CLINICAL LEVEL OF CARE ASSESSMENT COVER SHEET

Information and Directions for this Form: Thank you for completing the Level of Care Assessment for a Wyoming Youth. This is a crucial assessment that informs the qualifications of the youth you are providing information regarding. It is critical that every question (denoted by a highlighted area) is entirely and accurately completed. To complete this form, you must be designated as a Qualified Mental Health Professional (QMHP). The Wyoming Department of Health has defined this as 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.

The descriptions below describe each box that you will be completing on the following page.

1	This box collects demographics of the youth. For youth to qualify for the Wraparound Program, they must fall within the ages of 4 and 20.
2	Youth must have a current DSM 5 or ICD-10 mental, behavioral, or emotional disorder. The QMHP will denote the identified diagnosis and list the correct corresponding ICD 10 code.
3	The date of the most recent Mental Health Evaluation can be a formal psychiatric evaluation, or the last time you saw the youth and checked in on their mental health status.
4	There are two main catorgies to complete. The QMHP must fill out the appropriate section according to the age of youth that you are completing this form for (only one part will be completed). Youth Ages 4-17 (Serious Emotional Disturbance): The first part of this question is for any youth under the age of 18 and helps distinguish if the youth is having difficulties functioning in at least one area of their life. Youth Ages 18 + (Serious Persistent Mental Illness): The second part of the question concerns if youth above 18 have difficulties functioning in at least one life activity.
5	Wraparound is a home and community-based program. A QMHP would mark yes if it is presumed that the youth could function with additional support such as access to intensive, community-based, behavioral health and care coordination services (including evolving crisis plans) If the youth is currently in an out of home setting but can safely be served upon discharge with access to the supports mentioned above, please indicate “yes”. *Note:* Wraparound can begin to aid transition when a youth is in Out-of-Home Placement. This can be as far as 90 days in advance of the youth’s planned return to home date.
6	A youth must meet at least one of the Medicaid Criteria in this section. If one of the criteria in section six is marked, then a response of a “yes” would be appropriate.
7	Complete all required fields in this section. *Note:* A Level of Care will be considered valid for six (6) months while the youth is in the application process. Once enrolled, the Level of Care is valid for one (1) year after the signed date. A new Level of Care will be needed every year for continued wraparound services and/or each time a youth returns to the community from an out of home placement during wraparound enrollment.

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.

1	Name of Youth _____ Is the applicant between the ages of 4 and 20 years old.	____ Yes ____ No
2	Does the applicant have a current DSM 5 or ICD-10 *mental, behavioral, or emotional disorder?* Code number(s) and Primary Mental Health Diagnosis. _____	____ Yes ____ No
3	Date of most recent Mental health Evaluation.	_____ (MM/DD/YYYY)
4	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
5	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 could be safely served in the community upon discharge, with intensive, community-based services individualized to youth and family needs in place.	____ Yes ____ No ____ Yes ____ No
6	**Does the applicant meet at least one Medicaid Criteria (Below)** If ONE of the items below is checked, then YES is the appropriate answer for this question.	____ Yes ____ No

_____ 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.

_____ 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

_____ Extreme phobic/avoidant behavior

_____ Self-inducing vomiting, use of laxative, diuretics, strict dieting, fasting and/or vigorous exercise.

_____ Aggressiveness and/or explosive behavior

_____ History of repeating life-threatening injury to self/others, resulting in acute care admissions within the past 12 months.

_____ Extreme social isolation

7 CLEARLY PRINT the required information of the documenting a Qualified Mental Health Professional –Child (QMHP-C)

Name and Credentials: _____ License Number: _____

Agency Name: _____

Contact Telephone Number: _____ Contact Fax Number: _____

***QMHP-C Signature** _____ _____

Date (MM/DD/YYYY)

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