

Must be printed on BLUE paper

MDHHS Date Received Stamp

PIHP Date Received Stamp

HSW NEW APPLICANT WORKSHEET

PM S

Res Code: _____ FY: 20

M / F Age

DOB: _____

Name: _____ Medicaid ID# _____

PIHP: _____ CMH/MCPN: _____ County: _____

Residence: _____

CWP Grad Other Priority Group

DIAGNOSIS: DD / SMI

<u>MEDS</u>	# anti-psychotic meds
	# other psych meds

[Schizophrenia, Schizophreniform Disorder, or Schizoaffective Disorder (ICD code 295.xx); Delusional Disorder (ICD code 297.1); Psychotic Disorder NOS (ICD code 298.9); Psychotic Disorder due to a general medical condition (ICD codes 293.81 or 293.82); Dementia with delusions (ICD code 294.42); Bipolar I Disorder (ICD codes 296.0x, 296.4x, 296.5x, 296.6x, or 296.7); or Major Depressive Disorder (ICD codes 296.2x and 296.3x)]

HSW SERVICES Specified in the IPOS

IPOS DATE: _____

- Community Living Supports
- Enhanced Medical Equipment & Supplies
- Enhanced Pharmacy
- Environmental Modifications
- Family Training

- Goods and Services (s-d only)
- Out of Home Non-Voc Habilitation
- PERS
- Prevocational Services

- PDN (21+)
- Respite Care
- Supports Coordination
- Supported Employment

GOALS (Abbreviations acceptable):

RECOMMENDATION:

- Enroll in HSW - all 5 criteria met
 - LOC Applied Accurately
 - Meets ICF/IID LOC
 - LOC Documented on HSW Cert Form
 - QIDP Certified
 - Given Choice between HSW or institutional care
 - Date Certification Signed by QIDP (Section 2) _____
- PEND: Additional Information Needed (see reverse side for details)
- Do not Enroll in HSW

Reviewed by: _____

Date: _____