



# Children with Special Health Care Needs Manual

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John Weisman, Secretary  
Department of Health

Janna Bardi, Assistant Secretary  
Division of Prevention and Community Health

Lacy Fehrenbach, Director  
Office of Healthy Communities

Maria Nardella, Manager  
Healthy Starts and Transitions Unit (includes Children with  
Special Health Care Needs Program)

Meredith Pyle, Supervisor  
Children with Special Health Care Needs Program

*\*Sections of the manual originated in 1993 and have been updated periodically;  
revision dates are noted in the footer of each section.*

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(TDD/TTY call 711).

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The purpose of the *Children with Special Health Care Needs Manual* (CSHCN) is to provide core information about the structure, policies and procedures of the CSHCN Program. Most of the manual sections are of a permanent nature and remain accurate across time. The target audience is local health jurisdictions and other contractors who have contractual requirements for tasks, activities and/or deliverables that reference the CSHCN Manual for additional guidance.

<http://www.doh.wa.gov/Portals/1/Documents/Pubs/970-209-CSHCN-Manual.pdf>

The *CSHCN Orientation Notebook* is a companion to the CSHCN Manual. It is a document for CSHCN Coordinators in local health jurisdictions and other Public Health Nurses working with children and their families.

[http://www.doh.wa.gov/portals/1/documents/pubs/970-112\\_cshcnorientationnotebook.pdf](http://www.doh.wa.gov/portals/1/documents/pubs/970-112_cshcnorientationnotebook.pdf)

For additional information, or questions/comments, please contact:

Christy Polking  
CSHCN Special Services Consultant  
Post Office Box 47880  
Olympia, Washington 98504-7880  
360-236-3571  
FAX 360-586-7868

Email: [cshcn.support@doh.wa.gov](mailto:cshcn.support@doh.wa.gov)

CSHCN Website:

<http://www.doh.wa.gov/YouandYourFamily/InfantsChildrenandTeens/HealthandSafety/ChildrenwithSpecialHealthCareNeeds.aspx>

# Children with Special Health Care Needs Manual

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**Alert!** Each section listed in this table of contents has been created with a built-in link to take you directly to it—simply hover over the line item and Ctrl and Click to go directly to the page. As an Adobe (.pdf) document, the guide also is easily navigated by using bookmarks on the left side of the document. (If you don't immediately see the bookmarks, right click on the document and select Navigation Pane Buttons. Click on the bookmark icon on the left of the document.



# Section 1000 – Mission and Philosophy

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## 1100 Introduction

*This section uses a number of acronyms that are listed in the Appendices.*

In recent years, there has been a movement to reform the delivery of services to children and families. An increasing number of initiatives have been directed at the reorganization and restructuring of these services. Federal legislation has led to major federal and state initiatives to improve maternal and child health and to support the development of service delivery systems for infants and children, including those with special health care needs and their families.

The purpose of this section is to provide information about some of these activities and a philosophical framework for services for children, including those with special health care needs, from international, national, state, and agency perspectives.

## 1200 The International Perspective

In 1989, the United Nations adopted the Convention of the Rights of the Child, which is the first comprehensive international law for children. Each country can choose to ratify the convention and make it a part of their national law. The Convention protects children's rights by setting standards in health care, education, and legal, civil and social services. In 2002, two protocols were adopted to strengthen provisions for children in armed conflict.

Under the Convention the following Rights of the Child will be protected:

- **The Right to Survival** through the provision of primary health care, adequate food, clean water and shelter.
- **The Right to Protection** from abuse, neglect and exploitation, including the right to special protection in times of war, and
- **The Right to Develop** in a safe environment through formal education, constructive play, advanced health care and the opportunity to participate in the family social, economic, religious and political life of their culture, free from discrimination.

## 1300 The National Perspective

### 1310 A National Goal

In June of 1987, the Surgeon General of the United States called for the promotion of family-centered, community-based, coordinated care for children with special health care needs and their families. With the issuance of the Surgeon General's report, *Children With Special Health Care Needs: Campaign '87*, the creation, expansion, and improvement of community-based service systems for children with special health care needs became a national goal.

