STATE OF DELAWARE
DELAWARE HEALTH AND SOCIAL SERVICES
DIVISION OF MEDICAID & MEDICAL ASSISTANCE (DMMA)
Children's Community Alternative Disability Program

APPLICATION FOR HEALTH INSURANCE

Complete and sign this application form to apply for the Children's Community Alternative Disability Program. This program provides Medicaid coverage to children with a severe disability who do not qualify for Supplemental Security Income (SSI) or other Medicaid qualifying programs because of their parents' income and/or resources.

Return this application within 30 days of the date you asked for Medicaid. If you do not, this may change the date your child's Medicaid will start.

We also need you to provide us with the following:

- Verification of all income that is in the child's name;
- Copy of child's birth certificate;
- Copy of child's social security card;
- Copy of front and back of any health insurance card covering your child;
- Completed Caregiver Assessment form;
- Comprehensive Medical Report;
- Attending Physician's Certification.

Do not wait to send in your application if you do not have all the information. We will review your application and if more information is needed, we will tell you. Once we receive all the information we need, a written notice of decision will be sent to you.

Children who are approved for the Children's Community Alternative Disability Program must enroll with a managed care organization. An enrollment packet that explains benefits will be sent to you.

If you have questions please call the Division of Medicaid & Medical Assistance at 1-866-940-8963.

******REMEMBER TO SIGN AND DATE THE LAST PAGE OF THIS APPLICATION******

SECTION I: BASIC INFORMATION

Name & Address of Applicant: City: State: Zip Code:	Name & Address of Parent: City: State: Zip Code: Telephone number where parent can be reached: E-Mail Address:
If applicant does not have a street address, tell us where he/she lives:	If parent does not have a street address, tell us where he/she lives:
Has anyone been appointed as applicant's Legal Guardian/Power of Attorney? Yes ____ No _____ Name of Legal Guardian/Power of Attorney: **You will need to provide copies of Guardianship and/or Power of Attorney papers.**	

EDUCATION INFORMATION:

1. Is the child currently enrolled in school? Yes ____ No ____
2. If yes, what school are they enrolled in? _____
3. What is the highest grade level this child has completed? _____

SECTION II: HOUSEHOLD MEMBERS Tell us who lives in your household

*Race Code: I=American Indian/Alaskan Native; B=Black/African American; PI=Native Hawaiian/Pacific Islander; W=White; A=Asian
**Ethnic Code: H=Hispanic/Latino; N=Non-Hispanic/Latino

LAST NAME	FIRST NAME	M.I.	How is this person related to the applicant?	Are you applying for this person?	Birth Date Mo/Day/Yr	Sex M/F	Place of Birth	*Race **Ethnic Group Optional	Social Security Number	U.S. Citizen or Legal Alien? Answer for applicant only	Date of Entry in United States
			APPLICANT								
			MOTHER								
			FATHER								

Does a parent of any of the children applying live out of the home?

Child's Name	Parent's Name	Parent's Date of Birth	Parent's Address

SECTION III: INCOME Tell us about the applicant's (child's) earnings from paychecks, tips, babysitting, in-home sales, odd jobs.

	APPLICANT			MOTHER			FATHER		
SOURCE OF INCOME	$ AMOUNT	HOW OFTEN?	DIRECT DEPOSIT?	AMOUNT	HOW OFTEN	DIRECT DEPOSIT	AMOUNT	HOW OFTEN	DIRECT DEPOSIT
Employment Employer:									
Other Earned Income									
Social Security									
Pension									
Annuity									
Trust									
Long Term Care Insurance (LTCi)									
Other Income									
Other Income									
Other Income									

Please provide verification of all income.

SECTION IV: HEALTH INSURANCE INFORMATION

Name of Policy Holder	Name of Insurance	Who is Covered	What is Covered	Policy Number
			☐ Doctor ☐ Hospital ☐ Lab ☐ Tests ☐ X-ray	
			☐ Doctor ☐ Hospital ☐ Lab ☐ Tests ☐ X-ray	

Please provide copies of all insurance cards.

SECTION V: RESOURCES List resources in the APPLICANT'S (child's) name.

Type of Resource	Balance/Value	Where Located	Account Number	Name(s) of Owner(s)
Checking Account				
Savings Account				
Certificate of Deposit				
Stocks				
Bonds				
Trust Fund (i.e. Special Needs)				
Cash				
Other (Describe)				

Please provide current verification of all resources.

