DRAFT_Service Eligibility Determination Form

To be Utilized for Initial Prior Authorization

Child's Name: _____ Date of Birth: _____

Child's Medicaid Identification Number: _____

Provider/Agency Name: _____ Contact Person: _____

Provider/Agency Phone Number:_____NPI Number: _____

☐ This is an initial prior authorization request
*Initial is defined as an individual who has not accessed Children's DD services prior to 7/1/19 or an individual who has been out of services for more than 364 days.

☐ The individual has active Medicaid

☐ The individual is between birth and eighteen (18) years of age; or

☐ The individual is between eighteen (18) and twenty-one (21) years of age (through the month of their birthday) and the service requested does not duplicate any Adult service(s) they are receiving.

Screening

☐ The individual has had a screening completed within the last 365 days Date Completed: _____

☐ The screening has identified deficits in three (3) or more of the following functional areas or a combination of functional and behavioral needs: (please check those areas that apply)
*A deficit is defined as one point five (1.5) or more standard deviations below the mean for all functional areas or above the mean for maladaptive behaviors.

- ☐ Self-Care Standard Deviation of: _____
- ☐ Receptive & Expressive Language Standard Deviation of: _____
- ☐ Learning Standard Deviation of: _____
- ☐ Mobility Standard Deviation of: _____
- ☐ Self-Direction Standard Deviation of: _____
- ☐ Capacity for Independent Living Standard Deviation of: _____
- ☐ Economic Self-Sufficiency Standard Deviation of: _____
- ☐ Maladaptive Behaviors Standard Deviation of: _____

☐ The screening tool is attached

Physician Recommendation

☐ Physicians Recommendation Form is attached

Assessment and Clinical Treatment Plan

☐ The Assessment and Clinical Treatment Plan is attached

Implementation Plan(s)

☐ Implementation Plan(s) are attached