Children and Youth with Special Health Care Needs

Public Health
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PROGRAM GUIDEBOOK

Missouri Department of Health and Senior Services
Division of Community and Public Health
Section for Special Health Services
Bureau of Special Health Care Needs

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
DHSS

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FOREWORD

The purpose of the Guidebook is to provide practical written guidance for the Service Coordinators who implement the Children and Youth with Special Health Care Needs (CYSHCN) Program, a program that serves eligible children and families with special health care needs. CYSHCN has previously been known as the Children with Special Health Care Needs (CSHCN) Program, the Hope Program and the Crippled Children's Service (CCS).

CYSHCN service coordination is provided through partnerships with Local Public Health Agencies (LPHA) and the Bureau of Special Health Care Needs (SHCN) through contractual agreements. Service coordination is provided throughout all counties of the state of Missouri.

In an effort to provide condensed practical guidance, sections of the Guidebook merely provide a brief overview of content areas that have established written detailed information used for training and reference. The Program recognizes the Special Health Care Needs (SHCN) Information System, forms and letters are dynamic and undergo changes often. All additional detailed training manuals, forms, and letters referenced throughout the Guidebook will be maintained on a link provided on the CYSHCN Program web page for use by the Service Coordinators. Service Coordinators are encouraged to reference the CYSHCN Program web resources for current information. Training Coordinators are available for individual training needs.

The guidance provided has been developed and structured in a manner which will enhance the success of the CYSHCN Program. The CYSHCN Program framework assists in meeting the Program Philosophy, the SHCN Operational Plan and meets state and federal requirements of the CYSHCN Program and the Vision and Mission of the Missouri Department of Health and Senior Services (DHSS).

DHSS Vision: Healthy Missourians for Life.
DHSS Mission: To be a leader in promoting, protecting and partnering for health.

The CYSHCN Program is funded by federal Maternal and Child Health Bureau (MCHB) funds, as well as Missouri state general revenue. The statutes and rules governing the CYSHCN Program are Sections 201.010 – 201.130, RSMo and 19 CSR 40-1.010-1.080.

CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS (CYSHCN) PROGRAM DESCRIPTION

The Children and Youth with Special Health Care Needs (CYSHCN) Program provides assistance statewide for individuals from birth to age 21 who have or are at increased risk for a disease, defect or medical condition that may hinder their normal physical growth and development and who require more medical services than children and youth generally. The Program focuses on early identification and service coordination for individuals who meet medical eligibility guidelines. As payer of last resort, the Program provides limited funding for medically necessary diagnostic and treatment services for individuals whose families also meet financial eligibility guidelines.

Service coordination facilitates, implements, coordinates, monitors, and evaluates services and outcomes, and encourages participants/families to develop skills needed to function at their maximum level of independence.

Eligibility

To be eligible for Program services, the participant must:

- Be a resident of the State of Missouri,
- Be under age twenty-one (21),
- Have an eligible special health care need, and
- Meet financial eligibility guidelines for funded services.

Services

The Program provides two primary services:

- Program service coordination, which includes:
  - Outreach activities and early identification of participants,
  - Eligibility determination,
  - Assessment of needs,
  - Coordination of services through resource identification and referral,
  - Family support,
  - Service plan development/implementation,
  - Monitoring and evaluation,
  - Transition to community-based services, and
  - Closure.
- Limited funding for medically necessary diagnostic and treatment services for participants whose families meet financial eligibility guidelines.
  - Funded services may include but are not limited to: doctor visits, emergency care, inpatient hospitalization, outpatient surgery, prescription medication, diagnostic testing, orthodontia and prosthodontia (cleft lip/palate only), therapy (physical, occupational, speech and respiratory), durable medical equipment, orthotics, hearing aids, specialized formula, and incontinence supplies.

CYSHCN is payer of last resort. The Service Coordinator will assist the participant/family with resource identification and referral. All third party liability must be exhausted prior to accessing CYSHCN funds.

CYSHCN PROGRAM PHILOSOPHY

The Program philosophy is to provide for the early identification and integration of resources for all eligible children and youth who have a special health care need. Early identification and integration of resources will enhance the best possible health outcomes with the greatest degree of independence within the community.

The Program respects the dignity of each individual and their family, and partners with the participants/families to achieve coordinated, ongoing, comprehensive care within a medical home which will provide for successful transitions into adulthood.

CORE VALUES

The Program is guided by the following core values:

- Person-centered,
- Outcome oriented,
- Community inclusion,
- Family's involvement in ongoing planning,
- Personal/family responsibility for achieving independence, and
- Collaborative relationships in all areas.

Service coordination is provided to all Program participants, regardless of financial status. Limited funding is available to participants who are medically eligible for the Program, and whose family income is at or below one hundred eighty-five (185) percent of the Federal Poverty Guidelines.

The Program is the payer of last resort. The Service Coordinator will assist the participant/family with identification and access to any and all other payment sources before submitting requests for use of Program funds. The Program will be billed only after all third party sources have been exhausted.

SPECIAL HEALTH CARE NEEDS MISSION

To develop, promote, and support community-based systems that enable the best possible health and greatest degree of independence for Missourians with special health care needs.

Section for Special Health Services

Service Coordination Model

Definition, Principles and Key Components

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Service Coordination is a culturally competent, collaborative, proactive and comprehensive health care process designed to help each person achieve the best possible health and the greatest degree of independence. The primary mechanisms of Service Coordination are individualized assessment, planning, plan implementation, monitoring and transitioning.

Principles of Service Coordination

- The Participant's Abilities, Wishes, and Desires are Primary in Planning
- Participants Partner in Decision-Making
- Facilitation of Participant & Family Resourcefulness and Health Literacy
- Flexibility to Achieve Successful Collaboration
- Collaborative Relationships with the Program Participant, Family Members, Support Network, Health Care Providers and Other Caregivers
- Coordination of Health Care to Achieve Continuity and Positive Outcomes
- Adjustment of Support and Services Based on Changing Needs of Program Participants
- Coordination and Collaboration with Other Entities/Agencies to Ensure Efficiency in Administrative Case Management and Service Coordination Functions

Key Components of Service Coordination

- Engagement to Build Stable Collaborative Relationships
- Assessment to Determine Needs and Resources
- Planning to Address Needs
- Linkage with Community and Professional Health Care Resources
- Plan Implementation and Prior Authorization
- Monitoring and Adjustment
- Crisis Assistance
- Facilitation of Advocacy
- Transitioning

ROLE OF THE CYSHCN PROGRAM SERVICE COORDINATOR

The Service Coordinator is the contact person for the Program and will:

- Review the referral and evaluate if a referral is needed to other resources.
- Gather medical and financial information to determine eligibility for the Program.
- Talk with the participant/family about their current medical treatment.
- Complete a comprehensive assessment of needs for the participant/family.
- Help identify goals with the participant/family.
- Help identify what services are needed to reach these goals.
- Identify funding options and available resources for services needed.
- Help the participant/family identify and communicate with people on the care team for support, advocate for services or equipment, and locate these services.
- Assist the participant/family in accessing a medical home as needed or desired.
- Organize and participate in team conferences with the participant/family.
- Review the plan of care with the participant/family for ongoing needs, make changes as needed, and discuss participant/family satisfaction and compliance with services received.
- Determine at the time of transition or closure if the plan of care has been effective and if services are still needed.

*For Service Coordinator Use Only

SERVICE COORDINATION PROCESS

Service coordination is a culturally competent, collaborative, proactive and comprehensive health care process designed to help each participant/family achieve the best possible health and greatest degree of independence.

The primary mechanisms of service coordination are:

- Individualized Assessment;
- Planning;
- Implementation;
- Monitoring; and
- Transitioning.

Refer to the Training Guide for specific processes, activities, and principles regarding the primary mechanisms of service coordination.

INTERPRETER SERVICES

Service Coordinators must provide interpreter (language, Braille, or sign) services for a participant/family when the provision of service coordination is not possible due to the inability to communicate.

In an effort to promote a higher degree of independence and health literacy, consideration of referrals to resources to reduce language barriers are encouraged. Language barriers may interfere with the provision of services to the participant/family leading to misunderstandings and impacting Program effectiveness. Effective language services through a professional interpreter can help prevent these problems. Service Coordinators may utilize interpreter services during any communication with the participant/family when there is limited English proficiency.

Service Coordinators should use the current state contract for providing interpretation and translation services. All interpreter services must be documented in the SHS Information System services screen and limited to direct Program service coordination. Participants/families should be instructed in the use of interpreter services, if applicable. (See telephone interpreter service data sheet, instructions, and tip sheet.)

As a last resort, SHS will provide interpreter (language, Braille, or sign) services for a participant/family through an individual who is enrolled as a SHS provider when the provision of service coordination is not possible due to the inability to communicate and the use of the state contract is not possible. If unable to use the state contract, supporting documentation must be entered in the SHS Information System.

ENROLLMENT PROCESS

Referrals may be accepted from many sources. Examples of referral sources are health care providers, other state and/or local government agencies, schools, and advocacy organizations.

As appropriate, gather pertinent information and complete the CYSHCN Screener at the time a referral is received. If the Screener indicates there is a special health care need present, enter the participant information, including the referral source, into the SHS Information System. Create a hard copy file of referral documents and proceed with the enrollment process. Screeners for ineligible participants are kept in a file for one (1) year and then shredded.

Response to referrals and eligibility review will be conducted as soon as possible but no later than ten (10) business days of the date of the referral. Eligibility will be determined once the application packet has been provided and all required documentation has been received, reviewed and signed. The initial SC (Service Coordination) enrollment date shall be the date the positive Screener is completed with the participant/responsible party.

Good faith efforts should be made to meet face to face with the potential participants, and when appropriate, their family or guardian as soon as possible after the referral is received. All attempts to meet with the potential participants should be documented in the SHS Information System. Eligibility determination (Missouri resident, birth to twenty-one (21), lawful presence verification if applicable, medical and financial if applicable) is required for enrollment in the Program and is to be documented in the SHS Information System. Confidentiality should be maintained at all times during attempts to contact the applicants. Written correspondence should be reviewed for confidentiality. Phone messages should be left/recorded with consideration of maintaining confidentiality.

In an effort to determine eligibility as soon as possible, during the first contact with the applicant, provide them with a list of necessary information needed for enrollment and eligibility determination. The early request may allow the participant to gather all required documents prior to the initial interview and assessment. Copies of medical and financial information will be needed to make eligibility determinations. Verification of lawful presence will also be required if the applicant is age eighteen (18) or over. An eligibility letter will be provided after eligibility has been confirmed and the participant is enrolled.

If the potential participant is unable to be contacted by telephone to schedule an interview and assessment, a packet should be mailed to their primary address along with an appropriate cover letter.

An application packet should include, but is not limited to, the following information and forms:

- Application for Enrollment Letter(s),

- Application for Enrollment (CC-1),
- CYSHCN Program Fact Sheet,
- Special Health Care Needs (SHCN) Brochure,
- Family Partnership Brochure,
- HIPAA Privacy Policy Acknowledgement Form,
- Rights and Responsibilities and Acknowledgement,
- Authorization for Disclosure of Consumer Medical/Health Information,
- Emergency Preparedness Information (may be given and reviewed at time of interview and assessment), and
- Service Coordinator Contact Information (SHS toll free telephone number and LPHA street address and telephone number).

Paid Service eligibility will be effective the date complete documentation is received verifying all applicable eligibility. Requests for exceptions will be submitted to the Program Manager and documented electronically in the SHS Information System. Retroactive eligibility may be approved by the Program Manager or designee based upon review of the individual case. Limited funding will only be considered after the Paid Service enrollment date.

In the event the application packet is not returned within thirty (30) days and the Service Coordinator has determined good faith efforts have been made to contact the potential participant, the record may be closed. A letter should be mailed to the applicant and contain notification that as a result of non-responsiveness, the record is closed. Assistance, if needed, should be offered at a later date. All correspondence must provide the SHS toll free telephone number, the physical street address, and telephone number of the respective contracted Local Public Health Agency (LPHA).

All forms of contact and attempts to contact the applicant should be documented in the SHS Information System prior to closing the file. Maintain all hard copy files of closed referrals and forward to the appropriate SHS Regional Office upon request. (See Records Management section)

LAWFUL PRESENCE

Pursuant to RSMo 208.009, all Program participants must provide affirmative proof of United States citizenship or lawful presence in the United States to maintain continued program eligibility beyond their eighteenth (18th) birthday.

Twelve months prior to the participant's eighteenth (18th) birthday, the Service Coordinator shall contact designated Central Office staff, via email, to request a Missouri Birth Certificate information search. If this search is unsuccessful, the Service Coordinator must send a written notice (Lawful Presence Letter) to the participant/family requesting verification of lawful presence. A copy of the documentation shall be maintained in the participant's record. Acceptable forms of verification, recognized by the Department of Revenue, include:

- Valid Missouri Driver or Non-Driver License;
- U.S. Birth Certificate – certified with an embossed, stamped or raised seal issued by a state or local government (Hospital-issued birth certificates are not acceptable);
- U.S. Passport;
- Certificate of Citizenship, Naturalization, or Birth Abroad; or
- Any document issued by the federal government that confirms lawful presence in the United States.

If the name on the verification document does not match the participant's current name, additional documentation will be required to verify the name change.

Transition activities, including but not limited to resource identification and referral, should be initiated by the Service Coordinator six to twelve months prior to the participant's eighteenth (18th) birthday if it is anticipated the participant will have difficulty in obtaining documentation of lawful presence.

If all verifying documentation is not received by the Service Coordinator prior to the participant's eighteenth (18th) birthday, Program eligibility will end on midnight the day before the eighteenth (18th) birthday. The Service Coordinator shall send a closure letter thirty days prior to the participant's eighteenth (18th) birthday notifying the participant of the impending closure.

For new Program applicants eighteen (18) and over, the Service Coordinator must obtain all verifying documentation before Program enrollment can occur. The Service Coordinator is responsible for notifying Central Office if assistance is needed in obtaining Missouri Birth Certificate information for applicants eighteen (18) and over.

APPLICATION PROCESS

Application for Enrollment CC-1

The Application for Enrollment (CC-1) form must be completed, signed and dated as soon as possible but no more than six (6) months from the initial SC enrollment date.

Income Verification (See Determining Financial Eligibility section)

Documentation of income must be provided to determine financial eligibility. Internal Revenue Service (IRS) income information is necessary if required to file income taxes.

If not required to file income taxes, exempt status should be verified and maintained in the file and documented in the SHS Information System.

If IRS income information is not reflective of the family's current financial status, an estimated income will be allowed for the current tax year. Income verification using estimation will only be allowed until the next tax filing season or the next Annual Financial Eligibility Review (AFER) period.

Medical Eligibility (See Determining Medical Eligibility section)

Obtain appropriate signatures to allow for the request and review of medical information to determine medical eligibility. Detailed guidance for medical eligibility follows this section.

Insurance/MO HealthNet Status/Eligibility

Verify insurance/MO HealthNet coverage information. If the applicant does not have MO HealthNet coverage, a referral must be made to MO HealthNet. Participants must utilize all available funding resources. When insurance coverage is available, the participant/family must access and utilize this resource (including in-network providers).

Acceptable verification of MO HealthNet enrollment includes:

- A MO HealthNet card,
- Written documentation of eligibility determination from the Department of Social Services (DSS), or
- MO HealthNet status verified in the SHS Information System.

MO HealthNet eligibility must be reviewed and documented annually. Reapplication should be requested when there is a change in the participant's status that may affect MO HealthNet eligibility.

MO HealthNet Referral/Application Process Requirements

During the initial Program application process:

- A referral and MO HealthNet application must be made to Family Support Division (FSD) to determine MO HealthNet eligibility.
    - Eligibility reviews must be conducted annually for participants determined to be initially ineligible and when a change in financial or medical status has occurred.
- Two weeks following the MO HealthNet referral, the Service Coordinator must verify in the SHS Information System that an application was made.
- If a MO HealthNet application has been made, continue with determining Paid Service eligibility.
- If a MO HealthNet application has not been made within thirty (30) calendar days after referral, the Service Coordinator should contact the family/responsible party and remind them that Paid Service enrollment cannot occur until a MO HealthNet application has been submitted.
    - Participants may remain enrolled in Service Coordination without verification of a MO HealthNet application.
- Once the MO HealthNet determination has been made, verify that the status is accurately reflected in the SHS Information System and proceed with Paid Service enrollment if applicable.

Preliminary Determination

In the best circumstances, the Service Coordinator will have all information available at the time of the initial interview and assessment to make a preliminary eligibility determination. The Service Coordinator should not inform the applicant of the eligibility status until a final determination is made.

When determined eligible for the Program, the Service Coordinator will provide an eligibility letter to the participant/family as soon as possible. The Service Coordinator should review with the participant/family their responsibilities in maintaining enrollment and utilization of services.

When determined medically and/or financially ineligible, the Service Coordinator will communicate the ineligibility determination to the applicant as soon as possible. Referrals made to community resources on behalf of the applicant should be documented in the SHS Information System as an outgoing referral. Documentation of all actions should be made in the SHS Information System and hard copy information maintained in the hard file. The closed file should be forwarded to the appropriate SHS Regional Office upon request. (See Records Management section)

RESPONSIBLE PARTY/ALTERNATE CONTACT PERSON

In an effort to maintain lines of communication, a responsible party and alternate contact person shall be identified. Contact information for both shall be obtained and documented in the SHS Information System for each Program participant.

The responsible party is identified as the individual who holds legal responsibility for the participant. The responsible party is a person with whom sensitive health information can be shared by the Service Coordinator, or designated representatives of SHS. All forms must be completed and signed by the legally responsible party. Documentation verifying legal custody, guardianship or relative caregiver must be obtained and placed in the participant's legal record. Legal custody, guardianship, or relative caregiver must also be documented in the Progress Notes section of the SHS Information System.

The responsible party is determined as one of the following:

- A participant who is an emancipated minor;
- A participant eighteen (18) years of age or older;
- A participant eighteen (18) years of age or older and the parent (if the participant is claimed as a dependent on someone else's federal tax form);
- Any parent who has legal custody of his/her minor child;
- Any minor who is lawfully married;
- Any minor parent for himself/herself and any child in his/her legal custody;
- Any legal (court appointed) guardian for the participant;
- The individual with "physical" custody of the participant when living with other than both parents; or
- The legal guardian when the participant is in foster care.

The alternate contact person is someone who will know how to get in touch with the participant/family and can assist in contacting the family. Sensitive health information may not be shared with the alternate contact person.

The Service Coordinator will request the participant/family to identify both a responsible party and an alternate contact person during the initial interview and annually thereafter.

PARTICIPANT/FAMILY RESPONSIBILITIES

Conditions of participant eligibility are based on the following responsibilities of the participant/family. The following responsibilities will enhance the coordination and continuity of care, provide positive outcomes, and ensure effective utilization of Program services:

- The participant/family is responsible for providing accurate information concerning their financial status.
- The participant/family shall use all available health insurance benefits, MO HealthNet or other third-party payment sources including recoveries from third-party insurance sources through settlement of personal injury claims attributed to the condition being treated.
- The participant/family shall utilize third-party network providers.
- The participant/family shall enroll in any state or other public programs for which they are eligible in order to provide maximum comprehensive services.
- The participant/family must report any changes in income, household composition, insurance/ MO HealthNet coverage, or address within ten (10) business days after the date the participant/family becomes aware of the change.
- The participant/family must keep the Service Coordinator updated on the medical progress of the participant's individual care and service plan. The updates should take place every six (6) months, at a minimum.
- The participant/family must notify the Service Coordinator prior to receiving medical services that require a Prior Authorization through the Program.
- The participant/family must collaborate with the Service Coordinator to utilize providers who have been established active and are enrolled with the Program. Collaborative efforts will be made to enroll providers, when necessary to meet the individual needs of the participants.
- To maintain eligibility, the participant/family must complete an Annual Financial Eligibility Review (AFER). Failure to provide a timely response to AFER requests for information will result in discontinuation of services.
- The participant/family must actively and consistently meet all the conditions listed above to maintain Program eligibility.
- A participant/family who is determined ineligible for the Program may re-apply when changes occur that may make the applicant eligible.
- When an application is denied, the applicant will be informed of their right to appeal.

APPLICATION FOR ENROLLMENT LETTERS

The Application for Enrollment letters will be used when:

- The CYSHCN application packet is mailed to the participant/family, or
- The participant's incomplete application was received and additional information is needed, or
- The participant's application was determined to be ineligible for CYSHCN.

Application for Enrollment

Applicable when a participant has been referred to CYSHCN and wants to submit an application for enrollment.

Incomplete Application for Enrollment

Applicable when a participant failed to complete the CYSHCN application or include the required information.

Ineligible Application for Enrollment

Applicable when a participant's application is determined ineligible for CYSHCN.

Completing the Application for Enrollment Letters

- Print on letterhead.
- Complete the required fields with the participant's demographic information.
- Mark the fields indicating requested material.

Distribution

- Original mailed to the participant's responsible party.
- Copy retained in the participant's legal record.

DETERMINING MEDICAL ELIGIBILITY

Medical eligibility is based on the degree to which the condition routinely and predictably affects the participant's ability to carry out age-appropriate activities and hinders the achievement of normal growth and development thus contributing added responsibility on the family. The intent of the Program is to assist children and youth and their families to improve and restore, when possible, their individual optimum level of health, functioning, independence and resiliency. Childhood illnesses and conditions considered common and part of normal childhood development are not eligible.

The following factors shall be considered when determining eligibility: severity, complexity, extent of significant dysfunction or disability that is present or expected, duration of the disorder, and the likelihood the services will have a major impact on the condition. There must be reasonable expectation of improvement to be eligible for services. Diagnoses and disorders deemed fatal or that have a high degree of mortality are not eligible for limited funding. Service coordination is provided for community resources.

Based on the review of the diagnosis (ICD code) and supporting medical information, enter the diagnosis in the SHS Information System. It is important to remember the SHS Information System does not determine eligibility of participants. Eligibility is determined by the Service Coordinator, and when necessary, collaboratively with the Program Manager or designee. Only the applicant's/participant's health care professional can make a medical diagnosis and/or assign a diagnosis code. Service Coordinators and SHS staff are not permitted to make a medical diagnosis or assign Program participant diagnosis codes.

If the diagnosis code shows "blank" indicating ineligible or "required" indicating requires a clinical review in the SHS Information System, and the Service Coordinator believes the condition should be eligible, electronic notification along with medical records should be sent to the Program Manager for review.

The participant must have an eligible diagnosis (ICD code) documented on a signed Health Certification Form, in medical records, in CyberAccess, or be seeking an eligible medical diagnosis to be enrolled in the Program. In all instances, the participant must have a condition believed to be an eligible diagnosis. When a definitive diagnosis is not available, the health care provider must provide a general diagnosis reflecting an eligible condition. The general diagnosis is considered "limited" and provides Program eligibility allowing for diagnostic services while a specific condition(s) is being identified.

A Health Certification Form and/or medical information should be obtained from the appropriate health care provider prior to initial enrollment and reviewed annually thereafter to determine continued eligibility. A Health Certification Form must also be obtained if there is a change in the participant's medical condition (i.e. addition or deletion of a diagnosis). If the participant is enrolled for a specific procedure or

condition, continued eligibility beyond the treatment should be evaluated. If eligible for Paid Service enrollment, services must be directly related to the eligible diagnoses.

Participants/families who demonstrate independence in accessing and maintaining needed resources should be evaluated for continued Program participation. When enrolled for specific services, eligibility should be reviewed once the services have been received. Transitioning to a higher degree of independence should be continually assessed and evaluated for effectiveness.

LIMITED DIAGNOSIS

When a health care provider suspects an eligible medical condition exists, but a definitive diagnosis has not been established, the participant may meet medical eligibility criteria with a limited diagnosis. If the participant meets financial eligibility guidelines, limited funding will be considered for medically necessary diagnostic services. Eligible services include inpatient and outpatient diagnostic testing, professional fees, inpatient hospitalizations, surgical diagnostic services, and medications directly related to the eligible limited diagnosis.

All limited diagnoses require clinical review by the Program Manager prior to enrollment for the limited condition. The Service Coordinator must obtain and send medical records or a letter from the physician indicating there is a concern regarding a suspected condition that has not been clearly identified to the Program Manager. Upon approval, the Program Manager will enter the limited diagnosis into the SHS Information System and notify the Service Coordinator. Limited diagnosis enrollment extends for one (1) year with Service Coordinator review taking place every six (6) months. Extensions beyond one (1) year may be granted on a case by case basis pending clinical review by the Program Manager.