SECTION VI: RIGHTS AND RESPONSIBILITIES

I have read or have had read to me all statements on this form and the information I give is true and complete to the best of my knowledge. I understand that I could be penalized if I knowingly give false information. I understand that all information I give is confidential and federal and state laws limit disclosure of information about me.

I understand and agree to give proof of my statements. I understand and agree that the Department of Health and Social Services may contact other persons or organizations to obtain the necessary proof of my eligibility. I must give the Social Security Number for each person applying and it will be used to check records with other government agencies. The Division of Medicaid & Medical Assistance (DMMA) also asks me to give the Social Security Number of anyone whose income is used to determine my eligibility. Non-lawful aliens are not required to give a Social Security Number.

I understand that this application will be considered without regard to race, color, sex, age, disability, religion, national origin, or political belief.
I understand that I must apply for and accept other benefits that I may be eligible to get such as Unemployment Compensation or Social Security.

I will allow the Department of Health and Social Services, or its representatives, to act as my agent in recovering money spent by the medical assistance programs when other money from insurance, etc., becomes available to pay my medical bills. I may have to repay to the DMMA any medical assistance received for which I am not entitled. My obligation to repay such assistance applies both during my period of eligibility and after I am no longer receiving medical assistance.

As required by law as conditions of eligibility I assign all rights to medical support and to payment for medical care from any third party to the DMMA and I understand I must cooperate with the Division of Child Support Enforcement in establishing paternity and obtaining medical support for any child receiving medical assistance.

I understand that pregnant women are not required to cooperate in establishing paternity and obtaining medical support and that I may claim to have good cause for refusing to cooperate in establishing paternity or in identifying and providing information about liable third parties.

I understand that as a medical assistance recipient, I will automatically receive full child support services from the Division of Child Support Enforcement; unless I state that I want to receive only child support services related to medical support.

I understand that if I am a Medicaid applicant or recipient I have the right to a fair hearing if I am not satisfied with any decision made about my eligibility. I understand that I may be represented by an attorney or any other person I choose.

I agree to allow the Department of Health and Social Services, directly or through its agents, to have access to all medical and school-based health and related services records of every member of my household who is eligible for Medical Assistance in order to administer the medical assistance program, coordinate care, determine medical necessity, and evaluate or pay for pending or incurred medical services.

I certify, under penalty of perjury, that I am a U.S. Citizen or alien in lawful immigration status. I must give proof of lawful immigration status and it will be checked with Immigration and Naturalization Service. Non-lawful alien status will not be checked. This will not affect any public charge determination or lead to deportation proceedings. Non-lawful aliens may be eligible for emergency services and labor and delivery only.

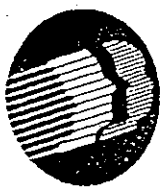
I agree to report within 10 days changes in my situation that could affect my eligibility, such as a change in how many people live with me, a new job or change in income, or if I move. This application must be signed by an adult household member (age 18 or over) or by an emancipated minor (under age 18).

_____ _____

Signature of Applicant or Representative Date

_____ _____

Signature of DMMA Worker Date



Primary Caregiver Assessment of Child's Health and Social Status

Applicant/child's name:_____ Medicaid ID #:_____

Purpose

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

Instructions:

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

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1. Identifying Information

_____ _____

Child's full name Date of Birth

_____ _____

Nicknames for Child used by family/friends Place of birth (hospital, city, State)

_____ lbs. ____ ozs. Problems experienced during pregnancy with this child:

Weight _____

Other persons living in the household:

Name	Relationship	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

2. Information about the child's disability:

A. What was the date of the onset of the disability? _____

B. Please describe in detail the medical diagnosis and symptoms of the child for whom you are applying. How are his/her abilities limited ?:

_____

_____

_____

_____

_____

_____

C. Is there any history of similar medical problems in the family? Yes___ No_____
If yes, please explain:

_____

_____

3. Information about the child's medical history:
Give concise and specific answers about your child's medical history.

A. Has the child any surgeries related to his/her current medical condition?
Yes _____ No ____ If yes, explain:

_____

_____

_____

B. What was his/her response to the surgery? Did it substantially improve his/her condition?

_____

_____

C. Has the child had any therapies? Yes ____ No ___
If yes, describe:

_____

_____

D. What was the response to therapy? Did it substantially improve his/her condition?

_____

_____

E. Has any special exercise been described for the child? Yes ____ No _____
If yes, describe:

_____

F. What was his/her response to exercise? Did it substantially improve his/her condition? _____

G. Is the child on a normal diet? Yes ____ No _____ If no, describe the special diet that has been prescribed:

_____

_____

H. Describe Any medications that the child takes and the frequency that those medications are used:

Name of medication	Dosage	How often taken

I. What equipment appliances or supplies does your child need on a routine basis to function (such as eyeglasses, wheelchair, braces, cast, crutches, cane, prosthetics, etc.?

