HIGH FIDELITY WRAPAROUND APPLICATION

A Medicaid home and community-based waiver - 1915(b) and 1915(c)

Parent/guardian

- Page 1: Intake Form. Every field is required to be filled out. Parent/guardian signature is **required**
- Page 2: Choice of Providers Form. Parent/guardian signature and initials are **required**
- Page 3: Freedom of Choice Statement. Parent/guardian signature is **required**
- Page 4: Family rights and responsibilities. Parent/guardian signature is **required**
- Release of information form: provided by the provider. Parent/guardian signature is **required**

Licensed Wyoming Clinician

- Page 5: Clinical Level of Care Assessment. Licensed clinician signature is **required**

Independent Assessor

- CASII/ESCII Instrument report and score sheet (2 copies) **required**
- Page 6: CASII/ECSII attestation. Independent assessor signature **required**
- Release of Information form: : provided by each provider. Parent/guardian, Family Care Coordinator and Independent Assessor signatures are **required**.

Family Care Coordinator

- Page 2: Choice of Providers Form. Family Care Coordinator and Parent/guardian signatures are **required**
- Page 7: Family Care Coordinator Application and Enrollment Checklist. Family Care Coorindator signature is **required**.
- Release of Information form: provided by each provider. Parent/guardian, Family Care Coordinator and Independent Assessor signatures are **required**.
- Compile and submit completed High Fidelity Wraparound application and submit to Magellan

Wyoming Department of Health

WYO MEDICAID DIVISION OF HEALTHCARE FINANCING

This section for Magellan Providers ONLY: A complete application equals **EVERYTHING** listed above (use the checklist on page 7 for further instructions).

Submit an application for High Fidelity Wraparound:

- If the youth has an active Medicaid number: Submit the completed application packet through Magellan's Provider Portal, www.MagellanProvider.com
- If the youth does not have an active Medicaid number: Submit the completed application packet to WYClinical@MagellanHealth.com

INTAKE FORM

Name of Applicant	**Date of Birth**	**Age**
Applicants Home and/or Mailing Address Physical Address _____ Mailing Address *(if different)* _____ _____ _____	**Social Security Number** **Email Address** *(Adult or Participant if 18 or older without guardian)* _____	
Preferred Language of Communication _____ English _____ Spanish _____ Other _____	**Phone Information** Home: _____ Mobile: _____ Work: _____ Other: _____	**Gender** _____ Male _____ Female
Primary Health Care Provider Name: _____ Address: _____ City, State, ZIP code: _____ Phone: _____	**Disability** Does applicant have a disability? ☐ Yes ☐ No Is the applicant deaf or hard of hearing? ☐ Yes ☐ No Is the applicant blind? ☐ Yes ☐ No	
Race *(check all that apply)* _____ American Indian or Alaska Native _____ White/Caucasian _____ Hispanic _____ Native Hawaiian/Pacific Islander _____ Asian _____ Black/African American _____ Other _____ _____ Not Reported/Unknown		
Applicant's location <u>at time of application</u> *(if not at home, please list complete address)* _____ Home _____ Residential treatment center _____ _____ In-state mental health facility _____ _____ Acute care hospital _____ _____ Juvenile detention/correction facility _____ _____ Other _____		
Medicaid Information Is applicant currently enrolled in Medicaid? _____ Yes _____ No If Yes, Medicaid Recipient Number: _____ Effective Date: _____ Is applicant currently enrolled in Kid Care CHIP? _____ Yes _____ No If Yes, Kid Care CHIP Number: _____ Effective Date: _____	*Note that if an applicant has Kid Care CHIP and is accepted to the waiver, the family must choose one coverage type. If eligible for the waiver, staff will outline the differences.*	
Name of Responsible Adult	**Is applicant currently receiving wraparound services?** _____ Yes _____ No	
Relationship to Applicant *(if guardian, include a copy of the guardianship order/court documents)* _____ Parent _____ Guardian _____ Other Family Member _____ Department of Family Services Custody _____ Grandparent _____ Other _____		
Adult Home and/or Mailing Address *(if different than applicant)* Physical Address _____ Mailing Address _____	**Adult Phone Information** Home: _____ Mobile: _____ Work: _____ Other: _____	
• I agree to participate in assessments/screenings to determine eligibility and the need for Care Management Entity services. • I authorize the release of information by my physician, hospital, community mental health center, other social service providers, school, health service providers and family members to and among State agencies and their agents on my child's medical condition and other relevant information necessary to determine appropriate home and community-based services for the Care Management Entity. • *I understand I may revoke this release of information in writing at any time.*		
Signature of Applicant/Parent/Guardian/Responsible Person	**Date** *month/day/year)*	**Time** *(a.m. /p.m.)*
Signature of Witness *(required ONLY if the signature of applicant is an "X")*		
Signature/Title of Individual Assisting in Completing Application		
For Internal Use Only _____ 1915 (b) waiver _____ 1915 (c) waiver		

