State of Delaware Health & Social Services
Division of Medicaid & Medical Assistance (DMMA)
Children's Community Alternative Disability Program

Worker Name: _____

Pool Code: _____

Location: _____

Medical Eligibility Fact Sheet

Child's Name: _____

Birthdate: _____ Client/MCI Id#: _____

Parent(s)/Legal Guardian: _____ Case # (AWW #): _____

Home Address: _____

_____ *Please circle* Kent New Castle Sussex

Telephone # : _____ Email Address: _____

Attending Physician: _____

Primary Diagnosis: _____

Other Diagnoses: _____

Date of Application: _____ *Please circle* APPLICATION RE-EVALUATION

The Medical Review Team has determined:

1) Meets Disability Criteria YES NO SSA Category # _____

2) Qualifying institutional level of care:

_____ Acute Hospitalization

_____ Super Skilled Facility

_____ Skilled Nursing Facility

_____ Intermediate Nursing Facility

_____ ICF/MD

_____ ICF/IID

_____ Does Not Need Institutional Care

3) Medical care received at home is appropriate YES NO

4) Estimated cost of medical care at less than the potential cost of Institutionalization YES NO

5) Approval duration _____

_____ Date

_____ Physician Signature

_____ Administrator Signature

Revised 7/18

MAP 150

STATE OF DELAWARE
DIVISION OF SOCIAL SERVICES

COMPREHENSIVE MEDICAL REPORT

NOTICE TO PHYSICIAN: The following information is for use in connection with the patient's application. Please make your report COMPLETE and LEGIBLE enough for a reviewing physician to determine the nature and severity of impairment.

NAME: _____ D.O.B. _____ SEX _____ MARITAL STATUS_____

1. Phyisical Measurements: Height:_____ Weight _____
2. HISTORY: A. Past History _____

B. Date of onset of present illenss or injury _____

C. Is there a previous history of this illness? _____ If "Yes", describe _____

3. PRESENT CONDITION (ALL MAJOR IMPAIRMENTS)

A. Subjective Symptoms: _____

B. Objective Findings: (Give report of X-rays, lab., or diagnostic tests, etc., with dates. Use separate sheet if necessary.)

C. Patient is: Ambulatory _____ Confined to: Wheelchair _____ Bed _____ Home _____ Hosp. _____

D. Mental Status: _____

4. DIAGNOSES: _____

5. PROGNOSIS: _____

6. REHABILITATION and/or MAINTENANCE GOALS: _____

7. TREATMENT: A. Therapy and response: _____

B. Date of first visit: _____ Frequency of visits: _____

C. Date when you last examined this patient: _____

D. Diet: _____

E. Medications: _____ _____

F. Recommended Activities: _____

8. PROGRESS: Patient's condition is:

Improving _____ Static _____ Deteriorating _____ Terminal _____

Nursing Care Plan (Suggestions for active care)

BED: Position in good body alignment and
Turn q _____ hrs.
Avoid _____ position
Prone position _____ X a day as tol.
SIT IN CHAIR ____ hrs. ____ X a day

WEIGHT BEARING: ____ Full ____ Partial
____ None on _____ leg
SOCIAL ACTIVITIES:
Encourage _____ group
_____ Individual
_____ Within home
_____ Outside home

EXERCISES:
ROM____ X a day to _____
by ____ Pt. ____ Family ____ Nurse
Stand ____ hrs. ____ X a day
Other:

Level of ability. Write "S" if needs supervision only		INDEPENDENT	NEEDS ASSISTANCE	UNABLE TO DO
BED ACTIVITY	Turns			
	Sits			
PERSONAL HYGIENE	Bathing: //////////	//////////	//////////	//////////
	Face, hair, arms			
	Trunk & perineum			
	Legs			
	Shaving			
	Oral Hygiene			
	Bladder			
	Bowels			
DRESSING	Arms			
	Trunk			
	Legs			
	Appliances			
FEEDING	//////////			
LOCOMOTION	Sitting			
	Standing			
	Wheelchair			
	Walking			
	Stairs			

Self-Care Status

COMMUNICATION	YES	NO	SEMI
Can Speak			
Can Write			
Understands speech			
Understands writing			
Understands English			
(If "no", what language?)			