When a definitive diagnosis has been established, the limited diagnosis is closed and the defined diagnosis is entered in the SHS Information System. The Service Coordinator will need to evaluate continued medical eligibility based on the newly defined diagnosis (ICD code) entered.

If the diagnosis is eligible, a new eligibility letter must be printed and mailed to the participant/family. A copy must be retained in the participant’s file.

If the diagnosis is ineligible, the participant’s Program eligibility for that diagnosis must be closed. When applicable, a new eligibility letter must be printed and mailed to the participant/family. A copy must be retained in the participant’s file.

CATEGORIES OF CARE

Established categories of care (19 CSR 40-1.030) are in place and provide guidance when determining eligibility. DHSS Executive Management authorizes which categories of care are considered open to participants for service coordination services and limited funding of direct care services. Budgetary considerations and eligibility for services may be imposed at the discretion of DHSS at anytime. Information regarding impending restrictions and/or eligibility requirements will be communicated as soon as possible.

Category I

Medical conditions requiring immediate life-saving medical treatment. The conditions include, but are not limited to:

- Burn care - requires grafting,
- Cardiac care - present at birth (congenital) requiring surgical intervention and/or in acute heart failure,
- Cleft lip and palate care - initial closure only,
- Genito-urinary care - related to congenital deformity, non-surgical care to enhance function,
- Myelomeningeocele (Spina Bifida) - surgical closure of myelocele,
- Neurology/Neurosurgery - care for depressed skull fractures, uncontrolled seizures, shunting procedures,
- Orthopedic care - care for acquired amputations, vertebral column fractures and dislocations with or without associated spinal cord injury, osteogenesis imperfecta, open complex fractures, infections of the bones,
- Pediatric surgery care - surgical procedures to repair congenital deformities which affect functioning, procedures to restore/improve functioning after severe injury.

<u>Conditions not covered under Category I:</u>

Cerebral Palsy; Juvenile Arthritis; Ear, Nose, Throat (ENT) care including hearing care, ENT surgical care, and rehabilitation care.

Category II

Medical conditions, which if not treated, could worsen or cause a crippling disability. A good prognosis should be expected. Conditions include, but are not limited to:

- Conditions covered in Category I,
- Arthritis care,
- Burn care - follow up and rehabilitation services,
- Cardiac care - not necessarily requiring surgical intervention and is not in cardiac failure,
- Cerebral palsy - surgical care and bracing,
- Cleft lip and palate care - surgical procedures (no orthodontia),
- ENT - surgical procedures requiring specialty care,

- Genito-urinary care - surgical procedures to correct abnormalities of the genital areas,
- Neurology care - care for the late effects of viral disorders affecting the physical and cognitive functional status,
- Neurosurgery - vascular surgeries to improve functioning of the central nervous system,
- Orthopedic care - congenital deformities, late effects of complicated fractures, club feet, non-malignant bone tumors,
- Pediatric surgery care - benign tumors, hemangiomas, lymphangiomas, and neurofibromas all of which must cause functional impairment or disfigurement,
- Spina bifida - rehabilitation services.

Conditions not covered under Category II:

ENT/hearing care.

Category III

Conditions that may require prolonged outpatient care and have a fair prognosis if treated include, but are not limited to:

- Conditions covered in Category I and II and associated follow-up care,
- Cerebral palsy - rehabilitation care,
- Cleft lip and palate - surgical care, orthodontia and speech therapy,
- ENT- surgical procedures including hearing care.

Category IV

Medical conditions having a poor to fair prognosis or uncertain restoration regardless of treatment. This is primarily a category for service coordination.

Category V

Medical diagnosis with a variable prognosis; enhancements allow improvements in activities of daily living, and physical appearance for psychological reasons including craniofacial anomalies (disfiguring facial conditions). If funding allows and budgetary restrictions are not in place, cosmesis (procedures affecting the appearance), inborn errors of metabolism, and special counseling would be considered in this category.

All categories may have funding ceilings and limitations imposed, and may be categorically suspended. Some conditions have restrictions for coverage and require a clinical review by the Program Manager to be enrolled. Conditions are reviewed on a case-by-case basis to determine if a clinical review needs to be conducted.

Limited funding cannot exceed $25,000.00 (twenty-five thousand dollars) per participant per state fiscal year beginning July 1 of each year. The funding limit is subject to available funds.

CONDITIONS NOT ELIGIBLE FOR CYSHCN SERVICES

Common childhood illnesses/conditions that would not be eligible for services include, but are not limited to:

- Abscesses
- Allergies
- Backache
- Colds
- Constipation
- Cough
- Croup
- Diaper rash
- Diarrhea
- Earaches
- Fever, non-specific
- General acute illnesses
- Headache
- Head lice
- Hyperopia (Farsightedness)
- Insect bites and stings
- Myopia (Nearsightedness)
- Non-specific rash/dry skin
- Nose bleeds
- Pink eye
- Simple fractures
- Sore throat
- Sunburns
- Tonsillitis
- Upper respiratory illness

Other ineligible conditions include but are not limited to:

- Asthma
- Behavioral Disorders
- Diabetes
- Failure to Thrive
- Malignant Neoplasms
- Mental Retardation
- Psychiatric Disorders

DETERMINING FINANCIAL ELIGIBILITY

Financial eligibility shall be determined by comparing the family income and size to the Special Health Services (SHS) financial eligibility guidelines.

Verifying Income:

- Federal Internal Revenue Service (IRS) income tax information shall be used to verify income.
- Income consists of the Adjusted Gross Income (AGI) reported on the applicant/participant's Federal IRS income tax form.
  - If the applicant/participant appears as a dependent on another person's IRS income tax form, use the AGI reported on the income tax form on which the applicant/participant appears as a dependent.
- When a child is in foster care and is in the legal custody of the state, income is reported as zero (0).
- When a participant/family is not required to file a Federal IRS tax form, the income is reported as zero (0).
- When it is not possible to use the AGI of the person who claims the applicant/participant as a dependent, use the following default process to determine whose AGI should be used in calculating financial eligibility:
  - Use the AGI of the person assigned medical financial responsibility if the court has assigned medical financial responsibility, or
  - Use the AGI of the individual having "physical custody" of the participant if the participant lives with someone other than both parents (i.e., one parent, relative, friend, etc.), or
  - Use the AGI of the individual who has assumed medical responsibility if the participant is in a court-ordered situation and the person assigned medical financial responsibility is out of compliance with the court order, or
  - If the participant has no determinable responsible person or fits none of the examples, consult with the Program Manager to determine whose AGI to use.
- An estimated income may be substituted for the AGI when the income tax information is not reflective of the family's current financial status.
  - The income tax information shall be considered non-reflective of the current status when a change has been in effect for at least three (3) months or when the family separates and the custodial adult has been deprived of access to the income for three (3) months or more.
  - Use the actual income to date (calendar year) as evidenced by pay stubs or other documentation and estimate the rest of the yearly income.
  - If income is requested to be estimated for a second consecutive year, a written request for consideration must be made to the Program Manager.
- For participants filing a Federal IRS tax extension, use the estimated income indicated on the extension form.
  - The AGI from the tax form must be entered as soon as the taxes are filed but no longer than six (6) months from the tax extension file date.

- For participants applying for an Individual Tax Identification Number (ITIN), use the estimated income.
- All financial verification documents and calculations must be retained in the participants' records.

Family Size:

- If the income is reported as zero (0), the family size is one (1).
- If the income is reported from the IRS income tax form, the family size is the number of all persons listed on the income tax form.
- Increase the family size by one (1) for each additional family member enrolled in a SHS Program.

Computing Financial Eligibility:

- Locate the family size on the financial eligibility guideline scale. The Financial Eligibility Guideline Scale is located on the AFER Secure Website.
- If the family income exceeds the maximum eligible income for the family size, the participant is not financially eligible.

Annual Financial Eligibility Review (AFER):

- Participants enrolled in Paid Service will be reviewed for continued financial eligibility on an annual basis.
- The AFER process will be conducted each year from January 1st through June 30th.
- Detailed information on the AFER process can be accessed on the AFER Secure Website.

OBTAINING AN INDIVIDUAL TAX IDENTIFICATION NUMBER (ITIN)

Some of our participants/families will need to obtain an Individual Tax Identification Number (ITIN) in order to file their tax return. An ITIN is a nine-digit tax processing number issued by the Internal Revenue Service (IRS). It is issued to individuals who do not have and are not eligible to obtain a Social Security Number. ITINs are issued regardless of immigration status because both resident and non-resident aliens may have a U.S. tax return and payment responsibilities under the Internal Revenue Code. Individuals must have a filing requirement and file a valid federal income tax form to receive an ITIN, unless they meet an exception.

Participants/families who need to obtain an ITIN must complete the Application for Individual Taxpayer Identification Number (IRS Form W-7), attach it to the required certified or notarized documents and the completed tax form, and submit all documents to the IRS. The participants/families must be able to prove their foreign status and identity.

Participants/families can obtain assistance with completion of this process by calling the IRS toll-free at 1-800-829-1040, scheduling an appointment at an IRS Taxpayer Assistance Center, or using the service of an Acceptance Agent. An Acceptance Agent is someone authorized by the IRS to assist individuals in obtaining ITINs.

Complete information on ITINs can be found at www.irs.gov.

For those who are waiting for an ITIN to be assigned and their tax form processed; you must enter a dollar amount if known in the “Adjusted Gross Income” field, you must select “Estimated”, and you must enter the “Family Size” in the SHS Information System even though you do not have any financial information.

It is the Service Coordinator’s responsibility to track those participants who are waiting for an ITIN and close the case if a completed tax return is not received within nine (9) months of enrollment. Continue to contact these participants/families on a monthly basis to determine the status of their ITIN application. If after nine (9) months SHS is not provided with the required information, the CYSHCN case will be closed. Service coordination can be provided as requested.

PARTICIPANTS IN THE CUSTODY/CARE OF OTHER STATE AGENCIES

Individuals residing in foster care and in the custody of Children's Division are eligible for CYSHCN services. Individuals who reside in a state-operated facility or who receive residential services from another state agency are not eligible for the Program.

DUAL ENROLLED PARTICIPANTS

In order to meet their needs, a participant may be enrolled in more than one SHS Program at a time.

The Healthy Children and Youth (HCY) Program authorizes medically necessary in-home services, such as private duty nursing, personal care aide and skilled nurse visits, that enable individuals to remain safely in their homes with their families. To be eligible for HCY, a participant must be birth to age 21, require in-home services as described above, and be enrolled in MO HealthNet (Fee for Service).

If a CYSHCN participant meets these criteria, they may also be enrolled in HCY. When this occurs the participant is said to be dual enrolled and has a Service Coordinator (SC) assigned to them for each program. Outlined below are the responsibilities of each Service Coordinator for these dual enrolled participants.

<u>HCY SC Responsibilities (as the lead SC):</u>

- All HCY Program requirements.
- Referral to and collaboration with the regional CYSHCN SC as appropriate.
  - Referral to CYSHCN is warranted when a need is identified that MO HealthNet does not cover and CYSHCN can provide financial assistance with.
  - ***To avoid duplication of service, CYSHCN cannot provide service coordination only if the participant is already receiving service coordination through HCY*.**
- SCA interview and entry (notify the CYSHCN SC of visit date/location and when SCA entry has been completed).
- If there is a HCY closure, notify the CYSHCN SC so they are aware of the situation and can assume the lead SC responsibilities.
- Participant/family questions, concerns, complaints regarding the HCY Program or services.

<u>CYSHCN SC Responsibilities:</u>

- All CYSHCN Program requirements.
- Referral to and collaboration with the regional HCY SC as appropriate.
  - Referral to HCY is warranted when a need for in-home service (PDN, PCA, Skilled Nurse Visits) is identified <u>and</u> the participant has MO HealthNet (Fee for Service).
- AFER (Annual Financial Eligibility Review) requirements.
- CYSHCN Prior Authorizations (including obtaining MO HealthNet denials and letters of medical necessity) and Service Plan entry.
- One annual face to face visit.
  - This visit may be in conjunction with the HCY SC visit; however, it is not required to be. The most optimum time would be in conjunction with the HCY SCA home visit.
- Annually print new SCA, review, and retain a copy for the CYSHCN file. (HCY SC will notify the CYSHCN SC when the SCA entry is completed.)

  - Ensure insurance information is updated in the SHS Information System.
  - Do not conduct or enter a separate SCA from the HCY SCA.
- If there is a CYSHCN closure, notify the HCY SC before the closure takes place to ensure all current needs/requests of CYSHCN have been satisfied.
  - There must be a current or ongoing financial need that CYSHCN is addressing for a HCY participant to remain dually enrolled in CYSHCN.
- Participant/family questions, concerns, complaints regarding the CYSHCN Program or services.

***The CYSHCN Program Manager and Regional Coordinator should be copied on all email correspondence with HCY Service Coordinators.

DOCUMENTATION

Documentation is essential in assessing the effectiveness of service coordination activities. The documentation should be entered promptly, be factual and accurate, and inclusive of all components of the activity. All documentation in the SHS Information System are legal documents of record. All contacts with or about the participant should be documented in the SHS Information System as soon as possible, but no longer than ten (10) business days after the date of the contact.

- Documentation should be written in first person, using complete sentences or bullet style formatting.
- The use of the “Home Visit Template” is encouraged.
- Documentation must be comprehensive enough to justify staff actions and shall include an action plan allowing others to intervene in the Service Coordinator's absence.
- Reports, Individual Educational Plans, etc., that are reviewed by staff and require no action should be initialed, dated, and filed. Receipt and review of documentation, along with a brief summary, must be noted in the SHS Information System.
- Do not copy and paste email correspondence (as a whole, screen shot, or quoted statement) into the SHS Information System. Instead, a summarization must be used to document the content of the message(s).

Entries in the SHS Information System “Forms” screen do not require additional documentation in the Progress Notes.

ANNUAL REQUIREMENTS

There are certain processes and documentation requirements that are required to be completed annually (at a minimum) after enrollment. These annual requirements include:

- A face to face home visit for completion of the Service Coordination Assessment. (See Comprehensive Assessment section)
- Review and obtain authorizing signatures on the following:
  - Rights and Responsibilities and Acknowledgement Form;
  - Privacy Policies and Acknowledgement Form; and
  - Authorization for Disclosure of Consumer Medical and Health Information as needed for specific information requests.
- Review the participant/family's emergency management plan. If a plan is not in place, provide emergency response materials and offer assistance in creating a plan.
- Review MO HealthNet eligibility status. Document the participant's eligibility status in the SHS Information System under the MO HealthNet contact type. Make a referral to MO HealthNet if a change takes place that affects the participant's MO HealthNet eligibility.
- Annual Financial Eligibility Review (AFER) – process for reviewing continued financial eligibility which takes place from January 1 to June 30 each year. Information on the AFER process and forms to be used are available on the AFER secure site.
- Review medical eligibility. A Health Certification Form (HCF) is sent to either the primary care physician or specialist upon initial enrollment. A HCF must also be obtained any time there is a change in the participant's medical condition (i.e. addition or deletion of a diagnosis).
- Review participant information (i.e. address, responsible party, responsible party address, insurance coverage) and update the SHS Information System as appropriate.

It is recommended that all forms requiring review and signature (other than the AFER forms) be discussed with participants during the annual face to face visit for completion of the annual assessment. In order to meet the needs of participants, service coordination activities may require more than annual visits and documentation.

GOOD FAITH EFFORT

A good faith effort consists of three (3) documented attempts to reach the participant/family.

These attempts should consist of two (2) phone calls or letters and at least one (1) attempted face to face contact.

All contacts and attempted contacts must be documented in the SHS Information System on the date of each attempt.

Participants who do not respond to multiple attempts to schedule appointments, to obtain signatures on required paperwork, or who do not comply with Program guidelines, should be discontinued from the Program and the record closed.

COMPREHENSIVE ASSESSMENT

Assessment is a continuous activity that begins when the referral/application is received and continues throughout the service coordination process. Comprehensive assessments are due annually but no later than thirteen (13) months from the last completed assessment.

The assessment information is obtained through the use of the Service Coordination Assessment (SCA). The initial SCA must be completed within thirty (30) calendar days of initial enrollment during a face to face home visit with the participant/family. If a SCA was completed more than six (6) months prior to the enrollment, a new assessment is required within thirty (30) days after the enrollment. If a home visit is not feasible, contact the Program Manager to request an exception to the home visit requirement.

A SCA must be completed initially, annually, and more frequently when warranted due to changing circumstances for <u>all</u> participants (excluding participants dually enrolled in the Healthy Children and Youth (HCY) Program).

Attempts to schedule the annual SCA should begin two (2) to four (4) weeks prior to the SCA due date. All attempts to schedule the SCA must be documented in the SHS Information System and should occur no more than two (2) weeks apart.

No Prior Authorization (PA) of funds will be considered prior to the completion of an assessment, including entry into the SHS Information System.

Information obtained during the assessment will be used in the development of the service plan.

- Contact the participant/family to schedule a face to face home visit to complete the SCA and service plan.
- During the face to face home visit, the Service Coordinator will:
  - Conduct an interview (using the SCA) and observe the participant/family in the home environment to obtain assessment information,
  - Identify services that the participant is currently receiving,
  - Determine if additional services are needed,
  - Explain what services are available and how to obtain these services,
  - Provide contact names, addresses and telephone numbers, and
  - Provide information about other resources that may be helpful to the participant/family.
- Review and obtain authorizing signatures on:
  - Rights and Responsibilities and Acknowledgement Form,
  - Privacy Policies and Acknowledgement Form, and
  - Authorization for Disclosure of Information (as needed).
- Review all available information, such as:
  - Medical reports and written information, and
  - Application for Enrollment (CC-1).

- When the SCA has been completed, the Service Coordinator will enter the information in the SHS Information System.

A CYSHCN Program enrollment requires an unmet need, goal, and plan statement to be entered in at least one (1) section of the SCA. If there are no unmet needs, goals, plans identified in any section of the SCA, but the participant wishes to remain enrolled in the CYSHCN Program, a statement reflecting the participant's wish to remain enrolled needs to be entered in the Participant/Family Statement Comments section of the SCA.

EMERGENCY RESPONSE IDENTIFICATION AND INFORMATION

The Service Coordinator will offer assistance to all participants/families who are enrolled in SHS programs to establish an Emergency Response Plan.

Emergency management and response materials/publications should be given to each participant/family. The Service Coordinator will offer assistance with the completion of an emergency management plan. The plan will be reviewed with the participant/family annually.

When an emergency such as a natural disaster or terrorism event occurs, the Service Coordinator shall contact participants/families whose care may have been compromised as soon as possible after the event to assess for unmet needs. The contact may be by phone or in person and will be documented in the SHS Information System.

LIMITED FUNDING

Solely dependent upon annual appropriations, the Program provides limited funding for medically necessary services directly related to the participant's eligible condition. Limited funding is considered for Program participants who meet both medical and financial eligibility guidelines.

The Program is the payer of last resort. Funding will be considered only after an initial/annual comprehensive assessment has been completed and all efforts to access other payer sources have been demonstrated. **All third party liability (TPL) and other payer sources must be exhausted, including utilization of in-network providers, prior to consideration of Program funding.**

Limited funding will be reimbursed at rates established by CYSHCN and is paid directly to providers who are enrolled as a Program provider. Reimbursement will not be made for participants or to providers who have not enrolled with CYSHCN. If a participant's provider is not enrolled with CYSHCN, the Service Coordinator will contact the SHS Central Office for assistance with the enrollment process. Services rendered prior to the provider becoming enrolled will not be reimbursed; however, emergency services will be considered by the Program Manager on a case-by-case basis.

Consideration of cost sharing to assist participants/families who maintain insurance will be reviewed on an individual basis. The Program will not reimburse providers at rates greater than the established negotiated rate set by the insurance company. Guidelines established by the participant's insurance company will prevail. That is, when prior authorization is required for services, the participant must comply with the insurance guidelines before limited funding is considered. Consideration will be made once the prior authorization has been submitted along with the provider's estimated cost and insurance reimbursement amount.

PRIOR AUTHORIZATION

Prior authorization of services allows the Program to plan and budget appropriately. Prior authorization provides a mechanism to monitor and evaluate both recurring and one-time expenses, as well as provide a projected amount of funding obligated for impending services.

The Program has limited resources. To ensure efficient utilization of these resources, Service Coordinators must take the necessary steps to document all known expenditures in the services screen in the SHS Information System. Examples of entries may include monthly recurring expenses for medications, equipment rentals, wound care supplies, and catheters; as well as one-time expense for equipment purchases, orthotics, and hearing aids.

Effective ongoing communication and planning with the participant/family is essential in coordinating services. Service Plans, or itemized expenditures, must be entered into the SHS Information System for all known expenses of any amount. Any changes in services should be reflected in the Service Plan to represent committed expenses.

All prior authorizations:

- Must be requested by the CYSHCN approved provider in writing and be directly related to the participant's CYSHCN eligible condition.
- Require written medical justification submitted by a CYSHCN approved provider and/or physician orders.
- Must be documented (including all events and information leading up to the request) in the Progress Notes section of the SHS Information System by the Service Coordinator.
- If the cost is known, the request must be documented on the Prior Authorization form and documented in the SHS Information System.
- If the cost is unknown or changes frequently (i.e. procedures, surgeries, medications) and is approved, the request must only be documented in the Service Plan section of the SHS Information System.
- Service Coordinators must authorize any services, supplies or equipment costing more than $300 annually.
- Service Coordinator and Program Manager must both authorize any services, supplies or equipment costing more than $2,500 annually.

For funding requests that require only Service Coordinator approval:

1. Obtain the necessary information to complete the Prior Authorization (PA) Request form.
    a. Letter of medical necessity
    b. Price quote (when applicable)
    c. Treatment plan (when applicable)
    d. Insurance/MO HealthNet coverage information (i.e. exclusions, deductibles, co-pays, etc…)
2. Complete the PA form and e-mail it to the designated Program staff.

3. The Service Coordinator will be notified via e-mail by designated Program staff if the PA is approved or if corrections are needed.
4. If corrections are necessary, the Service Coordinator will review/revise the PA and resubmit. (Steps 3 and 4 will be repeated until the PA is accepted and approved/denied.)
5. The Service Coordinator must inform the CYSHCN approved provider and the participant/family of the PA approval/denial; a copy of the PA is to be mailed/faxed to the CYSHCN approved provider and a copy kept in the participant file.
6. The PA must be documented in the Service Plan and Progress Notes section of the SHS Information System.

For funding requests that require Service Coordinator and Program Manager approval:

1. Complete steps 1 through 4 above.
2. The Program Manager will approve/deny the service and the PA will be e-mailed back to the Service Coordinator.
3. The Service Coordinator must inform the CYSHCN approved provider and the participant/family of the PA approval/denial; a copy of the PA is to be mailed/faxed to the CYSHCN approved provider and a copy kept in the participant file.
4. The PA must be documented in the Service Plan section of the SHS Information System by the Service Coordinator.
5. The PA will be documented in the Progress Notes section of the SHS Information System by the Program Manager.

For service requests that only require a Service Plan entry in the SHS Information System (PA Request form not required):

1. Forward a letter of medical necessity to the Program Manager along with an e-mail describing the service being requested.
2. Following Program Manager review of the requested service for medical necessity and direct relationship to the participant's Program eligible diagnosis, the Service Coordinator will be notified via e-mail of approval/denial.
3. The Service Coordinator must inform the CYSHCN approved provider and the participant/family of the service approval/denial.
4. Only approved service requests are documented in the Service Plan section of the SHS Information System.

The CYSHCN Program Reimbursement Rate Schedule provides an inclusive listing of services and prior authorization requirements.

APPEAL PROCESS

Special Health Service (SHS) applicants/participants/representatives have the right to appeal decisions regarding eligibility, the services received, or the services denied. All activities concerning the appeal will be documented in the SHS Information System within five (5) business days from the date of the receipt of the appeal. All documentation will be retained in the legal file.