CHOICE OF PROVIDERS FORM

Date	
Youth Name	**Guardian Name**
Reason for Completing This Form _____ New Member _____ Adding a provider _____ Changing a provider	
Guardian initials _____ Providers and services available through Magellan have been explained to me. _____ I understand that I can make the decisions about what High Fidelity Wraparound services will be provided to me or my youth. _____ I can make the decisions about which providers will work with my youth while he/she is a member of Magellan. _____ I understand that I/my youth have/has a right to change my provider(s) at any time for any reason. Magellan providers also have a right to stop providing services. But they must give a 30- day written notice to me/my youth. _____ I understand that I/my youth have/has the right to ask for informal dispute resolution or an administrative hearing if we are not given the choice of services or providers.	
Provider Chosen A list of Magellan providers has been shared with me and my questions have been answered. I have chosen to work with the following:	
Provider:	
Family Care Coordinator (required):	
Optional team members:	
Family support partner:	
Youth support partner:	
Potential team members:	
Mental health professional:	
School representative:	
Other (please specify):	
Signatures	
Signature of applicant/parent/guardian/legally responsible representative:	Date
Signature of witness (ONLY IF SIGNATURE IS AN“X”):	Date
Signature of Family Care Coordinator:	Date

FREEDOM OF CHOICE STATEMENT

Date	
Youth Name	
Services Available I/my youth have been given the choice to: Access State Amendment Waiver services in our home and in community-based settings (High Fidelity Wraparound) **OR** for my youth to be admitted to the hospital I understand that the cost of home and community-based waiver services must meet the waiver requirement of being cost-effective.	
Choice of Service _____ State Amendment Waiver. I/my youth have chosen to receive State Amendment Waiver services (High Fidelity Wraparound) rather than services in a hospital setting. I have been told of my right to choose any certified waiver provider for these services. Or _____ Hospital. I/my youth have chosen to receive services in a hospital setting.	
Signatures	
**I received training on my rights, and understand the process for instances of abuse, neglect, and exploitation.*	
Signature of participants/parent/guardian/legally authorized representative:	**Date**
Signature of witness (ONLY IF SIGNATURE IS AN X):	**Date**

FAMILY RIGHTS AND RESPONSIBILITIES

Your family has rights and responsibilities under the High Fidelity Wraparound program. In particular, as a member of High Fidelity Wraparound, your child or youth's rights are important. Family Care Coordinators must explain your child's rights at the first visit.

Youth Name	**Date**

Your rights
As an enrollee in the program, your child or youth has the right to:
• Be treated with respect, dignity and privacy.
• Be treated fairly, whatever his/her:
  ○ Race, religion, gender, sexual orientation, ethnic background and disability.
• Have your child's treatment and other information kept private. The only time we may share treatment records is when required. (The Confidentiality section in the family and youth handbook provides more details).
• Have access to care.
• Learn about treatment in a way that:
  ○ Respects your culture, you can understand and fits your needs.
• Take part in making your child's Plan of Care.
• Get information in a language your family can understand. Also, get things translated for free.
• Get information in other ways if you ask for it.
• Get information about Magellan and its:
  ○ Providers, programs and services.
  ○ Role in the treatment process.
• Be informed about the clinical rules followed in your child's care.
• Ask providers and others on the Child and Family Team about their work history and training.
• Not to be forced to do something you're not comfortable with (this is based on a federal law).
• Give your thoughts on the Rights and Responsibilities policy.
• Ask for a specific certified provider in our network.
• Have your child's team make decisions based on your youths' needs.
• Get healthcare services that obey Wyoming and federal laws.
• Help make decisions about your youth's healthcare. This includes the right:
  ○ To get a second medical opinion.
  ○ To say no to treatment. This is your right unless the court says otherwise.
• File a complaint or grievance about:
  ○ Magellan, a High Fidelity Wraparound provider or the care your youth receives.
• File an appeal about a Magellan action or decision.
• Get a copy of your youth's records. You can ask that they be changed or corrected.
	Your responsibilities
	As the parent or guardian of a child or youth, you have the responsibility to:
	• Fully participate with the Family Care Coordinator and team in developing and carrying out your Plan of Care.
	• Ensure Medicaid benefits are current.
	• Ensure safety of your child and anyone providing care in your home. Give Magellan the information they need. This helps support quality care and getting the right services.
	• Ask questions about your child's care. This helps everyone understand your child's condition. It helps create goals and plans you agree on.
	• Follow your child's Plan of Care. This plan is agreed upon by the whole team and it is the responsibility of everyone to make sure it is completed. If you encounter barriers, you can contact your Family Care Coordinator.
	• Attend all team meetings. You should call the family care coordinator as soon as you know you need to reschedule a meeting.
	• Tell the child and family team if the plan of care does not seem to be working.
	• Complete and help your child complete a survey from Magellan about your experience in our program. This will be asked of you after you've been enrolled in High Fidelity Wraparound for six months. You will get a call from Magellan's Family Support Specialist to complete this at your convenience, but must be done.
	• Share worries about the quality of your child's care.
	• Tell someone if you suspect abuse or fraud. (This is someone not being honest.) If you suspect abuse or fraud, call Magellan's Corporate Compliance Hotline. You can reach this number 24 hours a day, seven days a week.
	  • This hotline is run by an outside company.
	  • You do not have to give your name when you call.
	  • You can also send an email.
	  • Magellan will look into all calls and emails.
	  The calls and emails will stay private.

