

Children's Extensive Support Waiver Checklist Application

Department of Human Services
Division for Developmental Disabilities
July 2010

To be used for Initial Application to Waiting List, Enrollment and Continued Stay Reviews

The information contained in this packet **must** demonstrate the child meets the eligibility criteria for the CES waiver as follows:

The child demonstrates a behavior or has a medical condition that requires direct human intervention, more intense than a verbal reminder, redirection or brief observation of medical status, at least once every two hours during the day and on weekly average of once every three hours during the night. The behavior or medical condition must be considered beyond what is typically age appropriate and due to one or more of the following conditions:

A. Significant pattern of self-endangering behavior or medical condition which, without intervention will result in a life threatening condition/situation.

Definition of Significant pattern:

- ❖ The behavior or medical condition is *harmful to self or others*.
- ❖ Is evidenced by *actual events*.
- ❖ The events occurred within the past *six months; or*

B. A significant pattern of serious aggressive behaviors toward self, others or property.

- ❖ The behavior or medical condition is *harmful to self or others*.
- ❖ Is evidenced by *actual events*.
- ❖ The events occurred within the past *six months; or*

C. Constant vocalizations such as screaming, crying, laughing or verbal threats which cause emotional distress to caregivers.

- ❖ Definition of Constant: On average of 15 minutes each waking hour.

The above conditions shall be evidenced by parent statement/data which is corroborated by written evidence that:

- ❖ The child's behavior(s) or medical need(s) have been demonstrated; or
- ❖ It can be established that in the absence of existing intervention or prevention the intensity and frequency of the behavior or medical need would resume to a level that would meet the criteria listed above.

Evidence shall include, but not be limited to:

- ❖ Medical records, professional evaluations and assessments, educational records, insurance claims, Behavior Pharmacology reports, police report, social services reports; or
- ❖ Observation by a third party on a regular basis

Continued Stay Review _____ **Wait list** _____ **Initial Enrollment** _____

Information about the child:

Name:	Social Security Number:
Date of Birth:	Height and Weight:
Medicaid ID Number:	

Information about the parents/legal guardians and physician:

Names:	Address:
Phone Number:	Physician name and number:

Information about the Community Centered Board:

Community Centered Board:	Case Manager/Resource Coordinator:
Date of DD Eligibility by CCB:	Case Manager/Resource Coordinator Phone:
E-mail address of Case Manager/Resource Coordinator:	

Child's current living situation: (check one)

- _____ Lives with biological or adoptive parent(s) or legal guardian in the family home.
- _____ In out of home placement and could return home with provision of CES services. Please describe:

Please give information about what your child experiences including frequency (how often does it occur), duration (how long does it last) and intensity (what kind of injury it causes; such as bleeding, choking, bruising, etc.) Appendix A may be used as reference. Appendix B contains a list of possible interventions that may be used to address the conditions/behaviors. If you do not find the condition, behavior or intervention that you experience, please write it in. Please be as specific as you can. Page 3 is to be used for daytime interventions and Page 4 is to be used for nighttime interventions. Page 5 is a summary page where you can include important information that may not be reflected elsewhere in the application.

Daytime Interventions

Column 1 Medical Condition or Behavior (see Appendix A for examples)	Column 2 Frequency-how often does it occur during daytime awake hours? Mark both hourly and calendar frequency below for each intervention described.		Column 3 Duration- State how long each behavior/condition episode lasts; 15 minutes, 1 hour, 2 hours, etc.)	Column 4 Intensity-what is the injury to self or others-consequence of no intervention	Column 5 Direct Human Intervention- (more intense than a verbal reminder, redirection or brief observation of medical status) See Appendix B, enter code number of intervention here.
	<input type="checkbox"/> Every 15 minutes <input type="checkbox"/> Every hour <input type="checkbox"/> Every two hours <input type="checkbox"/> Other: Specify	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly			
	<input type="checkbox"/> Every 15 minutes <input type="checkbox"/> Every hour <input type="checkbox"/> Every two hours <input type="checkbox"/> Other: Specify	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly			
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	<input type="checkbox"/> Every 15 minutes <input type="checkbox"/> Every hour <input type="checkbox"/> Every two hours <input type="checkbox"/> Other: Specify	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly			
	<input type="checkbox"/> Every 15 minutes <input type="checkbox"/> Every hour <input type="checkbox"/> Every two hours <input type="checkbox"/> Other: Specify	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly			

Child's Name: _____

Nighttime Interventions-on a weekly average how many nights does intervention occur? _____

Typical Bedtime: _____ Typical morning awake time: _____ Total number of hours the child sleeps each night: _____

