Children's Extensive Support Waiver
Checklist Application
Division for Intellectual and Developmental Disabilities
February 2016

The information contained in this packet **must** demonstrate the child meets the eligibility criteria for the CES waiver as follows:

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 on 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:

A. *Significant pattern* of self-endangering behavior or medical condition which, without intervention will result in a life threatening condition/situation.

Definition of Significant pattern:

- The behavior or medical condition is ***harmful to self or others.***
- Is evidenced by ***actual events.***
- The events occurred within the past ***six months; or***

B. A *significant pattern* of serious aggressive behaviors toward self, others or property.

- The behavior or medical condition is ***harmful to self or others.***
- Is evidenced by ***actual events.***
- The events occurred within the past ***six months; or***

C. *Constant* vocalizations such as screaming, crying, laughing or verbal threats which cause emotional distress to caregivers.

- Definition of Constant: On average of 15 minutes each waking hour.

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

- The child's behavior(s) or medical need(s) have been demonstrated; or
- 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:

- Medical records, professional evaluations and assessments, educational records, insurance claims, Behavior Pharmacology reports, police report, social services reports; or
- Observation by a third party on a regular basis

Child's Name: First: _____ Last: _____

Continued Stay Review: ____
Initial Enrollment: ____

Requested Certification Period (include start and end date):
_____

Name:	Social Security Number:
Date of Birth:	Height and Weight:
Medicaid ID Number:	Special Notes:

Information about the parents/legal guardians and physician:

Names:	Address:
Phone Number:	Physician name and number:

Information about the Community Centered Board:

Community Centered Board:	Case Manager/Resource Coordinator:
Date of DD Eligibility by CCB:	Case Manager/Resource Coordinator Phone:
E-mail address of Case Manager/Resource Coordinator:	

Child's current living situation: (check one)
_____ Lives with biological or adoptive parent(s) or legal guardian in the family home.
_____ In out of home placement and could return home with provision of CES services. Please describe:

Child's Name: First: ______________________ Last: ____

Below provide accurate information about the medical conditions, behaviors or vocalizations of the child. Include frequency (how often does it occur), duration (how long does it last) and intensity (what kind of injury it causes; such as bleeding, choking, bruising, etc.) Page 5 is a summary page where you can include important information that may not be reflected elsewhere in the application. Page 3 is to be used for daytime interventions and Page 4 is to be used for nighttime interventions.

Daytime Interventions

Column 1 **Medical Condition or Behavior** (see Appendix A for examples)	**Column 2** **Frequency-how often does it occur**		**Column 3** **Duration- State how long each behavior/condition episode lasts; 15 minutes, 1 hour, 2 hours, etc.)**	**Column 4** **Intensity-what is the injury to self or others-consequence of no intervention**	**Column 5** **Intervention-See Appendix B, enter code number of intervention here.**
	☐ Every 15 minutes ☐ Every hour ☐ Every two hours ☐ Other: Specify	☐ Daily ☐ Weekly ☐ Monthly			
	☐ Every 15 minutes ☐ Every hour ☐ Every two hours ☐ Other: Specify	☐ Daily ☐ Weekly ☐ Monthly			
	☐ Every 15 minutes ☐ Every hour ☐ Every two hours ☐ Other: Specify	☐ Daily ☐ Weekly ☐ Monthly			
	☐ Every 15 minutes ☐ Every hour ☐ Every two hours ☐ Other: Specify	☐ Daily ☐ Weekly ☐ Monthly			
	☐ Every 15 minutes ☐ Every hour ☐ Every two hours ☐ Other: Specify	☐ Daily ☐ Weekly ☐ Monthly			
	☐ Every 15 minutes ☐ Every hour ☐ Every two hours ☐ Other: Specify	☐ Daily ☐ Weekly ☐ Monthly			
	☐ Every 15 minutes ☐ Every hour ☐ Every two hours ☐ Other: Specify	☐ Daily ☐ Weekly ☐ Monthly			

Child's Name: First: ______________________ Last: ____

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	☐ Every 15 minutes ☐ Every hour ☐ Every two hours ☐ Other: Specify	☐ Daily ☐ Weekly ☐ Monthly			
	☐ Every 15 minutes ☐ Every hour ☐ Every two hours ☐ Other: Specify	☐ Daily ☐ Weekly ☐ Monthly			
	☐ Every 15 minutes ☐ Every hour ☐ Every two hours ☐ Other: Specify	☐ Daily ☐ Weekly ☐ Monthly			
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	☐ Every 15 minutes ☐ Every hour ☐ Every two hours ☐ Other: Specify	☐ Daily ☐ Weekly ☐ Monthly			
	☐ Every 15 minutes ☐ Every hour ☐ Every two hours ☐ Other: Specify	☐ Daily ☐ Weekly ☐ Monthly			
	☐ Every 15 minutes ☐ Every hour ☐ Every two hours ☐ Other: Specify	☐ Daily ☐ Weekly ☐ Monthly			