Currently, health care reform is driving improvements in clinical care and chronic disease prevention. In 2011, federal Chronic Disease Prevention and Health Promotion Program Grant funding was directed toward building and strengthening capacity to prevent chronic disease and promote health. The primary requirement is to build a single statewide plan in coordination with partners to improve health. National priorities include:

- **The National Prevention Strategy** – a comprehensive plan to increase the number of Americans that are healthy at every stage of life.
- **Rethinking Maternal and Child Health** – combines health equity, social determinants, biology and environment in a *life course model*. The life course theory addresses these interactions in an understanding of health development over a lifespan and generations.
- **National Quality Strategy** – aims at making health care accessible, safe, and patient centered.
- **Healthy People 2020** – establishes goals for the prevention of chronic disease and measures the health of the nation.
- **The Triple Aim** – a framework developed by the Institute for Healthcare Improvement (IHI) that describes an approach to optimizing health system performance. It is IHI’s belief that new designs must be developed to simultaneously pursue three dimensions, called the “Triple Aim”. These three aims are as follows:
  - Aim 1.** Improving the patient experience of care (including quality and satisfaction);
  - Aim 2.** Improving the health of populations; and
  - Aim 3.** Reducing the per capita cost of health care.
- **Affordable Care Act** – On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (ACA). Along with the Health Care and Education Reconciliation Act of 2010, the law put in place comprehensive health insurance reforms. The law makes preventive care—including family planning and related care—more accessible and affordable for many Americans. For additional information, go to <http://www.hhs.gov/healthcare/about-the-law/read-the-law/>
- **National Standards for Systems of Care for Children and Youth with Special Health Care Needs.** This white paper, **Developing Structure and Process Standards for Systems of Care Serving Children and Youth with Special Health Care Needs** (March 13, 2014), along with the standards, outlines in detail the structures and processes needed for a high-quality, coordinated system of care for children with special health care needs. The report is unique in that it represents the consensus of a consortium of public and private organizations, and is the first-ever national, collective effort to detail the components of a high quality system. <http://www.lpfch.org/publication/standards-systems-care-children-and-youth-special-health-care-needs>

1320 Title V Maternal and Child Health Block Grant

Title V of the Social Security Act has authorized Maternal and Child Health (MCH) Services Programs since 1935. The Title V Federal-State partnership continues to provide a dynamic program to improve the health of all mothers and children including children with special health care needs. Significant amendments to the program were made in 1981 when seven categorical programs, the largest being the Maternal and Child Health Services and Crippled Children's Services programs, were consolidated into a single Maternal and Child Health Block Grant (MCHBG), allowing states discretion in use of federal funds to achieve goals consistent with identified state needs and the purpose of the enabling legislation.

Effective in 1986, programs for Crippled Children were re-designated as programs for Children with Special Health Care Needs (CSHCN) and new provisions relating to children's services were introduced. Title V was amended by the Omnibus Budget Reconciliation Act of 1989 (OBRA '89), Public Law 101-239 and a minimum of 30 percent of the block grant funding was/is earmarked for children with special health care needs and their families. In 1993, the Government Performance and Results Act, Public Law 103-62, required Federal agencies to establish measurable goals, and for the first time, funding decisions were linked directly with performance.

The purpose of Title V is to improve the health of all mothers and children consistent with the applicable health status goals and the Healthy People National Health Objectives, established under the Public Health Service Act. Healthy People 2020 builds on initiatives pursued over the past two decades and challenges individuals,

communities and professionals to take specific steps to ensure that good health, as well as long life, are enjoyed by all.

Funds allocated to the states by formula under the Block Grant, along with required matching state funds, enable states to:

- Assure mothers and children access to quality maternal and child health services;
- Reduce infant mortality, the incidence of preventable diseases and handicapping conditions, and the need for inpatient and long-term care services;
- Increase the number of children appropriately immunized against disease.
- Increase the number of low income children receiving health assessments and follow-up diagnostic and treatment services;
- Promote the health of mothers and infants by providing prenatal, delivery, and postpartum care for low-income, at-risk pregnant women,
- Promote the health of children by providing preventive and primary care services for low-income children;
- Provide rehabilitation services for blind and disabled individuals under the age of 16 receiving benefits under Title XVI (of the Social Security Act) to the extent medical assistance for such services is not provided under Title XIX;
- Promote family-centered, community-based, coordinated care (including care coordination services); and
- Facilitate the development of community-based systems of services for children with special health care needs and their families.

In 2015, the MCH Bureau transformed the MCHBG. This resulted in a change to different performance measures and proposed activities. For the Title V program, Washington (WA) State is focusing on three key domains – child health, children and youth with special health care needs, and cross-cutting issues. These are described in Section 1360.