- To appeal a decision made by CYSHCN, the applicant/participant/representative must notify the Service Coordinator within thirty (30) calendar days to request a review of the decision. The appeal must be in writing; the Service Coordinator will assist, if necessary.
- Within five (5) business days of the receipt of the appeal, the Service Coordinator will notify and forward the written appeal to the Program Manager.
- The Program Manager, in collaboration with the Bureau Chief, will review the appeal. The Program Manager and Bureau Chief will render a written decision to the applicant/participant/representative, and send a copy of the decision to the appropriate Service Coordinator within thirty (30) business days of the receipt of the appeal.
- If the decision is unsatisfactory to the applicant/participant/representative, the applicant/participant/representative must notify the Service Coordinator, in writing, within thirty (30) calendar days of the receipt of the decision to request a hearing. The request must be addressed to the Bureau Chief and must include the reason for the appeal and any supporting facts. The appeal must be signed, dated, and contain a return address.
- Within five (5) business days of the receipt of the request, the Service Coordinator will notify the Program Manager and the Bureau Chief of the request for a hearing.
- Within five (5) business days of the receipt of the request, the Bureau Chief will follow the appropriate chain of command to forward the request to the Department Director, or designee.
- A hearing will be conducted at a reasonable time, date, and place. The notice of the hearing will be mailed to the applicant/participant/representative at the address indicated on the appeal letter at least twenty (20) calendar days prior to the hearing.
- The Department Director, or designee, will appoint a hearing officer who has not been involved in the initial determination of the action in question. The hearing officer will preside at the hearing and prepare a report consisting of a statement of issues, findings of fact, conclusions, and recommendations.
- The applicant/participant/representative will have adequate opportunity to record the hearing proceedings, examine the contents of the case file, bring witnesses, establish all pertinent facts, advance arguments without undue interference and questions, or refute any testimony or evidence.
- The Department Director, or designee, will make a final decision based on the evidence and other material introduced at the hearing and the hearing officer's report. A letter outlining the Director's, or designee's, decision will be mailed to the applicant/participant/representative within ninety (90) calendar days after the

hearing date. A copy of the letter will also be filed in the participant's legal record.

An applicant/participant/representative who has exhausted all administrative remedies and who wishes to appeal the final decision of the Department will be entitled to judicial review.

COMPLAINTS

The Service Coordinator must follow the complaint policy of the agency that has been contracted by Special Health Services (SHS). Complaints or concerns received from customers regarding Program issues must also be reported to the CYSHCN Program Manager.

Customers include, but are not limited to, the following:

- Participant;
- Participant's family;
- Participant's representatives;
- Providers;
- Contracting agencies;
- Regulatory agencies;
- Payers;
- DHSS staff (outside of SHS);
- Elected officials; and
- Appointed officials.

MONITORING AND EVALUATION

The service plan, status of the medical condition, compliance with keeping appointments, progress toward reaching goals, and appropriateness of services will be reviewed with the participant/family every six (6) months and anytime there is a significant change. A full assessment and review of continued eligibility will be conducted annually. These contacts must be documented in the SHS Information System.

The following activities/techniques are suggested to assist the Service Coordinator in monitoring and evaluating the participant's services and goals.

Review the plan of care for comprehensive, continuous, and coordinated care.

- When available, review and discuss medical reports to determine the current heath status of the participant.
- If a change in the general health status, diagnosis, or treatment is found, make an appropriate entry in the SHS Information System.
- Update the service plan as needed to reflect changes.

Assess satisfaction with, compliance to, and accessibility of services.

- Maintain contact with the participant/family through phone calls or face to face contact, utilizing interpreters as needed.
- Discuss components of care: current, coordinated, family-centered, and accessible.
- Assess any barriers to accessing medical care such as transportation. **(Service Coordinators should not provide transportation to participants/families.)**
- As needed, help the family transition to new providers when insurance plans change.

TRANSPORTING PARTICIPANTS

Service Coordinators are not permitted to transport participants. Through service coordination, identify other means of transportation available for participants.

TRANSITION

Participants will have a transition plan in place for all appropriate times of transition, such as age, service discontinuation, change in a Service Coordinator or agency, or major life event.

Discussions about transition begin as soon as the participant is enrolled in the Program and continue periodically throughout enrollment. Discussions should include expected outcomes and behaviors appropriate to health care, educational/vocational, and independent living. Collaborate with other agencies to identify appropriate transition team members including the participant and the caregiver/family. When possible, schedule a transition meeting with the family and other appropriate key players within six (6) months of the anticipated transition.

The Transition Plan form may be completed to identify action steps, timelines, and person(s) responsible. The Transition Plan should address the participant's/family's concerns and priorities. Document in the SHS Information System that a Transition Plan has been placed in the participant file. If the Transition Plan form is not utilized, document necessary transition activities in the SHS Information System.

CLOSURES

The length of time participants are enrolled in services is unique to the individual's needs and progress towards goals. At the point that a participant has reached all their goals and sustained them over some time, the Service Coordinator and participant/family may discuss a change in Program enrollment or possible closure from enrollment. Through effective service coordination, it is the goal for all participants to ultimately be able to achieve and maintain their independence and no longer require CYSHCN services.

Participant and applicant cases are closed by the Service Coordinator for various reasons. In all instances, good faith efforts must be made to contact the participant/family to discuss the closure. These good faith efforts must be documented in the SHS Information System to show effective service coordination, and when appropriate, successful transition from Program services.

Reasons for closure may include:

- The applicant/participant demonstrates an unwillingness to cooperate with Program requirements such as responding to requests for information.
- The participant does not meet eligibility criteria.
- Request of the participant/family.
- Unable to locate after good faith efforts.
- The participant has become institutionalized or a Ward of the Court with guardianship assigned to the Department of Mental Health or the Division of Youth Services.
- The participant reaches the age of twenty-one (21).
- Program services are no longer needed.

Once the determination has been made to close the case, the Service Coordinator will:

- Document the reason for closure and closure date in the SHS Information System and
- Print the system generated closure letter from the SHS Information System.

The Service Coordinator must send a certified closure letter on all manual and automated closures. A copy of the closure letter must also be retained in the participant's record.

The following are guidelines to assist in determining closure dates:

- Deceased - date of death if known; otherwise use the date staff became aware of the death (notify Program Manager of all participant deaths using a Death Notification Form),
- Moved Out of State – date of move if known; otherwise use the date that staff became aware of move,
- Over Age – the day before the participant's twenty-first (21st) birthday,
- Not Medically Eligible (NME) - date medical information is received making the participant no longer medically eligible,

- Not Financially Eligible (NFE) – date financial information is received making the participant over financial eligibility guidelines, and
- All others – fourteen (14) calendar days after the date of the written notice to participant/family notifying them of closure.

FAMILY PARTNERSHIP FOR CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS

The Family Partnership provides information and support to children and youth with special health care needs and their families. These individuals are also given the opportunity to network with each other through various settings including regional and statewide meetings. Special Health Care Needs (SHCN) utilizes information from Family Partnership members to enhance the relationship between SHCN and the individuals and families they serve.

Family Partnership members include individuals with special health care needs as well as their parents, family members and legal guardians. The Family Partnership has Family Partners who share responsibility statewide and are also parents of individuals with special health care needs. In addition to providing information and resources to members, the Family Partners plan, schedule, and facilitate the Family Partnership meetings.

The goals of Family Partnership are to:

- Provide families the opportunity to offer each other support and information.
- Give families the opportunity to provide SHCN input on the needs of individuals with special health care needs.
- Build public and community awareness of the unique needs and issues facing families of individuals with special health care needs.
- Promote legislation for programs for individuals with special health care needs and their families.

To ensure continued collaboration between SHCN and Family Partnership, Service Coordinators are required to attend one Family Partnership regional meeting annually. Service Coordinators must also provide Family Partnership information to all participants upon initial enrollment and encourage participation in Family Partnership activities.

OUTREACH

Outreach activities are vital to the success and implementation of programs with Special Health Services (SHS). Providing information to the public regarding programs and services is an important part of service coordination. Much needed information will help communities respond to the special needs of children and assist their families access needed resources. A very large service network is comprised of hospitals, clinics, public health organizations, schools, government agencies and community groups, all of which serve special needs populations in various ways. The opportunities are almost endless for engaging in outreach activities and making connections in Missouri communities.

What is outreach?

An organized effort to expand awareness of and participation in SHS programs throughout Missouri. In essence, outreach is the mission of SHS: "To develop, promote and support community-based systems that enable the best possible health and greatest degree of independence for Missourians with special health care needs."

How does it strengthen the Program?

- Provides community/organizations with awareness of services that the Program offers.
- Provides an opportunity to learn how other agencies' services can benefit Program participants.
- Provides opportunities to work with stakeholders in an effort to promote positive outcomes, as well as advocate for participants and their families.
- Provides opportunities for feedback to improve Program and/or services.
- Builds collaboration with providers to assure participant's needs are met.

What are strategies for maintaining outreach?

Outreach is always a collaborative effort. Partnering agencies and organizations are often very interested in networking opportunities that will promote understanding and provide needed services to children and youth with special health care needs and their families. Opportunities and strategies for conducting and maintaining outreach may be found in the following areas: medical, education, and agency/community.

Medical

- Provide information to children's hospitals, doctors, nurses, therapists, and social workers.
- Attend therapy clinics and cleft lip and palate team meetings and become knowledgeable of children's hospital services.

Education

- Provide brochures to the school districts regarding programs, attend IEP meetings, and talk with school representatives (teachers, social workers, nurses, administrators) about services.

Agency/Community

- Become involved with maternal, child and family health community coalitions.
- Promote and attend Family Partnership activities.
- Present at local meetings.
- Make it a part of your routine by researching and visiting various organizations that may benefit participants.
- Include day-to-day conversations, such as phone referrals, explaining how to make referrals and share community resources.

Suggestions on how to conduct outreach

- Network with various organizations that have a similar mission and often provide services to the same population (health alliances, family coalitions, immigrant/refugee coalitions).
- Recognize the differences in providing outreach in urban vs. rural areas.
- Utilize outreach tools for identifying outreach sources and tracking activities.

MANDATORY REPORTING

Abuse and neglect occurs when a person(s) responsible for the care of a child, elderly or disabled person either deliberately or by extraordinary inattentiveness, permits the individual in his/her care to experience avoidable suffering and/or fails to provide one or more of the ingredients generally deemed essential for developing a person's physical, intellectual and emotional capacities.

Service Coordinators must report suspected abuse/neglect, whether or not it involves an enrolled participant with CYSHCN. Service Coordinators receiving third party allegations must direct the reporter to call the appropriate hotline and report the incident as well as make a hotline report themselves.

Things to report may include but are not limited to:

- Suspected neglect
- Any non-accidental physical injury or injury which is at variance with the history given
- Suspected sexual abuse
- Suspected emotional abuse
- Non-organic failure to thrive

How to report:

The following procedure shall be carried out when the decision to report a potentially abused/neglected child or adult has been made:

- For suspected child abuse/neglect staff will make an oral report (by telephone) to the **Children's Division at (800) 392-3738**.
- For suspected abuse or neglect of a disabled adult eighteen to sixty years of age or an elderly person age 60 or older staff will call the **Division of Senior Services & Regulation at (800) 392-0210**.
- Notify the Program Manager within one (1) business day of making the report by completing the Confidential Event Report Form and emailing it to the Program Manager.

Your employer may require you to follow additional protocol.

LEGAL TOPICS

Legal Name Change

Program participants who change their name must provide written proof (legal document) of the change before the name can be officially changed in the participant record or in the SHS Information System.

The Service Coordinator will view the legal document and record the information (including effective date) in the Progress Notes of the SHS Information System. A copy of the legal document must be kept in the participant's file.

Legal Recovery of Funds

In reference to Chapter 201, RSMo regarding subrogation rights for Crippled Children's Services, Service Coordinators will be asked to assist Central Office (CO) in the attempt of recovery of funds from Program participants when a legal settlement has been made.

Subpoena of Participant Records

The Program is required to respond to a subpoena for participant records. When a subpoena is received in a contracting agency office involving a participant's legal record, the following must occur:

- The subpoena for CYSHCN participant records shall be accepted by the Service Coordinator. The Service Coordinator shall notify the CYSHCN Program Manager within twenty-four (24) hours. The instructions in the subpoena must be followed.
- The subpoena for a CYSHCN Service Coordinator shall be accepted by the Service Coordinator. The Service Coordinator shall notify the CYSHCN Program Manager within twenty-four (24) hours. The instructions in the subpoena must be followed.

The Program Manager will work in collaboration with the Service Coordinator and contracting agency Administrator to track the legal process and actions generated by the subpoena.

Obtaining or Releasing Information

All information about the participant/family (verbal, electronic, or in written form) is confidential. All access to health/medical information should be requested, released, or viewed using a written and signed Health Insurance Portability and Accountability (HIPAA) document considered by DHSS to be compliant with current regulatory

guidance. If in doubt, please contact your designated HIPAA officer at the respective LPHA or Program representative for assistance.

Compliant documents:

- DHSS Notice of Privacy Policies and Acknowledgement forms are required upon enrollment and annually thereafter.
- DHSS Authorization for Disclosure of Consumer Medical Health Information form is necessary when requesting records and when sharing information on an as needed/need to know basis. A current original signed Authorization must be obtained and kept in the hard file.

Staff of contracted agencies must use the DHSS Authorization for Disclosure of Consumer Medical Health Information form when releasing SHS information.

Contractors or Providers may also require their own Authorization form in conjunction with the DHSS Authorization for Disclosure of Consumer Medical Health Information form.

Requests for participant records for legal proceedings must be in writing and sent to the Program Manager. The Program Manager will coordinate the release of information with the Service Coordinator.

MEDICAL RECORD REQUESTS AND FEES

The Program will consider paying the charges to obtain a copy of a participant's medical record, when the provider who has the information is not a SHS approved provider. The Program will not pay the charges to obtain a copy of a participant's medical record when the individual/facility who has the needed information is a SHS approved provider.

It is customary for health care providers to waive fees for state agencies when the purpose of the review is to conduct state business and carry out state statutes as found in 19 CSR 40-1 Crippled Children's Service (CCS). Because the services are provided through a contractual agreement with the LPHA's, the request for reimbursement will be processed at the current rate posted at: http://health.mo.gov/atoz/fees.php.

The Service Coordinator should attach a copy of the Fees for Medical Records form to each request for medical records. The form instructs the health care provider where to mail the records and who to bill for the records. The sheet must be individualized to reflect the Service Coordinator's name and address.

Providers that bill SHS must itemize the handling and per page fees for medical records in order to have their invoices accepted and processed. Invoices billed to the contracted agencies will not be accepted.

Invoices received at the LPHA should be sent to SHS immediately.

RECORDS MANAGEMENT

Individuals who apply or enroll in the Program must have a legal participant record in the Regional or Contractor Office.

- It is recommended that file content be organized in sections.
- Documents must be filed in descending chronological order within their appropriate section.
- Participant records must be kept in a locked centralized filing area.

Records Retention:

- All records must be retained until the participant file is closed.
  - All closed participant records must be forwarded to the Regional Office (RO) only upon request by the RO.
- An incomplete referral or an incomplete Application for Enrollment will be retained for three (3) months before the record is destroyed.
- A complete Application for Enrollment (signed CC-1) which is determined ineligible must be retained for microfilming.

Preparing Legal Files for Microfilming After Closure of a CYSHCN Record

Files must be appropriately prepared before sending them to the RO for microfilming. Prior to forwarding the file:

- Write the participant name, DCN and date of birth in pen on the file tab.
- Remove all staples, paperclips, dividers, and duplicate copies. (Shred all duplicates with identifying information, such as names and DCNs, which are removed.)
- All perforated forms should be separated at the perforation.
- Tape anything smaller than 3 x 5 on an 8 ½ x 11 sheet of paper. All information should be visible. Tape all four sides completely so no edge is loose.
- Remove post-it notes and tape to another sheet of paper.
- Remove any previously used tape. (Sticky surfaces will get stuck in the microfilm machine.)
- Cut off rough edges (spiral notebook paper edges, etc.).
- Correct participant's name on the file folder to match the current name in the SHCN Information System.
- Number each file folder if there is more than one for a participant.
- Assure all papers are facing up.
- Write on the outside of the file in pencil "microfilm ready".

Frequently Used Acronyms & Abbreviations for SHS Participant Documentation

Acronym/Abbreviations	Title/Phrase	Punctuation Required
A.M. or a.m.	At Morning (must use punctuation and numeric time 4a.m. or 4:00a.m.)	Yes
ABD or Abd	Abdomen	
ABI	Adult Brain Injury (currently used with or in place of AHI)	
ADD	Attention Deficit Disorder	
ADHD	Attention Deficit Hyperactive Disorder	
ADLs	Activities of Daily Living	
AFER	Annual Financial Eligibility Review	
AFO	Ankle, Foot Orthosis	
AGI	Adjusted Gross Income	
AHI	Adult Head Injury	
AIDS	Acquired Immune Deficiency Syndrome	
APC	Advanced Personal Care	
APR	April	
ARN	Authorized Registered Nurse Visit	
AROM	Active Range of Motion	
Assoc.	Association	Yes
AUG	August	
AV	Annual Visit	
BC/BS	Blue Cross Blue Shield (Insurance Plan)	
BIA	Brain Injury Association	
BID or b.i.d.	Twice a day	
Bi PAP	Bi-level Positive Air Pressure	
BM	Bowel Movement	
BP	Blood Pressure	
CAT	Comprehensive Assessment Tool	
CATH	Catheter	
CC	Cubic Centimeters	
CCS	Crippled Children's Services	
CD	Children's Division; Dept. of Social Services	
CDC	Centers for Disease Control & Prevention (Federal)	
CDS	Consumer Directed Services	
CERT	Center for Emergency Response/Terrorism	
CF	Cystic Fibrosis	
CHF	Congestive Heart Failure	
CHI	Closed Head Injury	
CIL	Centers for Independent Living	
CLP	Cleft Lip Palate	
CM	Case Management	
CMS	Center for Medicare & Medicaid Services (Federal - formerly HCFA)	
CO	Central Office	
COB or c.o.b.	Close of Business	
COPD	Chronic Obstruction Pulmonary Disease	
CP	Cerebral Palsy	
CPAP	Continuous Positive Air Pressure	
C-Section	Cesarean Section	
CSHCN	Children with Special Health Care Needs	
C-STAR	Comprehensive Substance Treatment Abuse and Rehabilitation	
CT Scan	Computerized Tomography Scan	
CYSHCN	Children and Youth with Special Health Care Needs	
DCN	Departmental Client Number	
DD	Developmental Disabilities	
DDD	Division of Development Disabilities (Formerly MRDD – DMH)	
DDS	Doctor of Dental Science or Doctor of Dental Surgery	
DEC	December	
DECUB	Decubitis	

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Frequently Used Acronyms & Abbreviations for SHS Participant Documentation

Acronym/Abbreviations	Title/Phrase	Punctuation Required
DESE	Department of Elementary & Secondary Education (State)	
DHSS	Department of Health & Senior Services (State)	
DME	Durable Medical Equipment	
DMH	Department of Mental Health (State)	
DNR	Do Not Resuscitate	
DOB	Date of Birth	
DOS	Date of Service	
DSDS	Division of Senior and Disability Services; DHSS	
DSS	Department of Social Services (State)	
DVT	Deep Vein Thrombosis	
DX or dx	Diagnosis	
DYS	Division of Youth Services (DSS)	
E	Eastern	
EEG	Electroencephalogram	
EKG	Electrocardiogram	
EMR	Emergency Medical Record	
EMS	Emergency Medical Services	
EMT	Emergency Medical Technician	
ENT	Ear, Nose, and Throat	
EOB	Explanation of Benefits	
EPSDT	Early Periodic Screening, Diagnosis & Treatment (Federal)	
ER	Emergency Room	
FAS	Fetal Alcohol Syndrome	
FEB	February	
FDA	Food and Drug Administration (Federal)	
FEMA	Federal Emergency Management Agency	
FPL	Federal Poverty Level (or guideline)	
Fri. or F	Friday	Yes
FT or ft	Foot (anatomy)	
F/U	Follow Up	Yes
FX or fx	Fracture	
GI	Gastro-Intestinal	
G-Tube	Gastronomy Tube	
GU	Genital Urinary	
H&P	History and Physical	
HCY	Healthy Children and Youth	
HIPAA	Health Insurance Portability and Accountability Act of 1996	
HIV	Human Immunodeficiency Virus	
HIV+	HIV-positive	
HMO	Health Maintenance Organization	
HR(s) or hr(s)	Hour(s)	
HR/DAY or hr/day	Hours Per Day	
HR/MO or hr/mo	Hours Per Month	
HR/WK or hr/wk	Hours Per Week	
HS or h.s.	Hour of Sleep	
HV	Home Visit	
IBTH	Birth Name Inquiry	
ICU	Intensive Care Unit	
IEP	Individualized Education Plan	
IFOX	Infocrossing HealthCare Services	
IFSP	Individualized Family Service Plan	
IM	Intra-Muscular	
Inv.	Invoice	Yes
IP	In-Patient	
IRS	Internal Revenue Service	
IV	Intravenous	

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Frequently Used Acronyms & Abbreviations for SHS Participant Documentation

Acronym/Abbreviations	Title/Phrase	Punctuation Required
JA	Juvenile Arthritis	
JAN	January	
JRA	Juvenile Rheumatoid Arthritis	
JUL	July	
JUN	June	
KAFO	Knee, Ankle Foot Orthosis	
KG or kg	Kilograms	
LB(s) or lb(s)	Pound(s)	
LBW	Low Birth Weight	
LE	Lower Extremities	
L	Left (anatomy)	
LLE	Left Lower Extremity	
LPHA	Local Public Health Agency	
LPN	Licensed Practical Nurse	
LTC	Long-Term Care	
LUE	Left Upper Extremity	
MAR	March	
MC+	MO HealthNet Managed Care Plus (Insurance Plan)	
M-F	Monday through Friday	
MHN	MO HealthNet	
MHD	MO HealthNet Division, DSS (Formerly DMS)	
MED (s)	Medication (s)	
MFAW	Medically Fragile Adult Waiver	
Mcg	Microgram	
Mg	Milligrams	
Ml	Milliliters	
MO or mo	Month	
MON or M	Monday	
MOS or mos	Months	
MOCARES	Missouri Care System	
MOHSAIC	Missouri Health Strategic Architectures & Information Cooperative	
MR	Mental Retardation	
MRI	Magnetic Resonance Imaging	
MVA	Motor Vehicle Accident	
N/A	Not Applicable	
NE	Northeast	
NEMT	Non-Emergency Medical Transportation Program	
NG-Tube	Nasal Gastric Tube	
NICU	Neonatal Intensive Care Unit	
NOV	November	
NW	Northwest	
O2	Oxygen	
O2 SAT	Oxygen Saturation	
OATS	Older Adults Transportation System	
OCT	October	
OHI	Open Head Injury	
OP	Out-Patient	
OT	Occupation Therapy	
OTC	Over-the-Counter	
OZ. (s) or oz. (s)	Ounce or ounces	
PA	Prior Authorization	
PAT	Parents as Teachers	
PC	Personal Care	
PCA	Personal Care Aide	
PCP	Primary Care Physician	
PDN	Private Duty Nursing	

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Frequently Used Acronyms & Abbreviations for SHS Participant Documentation

Acronym/Abbreviations	Title/Phrase	Punctuation Required
PDW	Physical Disabilities Waiver	
PEG-Tube	Percutaneous Endoscopic Gastrostomy Tube	
PET Scan	Positron Emission Tomography Scan	
PICC	Peripherally Inserted Central Catheter	
PICU	Pediatric Intensive Care Unit	
PKU	Phenylketonuria	
PM	Program Manager	
POC	Plan of Care	
P.M. or p.m.	Past Morning (must use punctuation & numeric time 1p.m. or 1:00p.m.)	Yes
PO or po	By mouth	
PRN or prn	As Needed	
PROM	Passive Range of Motion	
PSA	Perinatal Substance Abuse	
PT	Physical Therapy	
QD or q.d.	Every day	
QID or q.i.d.	Four times a day	
QOD or q.o.d.	Every other day	
R	Right (anatomy)	
RA	Rheumatoid Arthritis	
RC	Regional Coordinator	
RCF	Residential Care Facility	
RDS	Respiratory Distress Syndrome	
RLE	Right Lower Extremity	
RO	Regional Office	
ROM	Range of Motion	
RSV	Respiratory Syncytial Virus	
RUE	Right Upper Extremity	
Rx or RX	Prescription	
SAT or S	Saturday	
SB40	Senate Bill 40	
SC	Service Coordinator	
SCA	Service Coordination Assessment	
SE	Southeast	
SEMA	State Emergency Management Agency	
SEPT	September	
SHCN	Special Health Care Needs (Bureau of)	
SIDS	Sudden Infant Death Syndrome	
SHS	Special Health Services	
SL or s.l.	Sublingual	
SLE	Systemic Lupus Erythematosus	
SN	Skilled Nursing	
SNF	Skilled Nursing Facility	
SNV	Skilled Nursing Visits	
SPO2	Saturation Pulse/Oxygen	
SQ	Subcutaneous	
S/S or s/s	Signs and Symptoms	Yes
SSA	Social Security Administration	
SSDI	Social Security Disability Insurance	
SSI	Supplemental Security Income	
SSN	Social Security Number	
ST	Speech Therapy	
STD	Sexually Transmitted Disease	
Sun or Sn	Sunday	
SW	Southwest	
T&A	Tonsillectomy and Adenoidectomy	Yes
TANF	Temporary Assistance for Needy Families	

Revised November 18, 2014

Frequently Used Acronyms & Abbreviations for SHS Participant Documentation

Acronym/Abbreviations	Title/Phrase	Punctuation Required
TB	Tuberculosis	
TBI	Traumatic Brain Injury	
THCS	Transitional Home Community Support	
Thur or Th	Thursday	
TID or t.i.d.	Three times a day	
TPN	Total Parenteral Nutrition	
Trach or trach	Tracheostomy	
TTD/TTY	Teletypewriting Device for the Deaf/Teletypewriter	Yes
TUE or T	Tuesday	
UCR	Usual and Customary Rate	
UE	Upper Extremity	
UHC	United Health Care (Insurance Plan)	
URI	Upper Respiratory Infection	
US	Ultrasound	
UTI	Urinary Tract Infection	
VC	Verbal Confirmation	
VLBW	Very Low Birth Weight	
VR	Vocational Rehabilitation	
W/C	Wheel Chair	Yes
WED or W	Wednesday	
WIC	Special Supplemental Program for Women, Infants, and Children	
WT. or wt.	Weight	
X or x	Times (when BID, QID, or TID are not applicable)	
YR. or yr.	Year	

*****Abbreviations used for credentialing are not a part of this list. It is accepted practice that a person's name and the appropriate abbreviation for their credentials ie., M.D. (Medical Doctor), LPN (Licensed Practical Nurse), RN (Registered Nurse) is understood.**

Revised November 18, 2014

Special Health Services (SHS) - Annual Financial Eligibility Review (AFER) Form

Check the appropriate box to determine financial eligibility:

☐ Federal Income Tax Form filed for 2014 and a copy is attached.
Is the income filed in 2014 reflective of the current income status? If not, please provide explanation on separate letter to Service Coordinator and attach a copy of the tax form.

