Division of Medicaid and Medical Assistance

CHILDREN'S COMMUNITY ALTERNATIVE DISABILITY PROGRAM

AGENDA

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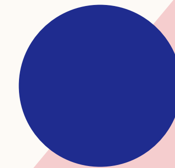


INTRODUCTION

The Children's Community Alternative Disability Program (CCADP) was formerly known as the Disabled Children's Program. CCADP is a Delaware Medicaid option designed to serve children with significant disabilities. Such children might otherwise qualify for nursing care in the home or a possible institutional setting. The State of Delaware desires that this program serve as many children as possible at home or in a non-institutional setting as long as it can be done safely, efficiently and economically. In general, any child whose disability profile meets a designated level of care may be eligible for this Medicaid without regard to parental income, resources or other health insurance.

ELIGIBILITY

Medicaid eligibility is available to children who meet ALL of the following 7 criteria established by Federal regulation (42 CFR 435.225)

1. The child must be 18 years of age or younger and under the age of 19.
2. The child's countable resources do not exceed $2000, the SSI limit for a single individual.
3. The child's countable income does not exceed 250% of the SSI benefit level. (We do not look at the parents' income or resources)

ELIGIBILITY CONTINUED

4. The child's profile is consistent with the level of care of a hospital, Skilled Nursing Facility (SNF), Intermediate Care Facility (ICF), Intermediate Care Facility for Mental Retardation (ICF/MR), or Intermediate Care Facility Institution for Mental Disease (ICF/IMD).
5. The child must meet Supplemental Security Income (SSI) medical disability standards codified at 42 U.S.C. 1382c(a)(presumptively met if child with chronic condition qualifies for SNF, ICF, ICF/MR, or ICF/IMD level of care).

6. It is appropriate to provide a comparable level of care in an alternative setting (ex: the natural family home).
7. The estimated Medicaid cost of care in the alternative setting is no higher than the estimated cost of the comparable facility-based level of care.

APPLICATION PROCESS

There are 3 DMMA sites that process CCADP applications, one in each county. The 3 locations are:

Sussex County – Thurman Adams State Service Center
546 S Bedford St.
Georgetown, DE 19947
302-515-3150

Kent County - Milford State Service Center
253 NE Front St.
Milford, DE 19963
302-424-7190

New Castle - Robscott Building
153 E Chestnut Hill Rd.
Newark, DE 19713
302-451-3621

APPLICATION PROCESS

- You can also apply online at www.assist.dhss.delaware.gov
- The applications can be dropped off, mailed or faxed in or submitted online
- There are also 4 forms that must be completed along with the application. These forms are: The Attending Physician's Certification and the Comprehensive Medical Report (both must be completed in their entirety by the attending physician and signed by him/her). The caregiver/parent must complete the Primary Caregiver Assessment and the Authorization to Disclose Information forms in their entirety.

***It is very important that ALL questions on ALL forms are answered. If something does not apply, then N/A needs to be entered in that section or question and the physician MUST sign **and** date the forms. The medical review team will not accept forms that are incomplete, and it could cause a delay in processing and determining eligibility.

Once the application and all the forms and any requested verifications are received by the case worker, the worker will determine financial eligibility and send the medical forms to the DMMA Medical Review team to determine if there is an approved Level of Care. Both financial and medical must be approved for the child to be eligible for CCADP.

MANAGED CARE ENROLLMENT

Individuals who are found eligible must enroll with a Managed Care Organization (MCO). The Health Benefits Manager is responsible for the enrollment process.

APPROVAL DURATION AND REVIEW

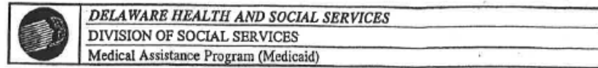
Approval of an initial application is generally effective for a period not to exceed one year. Subject to DSSM 14950 (6 month guaranteed eligibility) if the Division is aware of the likelihood of a material change in financial or medical status, initial approval may be for a shorter period.

Redetermination of eligibility is expected to occur on at least an annual basis and may otherwise be prompted by notice of a material change in financial or medical status. Redetermination shall include a reassessment of whether the child meets all seven eligibility criteria. If a child manifests a chronic profile, the Division may utilize abbreviated reassessment forms and rely on previous evaluations that remain clinically valid.

