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 in your community. 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 in Wyoming. 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), and must be actively/provisionally licensed in Wyoming.

The following are descriptions for 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 (before a youth's 21st birthday).
2	Youth must have a current DSM 5 or ICD-10 *mental, behavioral, or emotional disorder*. You as the QMHP will denote the identified diagnosis and list the correct corresponding F code number(s). This information is utilized to qualify the youth and to also inform services provided under Wraparound. You will list the Primary Diagnosis code for the youth first followed by any secondary diagnosis that the youth might have.
3	The date of the most recent Mental Health Evaluation is the date that you have last evaluated the youth. This might be a formal psychiatric evaluation, or it might be the last time you saw the youth and checked in on their mental status.
4	Section 5 is broken up by age category. You 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: 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 18-20: The second part of the question concerns if youth above 18 have difficulties functioning in at least one life activity. For either of these questions, you as the QMHP are looking to see if the youth is experiencing extreme enough difficulties that more help is needed to help that youth succeed in one or more areas of their life.
5	Wraparound is a home and community-based program. It is crucial that the youth you are completing this form for can be served safely in the community. Safety of the potential youth that are looking to be enrolled in the Wraparound Program will always be priority. If the youth is currently at home and can safely be served, then it would be appropriate to mark "Yes" and then disregard the next question. If the youth is in out of home placement and you have selected "No" to the first part of the question, you then can document if it is safe to serve the youth when they return to home. 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	Section six informs to the youths Medicaid Criteria. In order to qualify for services, a youth must meet at least one of the Medicaid Criteria in this section. If one of the below criteria is marked, then a "Yes" in the dialog box to the side would be appropriate. If the youth do not meet one of the listed Medicaid Criteria, they will not qualify for the Wraparound Program.
7	Finally, please ensure that you complete each line in Section 7. This includes your name, credentials, license number, agency, fax, and contact number. Once this information is all complete, please sign and date the form. A Level of Care will be good for six (6) months while the youth is in the application process. Once enrolled, the Level of Care is good for one (1) year after the signed date. Provisionally licensed individuals may sign with their supervisors' signatures accompanying theirs.

Thank you again for your help in serving Wyoming Communities and Youth. If you have any questions or concerns regarding this form, please reach out to the Magellan Customer Service Line at 1-855-883-8470.

CLINICAL LEVEL OF CARE

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?* Primary Mental Health Dx Code _____ Secondary Dx Code _____	☐ Yes ☐ No
3	Date of most recent Mental health Evaluation.	_____
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 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 QMHP-C

Name and Credentials: _____ License Number: _____

Agency Name: _____

Contact Telephone Number: _____ Contact Fax Number: _____

***QMHP-C Signature** _____ _____

Date

*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 sign with their supervisors' signatures accompanying theirs). Must be actively/provisionally licensed.