Specialized Foster Care

SPECIALIZED FOSTER CARE
1915(i) HOME AND COMMUNITY BASED SERVICES
NEEDS BASED ELIGIBILITY CHECKLIST

Please complete this checklist in order to determine the youth's eligibility for 1915(i) Home and Community Based Services for Specialized Foster Care. The provider must attach this completed Eligibility Checklist to the initial claim and annually thereafter through re-evaluation completion for the recipient through the Nevada Medicaid Provider Web Portal. Electronic Verification System (EVS) Chapter 3 Claims contains instructions for submitting claims and attaching documentation to claims. This Checklist must be completed by the designated Care Coordinator and may be completed after a review of the youth's records, including but not limited to treatment and placement history, Severely Emotionally Disturbed (SED) determination and Child and Adolescent Service Intensity Instrument (CASII) / Early Childhood Service Intensity Instrument (ECSII).

Youth's Name (Last, First): _____

Youth's Date of Birth: _____ Youth's Medicaid ID: _____

Child Welfare/Juvenile Justice Jurisdiction: _____

Effective Date Eligible for Services:_____

Youth must meet all of these criteria:

☐ age ≤ 19 ☐ Medicaid eligible ☐ Has a DSM-5 or DC 0:3 diagnosis

☐ Resides in a Nevada-licensed Specialized Foster Care (SFC) based setting not considered an institutional-level setting

AND youth must meet both criteria below under Impaired Functioning & Service Intensity AND must meet at least one criterion under Other Community Alternatives.

Impaired Functioning & Service Intensity *Must meet both*		
☐ SED determination = YES	**AND**	☐ CASII/ECSII Level ≥ 1

AND

Other Community Alternatives *Must meet at least one*
☐ At risk of higher level of care placement due to recent placement disruption within the past six months
☐ Current placement in emergency shelter or congregate care due to behavioral and mental health needs
☐ In need of transition to community-based living arrangement with intensive behavioral supports when returning or stepping down from residential treatment center or other higher level of care placement
☐ At risk of higher level of care placement because prior traditional family foster care and/or less restrictive community treatment services have not been successful

Care Coordinator *The Care Coordinator who completed this form must enter their name and sign below*
Care Coordinator Name (print or type): _____
Care Coordinator Signature:_____