

# SED Waiver Attachment A



## INITIAL CLINICAL ELIGIBILITY FORM

Complete all sections of this form and sign appropriately.

### Consumer/Child/Youth Information

|  |              |             |                   |                 |
|--|--------------|-------------|-------------------|-----------------|
| Last Name:   |              | First Name: |                   | Middle Initial: |
| Date of Birth:   | Address:     |             |                   |                 |
| City, State:   |              |             | Zip:              | Phone #:        |
| Email:   | Medicaid ID: |             | SSN #:            |                 |
| KAMIS ID:  | Sex:         |             | KanCare MCO:      |                 |
| Education/Vocation Status:   |              |             | Primary Language: |                 |
| DCF CUSTODY:    YES: <input type="checkbox"/> NO: <input type="checkbox"/> |              |             |                   |                 |

### Parent / Legal Guardian Information

|            |               |             |              |  |
|------------|---------------|-------------|--------------|--|
| Last Name: |               | First Name: |              |  |
| Address:   |               |             | City, State: |  |
| Zip:       | Phone/Cell #: |             | Email:       |  |

### Community Mental Health Center (CMHC)

|          |                |  |               |  |      |
|----------|----------------|--|---------------|--|------|
| CMHC:    |                |  |               |  |      |
| Address: |                |  | City, State:  |  | Zip: |
| Phone #: | Email Address: |  | Completed By: |  |      |

### Complete the Sections Below

|  |                               |   |
|--|-------------------------------|---|
| 1. Is the child/youth at least 4 years old?  | Yes: <input type="checkbox"/> |   |
|  | No: <input type="checkbox"/>  | <i>If NO: The child/youth does not meet SED Waiver minimum age criteria. If an exception to minimum age criteria will be requested, complete remainder of document.</i> |
| 2. Is the child/youth under 18 years of age? | Yes: <input type="checkbox"/> |   |
|  | No: <input type="checkbox"/>  | <i>If NO: The child/youth does not meet SED Waiver minimum age criteria. If an exception to maximum age criteria will be requested, complete remainder of document</i>  |

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|   |                               |  |            |            |
|---|-------------------------------|--|------------|------------|
| 3. Does the child/youth have a qualifying DSM diagnosis?  | Yes: <input type="checkbox"/> | Diagnosis:   |            |            |
|   |                               | Date of diagnosis:   |            |            |
|   |                               | Name/Credentials/Agency/Telephone of diagnosing QMHP:                |            |            |
|   | No: <input type="checkbox"/>  | The child/youth does not meet SED Waiver criteria                    |            |            |
| 4. Does the child/youth meet Serious Emotional Disturbance (SED) criteria?  | Yes: <input type="checkbox"/> | Date of determination of SED:  |            |            |
|   |                               | Name/Credentials/Agency/Phone# of QMHP making the SED determination: |            |            |
|   | No: <input type="checkbox"/>  | The child/youth does not meet SED Waiver criteria.                   |            |            |
| 5. Is the child/youth at risk for inpatient psychiatric hospitalization in absence of SED Waiver services?  | Yes: <input type="checkbox"/> |  |            |            |
|   | No: <input type="checkbox"/>  | The child/youth does not meet SED Waiver criteria.                   |            |            |
| <b>Record CBCL and CAFAS or PECFAS Results below</b><br><i>SED Waiver eligibility requires minimum scores on both Child Behavior Check List (CBCL), and the Child and Adolescent Functional Assessment Scale (CAFAS) or Preschool and Early Childhood Functional Assessment Scale (PECFAS) as applicable.</i> |                               |  |            |            |
| 6. CBCL (Valid if completed less than 6 months prior to Clinical Eligibility date.) Indicate t-scores and version used, as applicable.  |                               | <b>CBCL</b>  | <b>TRF</b> | <b>YSR</b> |
|   | <b>Internalizing</b>          |  |            |            |
|   | <b>Externalizing</b>          |  |            |            |
|   | <b>Total Problems</b>         |  |            |            |
|   | <b>Date of CBCL:</b>          |  |            |            |
| 7. Did the child/youth receive a score of at least 70 on any scale? (SED Waiver eligibility   | Yes: <input type="checkbox"/> |  |            |            |

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|   |                               |  |
|---|-------------------------------|--|
| <i>requires a minimum score of 70 on at least one scale).</i>   | No: <input type="checkbox"/>  | The child/youth does not meet SED Waiver criteria.<br>An exception can be requested with A CBCL score of 63-69. An exception form is required. Complete remainder of document.<br><b>Request Exception:</b> <input type="checkbox"/> |
| 8. CAFAS or PECFAS (Valid if completed less than 3 months prior to clinical eligibility date.)  | <b>Scale Scores:</b>          |  |
|   | School/Work Role Performance: | <b>Date of CAFAS/PECFAS:</b>   |
|   | Home Role Performance:        | Moods/Emotions:  |
|   | Community Role Performance:   | Self-Harm:   |
|   | Behavior Towards Others:      | Substance Abuse:   |
|   | <b>Total Score:</b>           |  |
| 9. Did the child/youth receive a minimum Total Score of 100, or a score of 30 on each of any two sub-scales? ( <i>SED Waiver eligibility criteria require a minimum Total Score of 100, or a minimum score of 30 on each of any two sub-scales</i> )                                | Yes: <input type="checkbox"/> |  |
|   | No: <input type="checkbox"/>  | The child/youth does not meet SED Waiver criteria.   |
| 10. Is an exception requested for<br><i>A request for an exception must include the completed Initial Clinical Eligibility Form and Attachments B,C,D,E, as applicable. Exception Request and documents must be submitted via KAMIS to SED Waiver Program Manager for approval.</i> |                               |  |
| a. Minimum Age  | Yes: <input type="checkbox"/> | Complete Attachment B  |
|   | No: <input type="checkbox"/>  | Continue filling form  |
| b. Age 18 Criteria  | Yes: <input type="checkbox"/> | Complete Attachment C or E (if applicable)   |
|   | No: <input type="checkbox"/>  | Continue filling form  |
| c. CBCL Score   | Yes: <input type="checkbox"/> | Complete Attachment D  |
|   | No: <input type="checkbox"/>  | Continue filling form  |
| <b>CURRENT EVIDENCE SUPPORTING CHILD/YOUTH'S SED WAIVER STATUS</b><br><i>(this form to be completed for all SED Waiver eligible individuals)</i>  |                               |  |
| 11. Description of specific behaviors/problems that put the child/youth at risk of inpatient psychiatric hospitalization without SED Waiver services.   |                               |  |