☐ Not required to file 2014 taxes.

☐ Request for Extension Form filed for 2014 and a written estimate of income is attached.

☐ Have applied for an Individual Tax Identification Number (ITIN).

☐ No longer interested in receiving SHS Services.

Verify the following information on file. If information is incorrect, please provide the correct information.

	Information on file:	Correct information:
Participant Name		
DCN		
Date of Birth		
Telephone Number		
Street Address		
City, State, Zip		
County		
Responsible Party Name		
Responsible Party Telephone		
Responsible Party Address		
Responsible City, State, Zip		
Alternate Contact(s) Name		
Alternate Contact Telephone		
Alternate Contact(s) Name		
Alternate Contact Telephone		
Alternate Contact(s) Name		
Alternate Contact Telephone		
Insurance		
Insurance		
Insurance		
MO HealthNet		☐ YES ☐ NO
Other Household members enrolled in a SHS Program.		

PARTICIPANT/RESPONSIBLE PARTY RIGHTS AND RESPONSIBILITIES:

Application is made for admission of the above name participant to Special Health Services. I authorize SHS to release or obtain information to or from any agencies which are participating in the treatment and care plan for the applicant. The information on this application form may be exchanged with agencies that administer relevant or applicable programs. I consent to the release of personal, financial, and medical information from this application form and supporting documents to the agencies that administer relevant or applicable programs for establishing and verifying eligibility and for performing evaluations. I understand that the agencies that administer such programs will maintain confidentiality of this information according to applicable laws. I have been informed that SHS provides care on a nondiscriminatory basis as required by Title VI of the Civil Rights Act of 1964. I understand SHS eligibility will not be considered until all information has been received by SHS. I understand that intentionally making a false or misleading statement or intentionally misrepresenting, concealing or withholding facts may result in repaying in cash the value of benefits received. I understand any medical insurance benefits I may receive for services authorized by SHS may be forwarded to the provider of service(s). I must cooperate with the providers of services and SHS in giving all information concerning trust funds, legal actions, settlements and third party payors i.e., medical insurance, MO HealthNet, etc. I have been advised and understand my rights and responsibilities under SHS. All the information I have provided is correct to the best of my knowledge.

Signature of Participant 18 or Older	Signature of Parent/Guardian	Date of Signature

Print from Crystal

STATE OF MISSOURI

AUTHORIZATION FOR DISCLOSURE OF CONSUMER MEDICAL/HEALTH INFORMATION

I, _____ authorize and request
(NAME OF CONSUMER, PARENT, GUARDIAN/LEGAL REPRESENTATIVE)

Check all that apply:

☐ Department of Mental Health (DMH) ☐ Department of Health and Senior Services (DHSS)

☐ Department of Social Services (DSS) ☐ Department of Elementary and Secondary Education (DESE)

☐ Other _____
(NAME OF FACILITY, AGENCY, MENTAL HEALTH CENTER, PERSON)

to **disclose/release** the below specified information of:

NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER

WHO RECEIVED SERVICES FROM (DATES)

to **(check all that apply)**

☐ Department of Mental Health (DMH) ☐ Department of Health and Senior Services (DHSS)

☐ Department of Social Services (DSS) ☐ Department of Elementary and Secondary Education (DESE)

☐ Other _____
(NAME OF FACILITY, AGENCY, MENTAL HEALTH CENTER, PERSON)

_____
(ADDRESS, CITY, STATE, ZIP)

THE PURPOSE OF THIS DISCLOSURE IS (CHECK ALL THAT APPLY)

☐ Eligibility Determination ☐ Assessment ☐ Aftercare

☐ Placement ☐ Transfer/Treatment ☐ Treatment Planning

☐ Continuity of Services/Care ☐ Conditional/Unconditional Release Hearing ☐ At Consumer's Request

☐ To share or refer my information to other Missouri state agencies (such as DMH, DHSS, DSS, DESE, etc.) to obtain services consistent with the _____ program (please complete the name of the program in which you want to participate)

☐ Other (specify) _____

THE SPECIFIC INFORMATION TO BE DISCLOSED IS (CHECK ALL THAT APPLY)

☐ Discharge Summary ☐ Progress Notes ☐ Treatment Plan and/or Review

☐ Social Service Assessment ☐ Educational testing, IEP, transcript, and/or grading reports

☐ Medical/Psychiatric Assessment(s)

☐ Psychometric testing, including intelligence quotient (IQ) results, neurological testing, or other developmental test results.

☐ Other _____

MO 650-2616 (1-03)

1. **READ CAREFULLY:** I understand that my medical/health information records are confidential. I understand that by signing this authorization, I am allowing the release of my medical/health information. The protected health information (PHI) in my medical record includes mental/behavioral health information. In addition, it may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), other communicable diseases, and/or alcohol/drug abuse.
2. Alcohol and drug abuse information records are specifically protected by federal regulations (42 CFR 2) and by signing this authorization without restrictions I am allowing the release of any alcohol and/or drug information records (if any) to the agency or person specified above. Please sign if you are authorizing the release of alcohol and drug abuse information:

   _____
3. This authorization includes both information presently compiled and information to be compiled during the course of treatment at the above-named facility or agency paying for services, during the specified time frame.
4. This authorization becomes effective on _____ . This authorization automatically expires on the following date, event or special condition _____ .
5. If I fail to specify an expiration date, this authorization will expire in one year.
6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so **IN WRITING** and present my written revocation to the health information management department (medical records) or client information center at this facility. I further understand that actions already taken based on this authorization, prior to revocation, will **NOT** be affected.
7. I understand that I have the right to receive a copy of this authorization. **A photographic copy of this authorization is as valid as the original.**
8. I understand that authorizing the disclosure of this medical/health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may request to inspect or request a copy of information to be used or disclosed, as provided in 45 CFR Section 164.524. I understand that any disclosure of information carries with the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my medical/health information, I can contact the health information management director (medical records director) or client information center, or designee, or the Privacy Officer for this covered entity.

THE FOLLOWING APPLIES TO ALCOHOL AND/OR DRUG ABUSE TREATMENT INFORMATION RECORDS: Prohibition of Redisclosure: This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR Part 2) prohibit you from making further disclosure of it without the specific written authorization of the person to whom it pertains, or as otherwise specified by such regulations. A general authorization for disclosure of medical or other information is NOT sufficient for this purpose.

My signature below acknowledges that I have read, understand, and authorize the release of my PHI.

SIGNATURE OF CONSUMER	DATE
WITNESS	DATE
SIGNATURE OF PARENT/LEGAL GUARDIAN/REPRESENTATIVE	

(Please include a Description of Authority to Act on Consumer's Behalf and attach a copy of the Document Granting Authority, where applicable)

NOTICE OF REVOCATION

DATE

I, _____ , (Consumer) hereby revoke my authorization of this disclosure of information to the agency/person listed above. This revocation effectively makes null and void any permission for disclosure of information expressly given by the above authorization. I understand that any actions based on this authorization, prior to revocation, will not be affected.

SIGNATURE OF CONSUMER	DATE
WITNESS	DATE
SIGNATURE OF PARENT/LEGAL GUARDIAN/REPRESENTATIVE	DATE

If you choose to revoke your authorization, please provide a copy of the completed revocation to the health information management director (medical records director), or the client information center, or to the Privacy Officer of this facility.

MO 650-2616 (1-03)

INSTRUCTIONS FOR COMPLETION OF AUTHORIZATION FOR DISCLOSURE OF CONSUMER MEDICAL/HEALTH INFORMATION

WRITE THE PARTICIPANT'S DCN IN THE UPPER RIGHT CORNER OF THE FORM DCN_____

1. When using the form to **GIVE** information to someone:

This row:	**Should contain:**
First Blank Line	The participant/parent/legal guardian's name.
First Set of Boxes	A check in the DHSS box
Who received services from (dates)	The dates covered by the release. The service coordinator should assist in determining the dates, based on the purpose of the form.
Second Set of Boxes	Check the box indicating the recipient if listed. If unlisted, check the "other" box and fill in the name of the recipient.
Purpose of this Disclosure	Check only the boxes that the client agrees to and that are necessary to satisfy the request. Examples include: • Conditional/Unconditional Release Hearing is DMH information. • At Consumer's Request is an "any and all" category, meaning it is okay to give the requester all of the information you have. • To share or refer my information to other Missouri state agencies. – complete the blank line indicating the program for which the participant wishes to apply.
Specific Information to be Disclosed	Check only boxes to which the client agrees and that we need to satisfy the request.

2. When using the form to **RECEIVE** information from someone:

This row:	**Should contain:**
First Blank Line	The participant/parent/legal guardian's name.
First Set of Boxes	Check the box of the appropriate state agency. If you are requesting information from a provider, check the **OTHER** box and fill in the name of the provider.
Who received services from (dates)	The dates covered by the release. The service coordinator should assist in determining the dates, based on the purpose of the form.
Second Set of Boxes	Check the box for DHSS.
Purpose of this Disclosure	Check only the boxes that the client agrees to and that are necessary to satisfy the request. Examples include: • Conditional/Unconditional Release Hearing is DMH information. • At Consumer's Request is an "any and all" category, meaning it is okay to give the requester all of the information you have. • To share or refer my information to other Missouri state agencies. – complete the blank line indicating the program for which the participant wishes to apply.
Specific Information to be Disclosed	Check only boxes to which the client agrees and that we need to satisfy the request.

Remember that any "OTHER" box can contain only one name or agency**.**

3. Several items on Page 2 of the Authorization require special attention:

- Item #2 – If this line is NOT signed you CANNOT release any information that is related to drug or alcohol abuse.
- Item #4 – The parent/guardian will decide the effective date. The second line allows the authorization to expire on a given date or upon occurrence of a specific event or condition.
- Item #7 – We must inform the participant/parent/guardian that we will provide a copy of this form if they want. If they want one, copy the form and mail it or bring it on the next visit.
- We require signatures of the participant (if they have capacity) or parent/guardian and a witness.
- The Notice of Revocation is on the form for convenience. The participant/parent/guardian completes it if they wish to revoke the authorization. They can also give you a written note revoking consent.

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SPECIAL HEALTH SERVICES (SHS)
Toll Free 800-451-0669

READ INSTRUCTIONS ON REVERSE FIRST.
PLEASE PRINT LEGIBLY IN BLACK INK.

APPLICATION FOR ENROLLMENT

SECTION A – PARTICIPANT INFORMATION (Individual being enrolled for services) | DCN

1. NAME (LAST, FIRST, MIDDLE)	2. DATE OF BIRTH	3. SOCIAL SECURITY NUMBER
4. ADDRESS (STREET, CITY, STATE, ZIP)	5. COUNTY	6. HOME TELEPHONE
	7. SEX / 8. RACE	9. PARTICIPANT/FAMILY DAYTIME PHONE
10. RESPONSIBLE PARTY NAME	11. RESPONSIBLE PARTY E-MAIL ADDRESS	
12. PRIMARY CARE PHYSICIAN NAME AND ADDRESS	13. SPECIALIST PHYSICIAN NAME AND ADDRESS	

14. PROGRAM ENROLLMENT (CHECK ONE)
☐ Adult Brain Injury ☐ Children and Youth with Special Health Care Needs ☐ Healthy Children and Youth

SECTION B - FAMILY INFORMATION (List all persons besides participant living in household)

15. NAME (LAST, FIRST, MIDDLE)	16. DATE OF BIRTH	17. RELATIONSHIP	18. SHS
PARENTS:			☐
			☐
OTHERS:			☐
			☐
			☐
			☐

19. DOES THE PARTICIPANT HAVE A COURT APPOINTED GUARDIAN? ☐ Yes ☐ No If Yes, Complete 20. TYPE OF GUARDIANSHIP _____	20. GUARDIAN NAME, ADDRESS AND TELEPHONE NUMBER
21. ALTERNATE CONTACT NAME	22. ALTERNATE CONTACT TELEPHONE NUMBER

SECTION C - FINANCIAL RESOURCES (Not applicable to HCY Program)

23. Did you file a Federal Income Tax Form? ☐ Yes ☐ No

If yes, attach a copy of the Income Tax Form. Do Not Send W-2. If no copy available, you should obtain a copy by calling the IRS at (800) 829-1040.
If no, why did you not file? ☐ Not required to file ☐ Requested extension of filing date (attach copy) ☐ Other

24. Has family income changed since filing Income Tax? ☐ Yes ☐ No Date of change _____ Estimate this year's current income _____

SECTION D - INSURANCE

25. Current Insurance Status (Check all that apply, include begin date and end dates of coverage) ☐ NONE

☐ MO HEALTHNET #	Begin Date	End Date
☐ MEDICARE#	Begin Date	End Date
☐ VETERAN'S ADMINISTRATION	Begin Date	End Date
☐ PRIVATE INSURANCE (NAME)	Begin Date	End Date
☐ OTHER (PLEASE SPECIFY)	Begin Date	End Date

SECTION E - MEDICAL CONDITION OR PROBLEM

SECTION F - SERVICES REQUESTED/NEEDED

SECTION G - AUTHORIZATION TO RELEASE INFORMATION

Application is made for admission of the above named participant to Special Health Services. I authorize SHS to release or obtain information to or from any agencies which are participating in the treatment and care plan for the applicant. The information on this application form may be exchanged with agencies that administer relevant or applicable programs. I consent to the release of personal, financial, and medical information from this application form and supporting documents to the agencies that administer relevant or applicable programs for establishing and verifying eligibility and for performing evaluations. I understand that the agencies that administer such programs will maintain confidentiality of this information according to the applicable laws. I have been informed that SHS provides care on a nondiscriminatory basis as required by Title VI of the Civil Rights Act of 1964. I understand SHS eligibility will not be considered until all information has been received by SHS. I understand that intentionally making a false or misleading statement or intentionally misrepresenting, concealing or withholding facts may result in repaying in cash the value of benefits received. I understand any medical insurance benefits I may receive for services authorized by SHS may be forwarded to the provider of service(s). I must cooperate with the providers of services and SHS in giving all information concerning trust funds, legal actions, settlements and third party payors i.e., medical insurance, MO HealthNet, etc. I have been advised and understand my rights and responsibilities under SHS. All the information I have provided is correct to the best of my knowledge.

26. SIGNATURE OF PARENT/GUARDIAN	27. SIGNATURE OF PARTICIPANT 18 OR OLDER	28. DATE

APPLICATION FOR ENROLLMENT

READ INSTRUCTIONS BEFORE COMPLETING FORM

SECTION A - PARTICIPANT INFORMATION

1. Enter participant's name (last, first, middle).
2. Enter participant's date of birth.
3. Enter participant's Social Security number.
4. Enter address (street, city, state, zip) where participant lives.
5. Enter county where participant lives.
6. Enter telephone number where participant lives.
7. Enter participant's sex.
8. Enter participant's race (W - White, B - Black, A - Asian, NA - Native American, PI – Pacific Islander, O - Other).
9. Enter participant/family daytime/work telephone number.
10. Enter the responsible party name.
11. Enter responsible party's email address.
12. Enter primary care physician name and address where participant receives his/her basic care (immunizations, etc.).
13. Enter physician name and address where participant receives his/her specialized care.
14. Program enrollment - check the box which best identifies the program in which the participant is interested.

SECTION B - FAMILY INFORMATION - List all persons besides participant living in household

15. Enter name of other individuals living in same household as participant.
16. Enter date of birth of other individuals living in the same household as participant.
17. Enter relationship of other individuals living in the same household with the participant.
18. If this individual receives services from Special Health Services (SHS) place a checkmark in the "SHS" column.
19. If the participant has a court appointed guardian, check "Yes" and enter type of guardianship.
20. Enter guardian name, address, and telephone number.
21. Enter name of an alternate contact - someone not in this household who will know how to get in touch with the participant/family.
22. Enter telephone number of alternate contact person.

SECTION C - FINANCIAL RESOURCES (Not applicable to HCY Program)

23. Check "Yes" if participant/family filed a Federal Income Tax Form. Attach a copy of the Federal Income Tax Form. DO NOT SEND A W-2 FORM. If participant/family does not have a copy of the Federal Income Tax Form, call (800) 829-1040 to obtain a copy from the IRS. Mail the copy to the service coordinator when it is received.
    Check "No" if participant/family did not file a Federal Income Tax Form and indicate the reason for not filing. (Attach copy of extension.)
24. Check "Yes" if the family income has changed since filing Federal Income Tax. If income has changed, give date of change and enter this year's estimated income.

SECTION D – INSURANCE

25. Current Insurance Status - Check the box(es) which describe participant's current insurance status. Include begin and end date of coverage.

SECTION E – MEDICAL CONDITION OR PROBLEM

Describe medical condition or problem the participant is having.

SECTION F - SERVICES REQUESTED/NEEDED

Enter services desired.

SECTION G - AUTHORIZATION TO RELEASE INFORMATION

26. Signature of Parent/Guardian. If guardianship has been granted, guardian must sign.
27. Participant 18 or older must sign the application. Parent must sign along with participant 18 years or older when participant is listed on parent's Federal Income Tax form as a dependent.
28. Enter date of signature.

CYSHCN CONFIDENTIAL EVENT REPORT FORM
(Not to be printed or retained in the participant record)

DATE OF EVENT:

PARTICIPANT NAME:

PARTICIPANT DCN:

SUMMARY OF REPORTABLE EVENT:

ACTION TAKEN BY SERVICE COORDINATOR (including date reported to appropriate agency):

DATE REPORTED TO PROGRAM MANAGER:

COMPLETED BY:

01-14-15

Death Notification

(Not to be printed or retained in the participant record)

CYSHCN ☐ ABI ☐ MFAW ☐ HCY ☐

Completed By:

Date:

1) **Participant Name:**

2) **Participant DCN:**

3) **Participant Date of Birth:**

4) **Participant Date of Death:**

5) **Participant City of Residence:**

6) **Place of Death (home, hospital, etc):**

7) **Cause of Death (cancer, traffic accident, etc):**

8) **Service Coordinator Name:**

9) **How SHS/Service Coordinator was informed of the Death:**

10) **Comments:**

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF SPECIAL HEALTH CARE NEEDS

HEALTH CERTIFICATION

PARTICIPANT NAME (LAST, FIRST, MI)		DATE OF BIRTH (MONTH/DAY/YEAR)
SOCIAL SECURITY NUMBER (LAST FOUR DIGITS) XXX–XX–___ ___ ___ ___	DCN NUMBER	SEX ☐ MALE ☐ FEMALE

ICD CODE	PRINCIPLE DIAGNOSIS
ICD CODE	OTHER PERTINENT DIAGNOSIS

FUNCTIONAL LIMITATIONS

☐ Amputation
☐ Bowel/Bladder (Incontinence)
☐ Contracture
☐ Hearing
☐ Paralysis
☐ Endurance
☐ Ambulation
☐ Speech
☐ Legally Blind
☐ Dyspnea with Minimal Exertion
☐ Other (specify) _____

PROGNOSIS

☐ Poor ☐ Guarded ☐ Fair ☐ Good ☐ Excellent

CURRENT TREATMENT PLAN INCLUDING BUT NOT LIMITED TO MEDICATIONS, DME, SUPPLIES, THERAPIES (FREQUENCY AND DURATION)

NAME/SIGNATURE OF PERSON FILLING OUT THE FORM	DATE
ATTENDING/PRESCRIBING PHYSICIAN NAME	ADDRESS
TELEPHONE NUMBER	FAX NUMBER
ATTENDING/PRESCRIBING PHYSICIAN SIGNATURE	DATE

MO 580-2915N (7-08)

Notice of Privacy Practices

This notice describes how the Missouri Department of Health and Senior Services may use and/or disclose medical information about you, and how you can get access to this information. Please review it carefully.

The Department of Health and Senior Services' (DHSS) mission is to protect and promote the health of Missourians. To do this, Missouri has enacted state laws and/or rules that require reporting of individually identifiable protected health information (PHI) to DHSS. These laws detail what data are confidential, under what circumstances the data may be disclosed, and penalties for inappropriate disclosures. DHSS staff and their associates are required to follow these laws. DHSS uses this and other health information to continuously assess the health of the population.

DHSS may disclose your health information to health care providers to carry out treatment, payment or health care operations. This information will only be shared with health care providers that have signed an agreement with DHSS or who have a direct treatment relationship with you. It will not be used for any other purpose except in an aggregate form that does not identify you, without your specific written consent or that of your guardian, durable power of attorney for health care, or parent, if you are a minor. Confidentiality of the information will be maintained as required by applicable state and federal laws. An example of these types of disclosures would be sharing your baby's newborn screening results only with your baby's doctor and not the general public or merchants that have a product they wish to sell you. Another example of a disclosure would be sharing your health information with an in-home services provider in order to coordinate care and services you receive.

The DHSS may contact you to provide appointment reminders or information about health-related benefits and services that may be of interest. DHSS may also disclose protected health information to other state or federal agencies such as MoHealthNet that provide funds for health care benefits an individual receives.

Under 45 CFR 160-164, you have the right to:

- Ask us to limit what we use or share. DHSS is not required to agree, and may say "no" if it would affect your care or if disclosure is required by state or federal law.
- Get a copy of your health care information, including laboratory tests. You may be charged a cost-based fee for copies.
- Ask us to amend or update your health care information if it is inaccurate.
- Get a list of those with whom we have shared information.
- Request confidential communications.
- Get a paper copy of this notice.
- Be notified if a breach occurs that may have compromised the privacy or security of your information.
- File a complaint if you feel your rights are violated.

The DHSS reserves the right to change its privacy practices described in this notice. The revised privacy practices will be effective for all PHI maintained by DHSS. DHSS will publish all revisions on the DHSS website at www.health.mo.gov. You may access and print a copy of the current policies or request a printed copy from DHSS. Requests for copies of your health care information may be sent in writing to DHSS at P.O. Box 570, Jefferson City, MO 65102, and should specify the information requested.