### 1330 Omnibus Budget and Reconciliation Act of 1989

In 1989, the Omnibus Budget and Reconciliation Act (OBRA) enacted amendments to a number of programs targeted to women, children, and families. The Title V MCH Block Grant was included in the amendments. The amendments redefined the mission of the state CSHCN programs. OBRA 1989 changes to Title V (MCH Block Grant) legislation recognized and strengthened the vital role of Title V agencies in addressing national priorities of promoting health and well-being of women, infants and children.

The amendments included specific provisions that addressed the relationship between Title V and Title XIX. They reinforced the need for working partnerships and interagency agreements between these two programs. In 1997, the Federal Maternal and Child Health Bureau (MCHB), together with its partners identified six national performance measures for state CSHCN programs.<sup>1</sup> These performance measures were used to measure progress towards the development of community based systems of service for all children including CSHCN and, at the time, were consistent with MCHB goals and Healthy People 2020 initiatives.

### 1340 Individuals with Disabilities Education Act (Formerly PL 99-457)

In April of 1970, Congress passed Public Law (PL) 91-230, the Education of the Handicapped Act (EHA). Congress, in 1975, amended the EHA with the passage of PL 94-142, the Education for Handicapped Children

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<sup>1</sup> Kogan MD, Dykton C, Hirai AH, et al. A New Performance Measurement System for Maternal and Child Health in the United States. *Maternal and Child Health Journal*. 2015;19(5):945-957. doi:10.1007/s10995-015-1739-5.

Act. This act mandated a "free, appropriate public education to school-aged children, regardless of handicapping condition" and provided incentive grants to serve children from the age of three years (i.e., preschool). The EHA was further amended in 1986 when Congress passed PL 99-457, the Education for the Handicapped Act Amendments of 1986.

PL 99-457 amended the EHA, Parts A-G, including a requirement that states provide a "free, appropriate public education" for children, ages three to five, who have handicapping conditions by school year 1990-91. Further, PL 99-457 created a new program, Part C (previously Part H), to help states develop comprehensive statewide early intervention programs for infants and toddlers, age birth to three, with disabilities and/or delays, and their families. It is Part C of PL 99-457 that has the greatest impact on infants and toddlers with disabilities, their families, and the many agencies that serve them.

Congress, in passing PL 99-457, felt that early intervention services are critical if children with disabilities and/or delays are to meet their developmental potential. PL 99-457 acknowledges the need to enhance the capacity of families in meeting the needs of their children with disabilities. Further, the law recognizes that to meet the needs of these children and their families, services need to be provided which are interagency and multidisciplinary. Consequently, PL 99-457 has implications for a wide range of agencies serving children and families, unlike PL 94-142, which primarily affected educational agencies. PL 99-457 requires collaboration and coordination among all service providers in order to deliver high quality, family centered services. This law was subsequently updated through amendments PL 101-476.

In October 1991, PL 102-119, the Individuals with Disabilities Education Act (IDEA) strengthened outreach activities, parent training, and personnel development goals. It required states to assure smooth transitions from early intervention to preschool services, updated definitions and terminology, and clarified parent rights.

IDEA Amendments of 1997 (PL 105-17) supported initiatives for transition services from high school to adult living. Because of these mandates, each student's Individualized Education Program (IEP) must include transition plans or procedures for identifying appropriate employment and other post-school adult living objectives for the student; referring the student to appropriate community agencies; and linking the student to available community resources, including job placement and other follow-up services. The amendment specifies that transition planning should begin at age 14 and the IEP must specifically designate who is responsible for each transition activity. For Early Intervention, the 1997 amendments changed Part H to Part C and clarified the natural environment requirement and the need to provide justification for each service not provided in the natural environment.

Reference is commonly made to two specific areas:

- IDEA Part B is the federal law that provides for special education and related services for children three through twenty-one.
- IDEA Part C is the federal law that promotes a comprehensive, coordinated early intervention system for infants and toddlers, birth to age three, with disabilities and/or delays, and their families. (See Section 1380).