• Use your rights. This will not affect the way Magellan and its providers treat you. • Talk with your child and family team about what strategies are right for your child. • Ask for information in a way that you can get to it easily. This applies if you have a visual, hearing or physical disability. This will help you know about the benefits and services you can get. • Receive training on my rights, and understand the process for instances of abuse, neglect, and exploitation.	
Parent/guardian signature:	**Date**

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**

CASII/ECSII ATTESTATION

CASII score _____ or **ECSII score _____**

Name of Applicant	**Date**

How to submit the CASII/ECSII score sheet and report:
If this is an initial evaluation – return to the chosen Family Care Coordinator for this youth. If this is for an annual re-evaluation or return to community evaluation, please submit following instructions below:

If the youth has an active Medicaid number - Submit the completed application packet through Magellan's Provider Portal, www.MagellanProvider.com.

If the youth does not have an active Medicaid number - Submit the completed application packet and one-day add form to WYClinical@MagellanHealth.com.

CASII/ECSII assessment, report and score sheet completed by: **Independent Assessor Name** (printed)	**Date**

Independent Assessor Signature

Agency: _____

City, State and ZIP Code: _____ Phone: _____

Medicaid Provider ID or NPI (if billing for additional modifier to providing application assistance)

How was the family referred to High Fidelity Wraparound?

_____ Provider Agency *Name of Agency:* _____
_____ WYHealth
_____ Department of Family Services
_____ Child Protective Services
_____ Juvenile probation
_____ Primary Care Physician
_____ Therapist
_____ Family self-referred/Magellan Clinical staff coordinated
_____ School *Name of School:* _____
_____ Other *Specify:* _____

FAMILY CARE COORDINATOR APPLICATION AND ENROLLMENT CHECKLIST

Magellan must receive a youth ***referral before the 14 day*** application period can begin. Everything on this page is required, to successfully submit a complete application to Magellan and for the Family Care Coordinator to bill for application period.

Name of Applicant	**Date of Birth**
_____ Verify Medicaid Eligibility – verify number with legal guardian and on application	**Date**
REQUIRED documents and steps for application processing: _____ *Pages 1-4: completed and signed by parent/guardian. Every single block must be filled out and answered. If it doesn't apply, enter NA (not applicable). _____ Explain High Fidelity Wraparound is home and community based and not for out of home placement (ex. cannot sign up for a home and community-based program for Medicaid to pay for out of home). _____ *Level of Care form (page 5): completed and signed by a qualified mental health professional, licensed in Wyoming – See Level of Care for list of QMHPs in Wyoming. ➢ Make sure the Level of Care is qualifying – this means all questions are answered yes and youth can be safely served at home and in the community – there are no exceptions for this. ➢ In the event of non-qualifying Leve of Care, stop the process and explain to the family the disqualification. Send Magellan the disqualifying Level of Care with explanation via secured email to WYClinical@MagellanHealth.com. _____ Contact Magellan's Care worker at 307-459-6162 to help family select approved Independent Assessor to do the CASII/ECSII. _____ *Independent Assessor form (page 6): Must be signed by the Independent Assessor. This is part of the application packet, along with the *CASII/ESCII tool and Scoring sheet. ➢ *Be present when the IA talks to the family for the CASII so you can utilize the information to begin filling out the ACE survey and the CANS assessment.* _____ Keep a copy of the CASII/ECSII for SNCD and POC/Crisis planning with the family. _____ The family has a copy of the CASII/ECSII – help them talk to the Independent Assessor about any questions. _____ Release of information (**two needed** for the CASII evaluator): One for family to get a copy and one for Family Care Coordinator. This form is provided by the provider. _____ Review each page of the application and required documents; a signature and/or initials are **required** on each page- follow instructions on the cover page _____ *Family Care Coordinator Attestation of completed application (page 7): Follow this checklist and sign below _____ Reviewed family rights and responsibilities (page 4) for enrollment in the Care Management Entity and participation in High Fidelity Wraparound, including the need for both caregiver and age appropriate youth to complete WFI-EZ survey in six months. _____ Upload completed application packet (*everything in red) to Magellan within 14 days of application period authorization ➢ If youth ***has an active Medicaid number*****:** Submit the completed application packet with this form through Magellan's Provider Portal at www.MagellanProvider.com ➢ If youth ***does not have an active Medicaid number***: Submit the completed application packet with this form via secured email to WYClinical@MagellanHealth.com	CASII score _____ or ECSII score _____

Agency:	
Street Address:	
City, State and ZIP Code:	
Telephone Number:	
Email address:	
Family Care Coordinator attestation: All the above was completed on time Family Care Coordinator signature _____ (*required for payment*) Family Care Coordinator printed name _____	**Date**