LET’S REVIEW SOME FORMS!

- Attending Physicians Certification
- Comprehensive Medical Report
- Primary Caregivers Assessment
- Authorization to Disclose

ATTENDING PHYSICIANS CERTIFICATION



DELAWARE HEALTH AND SOCIAL SERVICES
DIVISION OF SOCIAL SERVICES
Medical Assistance Program (Medicaid)

Children's Community Alternative Disability Program

Attending Physician's Certification

TO: Division of Social Services
Medicaid
____
____
____

Re: ________________
(Child's Name)
Birthdate: ________________
Parents: ________________
Address: ________________
____
____

I certify that the medical care received by the above named child is

_____ better than or equal to

_____ not as good as

care that the child would receive in an institutional setting and that the care

_____ is appropriate

_____ is not appropriate

to the child's needs.

____
Attending Physician's Signature

____
Date

Form 450 (New 10/2003) Document # 350701-03-10-06

COMPREHENSIVE MEDICAL REPORT

STATE OF DELAWARE
DIVISION OF SOCIAL SERVICES

COMPREHENSIVE MEDICAL REPORT

NOTICE TO PHYSICIAN: The following information is for use in connection with the patient's application. Please make your report COMPLETE and LEGIBLE enough for a reviewing physician to determine the nature and severity of impairment.

NAME: ________ D.O.B. ________ SEX ________ MARITAL STATUS ________

1. Physical Measurements: Height: ________ Weight ________
2. HISTORY: A. Past History ________
   B. Date of onset of present illness or injury ________
   C. Is there a previous history of this illness? ________ If "Yes", describe ________
3. PRESENT CONDITION (ALL MAJOR IMPAIRMENTS)
   A. Subjective Symptoms: ________
   B. Objective Findings: (Give report of X-rays, lab., or diagnostic tests, etc., with dates. Use separate sheet if necessary.)
   C. Patient is: Ambulatory ____ Confined to: Wheelchair ____ Bed ____ Home ____ Hosp. ____
   D. Mental Status: ________
4. DIAGNOSES: ________
5. PROGNOSIS: ________
6. REHABILITATION and/or MAINTENANCE GOALS: ________
7. TREATMENT: A. Therapy and response: ________
   B. Date of first visit: ________ Frequency of visits: ________
   C. Date when you last examined this patient: ________
   D. Diet: ________
   E. Medications: ________
   F. Recommended Activities: ________
8. PROGRESS: Patient's condition is:
   Improving ________ Static ________ Deteriorating ________ Terminal ________

MAP 25

DOCUMENT NO. 35-07-01-93-09-14 - ES 230

(OVER)

Nursing Care Plan (Suggestions for active care)

BED: Position in good body alignment and	WEIGHT BEARING: ____ Full ____ Partial	EXERCISES:
Turn q ________ hrs.	____ None on ________ leg	ROM____ X a day to ________
Avoid ________ position	SOCIAL ACTIVITIES:	by ____ Pt. ____ Family ____ Nurse
Prone position ____ X a day as tol.	Encourage ________ group	Stand ____ hrs. ____ X a day
SIT IN CHAIR ____ hrs. ____ X a day	________ Individual	Other:
	________ Within home	
	________ Outside home	

Self- Care Status

Level of ability. Write "S" if needs supervision only		INDE-PENDENT	NEEDS ASSISTANCE	UNABLE TO DO
BED ACTIVITY	Turns			
	Sits			
PERSONAL HYGIENE	Bathing: //////////	//////////	//////////	//////////
	Face, hair, arms			
	Trunk & perineum			
	Legs			
	Shaving			
	Oral Hygiene			
	Bladder			
	Bowels			
DRESSING	Arms			
	Trunk			
	Legs			
	Appliances			
FEEDING	//////////			
LOCO-MOTION	Sitting			
	Standing			
	Wheelchair			
	Walking			
	Stairs			

COMMUNICATION	YES	NO	SEMI
Can Speak			
Can Write			
Understands speech			
Understands writing			
Understands English			
(If "no", what language?)			