## 1350 The American with Disabilities Act

The Americans with Disabilities Act (ADA) was signed into law in July 1990. ADA is intended to protect qualified individuals with disabilities from discrimination on the basis of disability. ADA is the most comprehensive federal civil-rights statute protecting the rights of people with disabilities. It affects access to employment; state and local government programs and services; access to places of public accommodation such as businesses, transportation, and non-profit service providers; and telecommunications. WA State agencies, contractors and grantees must comply with the ADA of 1990.

ADA disability is defined as a physical or mental impairment, substantially limiting one or more major life activities. The ADA includes both obvious disabilities and many "hidden" disabilities, such as seizure disorder, diabetes, HIV/AIDS, specific learning disabilities and/or former drug and alcohol abuse.

## 1360 National MCH Objectives for the Year 2020

The Healthy People initiative process began in 1979 with *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention*, which was followed in 1990 by Healthy People 2000. Healthy People 2020 represents the fourth time that the U.S. Department of Health and Human Services (DHHS) has developed 10-year health objectives for the Nation.

The new initiative, Healthy People 2020, is a 10-year action plan to improve the health of all Americans, including children with special health care needs. The plan's overarching goals include:

- Attain high-quality, longer lives free of preventable disease, disability, injury, and premature death.
- Achieve health equity, eliminate disparities, and improve the health of all groups.
- Create social and physical environments that promote good health for all.
- Promote quality of life, healthy development, and healthy behaviors across all life stages.

In 2015, the Bureau transformed the MCH Block Grant. The MCHB of the Health Resources and Services Administration (HRSA) led a 21-month visioning process to engage input from MCH stakeholders and other national, state and local MCH leaders, families and other partners to improve, innovate, and transform the Title V MCH Services Block Grant. The process has helped inform the development of a new grant guidance for the next 5-year cycle beginning in fiscal year 2016. The triple aims of the transformation are to reduce burden, maintain flexibility, and increase accountability.<sup>2</sup>

Children with special health care needs and their families are best equipped to meet these goals when systems are in place to meet the performance measures established by the federal MCHB some of which are specific to children with special health care needs and others are for all children. These align with the National Standard for Systems of Care for children and youth with special health care needs.

MCHBG Population Domain: Developmental Screening	Child Health
MCHBG Population Domain: Medical Home	Children and Youth with Special Health Care Needs
MCHBG Population Domain: Adequate Insurance	Cross-Cutting

In addition, the program works to insure that there are provisions for "older" Block Grant performance measures.

- Families of children and youth with special health care needs are partners in decision-making at all levels and are satisfied with the services they receive.
- Children and youth with special health care needs receive coordinated comprehensive care within a medical home.

<sup>2</sup> Maternal Child Health J. 2015; 19(5): 927–931. Published online 2015 Feb 18. doi: [10.1007/s10995-015-1736-8](https://doi.org/10.1007/s10995-015-1736-8); PMID: PMC4428533. [Transformation of the Title V Maternal and Child Health Services Block Grant; Michael C. Lu, Cassie B. Lauver, Christopher Dykton, Michael D. Kogan, Michele H. Lawler, Lauren Raskin-Ramos, Kathy Watters, and Lee A. Wilson](#)

- Families of children and youth with special health care needs have adequate private and/or public insurance to pay for the services they need.
- Children are screened early and continuously for special health care needs.
- Community-based services for children and youth with special health care needs are organized so families can use them easily.
- Youth with special health care needs receive the services necessary to make transitions to all aspects of adult life, including health care, work, and independence.

## 1370 Institute of Medicine Report: The Future of Public Health

In 1988, the Institute of Medicine published its landmark report *The Future of Public Health*. The report defined the mission and core function of public health agencies. The mission of public health is to assure healthy conditions for all people. Core functions include assessment, policy development, and assurance. The report focused on ways to strengthen governmental public health infrastructure.

The Committee on Assuring the Health of the Public in the 21<sup>st</sup> Century was convened in 2001 with the charge to create a framework for public health in the United States that was more inclusive than the 1988 report. In the 2001 report, *The Future of the Public's Health*, the Committee uses the term “public health system” in a manner that builds on the 1988 usage, reflects present realities, and embraces the Healthy People goals. It recognizes both governmental components of the public health system and contributions of other sectors and entities. The report focuses on government public health *infrastructure and potential* partners in the public health system: the community, health care delivery systems, employers and business, the media, and academia.

In 2009 the Robert Wood Johnson Foundation asked the Institute of Medicine to convene a committee to examine measurement, the law, and funding in relation to public health. The institute of medicine subsequently released 3 reports with specific recommendations.

