CLINICAL LEVEL OF CARE ASSESSMENT

Name of Youth _____ Is the applicant between the ages of 4 and 20 years old? Is the applicant Medicaid eligible or currently have Medicaid?	 ____ Yes _____ No ____ Yes _____ No
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
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

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 TO SIGNING CLINICIAN: *This form is used for the purpose of enrollment into a home and community based Medicaid waiver program, not for hospital authorization. This form is used to verify an appropriate level of care at the time this form is completed. It is understood some information provided, is based on statements given by others who are not the signing clinician. The information provided in this application is to verify diagnosis and risk(s) present that may meet eligibility criteria for this program.*

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 Wyoming.**	**Date**