_____

_____

Does your child use any special adaptation in order to function? Yes___ No _____
Any assistive devices ? (List) _____

_____

Special Technology? (List) _____

J. Is your child incontinent? Yes _____ No _____

K. Does he/she require:

	Yes	No
Catheter?	____	____
Colostomy Care?	____	____
Gastrostomy Care?	____	____
Tracheotomy Care?	____	____
Preventative or decubitus care?	____	____
Tube feeding?	____	____

Any other care not described before in your answers?

_____

_____

L. List any current (within the past 6 months) or pending evaluations, assessments, x-rays, medical tests or laboratory studies:

Name of Procedure	Date done or scheduled

M. List any recent period(s) of hospitalization related to the child's current condition. Include the name(s) of the hospital(s), date(s) of hospitalization(s), and specify the reason the child was hospitalized:

Hospital Name & Location	Dates hospitalized	Reason

N. What is the current emotional state of the child? How does the child view himself/herself?

_____

_____

_____

_____

O. Does your child receive counseling? Yes ____ No _____

How Often ? _____

For What problem? _____

4. Information about the child's current abilities and limitations:

This section is for the primary caregiver's statement about the effect of the physical and/or mental illness or impairment on the child's ability to function. Compare the child's functional abilities now with the level of functioning prior to his/her disability.

_____

_____

_____

_____

_____

_____

_____

A. Does your child display or have any problems with the following:

	Yes	No
Emotional Withdraw	_____	_____
Bed wetting	_____	_____
Eating Disturbance	_____	_____
Sleep disturbance	_____	_____
Impulsivity	_____	_____
Fire Starting	_____	_____
Eating Disorder	_____	_____
Concentrating	_____	_____
Poor Concentration & Attention	_____	_____
Temper Tantrums	_____	_____
Negativity &Defiance	_____	_____
Lying	_____	_____
Cheating	_____	_____
Stealing	_____	_____
Physical Aggression	_____	_____
Self Injurious Behaviors	_____	_____
Destruction of Property	_____	_____
Functioning in School	_____	_____
Substance Abuse	_____	_____

B. Does the rest of the family make adjustments to accommodate child's impairment?

Yes _____ No _____

Explain:_____

_____

_____

C. How does your child get along with other family members?

_____

_____

_____

_____

D. Describe your child's friends:

_____

_____

_____

_____

_____

5. Has your child ever been tested or evaluated by any of the following agencies or organizations? Submit copies of applicable evaluation .

	Type of Evaluation or Testing from Agency
Division of Public Health	_____
Child Watch	_____
WIC program	_____

5. (Continued)

Division of Mental Retardation _____
Division of Alcohol & Drug Abuse _____
Division of Visual Impairment _____
Speech &Hearing _____
Division of Vocational Rehabilitation _____
Division of Child Mental Health _____
Special Needs Agency _____
United Cerebral Palsy _____
Independent Living _____

6. Information about the child's medical providers:

List name of doctors, clinics, therapists, home health agencies, and other medical providers that are providing care to your child. Indicate the date last seen by each provider, the frequency of the visits and the reason your child is seeing that provider related to the current medical condition.

Provider Name	Date last seen	Frequency Seen	Reason

7. Information about the child's social situation:

A. What are the child's favorite toys, games, activities, interests or hobbies?

_____
_____
_____

B. Does your child participate in any schools, church, sports, or community activities? Yes _____ No _____
If yes, describe:

_____

C. What are your child's likes/dislikes?

_____
_____

D If your child is a teenager, what are his/her plans for the future?

_____
_____

E. Does you child participate in home schooling? Yes ____ No _____

F. Does your child receive remedial assistance, tutoring from the community?
Yes _____ No_____

G. Is your child in a self contained or regular classroom? Yes___ No _____

H. How many days of school did your child miss? _____
In past month? _____
In past year? _____

I. Is child in special education program? Yes____ No____
When was the most recent IEP done? _____ If applicable, submit a copy of IEP.

