MEDICAID WAIVERS - CARE AT HOME PROGRAM
For Physically Disabled Children

APPLICATION COVER SHEET

(To be completed for **new** applications only.)

Client Name: _____ District: _____

SSN: _____ CIN: _____ CAH I: _____ CAH II: _____

Date of Application: _____

(1-5) LDSS obtains (County CAH Coordinator or designee). To be obtained and evaluated before involving case manager.

1. _____ Application Form Signed by Parent
2. _____ Proof of Medicaid Ineligibility
3. _____ Proof of Age/Birth Certificate D.O.B.: _____
4. _____ Proof of Physical Disability

_____ DSS-639 Expiration Date: _____ Group I _____
Group II _____

Disability Listing(s):
_____
_____

5. _____ Verification of Length of Institutional Stay (e.g., Inpatient Bill; Insurance Statement) from Hospital on letterhead, explanation of benefits from Insurance Company. Also, must list admission and discharge dates.

(6 & 7) Assessing Nurse-from CASA, CHHA, Public Health, VNA or acceptable other. Visit done by nurse and case manager, when possible.

6. _____ Pediatric Patient Review Instrument
7. _____ Plan of Care (P.O.C.)
_____ Path
_____ Home Assessment Abstract
_____ Fastep
_____ MAA-CN-1-8

6A. For Private Duty Nursing has the following been identified:
_____ Nursing Provider(s)
_____ Prior Approval

(8 & 9) Case Manager

8. _____ M.D. orders
9. _____ Budget Sheet

(10) CAH Coordinator, DDSO or Private CAH - CM

10. _____Case Manager: _____/ (_____) _____
Telephone Number
(_____) _____
Fax Number

11. _____ Other: Specify: _____