INITIAL APPLICATION
For
Children with Complex Medical Conditions (CCMC) Waiver Program

PART 1

Applicant (legal) Last Name: ________________________First Name:______________Date:______________

Nurse completing application:_________________________Phone:____________E-mail:__________________

Is the applicant Medicaid eligible in Alaska?
No ☐ Yes ☐ Medicaid Number: ____________________

Does the applicant have a severe chronic physical condition that would result in long-term care in a facility for more than 30 days per year?
No ☐ Yes ☐ if yes, please explain: ____

Does the applicant have a severe and chronic physical condition, which results in a prolonged dependency on medical care to maintain health and welfare?
No ☐ Yes ☐ if yes, please explain: ____

Does the applicant have a severe and chronic physical condition, which results in prolonged dependency on technology (device or instrument to replace or support a normal bodily function) to maintain health and welfare?
No ☐ Yes ☐ if yes, please explain: ____

AND

Does the applicant experience acute exacerbations or life-threatening conditions?
No ☐ Yes ☐ if yes, please explain: ____

AND

Does the applicant need extraordinary supervision and observation beyond what is considered appropriate for age and/or stage of development?
No ☐ Yes ☐ if yes, please explain: ____

AND

Does the applicant need frequent or life-saving administration of specialized treatments, or dependency on mechanical support devices?
No ☐ Yes ☐ if yes, please explain: ____

If all sections are marked "Yes", proceed to Part 2 of the Initial Application.

If <u>any</u> sections are marked "No", refer applicant to the Alaska Aging and Disability Resource Center (ADRC) at 1-877-625-2372, as this applicant will not meet eligibility criteria to qualify for the CCMC waiver.

CCMC Initial Application
PART 2

HAVE ____________
UNMET NEEDS ____________
HANDS ON CARE ____________
TOTAL SCORE ____________

Applicant information:

Last Name: First Name: Date:

Mailing Address:
City:
State: Zip:

Gender:
Birthdate:
SDS ID #:

Physical Address:
City:
State: Zip:

Phone: (hm)
Phone: (wk)

Legal Guardian (verify court appointment)
Address:
City:
State: Zip:

Phone: (wk)
Phone: (hm)
Phone: (msg)

INFORMANT FOR THIS ASSESSMENT:
RELATIONSHIP TO INDIVIDUAL:

PHONE:
AGENCY:

Primary Diagnosis: Secondary Diagnosis

Primary Physician: Address: Phone Number:

GENERAL INFORMATION: This is general information on the family. Please check all that applies. General Information questions are not scored.

Location: ☐ Child at Home ☐ Child in Nursing Facility ☐ Homeless

MEDICAL SERVICES:	**HAVE**	**NEED**	**HOUSING:**	**HAVE**	**NEED**
Pharmacy			Home Accessibility		
Therapies			Safety		
Medical Vendors			Heat		
Hospital			Water		
Clinic			Sanitation (Adequate for health/safety of child)		
Physician			Other:		
Home Health Nursing					
Respite			**FINANCIAL:**		
In Home Supports			Medical Insurance/Medicaid		
Food/Specialized Formula (Not totally subsidized)			Unpaid Medical Bills		
Other:			SSI		
			Section 8		
			I.H.S. Corporation		
			EFMP (Military Exceptional Family Program)		

Applicant Last Name: ________________________First Name:______________________Date:_____________

Section 1. TECHNOLOGY DEPENDENCE (One requiring both a medical device to compensate for the loss of a vital bodily function and substantial, ongoing nursing care to avert death or further disability.): Please check (x) all that apply.

