

DDS Psychology Team Checklist for CES Waiver Eligibility Reevaluations

<u>Required</u>	
<input type="checkbox"/>	DDS CES 703
<input type="checkbox"/>	Areas of Need
<input type="checkbox"/>	Psychological/psychoeducational/Developmental Evaluations inclusive of IQ and adaptive functioning
If available, please submit the following. NOT required	
<input type="checkbox"/>	Speech, OT, PT Evaluations if applicable
<input type="checkbox"/>	School Records (Evaluation/Programming Conference Decision form; Existing Data Review form; Notice of Action; IEP; transcript; etc.) if applicable
<input type="checkbox"/>	Psychiatric records (Admission/discharge summaries; treatment plans; etc.) if applicable
<input type="checkbox"/>	Medical records if applicable
<input type="checkbox"/>	Speech, OT, PT evaluations, if applicable

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES
CES WAIVER PLAN BUDGET SHEET (WORD)

CES WAIVER PERSON CENTERED SERVICE PLAN
PHYSICIAN LEVEL OF CARE CERTIFICATION/ PRESCRIPTION

Individual's Name _____

Medicaid # _____

A. DIAGNOSIS: *(Please check all that apply):*

Intellectual Disability Cerebral Palsy Epilepsy Autism

Mental Illness (explain) _____

Other (explain) _____

B. MEDICAL DIAGNOSIS (if applicable): _____

C. MEDICATION (List all medications below)

1. List all non-psychotropic medications: _____

2. List all psychotropic medications: _____

D. Is any psychotropic medication used for behavior? Yes No

E. MEDICATION MANAGEMENT PLAN (for medication(s) listed in C): _____

F. PROGNOSIS: _____

G. SPECIAL ORDERS: _____

I have examined the patient within the past 30 days, and I have reviewed the Person Centered Service Plan *(check one)*.

I certify the waiver services and level of care listed in the plan.

I disagree with the waiver services and level of care listed in the plan.

I disagree with the following waiver service(s) listed in the plan: _____

Physician's Name (Printed): _____

Telephone () - _____

Ext _____

Address: _____

Physician's Signature: _____

Date: _____

AREAS OF NEED

Name of Person being Assessed: _____ Date: _____

Self-Care

The ability to perform daily activities to meet basic life needs including eating/feeding, bathing, toileting, dressing, and hygiene/grooming.

Eating

Dressing

Toileting

Bathing

Hygiene/Grooming

Understanding and Use of Language

Communication involving verbalization or an alternative communication system which enables an individual to convey ideas and information to others (expressive) and understand communication from others (receptive).

Describe the person's ability to communicate with others.

Describe the person's ability to socially interact with others.

Describe the person's ability to seek and accept guidance from others.

Learning:

General cognitive competence; the ability to acquire new behaviors, perceptions, and information; and the ability to apply experiences to new situations.

Describe any barriers for the person to acquire new behaviors/perceptions/information/skills?

Describe the intensity and types of repetitions/prompts/reminders/supervision required for the acquisition and continued performance of new behaviors/perceptions/information/skills?

Describe the person's ability to generalize what is learned from one situation to another situation (give examples if able).

Describe how does the person respond to changes in routine?

Describe how does the person respond to decision making?

Mobility:

The ability to perform gross and fine motor skills. The capability of locomotion, either by independent ambulation or with mobility assistance such as environmental or adaptive equipment/mechanical aids.

Describe how is the person mobile (walk, wheelchair, walker, etc.).

Describe how the person would exit their apartment/house in the event of fire.

If the person uses a wheelchair, describe how the person transfers between their wheelchair, bed and toilet.

Self-Direction

The management of, and control over, one's personal and social life, by making decisions which affect and protect one's self interests.

Describe the person's ability to make travel plans and make and keep appointments in their community.

Describe the person's ability to budget and otherwise handle money.

Describe the person's susceptibility of being exploited by others.

Describe the person's ability to secure and take medication as prescribed. Include information on their ability to follow doctor's orders.

Describe the person's ability to identify and respond appropriately in the case of an emergency.

Describe the person's ability to participate in recreational activities.

Describe the person's ability to seek and maintain employment.

Describe the person's ability to engage in appropriate sexual relationships.

Capacity for independent Living

The age-appropriate ability to live without extraordinary support

Describe the person's ability to prepare and properly store food.

Describe the person's ability to maintain a clean house/apartment.

Describe the person's ability to do their laundry.

Describe the person's ability to shop at a grocery store and at a clothing store.

Considering all the above mentioned tasks, if this person had to spend every night for a month by themselves, what would it be like at the end of the month?

PLEASE PRINT

Name of Person Completing this Form _____

Name of Informant _____

Relationship of Informant to Person being Assessed _____