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12. Description the child/youth's family and current living situation that support the need for SED Waiver services

13. Description of factors in the child/youth's school/vocational placement that support the need for SED Waiver services

14. Description of other community risk factors that supports the child/youth's need for SED Waiver services

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|   |  |  |              |
|---|--|--|--------------|
| <b>QMHP name and credentials:</b>   |  | <b>Date:</b>   |              |
| <b>QMHP signature and credentials:</b>  |  |  |              |
| <b>QMHP Phone Number:</b>   |  |  |              |
| <b>CMHC:</b>  |  |  |              |
| <b>SED Waiver Designated Email Address:</b>   |  |  |              |
| <p><b>CRITERIA FOR SERIOUS EMOTIONAL DISTURBANCE (SED)- SED Waiver</b></p> <p>The term "Serious Emotional Disturbance" refers to a diagnosed mental health condition that substantially disrupts a child/youth's ability to function socially, academically, and/or emotionally.</p> <p><b>Complete the following checklist to determine if the child/youth has SED:</b></p>  |  |  |              |
| <b>Child/Youth Name:</b>  |  | <b>CMHC:</b>   |              |
| <b>Evaluator:</b>   |  | <b>Signature:</b>  | <b>Date:</b> |
| <p><b>AGE:</b></p> <p>The child/youth is under age 18 or under the age of 22 and has been receiving community based mental health services prior to the age of 18 that must be continued for optimal benefit.</p>   |  | <p>Yes: <input type="checkbox"/>      No: <input type="checkbox"/></p> |              |
| <p><b>DURATION and DIAGNOSIS:</b></p> <p>The child/youth currently has a diagnosable mental, behavioral, or emotional condition of sufficient duration to meet the diagnostic criteria specified within the most current DSM.</p> <p>Disorders include those listed in the most current DSM or the ICD-9 equivalent with the exception of DSM "V" codes, substance abuse or dependence, and developmental disorders, unless they co-occur with another diagnosable disorder that is accepted within this definition.</p>  |  | <p>Yes: <input type="checkbox"/>      No: <input type="checkbox"/></p> |              |
| <p><b>FUNCTIONAL IMPAIRMENT:</b></p> <p>The disorder must have resulted in functional impairment which substantially interferes with or limits the child/youth's role or functioning in family, school, or community activities.</p> <p>Functional impairment is defined as difficulties (internalizing and externalizing) that substantially interfere with or limit a child/youth from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. Functional impairments of episodic, recurrent and continuous duration are included.</p> <p>Children/Youth that would have met functional impairment criteria without the benefit of treatment or other support services are included in this definition.</p> <p>Functional impairment does not qualify if it is a temporary response to stressful events in the child/youth's environment. Functional impairment also does not qualify if it can be attributed solely to intellectual, physical, or sensory deficits.</p> |  | <p>Yes: <input type="checkbox"/>      No: <input type="checkbox"/></p> |              |

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| Which of the following functional areas has been disrupted as a direct result of the child/youth's mental health condition?<br>(Examples are not intended to be all inclusive and more than one can be marked). |  |
|---|--|
| <b>School</b>   | <i>for example: exhibiting behaviors that interfere with the xchild's ability to perform, such as inattentive in class, unable to sit in one place, unable to concentrate, withdrawn at school to the point that the child's ability to function at school is impacted, accumulating sick days as a result of being overwhelmed/depressed which places the student at risk for truancy, in-school suspension, out-of-school suspension</i> |
| <b>Family</b>   | <i>for example: at risk of out of home placement, physical aggression at home, suicidal, isolative and withdrawn to the point that youth is not engaging in day to day family activities.</i>  |
| <b>Community</b>  | <i>for example: impairment necessitates law enforcement contact such as youth is running away due to delusional symptoms; unable to or serious difficulty participating' in regular community and/or peer activities due to behavior, isolating from peers.</i>  |

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| Upload the following documents to client's KAMIS account:                      |                                     |
|--|-------------------------------------|
| <input type="checkbox"/>   | Initial Clinical Eligibility Packet |
| <input type="checkbox"/>   | SED Determination Form              |
| <input type="checkbox"/>   | Qualifying CAFAS                    |
| <input type="checkbox"/>   | Qualifying CBCL                     |
| <input type="checkbox"/>   | Strength and Needs (for MCO)        |
| <input type="checkbox"/>   | Provisional Plan of Care            |
| <input type="checkbox"/>   | Exception Request forms as needed   |
| Email to <a href="mailto:KDADS.SED@ks.gov">KDADS.SED@ks.gov</a> the following: |                                     |
| <input type="checkbox"/>   | Provisional Plan of Care            |
| <input type="checkbox"/>   | 3160                                |