Column 1 Medical Condition or Behavior (see Appendix A for examples)	Column 2 Frequency-how often does it occur during nighttime hours? Mark both hourly and calendar frequency below for each intervention described.		Column 3 Duration- State how long each behavior/condition episode lasts; 15 minutes, 1 hour, 2 hours, etc.)	Column 4 Intensity-what is the injury to self or others-consequence of no intervention	Column 5 Direct Human Intervention-(more intense than a verbal reminder, redirection or brief observation of medical status) See Appendix B, enter code number of intervention here.
	<input type="checkbox"/> Every 15 minutes <input type="checkbox"/> Every hour <input type="checkbox"/> Every three hours <input type="checkbox"/> Other: Specify	<input type="checkbox"/> Nightly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly			
	<input type="checkbox"/> Every 15 minutes <input type="checkbox"/> Every hour <input type="checkbox"/> Every three hours <input type="checkbox"/> Other: Specify	<input type="checkbox"/> Nightly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly			
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	<input type="checkbox"/> Every 15 minutes <input type="checkbox"/> Every hour <input type="checkbox"/> Every three hours <input type="checkbox"/> Other: Specify	<input type="checkbox"/> Nightly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly			

Child's Name: _____

Summary Page: (optional; limit to one page) Briefly describe the frequency and intensity of behaviors or medical condition not detailed in previous pages but may further demonstrate eligibility for CES.

For example this may include: nature and extent of injuries sustained within the past 6 months, the school environment (1:1 aide, what the aide does to help the child, details of a behavior plan, enclosed environment to limit distractions, interaction with specialized school teams, i.e. District Autism Team, etc.), or description and dates of emergency room visits, hospitalizations, police interventions, and non-routine behaviors or medical conditions.

Child's Name: _____

Pages 7 and 8 are to be completed ONLY for Continued Stay Review and ONLY if the child is NOT experiencing any behavioral/medical condition(s) that can be used as qualifying criteria DUE TO interventions provided by one of the following CES services specifically listed on pages 7 and 8. Do not complete these pages for initial enrollment.

If these pages are blank: do not fax to DDM

Adapted Therapeutic Recreational Activities and Fees	Description of service:	Behavior/medical condition this helps to modify:
Assistive Technology	Description of service:	Behavior/medical condition this helps to modify:
Behavior Services	Description of service:	Behavior/medical condition this helps to modify:
Community Connector	Description of service:	Behavior/medical condition this helps to modify:
Home Accessibility Adaptations	Description of service	Behavior/medical condition
Homemaker; Basic or Enhanced	Description of service	Behavior/medical condition

Child's Name: _____

Parent Education	Description of service	Behavior/medical condition
Personal Care	Description of service	Behavior/medical condition
Professional Services	Description of service	Behavior/medical condition
Respite	Description of service	Behavior/medical condition
Specialized Medical Equipment and Supplies	Description of service	Behavior/medical condition
Vehicle Modifications	Description of service	Behavior/medical condition
Vision Services	Description of service	Behavior/medical condition

Child's Name: _____

Case Manager/Resource Coordinator: List the documents you have which describe the behaviors, medical conditions or constant vocalizations associated with eligibility that have occurred **within the past six (6) months**. Examples shall include, but not be limited to any of the following: medical records, professional evaluations and assessments, educational records, including communication logs between parent and school, insurance claims, Behavior Pharmacology Clinic reports, incident reports, police reports, social services reports or observation by a third party on a regular basis. Sources of information need to be from external sources outside the family and CCB. Please do not include IEP.

Please do not send documents with the application, they will be requested if needed. These documents must be available if requested by the Dual Diagnosis Management or the Division for Developmental Disabilities (DDD).

Documents *older than six months* from the date of CES Checklist Application submission to Ascend will not be considered.

Documentation Page

Type of document or source of information	Date of document or source of information dd/mm/yy	Who prepared the document or provided the information?
	____/____/____	
	____/____/____	
	____/____/____	
	____/____/____	

Child's Name: _____

Information needed for Wait List, Enrollment, or continued Stay Review: **(Appendices do not need to be submitted)**

_____ ULTC 100.2

_____ CES Application Checklist Form

I certify, to the best of my knowledge, all information on this application is true and complete.

Signature

Date

(Circle one)

Parent

Legal Guardian

I certify, to the best of my knowledge, all information on this application is true and complete.

