COLORADO
Department of Health Care Policy & Financing

Children's Extensive Support Waiver Behavioral and Medical Supports Application

Revised – August 2019

The information documented in this application is used to determine if a child meets the eligibility criteria for the Home and Community Based Services Children's Extensive Support (HCBS-CES) waiver. The documentation included must show the child meets the following:

The child demonstrates a behavior or has a medical condition that requires direct human intervention, more intense than a verbal reminder, redirection or brief observation of medical status, at least once every two hours during the day and a weekly average of once every three hours during the night. The behavior or medical condition must be considered beyond what is typically age appropriate and due to one or more of the following conditions:

1. A significant pattern of self-endangering behavior or medical condition which, without intervention will result in a life-threatening condition or situation.
    a. Significant pattern is defined as the behavior or medical condition that is harmful to self or others as evidenced by actual events occurring within the past six months, OR,
2. A significant pattern of serious aggressive behavior toward self, others or property.
    a. Significant pattern is defined as the behavior is harmful to self or others, is evidenced by actual events occurring within the past six months, OR,
3. Constant vocalizations such as screaming, crying, laughing or verbal threats which cause emotional distress to caregivers.
    a. The term constant is defined as on the average of fifteen (15) minutes each waking hour.

The above conditions shall be evidenced by parent statement/data which is corroborated by written evidence that:

1. The child's behavior(s) or medical need(s) have been demonstrated; or
2. It can be established that in the absence of existing intervention or prevention the intensity and frequency of the behavior or medical need would resume to a level that would meet the criteria listed above.

Evidence shall include, but not be limited to:

1. Medical records, professional evaluations and assessments, educational records, insurance claims, police or social services reports or observation by a third party (friend, neighbor, church member, family not living in the same household etc.) on a regular basis.

Please provide accurate information about the medical conditions, behaviors and/or vocalizations of the child. Include frequency (how often it occurs during daytime and/or nighttime hours), duration (how long does it last), intensity (what kind of injury it causes), and what interventions are provided. Please provide a summary of important information that may not be reflected elsewhere in the application, to your case manager.

Client Information			
Client Name: Click or tap here to enter text.		Medicaid ID: Click or tap here to enter text.	Date of Birth: Click or tap here to enter text.
☐ CSR	☐ Initial Review	Requested Certification Period (start and end date): Click or tap here to enter text.	
Client has a developmental delay: ☐ Yes ☐ No		Date of Determination: Click or tap here to enter text.	
Client has a developmental disability: ☐ Yes ☐ No		Date of Determination: Click or tap here to enter text.	
Nighttime Interventions – on a weekly average how many nights does intervention occur? Click or tap here to enter text.			
Typical bedtime: Click or tap here to enter text.		Typical waketime: Click or tap here to enter text.	Typical hours of sleep each night: Click or tap here to enter text.

Interventions Needed							
Daytime	**Nighttime**	**Medical Condition or Behavior** *(See Appendix A for examples)*	**Frequency** How often does it occur during daytime and/or nighttime hours?		**Duration** How long does each behavior/condition episode last?	**Intensity** What is the injury to self or others - consequence of no intervention?	**Intervention** What intervention is used? *(See Appendix B for examples)*
☐	☐	Click or tap here to enter text.	☐ Every 15 minutes ☐ Every hour ☐ Every two hours ☐ Every three hours ☐ Other (Specify):	☐ Daily ☐ Weekly ☐ Monthly	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
☐	☐	Click or tap here to enter text.	☐ Every 15 minutes ☐ Every hour ☐ Every two hours ☐ Every three hours ☐ Other (Specify):	☐ Daily ☐ Weekly ☐ Monthly	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.

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Documentation Page

Case Manager/Resource Coordinator: List the documents, in your possession, which describe the behaviors, medical conditions or constant vocalizations described on this application that have occurred within the **past 6 months**. Examples shall include, but are not limited to: medical records, professional evaluations and assessments, education records, including communication logs between parent and school, insurance claims and police/social services reports.

Type of document or source of information	Date of document	Who prepared the document or provided the information
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
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State Plan Services *(include Behavioral Services provided through Health First Colorado (Medicaid)*		
State Plan Services?	Provider	Start Date and Frequency
☐ Yes ☐ No	Click or tap here to enter text.	Click or tap here to enter text.
☐ Yes ☐ No	Click or tap here to enter text.	Click or tap here to enter text.
☐ Yes ☐ No	Click or tap here to enter text.	Click or tap here to enter text.
☐ Yes ☐ No	Click or tap here to enter text.	Click or tap here to enter text.

Signature Page

10 CCR 2505 – 10 8.503.80.A. Client responsibilities: The parent or legal guardian of a client is responsible to assist in the enrollment of the client and cooperate in the provision of services. Failure to do so shall result in the client's termination from the HCBS-CES waiver. The parent or legal guardian shall:

1. Provide accurate information regarding the client's ability to complete activities of daily and nightly routines and medical and behavioral conditions.

Signatures		
Select one: ☐ Parent ☐ Legal Guardian I certify, to the best of my knowledge, all information on this application is true and complete.		
Signature: Click or tap here to enter text.	Print Name: Click or tap here to enter text.	Date: Click or tap here to enter text.
Case Manager/ Resource Coordinator I certify, to the best of my knowledge, all information on this application is true and complete.		
Signature: Click or tap here to enter text.	Print Name: Click or tap here to enter text.	Date: Click or tap here to enter text.

Operational Memo 18-020 provides instruction for submitting this CES application to EQ Health Solutions.

Please visit www.ColoradoPAR.com for additional support.