

## Medically Intensive Children's Program (MICP) Application and Instructions

This application is required for the Developmental Disabilities Administration (DDA) to process a request for skilled private duty nursing for children age 17 years and younger who meet the coverage criteria per WAC 182-551-3000.

Minimum criteria used to determine eligibility includes the following requirements. The child:

- Is enrolled in the Medicaid program and eligible for the categorically needy (CN) or medically needy (MN) scope of care, specifically Fee for Service; and
- Requires at least four (4) continuous hours of **skilled nursing** care per day that can be provided safely outside of an institution.

The MICP Program Manager authorizes services only after review of the application and only after program eligibility for the child has been determined, and reviewed by DDA clinical staff.

Once a complete MICP Application is received, the determination of MICP nursing eligibility can be made within 15 days. If it is anticipated that the child's individualized support needs are unable to be met in the family home, the DDA Case / Resource Manager is required to complete an assessment and meet with the child's parent/legal guardian to discuss out-of-home respite and Voluntary Placement Services if determined to be clinically eligible.

Washington State Medicaid is the payer of last resort for MICP services. DDA assessed hours are not in addition to hours paid by other sources. Authorization of services does not guarantee payment to providers.

If the child is not already enrolled in DDA services, a DDA application must also be submitted with the MICP application. See the forms listed below for DDA application.

These are the forms needed to be completed for DDA application: DSHS 14-012, Consent, DSHS14-151, Request for DDA Eligibility Determination, and DSHS 03-387, Notice of Privacy Practices for Client Confidential Information are available at the DSHS Electronic forms site <https://www.dshs.wa.gov/fsa/forms>.

**The completed application and supporting documents must be sent to BOTH contacts listed below:**

- The MICP Program Manager by preferred method of secure e-mail to [MICP@dshs.wa.gov](mailto:MICP@dshs.wa.gov) or fax at 360-438-8633.
- The child's Regional DDA Office to: Attention: Intake and Eligibility Coordinator. See the list of DDA regional fax numbers below.

Applications will not be processed until all information is received, boxes are checked for required information included in the packet and consent is signed by parent / guardian.

Region 1 Fax Number	509-568-3037
Region 2S Fax Number	206-720-3334
Region 2N Fax Number	425-697-4482
Region 3 Fax Number	253-597-4368



## Medically Intensive Children's Program (MICP) Application

CHILD'S NAME (LAST, FIRST)		DATE OF APPLICATION (MM/DD/YYYY):	DATE CHILD WAS ADMITTED TO HOSPITAL (MM/DD/YY):
<b>Contact Information</b>			
NAME OF HOSPITAL OR OTHER REFERRAL SOURCE SUBMITTING THIS APPLICATION		EMAIL ADDRESS	
NAME OF PERSON TO CONTACT REGARDING THIS APPLICATION		TELEPHONE / CELL NUMBER	
CHILD'S DATE OF BIRTH (MM/DD/YY)	CHILD'S MEDICAID NUMBER (REQUIRED) <b>Note: The child must be enrolled in Medicaid Fee for Service to receive MICP services.</b>		
CHILD'S ADSA ID (IF KNOWN)	Has a request for MICP nursing been made in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when:		
PARENT(S) / GUARDIAN NAME		DDA CASE RESOURCE MANAGER (IF KNOWN)	
PARENT'S HOME ADDRESS		PARENT'S CONTACT PHONE NUMBER	
FAMILY'S PRIMARY LANGUAGE <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other (specify: _____)			
<b>Placement Recommendations</b>			
<p>Do you feel the needs can be met in the family home?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No If no, include why you feel the child's needs are <b>unable</b> to be met in the family home. If out of home placement is being considered please contact Regional DDA Intake and Eligibility and Regional MICP Coordinator to discuss options for this family.</p>			
ANTICIPATED DATE OF DISCHARGE FROM HOSPITAL/ADMIT TO MICP (MM/DD/YYYY)		CODE STATUS	
<b>Diagnoses</b>			
List the child's diagnoses including developmental delay and any other health conditions.			

## Funding Sources

Check all that apply whether nursing care is paid by the funding source or not.

- Medicaid Fee for Services **(Required)**
- SSI
- Managed Care Plan (Would not qualify for MICP since Managed Care Plan would pay for nursing)
- Private insurance

**Note:** Your private insurance company may be required to cover the cost of private duty nursing, even if they have denied you this benefit. You may only have a limited time to appeal a denial or termination. If you are experiencing difficulties with your private insurance company, you should reference the law that requires some private insurance companies to cover private duty nursing (WAC 284-96-500 and WAC 284-44-500) and contact the Office of the Insurance Commissioner's hotline at 1-800-562-6900 for assistance resolving a dispute.

**If the client has private insurance, the following information is required:**

1. Name of insurance company: \_\_\_\_\_
2. Describe coverage for private duty nursing (e.g., what is covered, for how long, and what the maximum dollar limitations are for home nursing):
  
3. If insurance is now or will be paying for private duty nursing, how many hours per day will they be authorizing?  
\_\_\_ hours per day

- Other funding resources (i.e., trust, spend down plan, school hours) (explain):

## Conditions supporting request for MICP Private Duty Nursing

Check and complete all that apply.

- Tracheostomy with ventilator dependency due to:

- Tracheostomy with BiPAP dependency due to:

- Tracheostomy with CPAP dependency due to:

- Tracheostomy dependency due to:

Gastrostomy or Jejunostomy tube dependency for all nutrition:

Nasogastric or Nasoduodenal tube for all nutrition / medications:

Total parenteral nutrition (excluding GT or JT, explain):

Central Line. If yes, type (explain):

Complex medication regimen (explain):

Airway/respiratory instability (explain):

Other supporting information:

**CHECK BOXES and ATTACH all information that must be received by intake and Eligibility at the child's DDA regional office.**

Verification of DDA eligibility or completed form DSHS 14-151, Request for DDA Eligibility Determination.

Has this child been receiving DDA services?  Yes  No

If yes, name of case manager:

DSHS 14-012, Consent. Signed by parent / guardian.

DSHS 03-387, Notice of Privacy Practices for Client Confidential Information.

**Information to ATTACH to this application (check and attach all that apply). Must be current within three months. Please ATTACH all documents as applications missing information will be returned for additional information. Please check off the information included in this packet.**

- Psychosocial assessment that includes psychosocial history or summary, current family situation and presence of stresses within and upon the family.
- List of current medications and/or medication administration records (MAR)
- List of current treatments and/or treatment records (TAR)
- Ventilator/BiPAP/CPAP hours/day or frequency of use
- History and physical
- Recent interim summary, discharge summary, or clinic summary
- Recent nursing charting (if inpatient)
- Statement that the home care plan is safe for the child and is agreed to by the parent and/or the child's guardian/legal representative
- Other family supports such as Medicaid, school hours, hours paid by insurance or trust, other family members, etc.
- Family has private insurance and they will not pay.
  - Managed Care or other insurance has determined they will not cover this claim. Letter of denial attached.
  - Appeal has been made and second letter of denial is attached.

**Parent Legal Representative Request and Signature**

I am requesting Medically Intensive Children's Program (MICP) nursing services. I have been advised of the options available in which MICP nursing services may be provided to my child once clinical eligibility is determined.

PARENT/LEGAL REPRESENTATIVE SIGNATURE

DATE