the applicant be safely served in his/her home, school, and community with waiver services in place? ☐ **Yes** ☐ **No**

Does the applicant have a current (within the last year) evaluation with a mental health diagnosis? ☐ **Yes*** ☐ **No**

* If YES, please include a copy of the evaluation with this application for services.

CLEARLY PRINT the required information of documenting Qualified Mental Health Professional (QMHP):

Name and Credentials: _____ License Number: _____
Agency: _____
Contact Telephone Number: (_____) _____ Contact Fax Number: (_____)_____

QMHP Signature: _____ **Date:** _____

REQUIRED for Processing:

- ✓ **Completed application**
- ✓ **Completed CASII/ECSII tool and scoring sheet (A list of current CASII Providers is available at http://health.wyo.gov/mhsa/treatment/waiverindex.html)**
- ✓ Yes to evaluation question: Copy of clinical evaluation documenting DSM Axis I or ICD *mental health* diagnosis

∘ MAIL OR FAX ∘ MAIL OR FAX ∘ MAIL OR FAX ∘ MAIL OR FAX ∘ MAIL OR FAX ∘ MAIL OR FAX

To this Address:

Behavioral Health Division
Children's Mental Health Waiver Program
6101 Yellowstone Road, Ste 259A
Cheyenne, WY 82002

Fax Number:

307-777-1912

Part 3 -- APPLICATION PREPARED BY (this section completed **only if a person other than** the participant/participant's family or participant's guardian filled out the demographics on page one)	
Printed Name:	Date:
Signature:	
Agency:	
Address Street: _____ City / State / Zip: _____	
Telephone Number: ( )	

March 2013