8. Medical Insurance Information:
Describe all health insurance coverage that child has excluding Medicaid.

Insurance Company: _____
Policy Holder: _____
Policy/Group#(s): _____
Medical Insurance Information (continued)
Policy Holder's Employer: _____
% covered by Insurance: _____
Comments:
_____
_____

9. Have you ever applied for Supplemental Security Income for your child?
Yes____ No____ If yes, indicate the dates and disposition of the application.

Date(s) applied for SSI	Approved (check one)	Denied
_____	_____	_____
_____	_____	_____
_____	_____	_____

10. Why are you applying for the Children's Community Alternative Disability Program for your child?

_____
_____
_____
_____
_____
_____

This form was completed by: _____
Phone: _____
Relationship to the applicant: _____
Date completed: _____

AUTHORIZATION TO DISCLOSE INFORMATION TO DELAWARE HEALTH AND SOCIAL SERVICES
DIVISION OFMEDICAID & MEDICAL ASSISTANCE

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

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange) of the information listed below to Delaware Health and Social Services for determining my eligibility for medical assistance and/or food benefits:

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

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

This box is to be completed by DMMA (as needed). List additional information to identify the subject, the specific source, or the material to be disclosed.

This authorization ends when the information asked for is received, or 12 months from the date signed or until revoked by me in writing, whichever comes first.

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

STATE OF DELAWARE
DIVISION OF SOCIAL SERVICES

COMPREHENSIVE MEDICAL REPORT

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

NAME: _____ D.O.B. _____ SEX _____ MARITAL STATUS_____

1. Phyisical Measurements: Height:_____ Weight _____

2. HISTORY: A. Past History _____

B. Date of onset of present illenss or injury _____

C. Is there a previous history of this illness? _____ If "Yes", describe _____

3. PRESENT CONDITION (ALL MAJOR IMPAIRMENTS)

A. Subjective Symptoms: _____

B. Objective Findings: (Give report of X-rays, lab., or diagnostic tests, etc., with dates. Use separate sheet if necessary.)

C. Patient is: Ambulatory _____ Confined to: Wheelchair _____ Bed _____ Home _____ Hosp. _____

D. Mental Status: _____

4. DIAGNOSES: _____

5. PROGNOSIS: _____

6. REHABILITATION and/or MAINTENANCE GOALS: _____

7. TREATMENT: A. Therapy and response: _____

B. Date of first visit: _____ Frequency of visits: _____

C. Date when you last examined this patient: _____

D. Diet: _____

E. Medications: _____ _____

F. Recommended Activities: _____

8. PROGRESS: Patient's condition is:

Improving _____ Static _____ Deteriorating _____ Terminal _____

Please have physician sign the back of this form to avoid further delay. Thank you.

Nursing Care Plan (Suggestions for active care)

BED: Position in good body alignment and
Turn q _____ hrs.
Avoid _____ position
Prone position _____ X a day as tol.
SIT IN CHAIR _____ hrs. _____ X a day

WEIGHT BEARING: _____ Full _____ Partial
_____ None on _____ leg
SOCIAL ACTIVITIES:
Encourage _____ group
_____ Individual
_____ Within home
_____ Outside home

EXERCISES:
ROM _____ X a day to _____
by _____ Pt. _____ Family _____ Nurse
Stand _____ hrs. _____ X a day
Other:

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

Self-Care Status

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

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

MENTAL STATUS ✓
Alert
Forgetful
Confused
Occ. Confused

BED
Low Bed:
_____ yes _____ no
Side Rails:
_____ yes _____ no
Mattress:
_____ Regular
_____ Firm
Other:

Medications and Treatments
(Check appropriate column)

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

REMARKS:

Physician's Name _____
Physician's Address _____

Recommend Nursing Home Care _____ yes _____ no

Signature _____ Date _____

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

Children's Community Alternative Disability Program

Attending Physician's Certification

TO: Division of Social Services
Medicaid

_____

_____

_____

Re: _____
(Child's Name)

Birthdate: _____

Parents: _____

Address: _____

_____

_____

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

_____ better than or equal to

_____ not as good as

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

_____ is appropriate

_____ is not appropriate

to the child's needs.

_____
Attending Physician's Signature

_____
Date