If you think your privacy rights have been violated or have questions about HIPAA, you may contact the Secretary of the U.S. Department of Health and Human Services, Region VII, Office of Civil Rights at 601 East 12th Street, Room 248, Kansas City, Missouri 64106, www.hhs.gov/ocr/privacy/hipaa/complaints/, 1-800-368-1019 (telephone), 1-816-426-3686 (fax). We will not retaliate against you for filing a complaint.

For further information about this notice or if you think DHSS has violated your privacy rights, contact the DHSS Privacy Officer at 1-800-392-0272. This notice is effective as of October 1, 2014.

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
P.O. BOX 570 JEFFERSON CITY, MO 65102-0570
TELÉPHONE: 573-751-6400 FAX: 573-751-6010

RELAY MISSOURI for Hearing
and Speech Impaired 1-800-735-2966
VOICE: 1-800-735-2466

PRIVACY POLICIES ACKNOWLEDGEMENT FORM

1. CLIENT NAME (PRINT CLIENT'S FIRST NAME, MIDDLE INITIAL AND LAST NAME)		
2. CLIENT DATE OF BIRTH (M/D/Y)	3. CLIENT SOCIAL SECURITY NUMBER	4. CLIENT DCN (IF APPLICABLE)

I acknowledge that I have been given a copy of the Missouri Department of Health and Senior Services Notice of Privacy Policies and have been told where I can obtain any revisions made to this Notice.

PRINT THE FIRST NAME, MIDDLE INITIAL AND LAST NAME OF THE CLIENT/PARENT/GUARDIAN/DURABLE POWER OF ATTORNEY FOR HEALTH CARE

SIGNATURE OF THE CLIENT/PARENT/GUARDIAN/DURABLE POWER OF ATTORNEY FOR HEALTH CARE (DPOA-HC)	DATE

NOTE: If this document is signed by the Guardian or Durable Power of Attorney for Health Care, attach a copy of the Letters Appointing the Guardian or a copy of the Durable Power of Attorney for Health Care.

Please check one of the following to indicate the relationship between the client and the person whose signature appears on the line above:

- ☐ CLIENT
- ☐ CLIENT'S PARENT
- ☐ CLIENT'S GUARDIAN
- ☐ CLIENT'S DPOA-HC
- ☐ CLIENT REFUSED TO SIGN FORM

(For Staff Use Only)

Name of Bureau or Program

Address **City** **State** **Zip**

Staff Signature (if present when Notice provided) **Date**

Print Name

MO 580-2833 (7-07)

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF SPECIAL HEALTH CARE NEEDS
CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS

PRIOR AUTHORIZATION REQUEST

☐ NEW REQUEST
☐ CONTINUED REQUEST
☐ AMENDED REQUEST

Authorization approves the medical necessity of the requested service only. It does not guarantee payment, nor does it guarantee that the amount billed will be the amount reimbursed. Third party payers must be exhausted. The participant must be enrolled in the Children and Youth with Special Health Care Needs (CYSHCN) Program on the date of service. The provider must also be an enrolled provider on the date of service. CYSHCN Claims Submission Guidelines can be found at: www.health.mo.gov/living/families/shcn/pdf/ClaimsGuide.pdf.

NAME (LAST, FIRST, M.I.)	DATE OF BIRTH (MM/DD/YYYY)	DCN
ADDRESS	CITY	STATE / ZIP CODE
RELATED DIAGNOSIS CODE	DIAGNOSIS DESCRIPTION	SC ASSESSMENT (SCA) DATE

	BEGIN DATE OF SERVICE	END DATE OF SERVICE	HCPCS/CPT CODE	DESCRIPTION	AUTHORIZED REIMBURSEMENT AMOUNT	APPROVED	DENIED
1					$	☐	☐
2					$	☐	☐
3					$	☐	☐
4					$	☐	☐
5					$	☐	☐
				PA TOTAL	**$**		

DETAILED EXPLANATION OF MEDICAL NECESSITY FOR SERVICES OR EQUIPMENT. ATTACH PAGES AS NECESSARY.

THIRD PARTY PAYER INFORMATION

Insurance:	Yes ☐ No ☐	Name:	Deductible: $
	Is the item/service excluded from coverage? Yes ☐ (Documentation attached) No ☐		
MO HealthNet:	Yes ☐ No ☐	Spend Down: Yes ☐ (Amount, if known) $ No ☐	
	Is the item/service excluded from coverage? Yes ☐ (Documentation attached) No ☐		
Other:			

ENROLLED PROVIDER	**FOR CENTRAL OFFICE USE ONLY**
CONTACT NAME	**LETTER OF MEDICAL NECESSITY** ☐ RECEIVED ☐ APPROVED ☐ DENIED
PAYMENT ADDRESS	**PRICE QUOTE / INVOICE** ☐ RECEIVED ☐ APPROVED ☐ DENIED
CITY, STATE, ZIP	**ORTHODONTIC TREATMENT PLAN** (INCLUDING PICTURES) ☐ RECEIVED ☐ APPROVED ☐ DENIED
PHONE NUMBER	**DENIAL REASON**
SIGNATURE, SERVICE COORDINATOR	SIGNATURE, PROGRAM MANAGER
DATE	DATE

Rev. 6/24/15

CYSHCN Prior Authorization Request Instruction Form

Request Type: Check the box next to the type of request you are submitting.

- New: A request that was not being considered by CYSHCN in the previous (immediately preceding) authorization period.
- Continued: A request that CYSHCN is currently reimbursing for that needs to be extended into a new fiscal year or authorization period.
- Amended: A request that is currently being reimbursed by CYSHCN but has had a change occur to either units, time, or cost authorized.

Name: Full name as listed in MOHSAIC. Do not use alias or nicknames.

Date of Birth: Month/Day/Year of birth as listed in MOHSAIC.

DCN: Departmental Client Number as listed in MOHSAIC. If the participant is listed with more than one DCN, notify PM so the multiple DCNs may be merged.

Address, City, State/Zip: Participant's complete address as listed in MOHSAIC. If the participant has recently moved or there is a discrepancy, please update MOHSAIC before listing the new address on the PA form.

Primary Diagnosis Code: The ICD code that the requested service is most directly related to. The code must be active and CYSHCN eligible for the participant. Codes that require review and have not been approved in MOHSAIC by the PM are not acceptable to use on the PA form.

Diagnosis Description: Description of the diagnosis code listed in the previous field. This may be obtained from MOHSAIC, the participant's Health Certification Form or an ICD Code Book.

SC Assessment (SCA) Date: The date the SCA was completed with the participant/family as listed in Web MOHSAIC. Not the date it was started (if it was not completed on the same day) or the date it was entered. However, the SCA must be completely entered in Web MOHSAIC prior to the PA request being considered.

Begin Date of Service: The first day CYSHCN will consider reimbursing for the service. Not the first date the service was delivered. This date should not precede the date of the SC Signature authorizing services, unless prior approved by PM.

End Date of Service: The last day of the documented length of need, authorization period or fiscal year for which CYSHCN will consider reimbursing for the service. On-going requests end date on 12/31 or 6/30 depending on type of service. Therapies are typically authorized no longer than six months at a time, then re-evaluated; unless otherwise stated in the letter of medical necessity and prior approved by the PM. A PA may not cross fiscal years.

Service or Equipment Description:

- Service code and description of service or equipment being requested. Provider will be able to supply the service code when submitting their price quote (UCR).
- Also include the calculation for recurrent monthly expenses. UCR x quantity per month = monthly UCR x reimbursement rate = CYSHCN monthly reimbursement x no. of months in the authorization period = total authorized reimbursement amount.

9/13/10

Authorized Reimbursement Amount: The total authorized reimbursement amount for the entire authorization period. Not a monthly total for recurrent expenses. For one time reimbursements: UCR x reimbursement rate or the 'agreed upon rate', whichever is lower.

Approved/Denied: A check mark must be in the column indicating if each line item on the request was approved or denied. This will be done by the SC on requests that do not require PM approval. PM will place the check mark on all other requests.

Detailed Explanation of Medical Necessity for Services or Equipment:

- Purpose for the request as it relates to the participant's eligible diagnosis. You may simply reference the letter of medical necessity, if it accompanies the PA.
- Reference private insurance and MO HealthNet status.
- Note if the service/item is excluded from coverage. If so, documentation of the exclusion must accompany the PA request.
- Note any amount that insurance has agreed to pay (i.e. up to $500 or 80%). This amount is subtracted from the CYSHCN reimbursement amount, not the UCR.

Enrolled Provider: The SHCN provider as listed in Web MOHSAIC.

Contact Name: The person affiliated with the SHCN enrolled provider that supplied you with the PA information.

Address/City/State/Zip: The provider's complete billing address as listed in Web MOHSAIC (SC Payment Address). Not their physical location.

Denial Reason: For Central Office/PM use only.

Service Coordinator Signature & Date: The date the PA is completed, signed and sent to Central Office.

For Internal Use Only: For Central Office/PM use only.

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SPECIAL HEALTH SERVICES (SHS)
PO BOX 570, JEFFERSON CITY, MO 65102-0570
PHONE: 573-751-6246, FAX: 573-751-6237

RIGHTS AND RESPONSIBILITIES

The following programs are part of SHS: Children and Youth with Special Health Care Needs (CYSHCN), Healthy Children and Youth (HCY), Medically Fragile Adult Waiver (MFAW), and Adult Brain Injury (ABI). As a participant or family participating in any of these programs you have the following rights and responsibilities:

RIGHTS:

- You are entitled to the assignment of a Service Coordinator. This person helps to develop a plan based on service needs and goals that you and your family identify. Each service must be fully understood, how and why it is being provided, and who is responsible for payment. Any changes in the plan will be discussed with you.
- You have the right to request that services be discontinued at any time.
- You have the right at any time to review your record. Information and records of service are confidential and will not be released without your authorization, except as permitted or required by law. (SHS is required to share information with Department of Social Services, as needed, to assure appropriate medical service for MO HealthNet recipients.)
- You have the right to appeal decisions about the services you are receiving. To initiate this process for:
  - CYSHCN and ABI Programs, you must submit a written statement of your concerns to your Service Coordinator. You may expect a written response after your concerns have been reviewed and examined.
  - HCY and MFAW Programs, you must contact MHD Participant Services Unit, PO Box 6500, Jefferson City, MO 65101-6500, in writing or by phone at 1-800-392-2161.

RESPONSIBILITIES:

- Actively participate in completion of an Assessment and the development of a Service Plan, which includes choosing a provider.
- Actively participate in the development and implementation of a treatment plan for provider services.
- Keep SHS and provider appointments, or request in advance that they be changed.
- Express your opinions and concerns to your Service Coordinator and ask questions when you do not understand.
- Apply for benefits from all agencies/resources that may be able to provide assistance.
- Complete an initial application and provide information as requested to determine and maintain program eligibility.
- Notify SHS immediately of any changes in information such as: your address, telephone number, family size, income, guardian status and/or medical condition.
- Inform the Service Coordinator of any benefits or services you receive from any other agency such as MO HealthNet, Medicare, Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), Insurance, Vocational Rehabilitation, Department of Mental Health, Department of Health and Senior Services, and any other program.
- Respond promptly to requests made by your Service Coordinator or SHS staff.
- For participants in the CYSHCN Program, you shall make sure the service provider will accept CYSHCN payment and present the CYSHCN Eligibility Card to the service provider before covered services are delivered. If you have private insurance or MO HealthNet, you shall utilize in-network providers.
- For participants in the CYSHCN Program, you shall notify the Service Coordinator prior to receiving medical services that require prior authorization through the CYSHCN Program.
- For participants in the CYSHCN Program, you shall reimburse CYSHCN for the amount expended when you receive money from third party or insurance related to the injury, disability, or disease for which you are covered under the CYSHCN Program.
- For participants in the ABI Program, you shall maintain a lifestyle that does not interfere with active participation in any services provided through the program.

Failure to comply with any of these responsibilities may result in discontinuation from service. If you have questions or concerns, contact your Service Coordinator or call the toll free number (800) 451-0669.

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SPECIAL HEALTH SERVICES (SHS)
PO BOX 570, JEFFERSON CITY, MO 65102-0570
PHONE: 573-751-6246, FAX: 573-751-6237

RIGHTS AND RESPONSIBILITIES ACKNOWLEDGEMENT FORM

PARTICIPANT NAME	DCN

Program: ☐ CYSHCN ☐ HCY ☐ MFAW ☐ ABI

AS A PARTICIPANT, I ACKNOWLEDGE BY SIGNING THIS FORM THAT:

1) **I HAVE BEEN INCLUDED IN THE DISCUSSION OF MY RIGHTS AND RESPONSIBILITIES.**
2) **I HAVE RECEIVED A COPY OF MY RIGHTS AND RESPONSIBILITIES.**
3) **I CHOOSE TO CONTINUE MY PROGRAM ENROLLMENT.**

PARTICIPANT/GUARDIAN SIGNATURE	SERVICE COORDINATOR/WITNESS SIGNATURE
DATE	DATE

Fees for Medical Records

Providers enrolled with Special Health Services (SHS) are not eligible to receive payment for medical records per Children and Youth with Special Health Care Needs (CYSHCN) Program Provider Billing Guidelines.

Requested medical records should be **sent to**:

Attention: Name of Service Coordinator
LPHA/Agency's Name
LPHA/Agency's Address
LPHA/Agency's City, State, Zip

All invoices must be **billed to**:

Department of Health and Senior Services - Special Health Services
P.O. Box 570
Jefferson City, MO 65102

Providers that bill SHS must itemize the handling and per page fees for medical records in order to have their invoices accepted and processed. Invoices billed to the contracted agencies will not be accepted.

By February 1 each year, the annual adjustment and the adjusted handling and per page fees will be posted on the Department of Health and Senior Services' website at: http://health.mo.gov/atoz/fees.php.

Direct Deposit is a requirement of the Department of Health and Senior Services. To receive payment for Medical Records, a Vendor Input/ACH-EFT Application must be completed and submitted. The application and instructions may be obtained at http://health.mo.gov/living/families/shcn/cshcnproviders.php. Completed applications may be faxed to Special Health Services (SHS) at 573/522-2107, attention Provider Relations.

Usage Data Sheet

Please complete this form and forward to, Central Office, fax (573) 751-6237 or e-mail (SHCNCentralOffice@health.mo.gov).

Date _____ Time _____ Language _____

Name _____ Title _____

Regional Office Name
and/or
SHCN Contractor's Name _____

Program _____

Telephone Number Used to Make Call _____

Client's Name _____

Client's DCN _____

Name of Interpreter _____

Interpreter # _____

Revised 11/20/2014

How to Use Interactive Voice Response (IVR)

Step 1: **Call 1 888-338-7394**

Step 2: Enter Account Number **16675**, followed by # sign

Step 3: Select 1 to be connected directly to your Spanish interpreter, *or*
Select 2 to be connected directly to your Russian Interpreter, *or*
Select 3 to be connected directly to your Vietnamese interpreter, *or*
Select 4 to be connected directly to your Somali Interpreter, *or*
Select 9 for all other languages

***If you require a 3rd party call, press 9 to reach a Customer Service Representative**

Step 4: Enter Location Code **920**, followed by # sign

IVR FAQs:

What if I do not know my Account number?
You do need this information in order to reach the interpreter directly. If you are unsure of your account number, wait and the system will direct you to a live operator who will look up your account.

What is IVR?
IVR stands for Interactive Voice Response. CTS LanguageLink's IVR system allows a customer to quickly select the language desired for interpretation and be connected immediately to an interpreter without interaction with a live attendant. The benefit of this is an even faster connect time to your interpreter and better service to your limited English proficient (LEP) client.

What is a third party call?
A third party call is when you need CTS LanguageLink to call the LEP client and then bridge the call together with you and the interpreter.

How do I make a third party call with CTS LanguageLink?
If you need a third party call, **press 9** ***(even for Spanish)*** to reach a Customer Service Representative (CSR) and let the operator know you need a third party call. We are happy to assist you with this at no additional charge. Our ***interpreters are not able to make the third party call*** directly.

I need another language other than the ones listed. How do I get my interpreter on the line?
Press 9 for other languages and let the CSR know which language you require and they will connect you. If the language is unknown, you may reference the "Point to your Language" visual for help with most requested languages or ask a representative for assistance.

Please contact our Client Relations Team if you have any further questions:

Email: clientrelations@ctslanguagelink.com
Toll Free: 1 (855) 579-2704

TIPS AND ADVICE

How to Work with a Telephone Interpreter

YOUR ROLE

Telephone interpreters may receive several calls a day—each one requiring special attention in a specific field. When working with an interpreter over the phone, there are a few things you should keep in mind to ensure your call is handled quickly and successfully.

- Always speak in first person, just as you would in normal conversation. For example, say, "Do you have a fever?" rather than "Ask her if she has a fever, please."
- Immediately introduce yourself to the limited-English proficient (LEP) client and explain your reason for calling.
- Telephone interpretation is "consecutive" interpretation. That means you will experience pauses when the interpreter repeats each statement in the respective language.
- After you speak one-two sentences or finish a thought, pause to give the interpreter enough time to interpret.
- Be prepared to explain some things in more detail for the telephone interpreter. Some terminology and concepts may not have an equivalent in the target language.
- Control the conversation. The telephone interpreter is only there to interpret. You are responsible for making sure the LEP client receives the same service as an English-speaking client.
- Ask the interpreter and the LEP client questions to ensure they understand what you want to communicate.
- Avoid asking the interpreter for his/her opinion about the situation being interpreted.
- We can accommodate three-way telephone interpretation calls. Tell the call center agent the name and phone number of the third party, and they will arrange the call for you. The interpreter cannot facilitate this for you. You must ask the call center agent at the beginning of the call.
- Follow up by providing us with feedback about your interpretation services.

YOUR TELEPHONE INTERPRETER'S ROLE

We expect our interpreters to meet high standards and want to know when they are meeting our expectations. To that end, your feedback is critical

- Make sure your interpreter introduces himself/herself using a first name and ID number. They are not required to provide a last name.
- Your interpreter should not have a side conversation with you or the client. He or she must relay everything that is said back to you or your client. This includes any advice that the client may ask of the interpreter.
- Your interpreter should not discuss anything unrelated to the telephone interpretation assignment.

More questions about telephone interpretation? Contact us at 1-866-610-1338 or email info@ctslanguagelink.com.

Special Health Care Needs (SHCN)
Claims Submission Guidelines for CYSHCN Program

BILLING REMINDERS:

- The participant must be actively enrolled in the CYSHCN Program on the date of service.
- The provider must be an enrolled CYSHCN provider on the date of service.
- The provider must be in-network for the participant's private insurance, including MO HealthNet, for CYSHCN to consider reimbursement.
- The provider must submit claims on the appropriate billing form (CMS-1500, UB-04, or Dental Claim Form).
- A copy of the Explanation of Benefits (EOB) indicating the reimbursement received from insurance, a rejection statement, and/or the MO HealthNet Remittance Advice (RA) including an explanation and/or denial codes must be submitted with the claim.
- CYSHCN must receive provider claims within *60 calendar days* of the date of service or within *60 calendar days* of the EOB/RA process date but no longer than 6 months from the date of service.
  - Services delivered prior to June 30th must be submitted to CYSHCN no later than July 31st due to fiscal year limitations. CYSHCN is under no obligation to pay claims for dates of service in the prior fiscal year if these claims are submitted after July 31st.
- The provider must bill the Usual and Customary Rate (UCR) for all services, not the CYSHCN reimbursement amount.
- CYSHCN will consider the patient responsibility, up to the authorized reimbursement amount, after insurance has been exhausted.
- CYSHCN reimbursement for eligible services must be accepted as payment in full.
  - The provider cannot request payment for eligible services from CYSHCN participants or their families.
- Some services require prior authorization which must be obtained prior to delivery of services.
- CYSHCN will consider limited funding for eligible medical conditions up to $25,000 annually per participant.
- CYSHCN is the payer of last resort.
- CYSHCN may request medical records to assist in determining if services will be covered.

PHARMACY CLAIMS:

- Health Insurance Claim Form (CMS-1500),
- NDC – National Drug Code
- Name of medication (generic or brand name),
- Insurance EOB/MO HealthNet RA or insurance payment amount, and
- Participant's/Family's financial responsibility.

HEARING AID CLAIMS:

- Health Insurance Claim Form (CMS-1500 or UB-04),
- Insurance EOB (if applicable),
- MO HealthNet RA (if applicable), and
- Hearing Aid Invoice (wholesale cost).

DURABLE MEDICAL EQUIPMENT (DME) CLAIMS:

- Health Insurance Claim Form (CMS-1500),
- Insurance EOB (if applicable), and
- MO HealthNet RA (if applicable).

DENTAL CLAIMS:

- Health Insurance Claim Form (CMS-1500) or Dental Claim Form,
- Insurance EOB (if applicable), and
- MO HealthNet RA (if applicable).

Reimbursement of charges will be denied or delayed if specified claim attachments are not received.

Provider Enrollment/Questions:
(573) 751-6246

Claims Questions:
(573) 751-6245

Claims and supporting documentation should be sent to:
Special Health Care Needs
PO Box 570
Jefferson City, MO 65102
OR
Claims Fax: (573) 522-2107

For prior authorization requirements and reimbursement information visit:
http://www.health.mo.gov/living/families/shcn/pdf/cshcnrateschedule.pdf

3/3/14

PROVIDER APPEAL PROCESS:
Special Health Care Needs (SHCN) enrolled providers have the right to appeal decisions regarding denial of payment for services.

To appeal a decision made by SHCN, the provider must submit the following documentation to the Program Manager within *thirty (30) calendar days* of the SHCN warrant/voucher date:

- A letter describing the reason for the appeal;
- Documentation to support overturning the denial; and
- A copy of the claim being appealed.

The Program Manager will review the documentation and render a written decision to the provider within *thirty (30) business days* of the receipt of the appeal.

If the decision is unsatisfactory, the provider may submit a second appeal letter addressed to the Bureau Chief. The appeal and supporting documentation must be received by SHCN within *thirty (30) calendar days* of the Program Manager's written decision date. The Bureau Chief will review the documentation and render a written decision to the provider within *thirty (30) business days* of the receipt of the appeal.

If the decision is unsatisfactory, the provider may submit a final appeal letter to the Department Director, or designee. The appeal and supporting documentation must be received by SHCN within *thirty (30) calendar days* of the Bureau Chief's written decision date. The Department Director will make a final decision based on the evidence and documentation submitted with the appeal. A letter outlining the Director's decision will be mailed to the provider within *thirty (30) business days* of the receipt of the appeal.

CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS (CYSHCN) PROGRAM REIMBURSEMENT RATES

(For dates of service on or after 7/1/14)

SERVICE*	PRIOR AUTHORIZATION REQUIREMENTS**	REIMBURSEMENT RATE
AUDIOLOGICAL PROCEDURES	Required through PM regardless of cost for service plan entry	**80% UCR**
DENTAL (Up to 2 routine dental check-ups annually)	Not required	**80% UCR**
DENTAL (Orthodontic/Prosthodontic Procedures including Extractions)	Required through PM regardless of cost	**80% UCR**
DURABLE MEDICAL EQUIPMENT Includes:		
General DME	Required if greater than $300	**80% of UCR**
Repair	Required regardless of cost	**80% of UCR**
Rental (Up to purchase price)	Required regardless of cost	**Negotiated through Prior Authorization**
Orthotic & Prosthetic Devices	Required if greater than $300	**80% of UCR**
Augmentative Communication Evaluation & Device	Required through PM regardless of cost	**80% of UCR**
Disposable Supplies (Diapers, etc.)	Required if greater than $300	**80% of UCR**
Hearing Aids	Required through PM regardless of cost	**Wholesale cost plus 10%**
Cochlear Implants, FM Systems & Magnifiers	Required through PM regardless of cost	**80% of UCR**
Ear Molds	Required for service plan entry	**80% of UCR**
Hearing Aid Accessories	Required if greater than $300	**80% of UCR**
Hearing Aid Repair	Required regardless of cost	**80% of UCR**
EMERGENCY CARE CENTERS	Notification required within three (3) business days for service plan entry	**80% of UCR up to MO HealthNet Inpatient per diem rate**
EMERGENCY TRANSPORTATION	Not required	**80% UCR**
HEMOPHILIA FACTOR	Required for service plan entry	**Average Wholesale Price – 10.43% + Dispensing Fee**
INPATIENT HOSPITALIZATION Includes:	Required through PM regardless of cost:	
Evaluation & Treatment for Eligible Condition including Surgery & Special Procedures	Required for service plan entry	**80% of UCR up to MO HealthNet Inpatient per diem rate**
INTERPRETER FEES	Required for service plan entry	**$8.00/unit (1 unit equals 15 minutes)**
MEDICAL NUTRITIONAL SERVICES	Required through PM regardless of cost	**$16.50/unit (1 unit equals 15 minutes)**
OFFICE/OUTPATIENT CLINIC VISIT	Not required	**$25 Established Patient $60 New Patient**
OFFICE VISIT PROCEDURES	Required for service plan entry	**80% of UCR up to MO HealthNet Inpatient per diem rate**

CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS (CYSHCN) PROGRAM REIMBURSEMENT RATES

(For dates of service on or after 7/1/14)

OUTPATIENT PROCEDURES & SURGERY Includes:	Required through PM regardless of cost:	
Emergency	Notification required within three (3) business days for service plan entry	**80% of UCR up to MO HealthNet Inpatient per diem rate**
Non-Emergency	Required for service plan entry	**80% of UCR up to MO HealthNet Inpatient per diem rate**
PROFESSIONAL FEES – INPATIENT/OUTPATIENT (Ambulatory Surgical Centers, Anesthesiology, Consultation, Emergency, Pathology, Radiology & Special Procedures)	Not required	**Up to $100 paid in full. Balance of $100 or more, paid at 54% with a maximum reimbursement of $800 a day**
PRESCRIPTION MEDICATIONS Includes:		
Formula (Specialized)	Required through PM regardless of cost	**90% of UCR**
Pharmacy, Physician's Office & Treatment Center	Required for service plan entry	**90% of UCR**
THERAPIES/EVALUATIONS Includes:		
Auditory Therapy	Required through PM regardless of cost	**$16.50/unit (1 unit equals 15 minutes)**
Occupational Therapy	Required through PM regardless of cost	**$16.50/unit (1 unit equals 15 minutes)**
Physical Therapy	Required through PM regardless of cost	**$16.50/unit (1 unit equals 15 minutes)**
Respiratory Therapy	Required through PM regardless of cost	**$16.50/unit (1 unit equals 15 minutes)**
Speech Therapy	Required through PM regardless of cost	**$16.50/unit (1 unit equals 15 minutes)**
Evaluations/Re-Evaluations	Not required	**$60**

** Services must be medically necessary and directly related to the participant's eligible condition for CYSHCN to consider payment.*

*** Services exceeding $300 annually require prior authorization from the CYSHCN Service Coordinator. Services exceeding $2,500 annually require prior authorization through the CYSHCN Program Manager (PM).*

Rates are subject to change. For current reimbursement rates refer to:
http://health.mo.gov/living/families/shcn/pdf/cshcnrateschedule.pdf

For current claims submission guidelines refer to:
http://health.mo.gov/living/families/shcn/pdf/ClaimsGuide.pdf

CYSHCN will consider limited funding for eligible medical conditions up to $25,000 annually per participant.

PA and Service Plan Tip Sheet

- Refer to the CYSHCN Reimbursement Rate Schedule at http://health.mo.gov/living/families/shcn/pdf/cshcnrateschedule.pdf and the CYSHCN Prior Authorization Guidebook policy.
- PAs and supporting documentation should be emailed to Sam McElwaine and Linda Wilkerson and copy me. Include the participant's initials and service/supply/equipment being authorized in the subject line.
- No prior authorization of funding will be considered if the most current SCA (including entry in MOHSAIC) is more than 12 months old.
- Do not cross fiscal years in a PA or service plan line item. If a service is to extend beyond 6/30 of a particular year, a new line item ('Begin Date' of 7/1) must be completed.
- CYSHCN does not consider pre-payment for service. Payment will be considered on or after the first date of service.
- A HCPCS/CPT code must be included for each line item.
- 'Begin' and 'End Dates' must be included for each line item.
- 'Begin Date' cannot precede SC signature/submission date.
- Demographical information must match the participant's information in MOHSAIC.
- 'Related Diagnosis Code' must be an active and eligible diagnosis listed in the participant's MOHSAIC medical screen.
- The 'Authorized Reimbursement Amount' listed on the PA should reflect the total reimbursement amount for the entire authorization period, not just for one month.
- MHN and private insurance status must be listed by checking the appropriate boxes.
- If the participant has private insurance, the provider must be an in-network provider for the private insurance as well as a CYSHCN provider. The SC is responsible for verifying this prior to submitting a CYSHCN PA Request.
- If an insurance exclusion is listed on a PA, verification must accompany the PA request.
  - A page from the member handbook or a faxed letter on insurance letterhead is required. Verbal confirmation from a provider that an item is not covered will not be sufficient.
  - Once the exclusion has been approved, the provider need not bill private insurance prior to billing CYSHCN.
  - Verification of insurance exclusions must be sent in annually with renewal PAs.
  - If the participant's insurance has not changed, the original exclusion verification may be used by resubmitting it to CO along with the PA renewal.
- If the item is not excluded from private insurance coverage, prior authorize the full amount through CYSHCN as if insurance was not involved.
  - Calculate the assumed patient responsibility in the detailed explanation section of the PA (if known). EX. $500 deductible and 20% co-insurance: $5,000 DME UCR: CYSHCN would actually pay $1,400 ($5,000 - $500 deductible = $4,500 x 20% = $900 + $500 deductible = $1,400).

- In the detailed explanation of the PA state "CYSHCN will consider the remaining patient responsibility up to the above authorized reimbursement amount after private insurance has been exhausted."

- 'Provider Information' must match provider name and SC payment address in MOHSAIC.
- Price quotes (submitted with the PA) must be obtained initially and updated annually thereafter. Price quotes must be in writing, not verbal.
- Letters of medical necessity (submitted with the PA) must be obtained annually unless the condition/need has been established and approved by the PM as "lifetime".
- If a provider allows CYSHCN to pay the MHN approved rate, CYSHCN will authorize and pay the lesser amount between the MHN approved rate and the UCR x CYSHCN reimbursement rate. If the MHN rate is the lesser, the CYSHCN reimbursement rate is not applied.
  - CYSHCN pays 100% of the MHN approved rate.
  - The rate must be identified as an "agreed upon rate" or "MHN rate" on the PA and in service plan comments.
- Shipping and handling fees are not reimbursable through CYSHCN. The only exception is for hearing aids.
  - To reduce shipping costs, the provider may ship up to a 90 day supply at one time.
- Mileage is not reimbursable through CYSHCN, except for emergency transportation (ambulance).
- DME rental rates are only considered up to the purchase price of the DME. At that point, the DME is owned by the participant.
- Hearing aids are reimbursed at wholesale plus 10%.
  - The price quote must identify the provider's UCR and wholesale cost.
  - A catalog page or order sheet is also acceptable to verify wholesale cost.
- Orthodontic PAs require intra and extra oral pictures (not x-rays) to be submitted.
  - The pictures will need to be scanned in and e-mailed or mailed via postal service. Faxed pictures are not legible enough to ascertain the severity of the condition to establish medical necessity.
  - Private insurance and/or dental insurance benefits or exclusions must be verified prior to submitting the PA. Insurance payments will be deducted from the CYSHCN reimbursement amount. ($5,000 x 80% = $4,000 - $1,500 (insurance) = $2,500)
  - If the participant has MHN but there is not a MHN orthodontic provider within a 50 mile radius of the participant's home, a MHN exclusion is allowed. This needs to be indicated on the PA.
- Specialized formula PAs require a per can price quote as well as a corresponding cost per unit (1 unit = 100 calories) quote. Cost per case quotes are not acceptable unless the quantity requested is in whole cases (2 cases/month, 1 case/month).
  - EX. 48 cans/mos x 350 calories/can = 16,800 calories/100 calories /unit = 168 units x $2.16/unit = $362.88/mos or $7.56/can
- Diaper/Pull-up PAs require a per diaper/pull-up quote **<u>if</u>** what is being requested is not full cases.

- EX. If the request is for two full cases per month then a per case quote is acceptable. If the request is for 186 diapers which equals 1 case plus 30 diapers, then a per diaper quote needs to be obtained.

- If a MHN PA is required for a specific item, the MHN PA denial must be obtained and submitted with the CYSHCN PA.
- MHN PA requirements and quantities allowable by MHN are located in Section 19 of the DME Provider Manual located at: http://manuals.momed.com/collections/collection_dme/print.pdf.
  - ALL requests for items over and above what MHN is already providing (i.e. diapers, catheters, etc) must be approved by PM regardless of cost.
  - These CYSHCN PA requests will need to be accompanied by a MHN PA denial (when applicable) and a letter of medical necessity outlining not only the medical necessity for the item but also the extenuating circumstance(s) that justifies the medical necessity for quantities in addition to what MHN is supplying.
- CYSHCN will consider up to the quantity MHN allows (listed on website above) regardless if the participant has MHN coverage or not.
  - EX: If MHN allows for 30 catheters per month, CYSHCN will consider up to 30 catheters per month.
  - Requests for quantities in excess of what CYSHCN typically considers must be accompanied by a letter of medical necessity outlining not only the medical necessity for the item but also the extenuating circumstance(s) that justifies the medical necessity for the additional quantities being requested.
- PAs for PT, OT, and ST (New or Continued) require procedure codes, frequency of sessions, minutes per session and duration of need. Refer to the PA Info Request form (Tools).
- Interpreter Service: Authorized via service plan entry only. No paper PA is required.
- Paper PAs should not be completed for services when the cost is unknown (outpatient surgeries/procedures, hospitalization, etc…)
  - To prior authorize these services email the pre-certification request to the PM. Include the participant's name, DCN, the service being requested and the related diagnosis. (The PM may also request that a letter of medical necessity be submitted by the provider if the relationship between the requested service and related diagnosis is not evident.)
  - The PM will approve or deny via email correspondence.
- Service plan entry is completed only after a paper PA or email prior authorization request has been approved by the PM.
- The CYSHCN Reimbursement Amount should be listed in the 'Cost per Unit' field of the service plan and thus carried forward to the 'Total Cost' field.
  - The reimbursement calculation must be listed in the service plan comments. (UCR x CYSHCN Reimbursement Rate = Total Cost)
- Prior approval for surgeries/procedures is obtained by emailing the PM with the diagnoses, procedure/surgery being requested and expected date of service. A paper PA is not submitted.
  - A letter of medical necessity, procedure code(s), and estimated cost (if known) may also be required by the PM for review.

    - PM will email the approval/denial to the SC.
    - A service plan must be entered prior to the date of service for claims to be considered for coverage.
- Specific CPT/HCPCS codes should be utilized whenever possible. These should be obtained from the provider in writing along with the letter of medical necessity and price quotes.
- If a CPT/HCPCS code received from a provider and listed on a paper PA is not available in MOHSAIC to enter a service plan, contact CO to request that the code be added.
- If specific codes are unattainable from the provider, the SC may use the following codes for service plan entry as a last resort.
    - 0130 – Prescription – Cost is unknown and will be entered as $0. The specific drug names should be entered in the comment section. CO staff will enter the names of drugs that are received on claims as they are approved by the PM.
    - 0134 – Outpatient Hospital
    - 0135 – Outpatient Hospital Surgery – Cost is usually unknown and entered as $0. The specific surgery should be listed in the comment section.
    - 0133 – Inpatient Hospital – Cost is unknown and entered as $0. Reason for hospitalization (if known) should be entered in the comment section.
    - 0136 – ER Hospital Care – Cost is unknown and entered as $0. Reason for ER visit should be entered in the comment section.
    - A9901 – Shipping - Only reimbursed for hearing aids.
    - 0002 – Services Extended (Inpatient/Outpatient) is not necessary to enter for every participant "just in case". It is not treated as a "catch all". Each service should be authorized individually.
- Service plans using non-specific codes listed above, as well as E1399, require very specific comments to describe the actual service/item being authorized.
- Service plan comments should reflect the comments from the PA, including MHN and insurance billing requirements or exclusions.
- Items/procedures/services that require prior authorization must have the PA approved and/or service plan entered prior to the date of service to be considered for coverage. If not, the service will be denied as 'not authorized care'.
- If a participant closes, notify providers of all active service plans to shift payer responsibility to the family.

CYSHCN Prior Authorization Information Request

DATE

Provider Name
Address Line 1
Address Line 2

RE: Participants Name and DCN

Dear Provider:

A Prior Authorization (PA) is required in order to [continue/begin] coverage of services/supplies for the above named participant. Please complete and return this form along with a letter of medical necessity from the ordering physician. You will receive notification of the PA approval or denial. Dates of service occurring before the begin date of the PA will not be considered for reimbursement. If you have any questions, please contact me.

Sincerely,

SC Name
SC Phone
SC Fax

THERAPY: ☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Other ________________

CPT/HCPCS Code: ____

Length of Need: ____ (Example: 12 weeks, 3 months, 1 year)

Sessions per Week:_______________________

Minutes per Session: _______________________ (15 minutes = 1unit of service)

Representative Signature: ____ Date: ___________________

- -

DME/Supply/Item Requested: ____

CPT/HCPCS Code: ____

Length of Need: __________________________________ (Example 3 months, 6 months, 1 year, lifetime)

Quantity Requested per Month: ____

Usual and Customary Rate (UCR) per unit: ____

Representative Signature: ____ Date: _______________

01/14/15

CYSHCN PRIOR AUTHORIZATION REQUIREMENTS

SERVICE*	PRIOR AUTHORIZATION REQUIREMENTS**
AUDIOLOGICAL PROCEDURES	Required through PM regardless of cost for service plan entry
DENTAL (Cleft Lip and/or Palate Only – Up to 2 routine dental check-ups annually)	Not required
DENTAL (Cleft Lip and/or Palate Only – Orthodontic/Prosthodontic Procedures including Extractions)	Required through PM regardless of cost
DURABLE MEDICAL EQUIPMENT Includes:	
General DME	Required if greater than $300
Repair	Required regardless of cost
Rental	Required regardless of cost
Orthotic & Prosthetic Devices	Required if greater than $300
Augmentative Communication Evaluation & Device	Required through PM regardless of cost
Disposable Supplies (Diapers, etc.)	Required if greater than $300
Hearing Aids	Required through PM regardless of cost
Cochlear Implants, FM Systems & Magnifiers	Required through PM regardless of cost
Ear Molds	Required for service plan entry
Hearing Aid Accessories	Required if greater than $300
Hearing Aid Repair	Required regardless of cost
EMERGENCY CARE CENTERS	Notification required within three (3) business days for service plan entry
EMERGENCY TRANSPORTATION	Not required
HEMOPHILIA FACTOR	Required for service plan entry
INPATIENT HOSPITALIZATION Includes:	Required through PM regardless of cost:
Evaluation & Treatment for Eligible Condition including Surgery & Special Procedures	Required for service plan entry
INTERPRETER FEES	Required for service plan entry
MEDICAL NUTRITIONAL SERVICES	Required through PM regardless of cost
OFFICE/OUTPATIENT CLINIC VISIT	Not required
OFFICE VISIT PROCEDURES	Required for service plan entry
OUTPATIENT PROCEDURES & SURGERY Includes:	Required through PM regardless of cost:
Emergency	Notification required within three (3) business days for service plan entry
Non-Emergency	Required for service plan entry
PRESCRIPTION MEDICATIONS Includes:	
Formula (Specialized)	Required through PM regardless of cost
Pharmacy, Physician's Office & Treatment Center	Required for service plan entry
THERAPIES/EVALUATIONS Includes:	
Auditory Therapy	Required through PM regardless of cost
Occupational Therapy	Required through PM regardless of cost
Physical Therapy	Required through PM regardless of cost
Respiratory Therapy	Required through PM regardless of cost
Speech Therapy	Required through PM regardless of cost
Evaluations/Re-Evaluations	Not required

** Services must be medically necessary and directly related to the participant's eligible condition for CYSHCN to consider payment.*
*** Services exceeding $300 annually require prior authorization from the CYSHCN Service Coordinator.*
*** Services exceeding $2,500 annually require prior authorization from the CYSHCN Program Manager (PM).*

Reporting Date:

CYSHCN Emergency/Disaster Contact Reporting

Reporting Region:

	A	B	C	D	E	F	G	H	I	J
1	**Participant Name**	**DCN**	**Priority**	**Person Contacting Participant/Family (if other than listed Service Coordinator)**	**Service Coordinator**	**Were you able to contact? Yes/No**	**Who were you able to contact (Name and relationship to participant)**	**Was the family affected by the event? Yes/ No**	**Were Referrals made/resources provided? Yes/No**	**Comments (Please comment on how the family was affected and agency/resource family was referred to)**
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34										
35	Number of participants in the affected area	Number Contacted	Number attempted but unable to contact	Number Affected	Number not attempted to contact					
36										
37		% of participants in the affected area contacted	% unable to contact	% of participants/families affected	% remaining to contact					
38		#VALUE!	#VALUE!	#VALUE!	#VALUE!					

* Please email this form to paula.darr@health.mo.gov
*This form does not need to be kept in a participant record.
*All contact with or about the participant is to be documented

Missouri Department of Health and Senior Services
PO BOX 570, JEFFERSON CITY MO 65102-057 Phone: 573-751-6400 FAX: 573-751-6010
RELAY MISSOURI for Hearing and Speech Impaired 800-735-2966 VOICE 800-735-2466
GAIL VASTERLING
DIRECTOR
JEREMIAH W. (JAY) NIXON
GOVERNOR

CURRENT DATE

(PARTICIPANT/FAMILY NAME)
(STREET ADDRESS)
(CITY, STATE, ZIP)

ATTENTION: Participant/Parent/Guardian

(PARTICIPANT NAME) has been determined eligible for the Children and Youth with Special Health Care Needs (CYSHCN) Program. You must present this letter prior to receiving services from an enrolled SHS provider. As payer of last resort, CYSHCN will only consider funding medically necessary diagnostic and treatment services directly related to the conditions listed on the eligibility letter.

You or the provider of services must contact SHS regarding coverage. Services and equipment may require prior authorization. You have the right to appeal decision regarding eligibility, the services received, or the service denied.

For further information, contact SHS at:
(SERVICE COORDINATOR NAME)
(SERVICE COORDINATOR TELEPHONE NUMBER)
Or toll free at 800-451-0669

ATTENTION: Providers of Services

- Providers must be enrolled in SHS prior to the date of service to be eligible for reimbursement. For provider enrollment information please call 800-451-0669.
- Emergency services must be reported to SHS within 72 hours of delivery.
- SHS will discontinue reimbursement when the participant becomes ineligible. The participant will be responsible for all bills incurred after SHS eligibility ends.
- For prior authorization and reimbursement information visit: http://www.dhss.mo.gov/living/families/shcn/pdf/cshcnrateschedule.pdf
- For claims submission guidelines visit: http://www.dhss.mo.gov/living/families/shcn/pdf/ClaimsGuide.pdf

Send all bills to:
Special Health Services
PO BOX 570, JEFFERSON CITY MO 65102
FAX: 573-522-2107

To verify service coverage call:
(SERVICE COORDINATOR NAME)
(SERVICE COORDINATOR TELEPHONE NUMBER)

Eligibility Information

Present to provider before service is received.

PARTICIPANT:	(PARTICIPANT NAME)
DCN:	(PARTICIPANT DCN)
DOB:	(PARTICIPANT DOB)
COVERAGE PERIOD:	(PAID SERVICE ENROLLMENT TO END DATE)

SHS is payer of last resort. All other sources of payment must be exhausted before SHS will consider payment. Limited funding may be considered for medically necessary diagnostic and treatment services directly related to those eligible medical conditions listed.

Diagnostic Services for:

REQUIRED APPROVED LIMITED DIAGNOSES FROM MEDICAL SCREEN

Approved Medical Conditions:

NOT REQUIRED AND REQUIRED APPROVED DIAGNOSES FROM MEDICAL SCREEN

Print from MOHSAIC

CYSHCN SCREENER

The CYSHCN Screener is the first tool utilized when determining an individual's eligibility for the CYSHCN Program. Individuals who answer yes to all three parts of at least one screener question may be eligible to receive service coordination services (at minimum) from the Bureau of Special Health Care Needs (SHCN).

For more information or to make a referral, contact SHCN at **(800) 451-0669** or return the completed CYSHCN Screener to:
Bureau of Special Health Care Needs
P.O. Box 570
Jefferson City, MO 65102
FAX: 573-751-6237

Name: _____ DOB: _____ Address: _____

Responsible Party: _____ Responsible Party Phone: _____

Printed name of person completing Screener: _____ Date: _____

1. Does the individual currently need or use **medicine prescribed by a doctor** (other than vitamins)?
   ☐ Yes → Go to Question 1a ☐ No → Go to Question 2

   1a. Is this because of a physical disability or medical condition?
   ☐ Yes → Go to Question 1b ☐ No → Go to Question 2

   1b. Is this a condition that has lasted or is expected to last for at *least* 12 months?
   ☐ Yes ☐ No

2. Does the individual need or use **more medical care** than is usual for most individuals of the same age?
   ☐ Yes → Go to Question 2a ☐ No → Go to Question 3

   2a. Is this because of a physical disability or medical condition?
   ☐ Yes → Go to Question 2b ☐ No → Go to Question 3

   2b. Is this a condition that has lasted or is expected to last for at *least* 12 months?
   ☐ Yes ☐ No

3. Is the individual **limited or prevented** in any way in their ability to do the things most individuals of the same age can do?
   ☐ Yes → Go to Question 3a ☐ No → Go to Question 4

   3a. Is this because of a physical disability or medical condition?
   ☐ Yes → Go to Question 3b ☐ No → Go to Question 4

   3b. Is this a condition that has lasted or is expected to last for at *least* 12 months?
   ☐ Yes ☐ No

4. Does the individual need or get **special therapy**, such as physical, occupational or speech therapy?
   ☐ Yes → Go to Question 4a ☐ No

   4a. Is this because of a physical disability or medical condition?
   ☐ Yes → Go to Question 4b ☐ No

   4b. Is this a condition that has lasted or is expected to last for at *least* 12 months?
   ☐ Yes ☐ No

To avoid duplication of service, individuals receiving service coordination from another agency are not eligible to receive Service Coordination only.

Children and Youth with Special Health Care Needs (CYSHCN) Program

Description

The CYSHCN Program provides assistance statewide for individuals from birth to age 21 who have or are at increased risk for a disease, defect or medical condition that may hinder their normal physical growth and development and who require more medical services than children and youth generally. The Program focuses on early identification and service coordination for individuals who meet medical eligibility guidelines. As payer of last resort, the CYSHCN Program provides limited funding for medically necessary diagnostic and treatment services for individuals whose families also meet financial eligibility guidelines.

Eligibility

The participant must:

- Be a Missouri resident
- Be birth to age 21
- Have an eligible special health care need (conditions such as Cerebral Palsy, Cystic Fibrosis, Cleft Lip and Palate, Hearing Disorders, Hemophilia, Paraplegia, Quadriplegia, Seizures, Spina Bifida, and Traumatic Brain Injury)
- Meet financial eligibility guidelines for funded services (family income at or below 185% of the Federal Poverty Guidelines)

Services

The CYSHCN Program provides two primary services:

- Service coordination is provided to all participants, regardless of financial status.
  - Outreach/Identification and Referral/Application
  - Eligibility Determination
  - Assessment of Needs
  - Resource identification, referral and access
  - Family support
  - Service Plan Development/Implementation
  - Monitoring and Evaluation
  - Transition/Closure
- Limited funding for medically necessary diagnostic and treatment services for participants whose families meet financial eligibility guidelines.
  - Funded services may include but are not limited to: doctor visits, emergency care, inpatient hospitalization, outpatient surgery, prescription medication, diagnostic testing, orthodontia and prosthodontia (cleft lip/palate only), therapy (physical, occupational, speech and respiratory), durable medical equipment, orthotics, hearing aids, specialized formula, and incontinence supplies.

CYSHCN is payer of last resort. The Service Coordinator will assist the participant/family with resource identification and referral. All third party liability must be exhausted prior to accessing CYSHCN funds.