APPLIANCES	HAS	USES	NEEDS
Eyeglasses			
Dentures			
Hearing Aid			
Prosthesis			
Crutches			
Cane			
Wheelchair			
Other (specify)			

MENTAL STATUS	✓
Alert	
Forgetful	
Confused	
Occ. Confused	

BED
Low Bed:
___yes ___no
Side Rails:
___yes ___no
Mattress:
____ Regular
____ Firm
Other:

Medications and Treatments
(Check appropriate column)

	EVERY SHIFT	DAILY	2 OR 3X WEEKLY	WEEKLY	LESS THAN WEEKLY	PRN	CHECK ONLY IF PHYSICIAN ORDERED.
Catheter Irrigations							
Injections (identify)							
IV solutions, medications or clysis (identify)							
Sterile dressings, soaks or packs (describe body area)							
Physical Therapy by RPT							
Oxygen & Inhalation therapy							
Suction							
Colostomy Care							
Gastrostomy Care							
Tracheotomy Care							
Tube feeding							
Preventive Skin Care							
Decubitus Care							
Other (specify)							

REMARKS:

Physician's Name ________
Physician's Address ________

Recommend Nursing Home Care ____ yes ____no

Signature ________ Date ________

PRIMARY CAREGIVERS ASSESSMENT (7 PAGES)

Primary Caregiver Assessment of Child's Health and Social Status

Applicant/child's name: ______________________ Medicaid ID #: ______________

Purpose

The primary caregiver of the above named child must complete this form. The information provided about the child will be used in the determination of medical eligibility for the Children's Community Alternative Disability Program. Your social worker will send the completed form to the Medical Review Team that is responsible for making the medical eligibility determination. Medicaid is requesting that you provide medical and social information that will help in the decision about whether your child meets the requirements of the program.

Instructions:

This form should be completed and submitted with your application form. Please complete all questions. If a question does not apply to your child please write "N/A" in that area.

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1. Identifying Information

______________________ Child's full name

______________________ Date of Birth

______________________ Nicknames for Child used by family/friends

______________________ Place of birth (hospital, city, State)

Weight:

_______lbs.____ozs. Problems experienced during pregnancy with this child:______________

____

____

Other persons living in the household:

Name	Relationship	Age

AUTHORIZATION TO DISCLOSE

AUTHORIZATION TO DISCLOSE INFORMATION TO DELAWARE HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID & MEDICAL ASSISTANCE (DMMA)

Name of Person Whose Records Are to be Disclosed:	
Date of Birth (MM/DD/YYYY):	Social Security Number:

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange) of the information listed below to Delaware Health and Social Services and/or its Managed Care representatives: AmeriHealth Caritas and United Healthcare Community Plan of Delaware, for determining my eligibility for medical assistance and/or food benefits. This release may be used to ask for, receive and/or release information that is pertinent to my eligibility determination.

All my medical records:

1. All records and other information regarding treatment, hospitalizations, and outpatient care for my impairment(s).
2. Information about how my impairment(s) affect my ability to complete tasks, activities of daily living, and specific functions in the work/school environment.

All Financial records:

1. All records from financial institutions, including information of any accounts closed within the last 60 months.
2. Information from all sources of income (Social Security Administration, current and past employers, Annuity companies, etc).
3. All life insurance companies.

This authorization ends when the information asked for is received, or 12 months from the date signed or until revoked by me in writing, whichever comes first. I understand I may revoke this authorization at any time by notifying the providing organization in writing.

Signature of Individual Authorizing Disclosure:			
If not signed by subject of disclosure, specify basis for authority to sign (provide supporting documentation): ☐ Parent of Minor ☐ Power of Attorney ☐ Guardian ☐ Other			
Date Signed	Address		
Telephone Number:	City	State	Zip Code

You are not required to sign this form as a condition of eligibility and your health care and payment for health care will not be affected if you do not sign this form. However, you will still be required to provide the necessary information to DMMA in order for us to be able to determine your eligibility for Medicaid.

Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and therefore no longer protected by Federal privacy laws.