- For the Public's Health: The Role of Measurement in Action and Accountability (2010)
- For the Public's Health: Revitalizing Law and Policy to Meet New Challenges (2011)
- For the Public's Health: Investing in a Healthier Future (2012)

These three reports make a case for increased accountability of all sectors that affect health (clinical delivery systems, business, academia, government and non-government organizations, communities, and mass media). The committee reinforced the recognition that population health improvement is dependent on addressing the multiple determinants of health and needs to focus on a life course perspective.

## 1380 Early Intervention Services

The coordination and enhancement of WA State's existing early intervention services for infants and toddlers with disabilities was also addressed during the 1992 legislative session. A bill addressing early intervention services was incorporated into the Family Policy Initiative legislation as an amendment and passed as part of the Family State Policy Initiative bill.

State statute now requires that the Governor appoint a State Interagency Coordinating Council (SICC) and ensure that state agencies involved in the provision of, or payment for, early intervention services coordinate and collaborate in the planning and delivery of services. The Department of Early Learning (DEL) is designated as the lead agency for planning and implementing IDEA, Part C (see Section 1340); formerly, the lead agency was the Department of Social and Health Services (DSHS). The Department of Health (DOH) appoints a representative to the SICC who usually comes from the CSHCN Program. The legislation also establishes County Interagency Coordinating Councils as part of state law, calls for formal interagency agreements defining

relationships and financial and service responsibilities, and prohibits supplanting of funds or interruption of existing early intervention services.

## 1400 Washington State Perspective

### 1440 Organizational and Program Descriptions

#### ***1441 Washington State Board of Health***

The mission of the WA State Board of Health is to develop policies to promote, protect, maintain, and improve the health of all Washingtonians. To fulfill this mission, the Board is mandated by statute to serve as the focal point for professional and citizen health concerns and to gather these concerns into a coherent policy. For more information, go to: <http://sboh.wa.gov/AboutUs>

#### ***1442 Department of Health***

The Department of Health (DOH) protects and improves the health of people in WA State.

Our programs and services help prevent illness and injury, promote healthy places to live and work, provide information to help people make good health decisions and ensure our state is prepared for emergencies.

Our programs and services help ensure a safer and healthier WA by:

- Working to improve health through disease and injury prevention, immunization, and newborn screening
- Providing health and safety information, education and training so people can make healthy choices
- Promoting a health and wellness system where we live, learn, work, play and worship
- Addressing environmental health hazards associated with drinking water, food, air quality and pesticide exposure
- Protecting you and your family by licensing healthcare professionals, investigating disease outbreaks and preparing for emergencies

To accomplish all of these, we collaborate with many partners every day!

#### ***1443 Prevention and Community Health Division***

The Prevention and Community Health (PCH) Division supports the DOH's mission by collaborating with our partners and stakeholders to enhance the health of individuals, families, and communities. We work to prevent disease and promote a healthy start, healthy choices, and access to services. The division employees work in two primary locations and a few local health departments, to deliver public health services statewide.

#### ***1444 Office of Healthy Communities***

In WA, the Office of Healthy Communities (OHC), in the DOH, is the Title V agency that administers the federal Title V MCHBG.

The OHC is dedicated to making the healthy choice the easy choice in homes, communities, workplaces, healthcare settings, and schools. We work to prevent disease and promote health at every stage of life by implementing policies, systems, and environmental changes with a focus on health equity.

### ***1445 Access, Systems and Care Coordination***

The OHC – Access, Systems and Coordination (ASC) Section supports coordinated state and local systems to improve access to health services and information, increase health equity and improve the health of individuals, families and specific populations. Specifically, ASC focuses on Maternal and Infant Health, Genetics, Early Hearing Loss in Infants, Healthy Starts and Transitions, Child Health and Development, Children with Special Health Care Needs, Adolescent Health, Pregnant and Parenting Teens, and Women's Health.

### ***1446 Healthy Starts and Transitions***

The Healthy Starts and Transitions (HST) Unit supports integrated systems that improve access, linkages and coordination directed toward health, early and ongoing learning and development, and safe environments for all children and their families.

The Child Health and Development unit works to improve the health, development, learning, and well-being of children prenatally throughout childhood by increasing access to services, education/knowledge, and resources, including work through the different federal grants focusing on child abuse and neglect prevention, early mental health and developmental screening, and access to resource and referral. Additionally, the unit works to support the Help Me Grow Washington Partnership to meet the needs of children and families, child care providers, medical providers and other community partners.