Child's Name: First: ______________________ Last: ____

Nighttime Interventions-on a weekly average how many nights does intervention occur? ______________________________

Typical Bedtime: _______ Typical morning awake time: ____________ Total number of sleep each night: ___________

Column 1 **Medical Condition or Behavior** (see Appendix A for examples)	**Column 2** **Frequency-how often does it occur during nighttime hours.**		**Column 3** **Duration- State how long each behavior/condition episode lasts; 15 minutes, 1 hour, 2 hours, etc.)**	**Column 4** **Intensity-what is the current and ongoing injury to self or others?**	**Column 5** **Intervention-See page 5, enter number of intervention here.**
	☐ Every 15 minutes ☐ Every hour ☐ Every three hours ☐ Other: Specify	☐ Nightly ☐ Weekly ☐ Monthly			
	☐ Every 15 minutes ☐ Every hour ☐ Every three hours ☐ Other: Specify	☐ Nightly ☐ Weekly ☐ Monthly			
	☐ Every 15 minutes ☐ Every hour ☐ Every three hours ☐ Other: Specify	☐ Nightly ☐ Weekly ☐ Monthly			
	☐ Every 15 minutes ☐ Every hour ☐ Every three hours ☐ Other: Specify	☐ Nightly ☐ Weekly ☐ Monthly			
	☐ Every 15 minutes ☐ Every hour ☐ Every three hours ☐ Other: Specify	☐ Nightly ☐ Weekly ☐ Monthly			
	☐ Every 15 minutes ☐ Every hour ☐ Every three hours ☐ Other: Specify	☐ Nightly ☐ Weekly ☐ Monthly			
	☐ Every 15 minutes ☐ Every hour ☐ Every three hours ☐ Other: Specify	☐ Nightly ☐ Weekly ☐ Monthly			

Child's Name: First: _____ Last: _____

Summary Page: *(optional; limit to one page)* Briefly describe the frequency and intensity of behaviors or medical condition not detailed in previous pages but may further demonstrate eligibility for CES.

For example this may include: nature and extent of injuries sustained within the past 6 months, the school environment (1:1 aide, what the aide does to help the child, details of a behavior plan, enclosed environment to limit distractions, interaction with specialized school teams, i.e. District Autism Team, etc.), or description and dates of emergency room visits, hospitalizations, police interventions, and non-routine behaviors or medical conditions.

Child's Name: First: _____ Last: _____

Pages 7 and 8 are to be completed ONLY for Continued Stay Review and ONLY if the child is NOT experiencing any behavioral/medical condition(s) that can be used as qualifying criteria DUE TO interventions provided by a CES service as listed below. Do not complete these pages if the child is new to CES.

If these pages are blank: do not fax to State Level Reviewer

Assistive Technology	Description of service:	Behavior/medical condition this helps to modify:
Behavior Services	Description of service:	Behavior/medical condition this helps to modify:
Home Accessibility Adaptations	Description of service:	Behavior/medical condition this helps to modify:
Personal Care	Description of service:	Behavior/medical condition this helps to modify:
Professional Service; **Hippo-therapy** **Movement therapy** **Massage therapy**	Description of service:	Behavior/medical condition this helps to modify:

Child's Name: First: _____ Last: _____

Specialized Medical Equipment and Supplies	Description of service:	Behavior/medical condition this helps to modify:
Respite	Description of service:	Behavior/medical condition this helps to modify:
Vision	Description of service:	Behavior/medical condition this helps to modify:

Child's Name: First: _____ Last: _____

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 six (6) months**. Examples shall include, but not be limited to any of the following: medical records, professional evaluations and assessments, educational records, including communication logs between parent and school, insurance claims, Behavior Pharmacology Clinic reports, incident reports, police reports, social services reports or observation by a third party on a regular basis. Sources of information need to be from external sources outside the family and CCB. D*o not include IEP*. *Do not list the ULTC 100.2 or the CES application as documentation.* **Do not send documents with the application, documents will be requested if needed. All documents listed below must be available if requested by the State Level Reviewer or the Division for Intellectual and Developmental Disabilities (DIDD).** Any behaviors or medical conditions listed in this application are subject to documentation.

Type of document or source of information	**Date of document or source of information dd/mm/yy**	**Who prepared the document or provided the information?**
	_____/_____/_____	
	_____/_____/_____	
	_____/_____/_____	

Child's Name: First: _____ Last: _____

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 living, daily and nightly routines and medical and behavioral conditions.

Parent or Legal Guardian: (Circle one)

I certify, to the best of my knowledge, all information on this application is true and complete.

Signature	Print Name	Date

Case manager/Resource Coordinator

I certify, to the best of my knowledge, all information on this application is true and complete.