APPLIANCES	HAS	USES	NEEDS
Eyeglasses			
Dentures			
Hearing Aid			
Prosthesis			
Crutches			
Cane			
Wheelchair			
Other (specify)			

MENTAL STATUS	✓
Alert	
Forgetful	
Confused	
Occ. Confused	

BED
Low Bed:
____yes ____no
Side Rails:
____yes ____no
Mattress:
____ Regular
____ Firm
Other:

Medications and Treatments
(Check appropriate column)

	EVERY SHIFT	DAILY	2 OR 3X WEEKLY	WEEKLY	LESS THAN WEEKLY	PRN CHECK ONLY IF PHYSICIAN ORDERED.
Catheter Irrigations						
Injections (identify)						
IV solutions, medications or clysis (identify)						
Sterile dressings, soaks or packs (describe body area)						
Physical Therapy by RPT						
Oxygen & Inhalation therapy						
Suction						
Colostomy Care						
Gastrostomy Care						
Tracheotomy Care						
Tube feeding						
Preventive Skin Care						
Decubitus Care						
Other (specify)						

REMARKS:

Physician's Name_____
Physician's Address_____
_____

Recommend Nursing Home Care ____ yes ____no

*Signature*_____ Date_____

DELAWARE HEALTH AND SOCIAL SERVICES
DIVISION OF SOCIAL SERVICES
Medical Assistance Program (Medicaid)

Children's Community Alternative Disability Program

Attending Physician's Certification

TO: Division of Social Services
Medicaid

_____

_____

_____

Re: _____
(Child's Name)

Birthdate: _____

Parents: _____

Address: _____

_____

_____

I certify that the medical care received by the above named child is

_____ better than or equal to

_____ not as good as

care that the child would receive in an institutional setting and that the care

_____ is appropriate

_____ is not appropriate

to the child's needs.

_____
Attending Physician's Signature

_____
Date

Primary Caregiver Assessment of Child's Health and Social Status

Applicant/child's name: _____ Medicaid ID #: _____

Purpose

The primary caregiver of the above named child must complete this form. The information provided about the child will be used in the determination of medical eligibility for the Children's Community Alternative Disability Program. Your social worker will send the completed form to the Medical Review Team that is responsible for making the medical eligibility determination. Medicaid is requesting that you provide medical and social information that will help in the decision about whether your child meets the requirements of the program.

Instructions:

This form should be completed and submitted with your application form. Please complete all questions. If a question does not apply to your child please write "N/A" in that area.

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1. Identifying Information

_____ _____

Child's full name Date of Birth

_____ _____

Nicknames for Child used by family/friends Place of birth (hospital, city, State)

Weight:

_____lbs.____ozs. Problems experienced during pregnancy with this child:_____

_____

_____

Other persons living in the household:

Name	Relationship	Age

2. Information about the child's disability:

   A. What was the date of the onset of the disability? _____

   B. Please describe in detail the medical diagnosis and symptoms of the child for whom you are applying. How are his/her abilities limited?

   C. Is there any history of similar medical problems in the family? Yes____ No____
   If yes, please explain:

3. Information about the child's medical history:
   Give concise and specific answers about your child's medical history.

   A. Has the child any surgeries related to his/her current medical condition?
   Yes____ No____ If Yes, explains:

   B. What was his/her response to the surgery? Did it substantially improve his/her condition?

   C. Has the child had any therapies? Yes____ No____ If Yes, describe:

   D. What was the response to therapy? Did it substantially improve his/her condition?

   E. Has any special exercise been described for the child? Yes____ No____ If Yes, describe:

F. What was his/her response to exercise? Did it substantially improve his/her condition?

_____

_____

G. Is the child on a normal diet? Yes____ No____ If no, describe the special diet that has been prescribed: _____

_____

H. Describe **all** medications that the child takes and the frequency that those medications are used:

Name of medication	Dosage	How often taken

I. What equipment, appliances or supplies does your child need on a routine basis to function (such as eyeglasses, wheelchair, braces, cast, crutches, cane, prosthetics, etc.)?_____

_____

_____

Does your child use any special adaptation in order to function? Yes____ No____

Any assistive devices? (List) _____

_____

Special Technology? (List) _____

_____

J. Is your child incontinent? Yes____ No____

K. Does he/she require:

	Yes	No
Catheter?	_____	_____
Colostomy care?	_____	_____
Gastrostomy care?	_____	_____
Tracheotomy care?	_____	_____
Preventative or decubitus care?	_____	_____
Tube feeding?	_____	_____

Any other care not described before in your answers?

_____

_____

L. List any current (within the past 6 months) or pending evaluations, assessments, x-rays, medical tests or laboratory studies:

Name of Procedure	Date done or scheduled

M. List any recent period(s) of hospitalization related to the child's current condition. Include the name(s) of the hospital(s), date(s) of hospitalization(s), and specify the reason the child was hospitalized:

Hospital Name & Location	Dates Hospitalized	Reason

N. What is the current emotional state of the child? How does the child view himself/herself?

_____

_____

_____

_____

O. Does your child receive counseling? Yes____ No____

How often?_____

For what problem?_____

4. Information about the child's current abilities and limitations:

This section is for the primary caregiver's statement about the effect of the physical and/or mental illness or impairment on the child's ability to function. Compare the child's functional abilities now with the level of functioning prior to his/her disability.