The Children with Special Health Care Needs unit supports culturally competent, community-based, integrated systems of care for children and youth with special health care needs and their families and includes MCHBG, Medicaid and other federally funded activities such as Great LINC (Links to Integrate and Coordinate Services for Children and Youth with Special Health Care Needs) and AS3D (Innovation in Care Integration for Children and Youth with Autism Spectrum Disorders and Other Developmental Disabilities) grants.

### ***1447 Children with Special Health Care Needs Program***

The Children with Special Health Care Needs Program (CSHCN) is in the HST unit in the OHC at the DOH. The CSHCN Program, in partnership with families, national, state and local leaders, private and non-profit organizations, identifies and acts on emerging health issues facing children with special health care needs and their families. Together with our partners, CSHCN promotes and provides information leadership, linkages and joint problem solving.

The program promotes an integrated system of services for infants, children and youth up to age 18 years who have or are at risk for chronic physical, developmental, behavioral, or emotional conditions and require health and related services of a type or amount beyond what is generally needed.

At the state level, the program collaborates with families, policy makers, health care providers, agencies, and other public-private leaders to identify and improve health system issues that impact this population.

At the local level, the program supports contractors to help families with resources and linkages to community services including family support, care coordination, and health information. More details are described below.

This work is guided by the following principles:

- Families are the core of the health services system

Families are equal partners with experience, expertise and have many strengths. Families should be included in decision making at all levels.

- The community is the center of service provision

Services for children with special health care needs and their families should be delivered as close to home as possible. Community capacity is built through joint decision making, problem solving, sharing of knowledge, understanding of diversity, integration of service systems, and coordination between systems of care.

- Systems of care are comprehensive

Comprehensive systems of care are holistic, taking into consideration the child, family, providers, communities, health plans and the non-medical impacts on the health of the child. Comprehensive systems of care reflect full participation and joint responsibility, are cost effective, and assure quality services.

- Systems of care are culturally competent

Culturally competent systems of care incorporate the health beliefs and values of all by recognizing and acknowledging the importance of culture in all aspects of peoples' lives. This is reflected in flexible systems of care which recognize and respect the values of all.

*Organizational charts for DOH, PCH, OHC, HST, and CSHCN are in the Appendices.*

# Section 2000 - Legal Authority

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## 2100 Introduction

*This section continues to use a number of acronyms that are listed in the Appendices.*

The statutory authority for CSHCN services is defined by the Revised Code of Washington (RCW). The RCW is intended to "embrace in a revised, consolidated, and codified form and arrangement all the laws of the state of a general and permanent nature." RCW 43.20A.635 pertains to services for children with disabilities is directly quoted in Section 2200 below.

The Washington Administrative Code (WAC) provides agency rules for implementing state law as defined in the RCW. The sections pertaining to the Department of Health, Children with Special Health Care Needs Program, are from the 1999 WAC Chapter 246-710, and quoted in section 2300 below. These WAC amendments brought the rules into compliance with current program operations and did not add any new requirements.

## 2200 RCW 43.20A.635: Services for Children with Disabilities.

It shall be the duty of the secretary of social and health services and he shall have the power to establish and administer a program of services for children who are crippled or who are suffering from physical conditions which lead to crippling, which shall provide for developing, extending, and improving services for locating such children, and for providing for medical, surgical, corrective, and other services and care, and facilities for diagnosis, hospitalization, and after care; to supervise the administration of those services, included in the program, which are not administered directly by it; to extend and improve any such services, including those in existence on April 1, 1941; to cooperate with medical, health, nursing, and welfare groups and organizations, and with any agency of the state charged with the administration of laws providing for vocational rehabilitation of physically handicapped children; to cooperate with the federal government, through its appropriate agency or instrumentality in developing, extending, and improving such services; and to receive and expend all funds made available to the department by the federal government, the state or its political subdivisions, or from other sources, for such purposes. [1979 c 141 ~ 52; 1965 c 8 ~ 43.20.130. Prior: 1941 c 129 ~ 1; Rem. Supp. 1941 ~ 9992-107a; prior: 1937 c 114 ~ 7. Formerly RCW 74.12.210; 43.20.130.]

