

**DEPARTMENT OF MENTAL HEALTH/DIVISION OF DD  
Missouri Children's Developmental Disabilities Waiver  
APPLICATION FOR SLOT REQUEST**

REGIONAL OFFICE:	DATE:
Support Coordinator Name & phone #	
Support Coordinator's email address:	

Child's Name:	
DMH #	
Date of Birth:	
Social Security #:	
DCN:	
PON Score & date verified in CIMOR:	
Date placed on MOCDD wait list:	
Identify on-going waiver service requested?	

**\*\*IT'S MANDATORY ALL QUESTIONS ARE ANSWERED FOR CHILD TO BE CONSIDERED\*\***

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	ICF/DD Level of Care entered In CIMOR?
<input type="checkbox"/>	<input type="checkbox"/>	Is the child 17 ½ years of age or younger?
<input type="checkbox"/>	<input type="checkbox"/>	Is the child living in his/her natural home?
<input type="checkbox"/>	<input type="checkbox"/>	Is the child at risk of needing ICF/DD services if waiver services are not accessed? Give additional details below.
<input type="checkbox"/>	<input type="checkbox"/>	Is the primary caregiver disabled or experiencing an acute or chronic health condition? Give additional details below.
<input type="checkbox"/>	<input type="checkbox"/>	Are there other children in the home? Give additional details below.
<input type="checkbox"/>	<input type="checkbox"/>	Are there other children with a disability in the home? Give additional details below.
<input type="checkbox"/>	<input type="checkbox"/>	Does the family have private insurance for the child?
<input type="checkbox"/>	<input type="checkbox"/>	Has the child been <b>denied</b> MO HealthNet eligibility within the last 12 months? The family <u>must</u> have applied for MO HealthNet , including MO HealthNet for Kids and MO HealthNet for Disabled Children, and been denied within the last 12 months. <b>A denial letter is required.</b>
<input type="checkbox"/>	<input type="checkbox"/>	Is the Current Standard Means Test on file? Family income reported: \$_____ annual ( <b>must provide</b> )
<input type="checkbox"/>	<input type="checkbox"/>	Does the family understand and agree to ANNUAL redetermination of eligibility? Annually, each child's eligibility for the waiver must be redetermined. This must be explained to the parents. Children must continue to meet ALL of the eligibility criteria in order to continue participation in the MOCDD Waiver. This includes cooperating in the MO

		HealthNet reapplication process with Family Support Division.
<input type="checkbox"/>	<input type="checkbox"/>	Does the family understand that eligibility for the MOCDD Waiver ends on the child's 18 <sup>th</sup> birthday?
<input type="checkbox"/>	<input type="checkbox"/>	Does the family desire to Self – Direct state plan or waiver services? They must only Self-Direct one.

Please give **detailed** information explaining why the child is at risk for ICF/DD level of care placement?

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Please give **detailed** information regarding family size including information concerning caregivers (how many caregivers, relationship to the child, their ages, do one or both parents work outside the home, etc.). Please include information about other available and /or informal support systems (supports provided by grandparents, extended family and friends) and how much support they are able to provide.

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Please give **detailed** information regarding the child's developmental disability, health/medical status, and prognosis:

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THE FOLLOWING INFORMATION SHOULD DESCRIBE NOT ONLY THE NEEDS OF THE CHILD &

<p><u>FUNDING SOURCES, BUT ALSO WHO IS OR WILL BE RESPONSIBLE FOR PROVIDING THE SERVICE, SUPPORT, OR CARE.</u> This includes family &amp; caregivers involved in providing care for the child. Indicate if the family has established a caregiver or is arranging for one that potentially can contract &amp; enroll as a waiver provider.</p>
<p>INDICATE SERVICES &amp; COSTS THE FAMILY WILL PAY, or other payment source not otherwise listed on this form:</p>
<p>SERVICES INCLUDED IN CHILD'S IEP OR IFSP presumed to be provided through school or First Steps:</p>
<p>SERVICES AND COSTS THE CHILD'S PRIVATE INSURANCE WILL PAY:</p>
<p>SERVICES AND COSTS THE RO OR A SB-40 IS FUNDING:</p>
<p>SPECIFY <u>MEDICAID STATE PLAN SERVICES</u> AND COSTS TO BE APPLIED TO MO HealthNet. Such as, PRIVATE DUTY NURSING, PERSONAL CARE, SPEECH THERAPY, OT, PT, DME, PRESCRIPTIONS, ETC.: For each state plan service the child needs, indicate the approximate frequency &amp; duration.</p>
<p>SPECIFY the <u>ON-GOING</u> WAIVER SERVICES NEEDS OF THE CHILD and expected costs to be incurred by Division of DD: Indicate type of waiver service and the frequency &amp; duration of the waiver service. Such as PCA 3 hrs/day, 5 days/wk</p>
<p>SPECIFY WAIVER SERVICES NEEDED BY THE CHILD WHICH MAY BE ONE TIME or PERIODIC NEEDS: Eg, Environmental Adaptations which may be planned over a period of a year or two; Specialized Equipment</p>

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FPU Liaison

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Regional Office Director or Designee

Revised 04/19/13 ss