_____

_____

_____

_____

_____

_____

A. Does your child display or have any problems with the following:

	Yes	No
emotional withdraw	_____	_____
bed wetting	_____	_____
eating disturbance	_____	_____
sleep disturbance	_____	_____
impulsivity	_____	_____
fire starting	_____	_____
eating disorder	_____	_____
concentrating	_____	_____
poor concentration & attention	_____	_____
temper tantrums	_____	_____
negativity & defiance	_____	_____
lying	_____	_____
cheating	_____	_____
stealing	_____	_____
physical aggression	_____	_____
self injurious behaviors	_____	_____
destruction of property	_____	_____
functioning in school	_____	_____
substance abuse	_____	_____

B. Does the rest of the family make adjustments to accommodate child's impairment?
Yes____ No____
Explain:_____

C. How does your child get along with other family members?

D. Describe your child's friends:

5. Has your child ever been tested or evaluated by any of the following agencies or organizations? Submit copies of applicable evaluations.

	Type of evaluation or testing from agency:
Division of Public Health	_____
Child Watch	_____
WIC program	_____
Division of Developmental Disabilities Services	_____
Division of Alcohol & Drug Abuse	_____
Division of Visual Impairment	_____
Speech & Hearing	_____
Division of Vocational Rehabilitation	_____
Division of Child Mental Health	_____
Special Needs Agency	_____
United Cerebral Palsy	_____
Independent Living	_____

6. Information about the child's medical providers:
   List names of doctors, clinics, therapists, home health agencies, and other medical providers that are providing care to your child. Indicate the date last seen by each provider, the frequency of the visits and the reason your child is seeing that provider related to the current medical condition.

Provider Name	Date last seen	Frequency seen	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

7. Information about the child's social situation:

   A. What are the child's favorite toys, games, activities, interests or hobbies?
   _____
   _____
   _____

   B. Does your child participate in any schools, church, sports or community activities?
   Yes____ No____ If yes, describe:_____
   _____

   C. What are your child's likes/dislikes?
   _____
   _____

   D. If your child is a teenager, what are his/her plans for the future?
   _____
   _____

E. Does your child participate in home schooling? Yes____ No____

F. Does your child receive remedial assistance, tutoring from the community? Yes____ No____

G. Is your child in a self-contained or regular classroom? Yes____ No____

H. How many days of school did your child miss?_____
In the past month?_____
In the past year?_____

I. Is child in special education program? Yes____ No____
When was the most recent IEP done?_____ If applicable, submit a copy of IEP.

8. Medical Insurance Information:
Describe all health insurance coverage that your child has. **Medicaid** ☐ **CHIP** ☐

Insurance Company:_____
Policy Holder:_____
Policy/Group#(s):_____
Policy Holder's Employer:_____
% covered by Insurance:_____
Comments:_____
_____
_____

9. Have you ever applied for Supplemental Security Income for your child?
Yes____ No____ If yes, indicate the dates and disposition of the application.

Date(s) applied for SSI	Approved (check one)	Denied
_____	_____	_____
_____	_____	_____
_____	_____	_____

10. Why are you applying for the Children's Community Alternative Disability Program for your child?
_____
_____
_____
_____
_____

This form was completed by:_____

Phone:_____

Relationship to the applicant:_____

Date completed:_____

AUTHORIZATION TO DISCLOSE INFORMATION TO DELAWARE HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID & MEDICAL ASSISTANCE (DMMA)

Name of Person Whose Records Are to be Disclosed:	
Date of Birth (MM/DD/YYYY):	Social Security Number:

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange) of the information listed below to Delaware Health and Social Services and/or its Managed Care representatives: AmeriHealth Caritas and United Healthcare Community Plan of Delaware, for determining my eligibility for medical assistance and/or food benefits. This release may be used to ask for, receive and/or release information that is pertinent to my eligibility determination.

All my medical records:

1. All records and other information regarding treatment, hospitalizations, and outpatient care for my impairment(s).
2. Information about how my impairment(s) affect my ability to complete tasks, activities of daily living, and specific functions in the work/school environment.

All Financial records:

1. All records from financial institutions, including information of any accounts closed within the last 60 months.
2. Information from all sources of income (Social Security Administration, current and past employers, Annuity companies, etc).
3. All life insurance companies.

This authorization ends when the information asked for is received, or 12 months from the date signed or until revoked by me in writing, whichever comes first. I understand I may revoke this authorization at any time by notifying the providing organization in writing.

Signature of Individual Authorizing Disclosure:			
If not signed by subject of disclosure, specify basis for authority to sign (provide supporting documentation): ☐ Parent of Minor ☐ Power of Attorney ☐ Guardian ☐ Other			
Date Signed	Address		
Telephone Number:	City	State	Zip Code

You are not required to sign this form as a condition of eligibility and your health care and payment for health care will not be affected if you do not sign this form. However, you will still be required to provide the necessary information to DMMA in order for us to be able to determine your eligibility for Medicaid.

Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and therefore no longer protected by Federal privacy laws.