**NOTE: This RCW refers to the Department of Social and Health Services. We are currently working with the WA State Board of Health and the Department of Health's policy staff to get technical correction of the RCW to reflect DOH language and update this RCW.**

## 2300 CSHCN WAC Rules Currently in Effect

### 2310 Declaration of Purpose (WAC 246-710-001)

The following rules implement RCW 43.20.140 and Chapter 43.70 RCW. The state board of health may develop rules that are necessary to implement RCW 43.20A.635 authorizing the secretary of the department of health to administer a program of services for children with special health care needs. The purpose of the CSHCN Program is to develop, extend, and improve services and service systems for locating, diagnosing, and treating children with special health care needs within available resources.

## 2320 Definitions (WAC 246-710-010)

1. "Client" means an individual with special health care needs, seventeen years of age or younger, who is being served by a local CSHCN agency.
2. "Children with special health care needs" means children with disabilities or handicapping conditions; chronic illnesses or conditions; health related educational or behavioral problems; or children at risk of developing such disabilities, conditions, illnesses or problems.
3. "CSHCN" means the children with special health care needs program.
4. "Department" means department of health.
5. "Local CSHCN agency" means the local health jurisdiction or other agency locally administering the CSHCN program for the county where the client resides in the state of WA.
6. "Service systems" means community-based systems of services such as primary and specialty medical services, early intervention, special education, and social and family support services for children with special health care needs and their families.
7. "Services" means health-related interventions, including early identification, care coordination, medical, surgical and rehabilitation care, and equipment provided in hospitals, clinics, offices, and homes by local CSHCN agencies, physicians and other health care providers.

## 2330 Program Limitations (WAC 246-710-030)

1. The department may reduce the scope of CSHCN services and impose or revise funding limitations on certain services when required for budgetary reasons to accommodate available funding.
2. Financial eligibility for a client must be determined annually when health-related services and equipment are paid for with CSHCN funds. Financial eligibility will be determined according to national standards of living for low-income families such as federal poverty levels or state median income adjusted for family size. Financial eligibility is not entitlement to CSHCN services.

## 2340 Authorization of Services (WAC 246-710-050)

Authorization for services paid for with CSHCN funds will be accomplished in accordance with the following:

1. Financial eligibility for a client has been determined.
2. A request for services to be paid for with CSHCN funds has been reviewed for consistency with program directions. Services must be recognized as an acceptable form of treatment by a significant portion of the professional community.
3. No services will be authorized for out-of-state providers if an equivalent service is available within the state of Washington. However, use of resources in bordering states will be authorized when appropriate.

## 2350 Qualifications of Hospitals and Providers (WAC 246-710-060)

Providers of services paid for with CSHCN funds must meet the following minimum qualifications:

1. Hospitals will be:
  - (a) Accredited by the joint commission on the accreditation of health care organizations; and
  - (b) Licensed in the state where the hospital is located.
2. Physicians will be:
  - (a) Licensed to practice medicine in WA, or other state where they practice; and
  - (b) Board-certified or board-eligible by the appropriate specialty board.
3. Providers other than physicians will be:
  - (a) Licensed or certified in WA or in the state where they practice; or
  - (b) Accredited by the appropriate national professional organization when there is no state licensure or certification process.

## 2360 Fees and Payments (WAC 246-710-070)

1. Payments to providers of services using CSHCN funds will be made using the current CSHCN standards and payment schedules, including the WA State Health Care Authority (HCA) – Medicaid Program fee schedule and the CSHCN supplemental fee schedule.
2. A provider will accept the fees paid under this section as full payment for services rendered.

## 2370 Third-Party Resources (WAC 246-710-080)

CSHCN is a secondary payer to all private and other public funded health programs. The department may pay for services with CSHCN funds only after payment by all entitlement programs and by all other private and public funding resources, except where prohibited by federal law.

## 2380 Repayment (WAC 246-710-090)

Repayment to the department from the provider, family or other source is required should insurance benefits, trusts, court-awarded damages or like funds become available, and where payments have been made to the family or provider for services paid for by CSHCN.

**NOTE: We are currently working with the WA State Board of Health and the Department of Health's policy staff to get technical correction of the RCW as well as updating the WAC to reflect current practice.**

## Section 3000 - Organization

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## 3100 Children with Special Health Care Needs Program

### 3110 Introduction

*This section continues to use a number of acronyms that are listed in the Appendices.*

The Children with Special Health Care Needs (CSHCN) Program administration is housed in the Office of Healthy Communities (OHC) under the Healthy Starts and Transitions Unit. OHC is part of the Prevention and Community Health (PCH) Division in the Department of Health (DOH). See organizational charts in Appendices.