Special Health Care Needs
PO Box 570
Jefferson City, MO 65102-0570

Phone: (573) 751-6246
Toll-free: (800) 451-0669
http://health.mo.gov/living/families/shcn/

Missouri Department of Health and Senior Services
Special Health Care Needs
Children and Youth with Special Health Care Needs (CYSHCN) Program
Service Coordination Contact Information

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Denesha Snell
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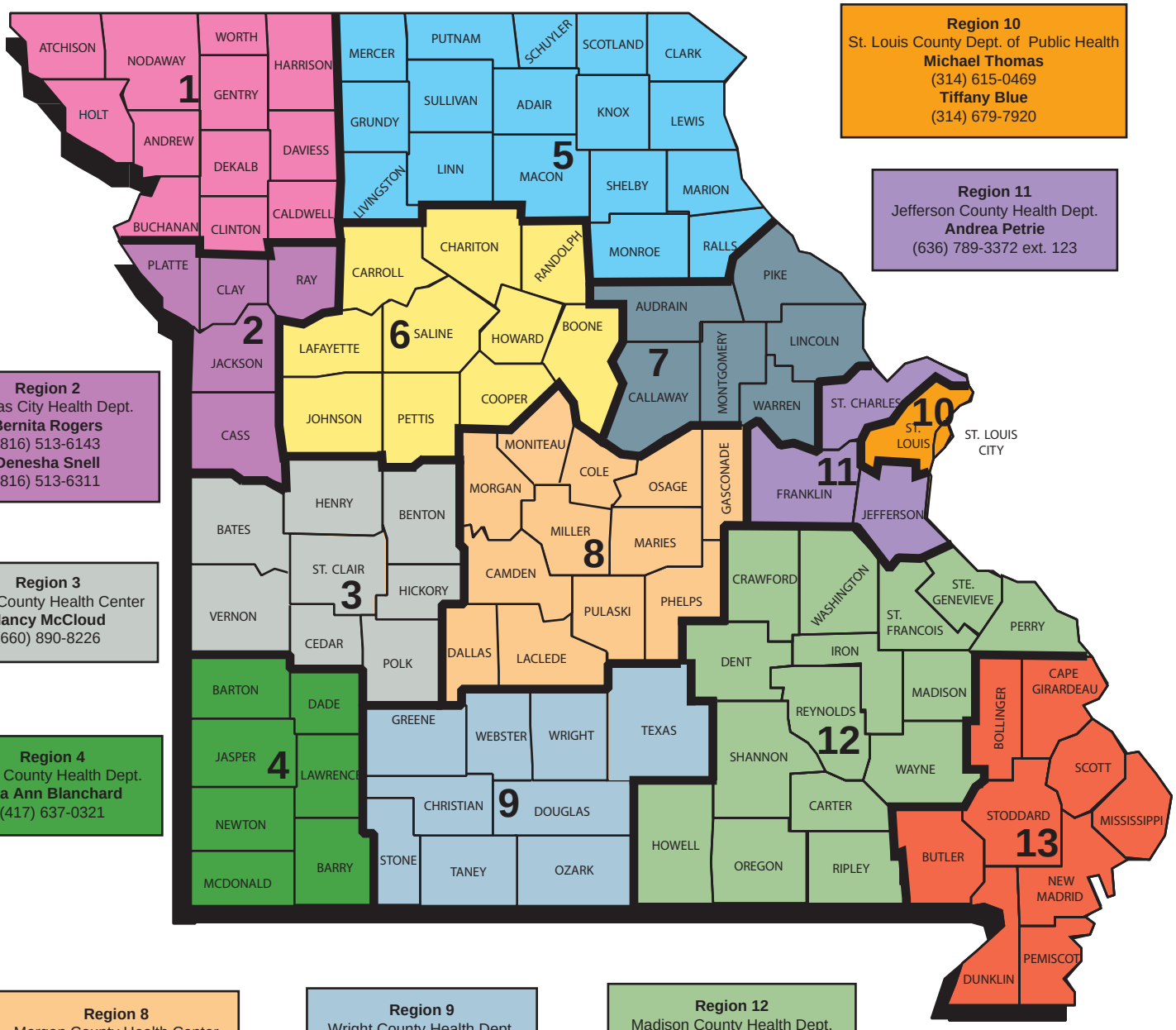
Andrea Petrie
(636) 789-3372 ext. 123



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6.10.15

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PO Box 570
Jefferson City, MO 65102-0570

Phone: (573) 751-6246
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http://health.mo.gov/living/families/shcn/

CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS (CYSHCN) PROGRAM REIMBURSEMENT RATES

(For dates of service on or after 7/1/14)

SERVICE*	PRIOR AUTHORIZATION REQUIREMENTS**	REIMBURSEMENT RATE
AUDIOLOGICAL PROCEDURES	Required through PM regardless of cost for service plan entry	**80% UCR**
DENTAL (Up to 2 routine dental check-ups annually)	Not required	**80% UCR**
DENTAL (Orthodontic/Prosthodontic Procedures including Extractions)	Required through PM regardless of cost	**80% UCR**
DURABLE MEDICAL EQUIPMENT Includes:		
General DME	Required if greater than $300	**80% of UCR**
Repair	Required regardless of cost	**80% of UCR**
Rental (Up to purchase price)	Required regardless of cost	**Negotiated through Prior Authorization**
Orthotic & Prosthetic Devices	Required if greater than $300	**80% of UCR**
Augmentative Communication Evaluation & Device	Required through PM regardless of cost	**80% of UCR**
Disposable Supplies (Diapers, etc.)	Required if greater than $300	**80% of UCR**
Hearing Aids	Required through PM regardless of cost	**Wholesale cost plus 10%**
Cochlear Implants, FM Systems & Magnifiers	Required through PM regardless of cost	**80% of UCR**
Ear Molds	Required for service plan entry	**80% of UCR**
Hearing Aid Accessories	Required if greater than $300	**80% of UCR**
Hearing Aid Repair	Required regardless of cost	**80% of UCR**
EMERGENCY CARE CENTERS	Notification required within three (3) business days for service plan entry	**80% of UCR up to MO HealthNet Inpatient per diem rate**
EMERGENCY TRANSPORTATION	Not required	**80% UCR**
HEMOPHILIA FACTOR	Required for service plan entry	**Average Wholesale Price – 10.43% + Dispensing Fee**
INPATIENT HOSPITALIZATION Includes:	Required through PM regardless of cost:	
Evaluation & Treatment for Eligible Condition including Surgery & Special Procedures	Required for service plan entry	**80% of UCR up to MO HealthNet Inpatient per diem rate**
INTERPRETER FEES	Required for service plan entry	**$8.00/unit (1 unit equals 15 minutes)**
MEDICAL NUTRITIONAL SERVICES	Required through PM regardless of cost	**$16.50/unit (1 unit equals 15 minutes)**
OFFICE/OUTPATIENT CLINIC VISIT	Not required	**$25 Established Patient $60 New Patient**
OFFICE VISIT PROCEDURES	Required for service plan entry	**80% of UCR up to MO HealthNet Inpatient per diem rate**

CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS (CYSHCN) PROGRAM REIMBURSEMENT RATES

(For dates of service on or after 7/1/14)

OUTPATIENT PROCEDURES & SURGERY Includes:	Required through PM regardless of cost:	
Emergency	Notification required within three (3) business days for service plan entry	**80% of UCR up to MO HealthNet Inpatient per diem rate**
Non-Emergency	Required for service plan entry	**80% of UCR up to MO HealthNet Inpatient per diem rate**
PROFESSIONAL FEES – INPATIENT/OUTPATIENT (Ambulatory Surgical Centers, Anesthesiology, Consultation, Emergency, Pathology, Radiology & Special Procedures)	Not required	**Up to $100 paid in full. Balance of $100 or more, paid at 54% with a maximum reimbursement of $800 a day**
PRESCRIPTION MEDICATIONS Includes:		
Formula (Specialized)	Required through PM regardless of cost	**90% of UCR**
Pharmacy, Physician's Office & Treatment Center	Required for service plan entry	**90% of UCR**
THERAPIES/EVALUATIONS Includes:		
Auditory Therapy	Required through PM regardless of cost	**$16.50/unit (1 unit equals 15 minutes)**
Occupational Therapy	Required through PM regardless of cost	**$16.50/unit (1 unit equals 15 minutes)**
Physical Therapy	Required through PM regardless of cost	**$16.50/unit (1 unit equals 15 minutes)**
Respiratory Therapy	Required through PM regardless of cost	**$16.50/unit (1 unit equals 15 minutes)**
Speech Therapy	Required through PM regardless of cost	**$16.50/unit (1 unit equals 15 minutes)**
Evaluations/Re-Evaluations	Not required	**$60**

** Services must be medically necessary and directly related to the participant's eligible condition for CYSHCN to consider payment.*

*** Services exceeding $300 annually require prior authorization from the CYSHCN Service Coordinator. Services exceeding $2,500 annually require prior authorization through the CYSHCN Program Manager (PM).*

Rates are subject to change. For current reimbursement rates refer to:
http://health.mo.gov/living/families/shcn/pdf/cshcnrateschedule.pdf

For current claims submission guidelines refer to:
http://health.mo.gov/living/families/shcn/pdf/ClaimsGuide.pdf

CYSHCN will consider limited funding for eligible medical conditions up to $25,000 annually per participant.

Special Health Care Needs (SHCN)
Claims Submission Guidelines for CYSHCN Program

BILLING REMINDERS:

- The participant must be actively enrolled in the CYSHCN Program on the date of service.
- The provider must be an enrolled CYSHCN provider on the date of service.
- The provider must be in-network for the participant's private insurance, including MO HealthNet, for CYSHCN to consider reimbursement.
- The provider must submit claims on the appropriate billing form (CMS-1500, UB-04, or Dental Claim Form).
- A copy of the Explanation of Benefits (EOB) indicating the reimbursement received from insurance, a rejection statement, and/or the MO HealthNet Remittance Advice (RA) including an explanation and/or denial codes must be submitted with the claim.
- CYSHCN must receive provider claims within *60 calendar days* of the date of service or within *60 calendar days* of the EOB/RA process date but no longer than 6 months from the date of service.
  - Services delivered prior to June 30th must be submitted to CYSHCN no later than July 31st due to fiscal year limitations. CYSHCN is under no obligation to pay claims for dates of service in the prior fiscal year if these claims are submitted after July 31st.
- The provider must bill the Usual and Customary Rate (UCR) for all services, not the CYSHCN reimbursement amount.
- CYSHCN will consider the patient responsibility, up to the authorized reimbursement amount, after insurance has been exhausted.
- CYSHCN reimbursement for eligible services must be accepted as payment in full.
  - The provider cannot request payment for eligible services from CYSHCN participants or their families.
- Some services require prior authorization which must be obtained prior to delivery of services.
- CYSHCN will consider limited funding for eligible medical conditions up to $25,000 annually per participant.
- CYSHCN is the payer of last resort.
- CYSHCN may request medical records to assist in determining if services will be covered.

PHARMACY CLAIMS:

- Health Insurance Claim Form (CMS-1500),
- NDC – National Drug Code
- Name of medication (generic or brand name),
- Insurance EOB/MO HealthNet RA or insurance payment amount, and
- Participant's/Family's financial responsibility.

HEARING AID CLAIMS:

- Health Insurance Claim Form (CMS-1500 or UB-04),
- Insurance EOB (if applicable),
- MO HealthNet RA (if applicable), and
- Hearing Aid Invoice (wholesale cost).

DURABLE MEDICAL EQUIPMENT (DME) CLAIMS:

- Health Insurance Claim Form (CMS-1500),
- Insurance EOB (if applicable), and
- MO HealthNet RA (if applicable).

DENTAL CLAIMS:

- Health Insurance Claim Form (CMS-1500) or Dental Claim Form,
- Insurance EOB (if applicable), and
- MO HealthNet RA (if applicable).

Reimbursement of charges will be denied or delayed if specified claim attachments are not received.

Provider Enrollment/Questions:
(573) 751-6246

Claims Questions:
(573) 751-6245

Claims and supporting documentation should be sent to:
Special Health Care Needs
PO Box 570
Jefferson City, MO 65102
OR
Claims Fax: (573) 522-2107

For prior authorization requirements and reimbursement information visit:
http://www.health.mo.gov/living/families/shcn/pdf/cshcnrateschedule.pdf

3/3/14

Missouri Department of Health and Senior Services
Special Health Care Needs
Children and Youth with Special Health Care Needs (CYSHCN) Program
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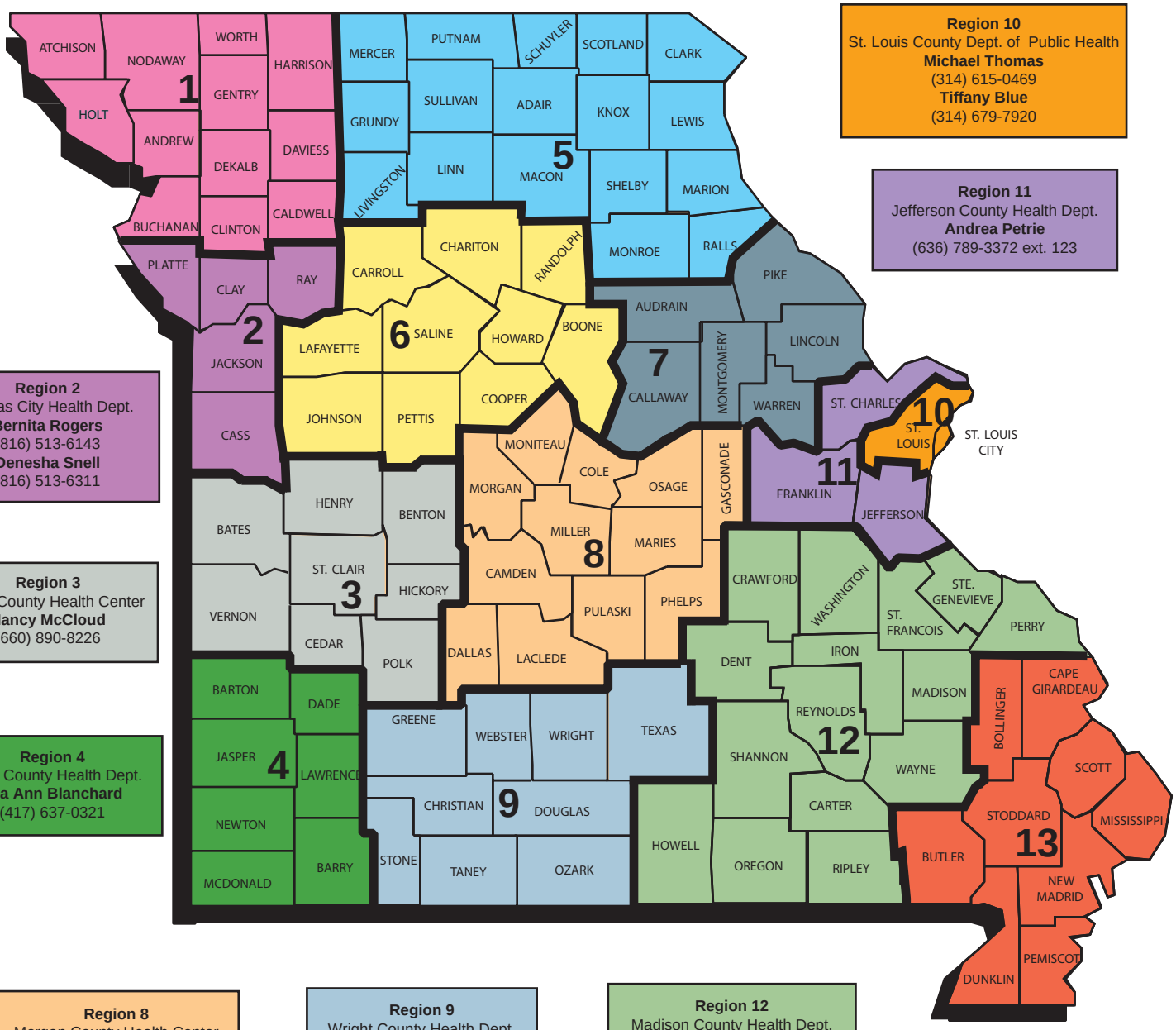

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6.10.15

SPECIAL HEALTH CARE NEEDS
TRANSITION PLAN

PARTICIPANT NAME/DCN_____**MEETING DATE** _____

DOMAIN (HC/E-V/IL)	**TRANSITION ACTION**	**PERSON(S) RESPONSIBLE**	**EXPECTED COMPLETION DATE**	**ACTUAL COMPLETION DATE**

Transition Meeting Participants

_____ NAME/RELATIONSHIP/AGENCY

_____ NAME/RELATIONSHIP/AGENCY

_____ NAME/RELATIONSHIP/AGENCY

_____ NAME/RELATIONSHIP/AGENCY

_____ NAME/RELATIONSHIP/AGENCY

_____ NAME/RELATIONSHIP/AGENCY

3-2-09

SPECIAL HEALTH CARE NEEDS TRANSITION PLAN

INSTRUCTIONS

The purpose of this form is to summarize activities to be completed for transition. The original form is to be kept in the participant's SHCN file. Copies of the form should be provided to the participants of the transition plan meeting. Multiple copies of the form can be used as necessary.

Domain: Enter "HC" (Health Care), or "E/V" (Educational/Vocational), or "IL" (Independent Living)

Transition Action: Enter the action that is expected to occur and the reason for the action.
For example: The participant/family is eligible for SSI. Record "Apply for SSI for determination of eligibility".

Person(s) Responsible: Enter the person(s) or agency responsible for completing the Transition Action.
For example: The participant needs to complete an assessment for Vocational Rehabilitation to determine vocational potential. Record the names of the participant and the Vocational Rehabilitation Counselor.

Expected Completion Date: Record the date that the Transition Action is expected to be completed.

Actual Completion Date: Utilize this column at a later date to record when the Transition Action has been completed.

Transition Meeting Participants: Ask each individual involved in the transition plan meeting to sign the form and record their relationship to the participant and/or the agency they represent. For example: John Doe (participant); Linda Doe (participant's mother); Joe Henry (SHCN Service Coordinator). Signatures are only needed on the first page.

3-2-09

Current Date

Dear Participant/Responsible Party:

The Children and Youth with Special Health Care Needs Program is required to verify financial eligibility each year.

If you **want to** continue receiving services the following information must be submitted by May 31, 2015:

- The enclosed AFER form with all information completed, including your signature and date.
- Copies of your 2014 tax form if you filed federal income tax. DO NOT SEND A W-2. If you do not have a copy of your income tax information, please call the IRS at 800-829-1040 or visit their web site at www.irs.gov .

Services with the Children and Youth with Special Health Care Needs Program **will end on June 30, 2015** if you fail to provide any of the requested information.

If you **do not want** to continue receiving services through the Children and Youth with Special Health Care Needs Program, check the box on the AFER form, sign and date the form, and return it to your Service Coordinator.

If you need assistance, contact your Service Coordinator at the address and phone number listed below.

Service Coordinator Name
Service Coordinator Street Address
Service Coordinator City State Zip

Toll Free: 800-451-0669

Print from AFER Site

CURRENT DATE

NAME
ADDRESS
CITY, STATE, ZIP

REGARDING: PARTICIPANT, Name
DATE OF BIRTH: Date of Birth
DCN: DCN

Dear Participant/Responsible Party:

Special Health Services (SHS) [Select Appropriate Program], must have the following information before processing the Annual Financial Eligibility Review (AFER) application. Respond only to the item(s) marked. The requested information must be returned by May 31, 2015. If SHS does not receive the requested information, service will end effective June 30, 2015.

- ☐ SHS did not receive a copy of your income tax form for 2014. If you do not have a copy of your income tax form, please call the IRS at 800/829-1040 or visit the IRS web site at www.irs.gov. The IRS will send you a copy of your form.
- ☐ The income tax form submitted did not list the participant as a dependent on the income. A copy of the income tax form listing the participant as a dependent is needed.
- ☐ The AFER form indicated you requested an income tax extension. A copy of the extension request form must be sent along with a written statement of your estimated income for 2014.
- ☐ The appropriate person did not sign the AFER form.
- ☐ The AFER form was not complete. Complete the highlighted areas.

If you have questions contact me at the phone number or address listed below.

Sincerely,

Service Coordinator Name
SC Street Address
SC City, State & Zip
Service Coordinator Telephone Number
Toll Free: 800-451-0669

typist initials
c: recipient file

Print from AFER Site

(DATE)

(PARTICIPANT/FAMILY NAME)
(STREET ADDRESS)
(CITY, STATE, ZIP)

REGARDING: (PARTICIPANT NAME)
DATE OF BIRTH: (PARTICIPANT DATE OF BIRTH)
DCN: (PARTICIPANT DEPARTMENT CLIENT NUMBER)

(SALUTATION):

(YOU) (YOUR CHILD) have been referred to the Children and Youth with Special Health Care Needs (CYSHCN) Program for possible assistance. If (YOU) (YOUR CHILD) meets eligibility guidelines, CYSHCN will provide service coordination and may provide financial assistance.

To apply:

- Complete the enclosed application as instructed,
- Attach a copy of your current Federal Income Tax Form, and
- Return the information to the address listed below within one (1) month from the date of this letter.

It is important that an alternate contact or daytime telephone number be listed on the application, as we may need to contact you.

Completion of the application does not guarantee assistance. If you have questions, please call the number listed below.

Sincerely,

(SERVICE COORDINATOR NAME)
(TITLE)
Children and Youth with Special Health Care Needs
(LPHA STREET ADDRESS)
(CITY, STATE, ZIP)
(LPHA PHONE NUMBER)
Toll Free: 800-451-0669

SC/ss
Enclosure(s)

c: participant file

Application for Enrollment, Incomplete – 01-14-15

(DATE)

(PARTICIPANT/FAMILY NAME)
(STREET ADDRESS)
(CITY, STATE, ZIP)

REGARDING: (PARTICIPANT NAME)
DATE OF BIRTH: (PARTICIPANT DATE OF BIRTH)
DCN: (PARTICIPANT DEPARTMENT CLIENT NUMBER)

(SALUTATION):

Children and Youth with Special Health Care Needs is unable to process your (re) application for enrollment. You must submit the following information:

- ☐ Participant's name;
- ☐ Participant's date of birth;
- ☐ Participant's street/PO Box, city, state, zip, county;
- ☐ Participant's sex/race;
- ☐ Parent/guardian name and address;
- ☐ Head of household social security number;
- ☐ Income (current IRS 1040) – Income tax return for (YEAR);
- ☐ Total number of family members in household;
- ☐ Diagnosis/services requested;
- ☐ Insurance information;
- ☐ Date and signature; or
- ☐ Other:

If the requested information is received <u>after 30 days or more</u>, from the date of this request, you will be required to reapply.

If you have questions, please contact me at (PHONE NUMBER).

Sincerely,

(SERVICE COORDINATOR NAME)
(TITLE)
Children and Youth with Special Health Care Needs
(LPHA STREET ADDRESS)
(CITY, STATE, ZIP)
(LPHA PHONE NUMBER)
Toll Free: 800-451-0669

SC/ss
Enclosure(s)
c: participant file

(DATE)

(PARTICIPANT/FAMILY NAME)
(STREET ADDRESS)
(CITY, STATE, ZIP)

REGARDING: (PARTICIPANT NAME)
DATE OF BIRTH: (PARTICIPANT DATE OF BIRTH)
DCN: (PARTICIPANT DEPARTMENT CLIENT NUMBER)

(SALUTATION):

The application for enrollment in the Children and Youth with Special Health Care Needs Program has been reviewed and (YOU) (YOUR CHILD) is not eligible for the following reason:

- Income exceeds financial eligibility criteria;
- Medical condition is not eligible according to program guidelines; or
- Age exceeds program eligibility.

If you have questions, please contact me at (PHONE NUMBER) for assistance.