Signature (Case Manager/Resource Coordinator)

Date

Community Centered Board

Please Print Your Name

When this application packet is complete, please send to:

Debra Money, RN Program Coordinator
Children's Extensive Support Waiver
Dual Diagnosis Management
227 French Landing Drive, Suite 250
Nashville, TN 37228
Phone 1-877-431-1388 ext. 3203
FAX: 1-877-431-9568
dmoney@ascendami.com

Child's Name: _____

Appendix A

To qualify for the CES waiver –The child must demonstrate a **behavior** or has a **medical condition** or **constant vocalization** that requires **direct human intervention, more intense than a verbal reminder, redirection or brief observation of status**, at least once **every two hours during the day and on a weekly average of once every three hours during the night**. The behavior or medical condition must be considered **beyond what is typically age appropriate** and due to one or more of the following conditions;

Medical Condition

Neurological

Seizures/neurological condition

Tics

Tremors

Respiratory problems

Other lung or airway issues

Aspiration

Digestive

Choking

Nothing by mouth

Feeding disorder

Swallowing disorder

Sensory Issues with Feeding

Colostomy or _____ostomy

Diarrhea

Constipation

Other elimination Issues

Reflux

Specify any other digestive issues

Tracheostomy

Immune System

Food Allergies

Immune system compromised

Illness

Musculo/skeletal Issues

Paralysis

Muscle Spasms

Muscle Atrophy (weakness or loss of muscle)

Scoliosis

Joint Pain

Other Musculo/skeletal Issues

Skin

Skin Breakdown

Unable to regulate body temperature

Other Skin issues

Sensory

Visual Impairments

Hearing Impairments

Smelling Impairments

Overall sensory issues

Lack of awareness of injury sustained

Appendix A1

Behavioral Conditions

Self-endangering Behavior

Thoughts of suicide
Wandering
Elopement (running away)
Leaving car restraint
Interfering with driver of vehicle
Climbing with high risk of injury
Jumping with high risk of injury
Head banging on hard surface
Hitting head with fist causing bleeding, bruising, eye

injury

Fire Setting
Dangerous/inappropriate sexual behavior
Flailing arms/incidental hitting
Lack of kitchen safety
Lack of household safety
Pica (eating unusual things, dirt, plaster, etc.)
Stuffing mouth with food and chokes
Refuses to eat
Packing nose, ears, mouth with foreign items
Chemical mixing
Lack of awareness of injury sustained
Breaking of skin due to picking or pinching
Inappropriate dress for weather
Other: Describe on description page

Serious Aggressive Behavior

Fascination with Sharp Objects

Breaking of skin or gouging

Biting-self or others
Hitting/grabbing-self or others
Kicking
Pushing
Spitting
Twisting of skin
Pinching
Choking others
Head Butting
Smearing feces
Inappropriate urination
Shredding of clothing
Destruction of home/contents
Property damage
Aggression to animals
Other: Describe on description page

Constant Vocalization

Screaming
Crying
Shrieking
Humming
Laughing
Grunting
Swearing
Perseveration (need to repeat)
Echolalia (echoes everything he/she hears)
Other: Describe on description page

Appendix A2

Appendix B

Medical Interventions	
1	ER Visits
2	Hospitalizations
3	Doctor Visits
4	Mental Health Visits
5	Surgeries
6	911 calls
7	Social Services contact
8	Police Interventions
9	Oxygen
10	Suctioning
11	Bi-pap
12	C-pap
13	Pulse-ox
14	Nebulizers
15	Heart monitor
16	Dialysis
17	Tube feeding
18	Adaptive equipment
19	Repositioning
20	Special diet
21	Wound care
22	Skin care
23	Diapering
24	Interventions during seizures
25	Wheelchair ramp
26	ABI Vest
27	1 on 1 supervision
28	Response to medical equipment alarms
29	Administration of medications via G-tube
30	CPR
80	Other: Specify

Behavioral Interventions	
1	ER Visits
2	Hospitalizations
3	Doctor Visits
4	Mental Health Visits
5	Surgeries
6	911 calls
7	Social Services contact
8	Police Interventions
50	1 on 1 supervision
51	Environmental adjustments
52	Modifications to Home
53	Safe Room
54	Locks on Door/Window
55	Alarm System
56	Specialized Clothing
57	Parent vigilance at night
58	Locking child's bedroom door at night
59	Child sleeps with parents
60	Mattress on floor
61	Child's room is bare
62	Baby Monitors
63	Physically removing child from situation
64	Physically holding child for safety
65	Sensory input: Specify
66	Behavior Plan
67	Homebound
68	1:1 Para at school
69	Early Dismissal from school
70	Suspensions/Expulsions from school
71	Suspensions/Expulsions from school bus
72	Harness used in car/bus

73	Seat belt locks
74	Car seat not required by law
75	Prevention of ingestion of medications, poisons, cleaning liquids, etc.
76	Prevention of pica
77	Prevention of suicide attempts
78	Prevention of sexual aggression
79	Prevention of non-aggressive but inappropriate behavior
80	Other: Specify