MEDICAID WAIVERS - CARE AT HOME PROGRAM
For Physically Disabled Children
APPLICATION COVER SHEET

(To be completed for **new** applications only.)

Client Name: _____ District: _____

SSN: _____ CIN: _____ CAH I: _____ CAH II: _____

Date of Application: _____

(1-5) LDSS obtains (County CAH Coordinator or designee). To be obtained and evaluated before involving case manager.

1. _____ Application Form Signed by Parent
2. _____ Proof of Medicaid Ineligibility
3. _____ Proof of Age/Birth Certificate D.O.B.: _____
4. _____ Proof of Physical Disability
5. _____ Case Management Selection Form

_____ DSS-639 Expiration Date: _____ Group I _____
Group II _____

Disability Listing(s):
_____
_____

6. _____ Verification of Length of Institutional Stay (e.g., Inpatient Bill; Insurance Statement) from Hospital on letterhead, explanation of benefits from Insurance Company. Also, must list admission and discharge dates.

(7 & 8) Assessing Nurse-from CASA, CHHA, Public Health, VNA or acceptable other. Visit done by nurse and case manager, when possible.

7. _____ Pediatric Patient Review Instrument
8. _____ Plan of Care (P.O.C.)
_____ Path
_____ Home Assessment Abstract
_____ Fastep
_____ MAA-CN-1-8

7A. For Private Duty Nursing has the following been identified:
_____ Nursing Provider(s)
_____ Prior Approval

(9,10 & 11) Case Manager

9. _____ M.D. orders
10. _____ Budget Sheet
11. _____ Case Management Plan of Care

(12) CAH Coordinator, DDSO or Private CAH - CM

12. _____ Case Manager: _____/ (_____) _____
Telephone Number
(_____) _____
Fax Number

13. _____ Other: Specify: _____