Sincerely,

(SERVICE COORDINATOR NAME)
(TITLE)
Children and Youth with Special Health Care Needs
(LPHA STREET ADDRESS)
(CITY, STATE, ZIP)
(LPHA PHONE NUMBER)
Toll Free: 800-451-0669

SC/ss
Enclosure(s)

c: participant file

Missouri Department of Health and Senior Services
PO BOX 570, JEFFERSON CITY MO 65102-0570 Phone: 573-751-6400 FAX: 573-751-6010
RELAY MISSOURI for Hearing and Speech Impaired 800-735-2966 VOICE 800-735-2466
GAIL VASTERLING **JEREMIAH W. (JAY) NIXON**
DIRECTOR GOVERNOR

DATE

(PARTICIPANT NAME)
(STREET ADDRRESS)
(CITY, STATE, ZIP)

REGARDING: (PARTICIPANT NAME)
DATE OF BIRTH: (PARTICIPANT DOB)
DCN: (PARTICIPANT DCN)

ATTENTION: Participant/Parent/Guardian

Services through Special Health Services (SHS), Children and Youth with Special Health Care Needs shall be closed on [CLOSURE DATE] for the following reasons:

- ☐ The participant is not medically eligible.
- ☐ The participant/family income exceeds financial eligibility criteria.
- ☐ The participant has no present need for services, based on evaluation, assessment; or medical report.
- ☐ The participant/family has become a non-Missouri resident.
- ☐ The participant/family requests discontinuation.
- ☐ The participant/family does not follow specific program requirements, i.e.
- ☐ The participant's age exceeds program eligibility.
- ❒ The participant is receiving services from another source.

You may reapply at any time and you always have the right to appeal any decision made by SHS. If you have any questions, please contact the Service Coordinator at (573) 378-0234.

Sincerely,

(SERVICE COORDINATOR NAME)

Special Health Services
(LPHA)
(STREET ADDRESS)
(CITY, STATE, ZIP)
(LPHA PHONE NUMBER)
Toll Free: 800-451-0669

c: participant file

Print from MOHSAIC

Missouri Department of Health and Senior Services
PO BOX 570, JEFFERSON CITY MO 65102-0570 Phone: 573-751-6400 FAX: 573-751-6010
RELAY MISSOURI for Hearing and Speech Impaired 800-735-2966 VOICE 800-735-2466
GAIL VASTERLING **JEREMIAH W. (JAY) NIXON**
DIRECTOR GOVERNOR

CURRENT DATE

(PARTICIPANT/FAMILY NAME)
(STREET ADDRESS)
(CITY, STATE, ZIP)

Regarding: (PARTICIPANT NAME)
Date Of Birth: (PARTICIPANT DOB)
DCN: (PARTICIPANT DCN)

ATTENTION: Participant/Parent/Guardian

I am sorry to hear about [PARTICIPANT NAME] death. Please accept my sympathy.
The Special Health Services (SHS) record has been closed. If I may be of further assistance, please feel free to contact me.

Sincerely,

(SERVICE COORDINATOR NAME)

Special Health Services
(LPHA)
(STREET ADDRESS)
(CITY, STATE, ZIP)
(LPHA PHONE NUMBER)
Toll Free: 800-451-0669

c: participant file

Print from MOHSAIC

(DATE)

(PARTICIPANT/FAMILY NAME)
(STREET ADDRESS)
(CITY, STATE, ZIP)

REGARDING: (PARTICIPANT NAME)
DATE OF BIRTH: (PARTICIPANT DATE OF BIRTH)
DCN: (PARTICIPANT DEPARTMENT CLIENT NUMBER)

(SALUTATION)

Your child may be eligible for assistance through the Missouri Department of Health and Senior Services, Bureau of Special Health Care Needs (SHCN), Children and Youth with Special Health Care Needs (CYSHCN) Program. This program provides service coordination and limited funding for medical care and related services for eligible participants ages birth to twenty-one (21).

Enclosed is a fact sheet that explains the CYSHCN Program, including eligibility guidelines and services offered through the program. Participating in the CYSHCN Program will not affect your eligibility for any other state or federal program (SSI, Medicaid, etc.).

If you would like more information or an application, please call the office listed below or toll-free at 1-800-451-0669.

Sincerely,

(SERVICE COORDINATOR NAME)
(TITLE)
Children and Youth with Special Health Care Needs
(LPHA STREET ADDRESS)
(CITY, STATE, ZIP)
(LPHA PHONE NUMBER)

SC/ss
Enclosure(s)

CURRENT DATE

Responsible Party Name
Address
City ST Zip

REGARDING: PARTICIPANT, Name
DATE OF BIRTH:
DCN:

Dear Mr. and Mrs. Last Name:

The law presumes all adults (age 18 and over) have the capacity for decision-making. This applies to everyone, including people with disabilities. Therefore, at age 18, your child will be making decisions regarding their participation and services provided through the CYSHCN Program.

The information provided in this packet is given to help you explore if your child may need help in decision-making with the ultimate goal being the safest but least restrictive approach.

The information enclosed is provided by the MO Family-To-Family Resource Center (formerly known as MO Developmental Disability Resource Center). Additional information may be found on their website at http://moddrc.org/fast_fact.php?disID=184. If you have any questions or need assistance in accessing the website information, please contact me at 1-800-451-0669.

Sincerely,

(SERVICE COORDINATOR NAME)
(TITLE)
Children and Youth with Special Health Care Needs Program
(LPHA STREET ADDRESS)
(CITY, STATE, ZIP)
(LPHA PHONE NUMBER)
Toll Free: 800-451-0669

SC/ss
Enclosure(s)

c: participant file

A NEW WAY TO SUPPORT FAMILIES

Missouri Guardianship: Understanding Your Options & Alternatives

Welcome to the Missouri Developmental Disabilities Resource Center (MODDRC). You are receiving this letter with an enclosed packet of information because a request was made by you (or someone on your behalf) to the MODDRC.

We have compiled information from a number of sources and have included them in this packet, which is designed to provide:

- **Topical Information**
- **Personal Experiences and**
- **Resources**

The MODDRC, which has now expanded to include Missouri's Family-to-Family Health and Disability Information Center, seeks to inform and connect individuals with disabilities or special health care needs and/or their families to peer support. We provide opportunities for leadership development and volunteerism. We also seek to provide information and training to community agencies so that they can provide services to individuals with disabilities or special health care needs and/or their families. When contacting the MODDRC, you are connecting to staff with first-hand knowledge about disability related issues because they have the experience of living with the disability, either as an individual, parent or family member.

Thank you for using the MODDRC. This packet of information is one of the many ways that the MODDRC can support you in your journey with disability. We hope you will connect with us again.

MISSOURI FAMILY TO FAMILY RESOURCE CENTER
DISABILITY & HEALTH INFORMATION CENTER

Missouri Family to Family Disability & Health Information Center is housed within Missouri's University Center for Excellence in Developmental Disabilities Education, Research and Services (UCEDD) at the University of Missouri-Kansas City, Institute for Human Development.

This packet was developed with funding from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, Division of Services for Children with Special Health Needs, grant number H84MC08005, grant number D70MC09834, as well as Federal Funding from the Missouri Planning Council on Developmental Disabilities as established through the - P.L. 106-402

Overview

The purpose of this section is to help you gain a better understanding of a specific topic related to disability or special health care need. It is intended to provide a basic explanation of the topic and specific tips for success and may include:

- An overview of the topic
- Current practices
- Skills
- Tools

If you would like more information on this topic, please feel free to contact us again.

Overview: Missouri Guardianship: Understanding Your Options and Alternatives

Why are you thinking about Guardianship?

Someone may be telling you that you or someone you love needs to have a guardian. It might be school staff (schools routinely send out a letter about guardianship when a child who has an IEP turns 17), a medical professional, a service coordinator, or even another parent.

There is often a general assumption that just because someone has a disability (especially if it is a developmental disability) or special healthcare need, he or she will need a guardian as an adult. In reality, everyone is presumed competent to make choices about their own lives when they become an adult, unless a court says otherwise. With the right supports, many people with disabilities or special healthcare needs are able to remain "their own person," making their own decisions and being in charge of their own lives. The trick is to find a balance – giving the person enough support and protection so they can live a safe and healthy life without taking away their rights and freedom to make choices and decisions for themselves.

There are a lot of reasons why individuals with developmental disabilities, their families, and key supporters might be considering their guardianship options and alternatives for decision making support and/or protection. For example:

- You have a child with a developmental disability close to the age of 18.
- You have been told by an educator, service provider, or other professional that you need guardianship to maintain your rights to provide support and/or protection for someone you care about.
- Someone is pressuring you to file for guardianship.
- You or someone you know is, or is at risk for being, taken advantage of by others.
- You have fears and concerns in relation to your current guardianship status.
- You currently have a guardian, but don't think you need one, or you don't agree with the decisions they are making for you.
- The individual you are concerned about currently needs protection or assistance.
- You are seeking information about guardianship because someone you care for or someone you work with is experiencing a difficult time.

Before pursuing guardianship, it is important that you consider whether guardianship will achieve the outcome you desire. **Guardianship is not a quick fix,** it is a legal action that limits or denies a person the right to make their own decisions. It is important to consider the individual's needs for support and/or protection and then ask, "How will having a guardian address each specific need?"

Simply because a person has a developmental disability is not a reason to assume that he/she cannot make decisions or express preferences. Sometimes a person needs help making decisions and an advocate or guardian may be beneficial.

Why is Understanding Your Options and Alternatives Important?

When an individual is declared incapacitated for the purposes of guardianship he/she may lose many rights that are often taken for granted such as the right to vote, obtain a drivers license, consent or object to medical care, or enter into contracts like marriage or home ownership. Individuals with a guardian may not get to decide where they live, with whom they live, where they go in the community or how their money is spent. **The freedom to make these decisions plays an important part in defining all of us as human beings and determining our quality of life.**

Different individuals have different situations, needs, and available supports. Deciding what alternative(s) or guardianship option(s) will work best in your unique circumstance can be difficult. Each alternative to full guardianship has advantages and disadvantages, which must be considered. Understanding the options and alternatives will help you make informed decisions and find the least restrictive way(s) to provide an individual with the care, support, and protection he/she needs.

It is not uncommon for guardianship to be suggested for individuals who need help with regular activities of daily living such as paying bills, managing medications, or buying groceries and preparing meals. Prior to seeking guardianship it is important to understand the implications and long term effects of guardianship on an individual's life.

Since guardianship involves the loss of fundamental rights, it should only be considered when a person cannot make informed decisions on their own or when accommodated or supported in their decision-making. Guardianship can be very difficult to modify or terminate. Parents do not need to become guardians of their adult children in order to stay involved. Options and alternatives should not be based on a diagnostic label, but rather you should consider an individual's strengths and specific decision-making and protection needs.

Remember, there are ways other than guardianship to provide support and protection for an individual with a disability or special healthcare need and to establish decision-making supports in certain areas. Learning about alternatives may take effort on your part, but it may allow a person to keep more of their legal rights and stay involved in decisions about their own lives. Gather all of the facts so you can make an informed decision about whether guardianship is the best choice.

How do you know if you or someone you care about needs decision making support and/or protection?

The first step is to determine individual level of ability in key areas of life. You can use the checklist, "the tool," provided in ***MO Guardianship: Understanding Your Options and Alternatives***, developed by the UMKC Institute for Human Development (UCEDD), to help with this. It's best if several members of the individual's support team and the individual complete the form to determine what appropriate option or alternative meets the individual's need for support and/or protection.

The **tool** provides questions to help you **examine key areas** of an individual's life including:

- Employment
- Money management
- Health & nutrition
- Relationships
- Personal safety
- Community living
- Personal decision-making
- Determining & directing services and supports

What are the Options and Alternatives?

Alternatives to guardianship may allow individuals to hold on to some or all of their rights. They include:

- **General Supports** – natural, unpaid, and community resources and may include family, friends, and advocacy organizations.
- **Decision-Making Supports** – create legal documents (such as Power of Attorney) giving authority to someone on behalf of the individual in certain areas.
- **Money Management Supports** – help manage financial obligations and avoid exploitation. These supports include sucht things as joint bank accounts and trusts.
- **Personal Safety Supports** – are useful for individuals at risk for being abused/neglected by an intimate partner, spouse, family member, personal assistant or caregiver.

Full explanation of alternatives can be found in ***MO Guardianship: Understanding Your Options and Alternatives.***

Accessing your Guardianship Options & Alternatives

Once you've determined an individual's areas of need and identified appropriate options and alternatives to meet those needs, you'll need to access the alternatives you've selected and/or petition the court for a limited or full guardianship or a restoration of capacity to terminate or reduce a full guardianship.

How do I access the alternatives to guardianship?

- Build a support group
- Practice person-centered decision making
- Be aware that because guardianship is court-ordered you may need to seek appropriate legal counsel.
- Many of the alternatives are easily accessible at little or no cost.

What can you access **on your own** (*without an attorney*)?

- Friends/Family
- Advisors/Advocacy Organizations
- Community supports
- Representative Payee
- Limited and/or Joint Bank Accounts
- Direct Deposit and Automatic Bill Pay
- Protection Orders (TRO)
- Personal Contract/Agency Agreement

What might you **need an attorney to access**?

- Durable Power of Attorney
- Durable Power of Attorney for Health Care
- Living Will
- Living Trust
- Special Needs Trust
- Adult Protective Services
- Limited Guardianship
- Full/Plenary Guardianship

For help finding more information about this or other subjects, please contact us at the Missouri Family-to-Family Resource Center. We're here to help.

Works Cited

1-A Guide to Understanding Adult Guardianship and Guardianship Alternatives in Maine

2-Oklahoma Department of Human Services, Capacity Assessment. www.okdhs.org

MO Guardianship: Understanding Your Options & Alternatives. UMKC Institute for Human Development: A University Center for Excellence in Developmental Disabilities. www.ihd.umkc.edu

The Missouri Bar. http://www.mobar.org

Important Things to Remember

Autonomy

The word **"autonomy"** refers to the right of a person to make informed decisions about what happens to him or her such as the choice of whether to consent, refuse to consent, withdraw consent, or otherwise exercise freedom of choice in determining one's own actions and activities.

Self-determination

Self-determination refers to people making choices and decisions based on their own preferences and interests, to monitor and regulate their own actions, and to be goal-oriented and self-directing.

Self-determination provides individuals with the freedom and opportunity to make choices and decisions about all important aspects of one's life with freely chosen supports, as needed. It also gives the individual the ability to organize the support or assistance they need in ways that are unique to the individual. The individual is provided opportunities to practice responsibility and contribute to one's community and act as a citizen. It empowers individuals because the supports and protections focus on the desires and abilities of the individual. Self-determination actively involves the individual in the decisions being made about appropriate levels of support and protection for that individual's unique needs with a support group/team of family members, friends, and professionals. Finally, self-determination ensures that protections and supports are respectful of the individual.

What is person-centered decision making?

Person-centered decision making is the key component in helping a person maintain a sense of autonomy and self-determination by focusing on the desires and abilities of the individual. It involves a support team of family members, friends, professionals, and *most importantly* the individual. The individual chooses the members.

Person-centered decision making recognizes that individuals who have a disability may communicate choices, likes, and wishes in non-traditional ways which may include actions. The individual plays an important role in identifying areas in which assistance and support may be needed and how the team can meet those needs.

Family support Advocacy & Services

This section will provide you with a listing of agencies focused on areas such as educational, medical care or social services to individuals with developmental disabilities or special health care needs. This includes listings such as state or local agencies, hospitals, clinics or education systems.

Support for Families

Missouri Family-to-Family Resource Center
Housed at the UMKC-Institute for Human Development, UCEDD
215 W. Pershing
Kansas City, MO 64108
Phone: 816.235.1763
Toll Free: 800.444.0821
web: http://www.mofamilytofamily.org

Missouri Family-to-Family is a statewide network of parents, family members, and individuals with disabilities and/or special health care needs providing information and peer support through the MOF2F Disability & Health Information Center and Sharing Our Strengths (SOS). SOS is a statewide support network of parents, family members, individuals with developmental disabilities and/or special healthcare needs, and professionals who are matched with peer mentors to share experiences, offer emotional support, and to network with others. You can request an individual parent to parent or peer support match with another parent or individual who has experienced similar circumstances.

MO Guardianship: Understanding Your Options and Alternatives, developed by UMKC Institute for Human Development (UCEDD), is a manual that describes guardianship options and alternatives in detail to assist you in planning for your/your child's future. This manual and accompanying tool can be obtained from Missouri's Family-to-Family Health and Disability Resource Center by calling us at 800.444.0821 or by requesting it online.

People First of Missouri
1-800-558-8652
www.missouripeoplefirst.org

People First of Missouri is a self-advocacy, self-help organization that was formed by, is run by, and exists for people with developmental disabilities. PFMO members teach and empower people to understand their rights and responsibilities and to speak up for themselves (self-advocacy); stands up for one another to help people live the life they want with the supports they need (advocacy for one another); advocate for community services that allow people to have choices and control over their supports and lives (advocacy at the systems level); and work to create change in communities to ensure opportunity and full, meaningful participation for all people (advocacy within the community).

Missouri

Service Systems

The purpose of this section is to provide you with a listing of agencies focused on areas such as educational, medical care or social services to individuals with developmental disabilities or special health care needs. This includes listings such as state or local agencies, hospitals, clinics or education systems.

Missouri Service System Contacts

Finding an Attorney

- **The Missouri Bar Lawyer Referral Service** provides referrals for attorneys on a statewide basis, except for St. Louis and Springfield, and can be reached at 573-636-3635, Monday through Friday 9am until Noon and 1pm until 3pm.
- **St. Louis Metropolitan Bar Lawyer Referral Service** can be reached at 314-621-6681.
- **Springfield Metropolitan Bar** can be reached at 417-831-2783

If you cannot afford an attorney contact :

Missouri Protection and Advocacy Services
at 800-392-8667 or visit www.moadvocacy.org

- Jefferson City Office (Administration)
  925 S. Country Club Drive
  Jefferson City, MO 65109
  Tel: 573-893-3333 / 866-777-7199
  Fax: 573-893-4231
- Jefferson City Office (Application Unit)
  925 S. Country Club Drive
  Jefferson City, MO 65109
  Tel: 573-659-0678 / 800-392-8667
  Fax: 573-659-0677
- St. Louis Office
  1992 Innerbelt Business Center Drive
  Overland, MO 63114
  Tel: 314-785-1702 / 800-233-3958
- Kansas City Office
  3100 Main Street, Suite 207
  Kansas City, MO 64111
  Tel: 816-756-1001 / 800-233-3959
- Fulton Office
  P.O. Box 6187
  Fulton, MO 65251
  Tel: 573-592-2738 (JC office X-20)

Legal Aid of Western Missouri provides free/low cost legal services:

- Kansas City Central Office 816-474-6750
  - 1125 Grand Blvd. #1900
    Kansas City, MO 64106
- Kansas City West Office 816-474-9868
  - 920 Southwest Blvd.
    Kansas City, MO 64108
- Joplin 1-800-492-7095, 417-782-1650
  - 302 S. Joplin
    Joplin, MO 64801
- St. Joseph 1-800-892-2101, 816-364-2325
  - 106 S. 7th St., 4th Floor
    St. Joseph, MO 64502
- Warrensburg 1-800-892-2943, 660-747-7101
  - 305 N. Holden
    Warrensburg, MO 64093

Missouri Department of Health and Senior Services
P.O. Box 570, Jefferson City, MO 65102-0570 Phone: 573-751-6400 FAX: 573-751-6010
RELAY MISSOURI for Hearing and Speech Impaired 1-800-735-2966 VOICE 1-800-735-2466

Gail Vasterling
Director

Jeremiah W. (Jay) Nixon
Governor

CURRENT DATE

NAME
ADDRESS
CITY, STATE, ZIP

REGARDING: PARTICIPANT NAME
DATE OF BIRTH: DATE OF BIRTH
DCN: DCN

Dear Program Participant/Responsible Party:

Children and Youth with Special Health Care Needs Program participants must provide proof of United States citizenship or lawful presence in the United States to continue eligibility in the program beyond their eighteenth birthday. This is in compliance with Missouri State Statute (RSMo 208.009).

Participants must submit a copy of one of the following documents:

- Valid Missouri Driver or Non-Driver License;
- U.S. Birth Certificate – issued by a state or local government (hospital-issued birth certificates are not acceptable);
- U.S. Passport;
- Certificate of Citizenship, Naturalization, or Birth Abroad; or
- Any document issued by the federal government that confirms lawful presence in the United States.

To remain enrolled in the Children and Youth with Special Health Care Needs Program, a copy of one of the documents listed above must be sent to the Service Coordinator listed below prior to PARTICIPANT NAME's eighteenth birthday.

Questions may be directed to the Service Coordinator at 800-451-0669.

Sincerely,

Service Coordinator Name
SC Street Address
SC City, State & Zip
SC Telephone Number
Toll Free: 800-451-0669

c: Participant File

Missouri Department of Health and Senior Services
P.O. Box 570, Jefferson City, MO 65102-0570 Phone: 573-751-6400 FAX: 573-751-6010
RELAY MISSOURI for Hearing and Speech Impaired 1-800-735-2966 VOICE 1-800-735-2466

Gail Vasterling
Director

Jeremiah W. (Jay) Nixon
Governor

CURRENT DATE

NAME
ADDRESS
CITY, STATE, ZIP

REGARDING: PARTICIPANT, Name
DATE OF BIRTH: Date of Birth
DCN: DCN

Dear Program Participant/Responsible Party:

Children and Youth with Special Health Care Needs (CYSHCN) Program participants are required to provide proof of United States citizenship or lawful presence in the United States to continue eligibility in the program beyond their eighteenth birthday. This is in compliance with Missouri State Statute (RSMo 208.009).

Participants must submit a copy of one of the following documents:

- Valid Missouri Driver or Non-Driver License;
- U.S. Birth Certificate – issued by a state or local government (hospital-issued birth certificates are not acceptable);
- U.S. Passport;
- Certificate of Citizenship, Naturalization, or Birth Abroad; or
- Any document issued by the federal government that confirms lawful presence in the United States.

To remain enrolled in the CYSHCN Program, a copy of one of the documents listed above must be sent to the Service Coordinator listed below prior to PARTICIPANT NAME's eighteenth birthday. **Services through the CYSHCN Program will be closed on PARTICIPANT DOB if documentation has not been received**.

Questions may be directed to the Service Coordinator at 800-451-0669.

Sincerely,

Service Coordinator Name
SC Street Address
SC City, State & Zip
SC Telephone Number
Toll Free: 800-451-0669

c: Participant File

(DATE)

(PARTICIPANT/RESPONSIBLE PARTY NAME)
(STREET ADDRESS)
(CITY, STATE, ZIP)

REGARDING: New Children & Youth with Special Health Care Needs (CYSHCN) Program Service Coordinator

(SALUTATION):

I'd like to take this opportunity to introduce myself. My name is (CYSHCN Service Coordinator Name), and I am the newest member of the CYSHCN Program team. I am assuming the roles and responsibilities of serving you in the capacity of the CYSHCN Program Service Coordinator. I look forward to getting to know you, as well as providing you with the best possible service.

Thank you for your patience during this transition period. I have included my contact information, and business card. I encourage you to keep my information readily available.

I will be attempting to contact you by telephone in the near future. Please feel free to contact me at any time if you have questions about our program and how we can assist you. If I am away when you call, please leave your telephone number on my voice mail and indicate the best time for me to return your call.

Sincerely,

(SERVICE COORDINATOR NAME)
(TITLE)
(LPHA STREET ADDRESS)
(CITY, STATE, ZIP)

(LPHA TELEPHONE NUMBER)
800-451-0669

Enclosure(s)

c: Participant file

(DATE)

(PARTICIPANT/FAMILY NAME)
(STREET ADDRESS)
(CITY, STATE, ZIP)

REGARDING: (PARTICIPANT NAME)
DATE OF BIRTH: (PARTICIPANT DATE OF BIRTH)
DCN: (PARTICIPANT DEPARTMENT CLIENT NUMBER)

(SALUTATION)

Your child has recently been referred to the Missouri Department of Health and Senior Services, Bureau of Special Health Care Needs (SHCN) by the Department of Social Services, Children's Division. The Children and Youth with Special Health Care Needs (CYSHCN) Program, within SHCN, provides service coordination and limited funding for medical care and related services for eligible participants ages birth to twenty-one (21).

Enclosed is a fact sheet that explains the CYSHCN Program, including eligibility guidelines and what services may be offered. Participating in the CYSHCN Program will not affect your eligibility for any other state or federal program (SSI, Medicaid, etc.).

If you would like more information or an application, please call the office listed below or toll-free at 1-800-451-0669.

Sincerely,

(SERVICE COORDINATOR NAME)
(TITLE)
Special Health Care Needs
(LPHA STREET ADDRESS)
(CITY, STATE, ZIP)
(LPHA PHONE NUMBER)

SC/ss
Enclosure(s)