Signature	Print Name	Date

Send completed application to:

eQHealth

FAX: 855-751-0332

Email: coloradoCES@eqhs.org

Child's Name: First: _____ Last: _____

Appendix A

DO NOT SUBMIT TO REVIEWER

To qualify for the CES waiver –The child must demonstrate a **behavior** or has a **medical condition** or **constant vocalization** that requires **direct human intervention, more intense than a verbal reminder, redirection or brief observation of status**, at least once **every two hours during the day and on 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;

Medical Condition

Neurological
- Seizures/neurological condition
- Tics
- Tremors

Respiratory problems
- Other lung or airway issues
- Aspiration

Digestive
- Choking
- Nothing by mouth
- Feeding disorder
- Swallowing disorder
- Sensory Issues with Feeding
- Colostomy or _____ostomy
- Diarrhea
- Constipation
- Other elimination Issues
- Reflux
- Specify any other digestive issues
- Tracheostomy

Immune System
- Immune system compromised
- Illness

Musculo/skeletal Issues
- Paralysis
- Muscle Spasms
- Muscle Atrophy (weakness or loss of muscle)
- Scoliosis
- Joint Pain
- Other Musculo/skeletal Issues

Skin
- Skin Breakdown
- Unable to regulate body temperature
- Other Skin issues

Sensory
- Visual Impairments
- Hearing Impairments
- Smelling Impairments
- Overall sensory issues
- Lack of awareness of injury sustained

Child's Name: First: _____ Last: _____

Appendix A1-DO NOT SUBMIT TO REVIEWER

Behavioral Conditions

Self-endangering Behavior

- Thoughts of suicide
- Wandering
- Elopement (running away)
- Leaving car restraint
- Interfering with driver of vehicle
- Climbing with high risk of injury
- Jumping with high risk of injury
- Head banging on hard surface
- Hitting head with fist causing bleeding, bruising, eye injury
- Fire Setting
- Dangerous/inappropriate sexual behavior
- Lack of kitchen safety
- Lack of household safety
- Pica (eating unusual things, dirt, plaster, etc.)
- Stuffing mouth with food and chokes
- Packing nose, ears, mouth with foreign items
- Chemical mixing
- Lack of awareness of injury sustained
- Breaking of skin due to picking or pinching
- Inappropriate dress for weather
- Other: Describe on description page

Serious Aggressive Behavior

- Fascination with Sharp Objects

Breaking of skin or gouging

- Biting-self or others
- Hitting/grabbing-self or others
- Kicking
- Pushing
- Spitting
- Twisting of skin
- Pinching
- Choking others
- Head Butting
- Smearing feces
- Inappropriate urination
- Shredding of clothing
- Destruction of home/contents
- Property damage
- Aggression to animals
- Other: Describe on description page

Constant Vocalization

- Screaming
- Crying
- Shrieking
- Humming
- Laughing
- Grunting
- Swearing
- Perseveration (need to repeat)
- Echolalia (echoes everything he/she hears)
- Other: Describe on description page

Child's Name: First: _____ Last: _____

Appendix B- DO NOT FAX

Medical Interventions	
1	ER Visits
2	Hospitalizations
3	Doctor Visits
4	Mental Health Visits
5	Surgeries
6	911 calls
7	Social Services contact
8	Police Interventions
9	Oxygen
10	Suctioning
11	Bi-pap
12	C-pap
13	Pulse-ox
14	Nebulizers
15	Heart monitor
16	Dialysis
17	Tube feeding
18	Adaptive equipment
19	Repositioning
20	Special diet
21	Wound care
22	Skin care
23	Diapering
24	Interventions during seizures
25	Wheelchair ramp
26	ABI Vest
27	1 on 1 supervision
28	Response to medical equipment alarms
29	Administration of medications via G-tube
30	CPR
80	Other: Specify

Behavioral Interventions	
1	ER Visits
2	Hospitalizations
3	Doctor Visits
4	Mental Health Visits
5	Surgeries
6	911 calls
7	Social Services contact
8	Police Interventions
50	1 on 1 supervision
51	Environmental adjustments
52	Modifications to Home
53	Safe Room
54	Locks on Door/Window
55	Alarm System
56	Specialized Clothing
57	Parent vigilance at night
58	Locking child's bedroom door at night
59	Child sleeps with parents
60	Mattress on floor
61	Child's room is bare
62	Baby Monitors
63	Physically removing child from situation
64	Physically holding child for safety
65	Sensory input: Specify
66	Behavior Plan
67	Homebound
68	1:1 Para at school
69	Early Dismissal from school
70	Suspensions/Expulsions from school
71	Suspensions/Expulsions from school bus
72	Harness used in car/bus
73	Seat belt locks
74	Car seat not required by law
75	Prevention of ingestion of medications, poisons, cleaning liquids, etc.
76	Prevention of pica
77	Prevention of suicide attempts
78	Prevention of sexual aggression
79	Prevention of non-aggressive but inappropriate behavior
80	Other: Specify