RESPIRATORY:	**HAVE**	**UNMET NEEDS**	**ELIMINATION:**	**HAVE**	**UNMET NEEDS**
Ventilator per		☐	Urinary/Suprapubic Catheter	☐	☐
CPAP/BIPAP		☐	Dialysis	☐	☐
Oxygen per		☐	Colostomy	☐	☐
Tracheostomy		☐	Ileostomy	☐	☐
Medical Air	☐	☐	Jejunostomy	☐	☐
Options:	☐	☐	Mitrofanoff	☐	☐
Options:	☐	☐	Other:	☐	☐
MONITORS:			**EQUIPMENT:**		
CO2 Monitor	☐	☐	Hospital Bed	☐	☐
Cardiac/Apnea	☐	☐	Wheelchair/Stroller	☐	☐
Oximeter	☐	☐	Feeding Pump	☐	☐
Options:	☐	☐	IV Pump	☐	☐
Options:	☐	☐	Commode	☐	☐
IV'S: Date of insertion:			In Home Lift System (over 50 lbs.)	☐	☐
Central Lines (Broviac, Hickman PIC, Med port, etc.)	☐	☐	Vehicle Lift System (over 50 lbs.)	☐	☐
Peripheral IV's (Hep Lock)	☐	☐	Suction Machine	☐	☐
Options:	☐	☐	Nebulizer	☐	☐
FEEDING: Insertion date:			Positioning Devices:	☐	☐
Gastrostomy Tube	☐	☐	Specialized Car Seat	☐	☐
Jejunstomy Tube	☐	☐	Bath Chair	☐	☐
Nasogastric Tube	☐	☐	Feeder Seat	☐	☐
Specialized Supplemental Formula/Nutrition	☐	☐	Prone/Supine Stander	☐	☐
Fluid restriction	☐	☐	AFO's	☐	☐
Options:	☐	☐	Body Braces	☐	☐
Options:	☐	☐	Other:	☐	☐
Options:	☐	☐	Other:	☐	☐

TOTAL _____ _____ TOTAL _____ _____

Applicant Last Name: ________________________________First Name:___________________________Date:_________________

Section 2. OTHER SUPPORTS AND SPECIAL CARE NEEDS BEYOND WHAT IS CONSIDERED APPROPRIATE FOR AGE AND/OR STAGE OF DEVELOPMENT – Please check (x) all that apply**.**

ACTIVITIES OF DAILY LIVING: (beyond age appropriateness)	**(X)**	**PROCEDURES:**	**(X)**
Non-ambulatory requiring patient lift or 2 person lift	☐	Physical, Occupational and Speech therapy or other Assistive Technology. (Script with specified time and duration required.)	☐
Communication	☐	Chest Percussion Therapy	☐
Dressing	☐	Respiratory Treatments	☐
Feeding	☐	Suction	☐
Bathing	☐	Stoma Care	☐
Toileting/Diapering	☐	Wound Care	☐
Positioning	☐	Dressing Changes	☐
Bowel Program (If checked, explain program in comments section.)	☐	Transportation such as medical visits, therapies, etc. (Beyond parental obligation- e.g. School)	☐
Bladder Program (If checked, explain program in comments section below.)	☐	Transports w/ Attendant (If yes, please explain)	☐
Other:	☐	Other: (Shunt care, etc.)	☐

TOTAL _______

Section 3. OBSERVATION AND MONITORING – Please check (x) all needed assistance**.**

OBSERVATION AND MONITORING OF PHYSICAL CONDITION:	**(X)**
Medication Side Effects (Med list with supporting documentation must be submitted with application .)	☐
Skin- If checked, please explain:	☐
Respiratory Status	☐
Cardiac Status	☐
Neurological Status (seizures, levels of consciousness, etc.)	☐
Genitourinary Status	☐
Gastrointestinal Status	☐
Musculoskeletal	☐
Miscellaneous Testing: (Beyond routine monitoring such as urine glucose, hema-occult, bleeding times, etc.)	☐
Miscellaneous Monitoring: (I & O; Daily weights, etc. Please identify and explain need for monitoring under additional comments section below.)	☐
Other:	☐
Other:	☐
Other:	☐
Other:	☐

TOTAL (Total must be 20 or greater to proceed) _____

Applicant Last Name: ______________________________First Name:_________________________Date:________________

Please complete the following:

1. Overview of condition-

2. Formal and informal supports-

3. Specific needs – service or equipment-

4. Nursing needs and oversight-

Additional comments:

____ ______________________

Printed Name of Registered Nurse completing application **Date**

____

Signature of Registered Nurse completing application

Note- Initial Screenings must be submitted within 3 months of signature to ensure current information is captured.

Required documentation to successfully submit this application includes:

- **UNI-09** Verification of Diagnosis (VOD) - Must be signed within 6 months of submission to be successfully processed.
- **UNI-16** Release of Information (ROI) - Allows SDS to follow up with providers for additional information.
- Legal documents (if applicable) – Court appointed guardian, foster care, etc.