The CSHCN Program promotes and facilitates an integrated system of services for infants and children with or at risk for special health care needs through partnerships with other state level agencies, local health jurisdictions, local private and nonprofit agencies, the University of Washington, Seattle Children's, Neurodevelopmental Centers, and other tertiary care centers; and in collaboration with other DOH programs.

Authority for services comes from Title V of the Social Security Act, the Revised Code of Washington (RCW), and the Washington Administrative Code (WAC) as defined in Section 2000. Funding for services comes from a variety of sources including Title V, MCH Block Grant, State General Funds, and interagency agreements with other state agencies.

### 3120 Purpose

The CSHCN Program works to give children with special health care needs the opportunity to achieve the healthiest life possible and develop to their fullest potential. Emphasis is placed on the capacity of communities to support children and families and on developing and/or enhancing the capacity of statewide systems of care that are family centered, community-based, coordinated, and culturally competent.

At the state level, the CSHCN Program collaborates with families, policy makers, health care providers, agencies and other public-private leaders to:

- Identify and address health system issues that impact this population;
- Improve and enhance system infrastructure and quality;
- Evaluate and assess programs and services;
- Influence priority setting, planning, and policy development;
- Support parent organizations in developing and distributing health and resource information
- Support community efforts in assuring the health and well-being of children with special health care needs and their families.

### 3130 Target Population

Children with special health care needs are those who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and require health and related services of a type or amount beyond that required by children generally.<sup>1</sup>

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<sup>1</sup> McPherson M, Arango P, Fox H, Lauver C, McManus M, Newacheck P, Perrin J, Shonkoff J, Strickland B. A new definition of children with special health care needs. *Pediatrics*, 102(1):137-140, 1998

The population includes children who have or are at risk for:

- disabilities and handicapping conditions;
- chronic illness and conditions;
- health-related educational or behavioral health issues and concerns.

## 3200 Regional System

### 3210 Introduction

In 1988, a regional system was established to improve service coordination and statewide communication between the CSHCN Program and local CSHCN Programs and local health jurisdictions (LHJs). A LHJ is the county health department or district. The two exceptions are Yakima and Kittitas. In these two counties, the CSHCN program is managed through contracts with Yakima Valley Memorial Hospital/Children’s Village for Yakima County and Community Health of Washington in Kittitas County.

The state is sectioned into four geographical CSHCN regions. This valuable system continues today, providing communication opportunities for those who serve and know about children with special health care needs.

They are:

CENTRAL		
Benton-Franklin Chelan-Douglas Grant	Kittitas Okanogan	Walla Walla Yakima
EAST		
Adams Asotin	Garfield Lincoln	Spokane Whitman
Columbia	NE Tri-County (includes Ferry, Pend Oreille, & Stevens)	
NORTHWEST		
Clallam Island Jefferson	King Kitsap San Juan	Skagit Snohomish Whatcom
SOUTHWEST		
Clark Cowlitz Grays Harbor Klickitat	Lewis Mason Pacific Pierce	Skamania Thurston Wahkiakum

Agencies that contract with the CSHCN Program are required to participate in the Regional System.

## 3220 Purpose

The purpose of the CSHCN Regional System is to:

- provide a framework for communication and networking within and between the state, the CSHCN region and the local county CSHCN Programs;
- promote state and local team building by providing a mechanism for CSHCN Coordinators to participate in the state decision-making process and to make recommendations regarding local program issues and needs to the CSHCN Program;
- empower CSHCN Coordinators to make eligibility and service authorization decisions at the local level;
- facilitate the identification of regional resources; and
- include other partners at both regional and state levels.

## 3230 Membership

Members of the CSHCN Regional System include local CSHCN Coordinators and administrative support staff, and others involved with children with special health care needs (e.g., representatives of parent organizations, neurodevelopmental centers, Medicaid managed care plans, and schools).

## 3240 Regional Representatives

One CSHCN Coordinator from each region serves as a representative for that region; this role can also be shared among two or more CSHCN Coordinators. The designee or designees assume a leadership role in facilitating communication and activities within regions, between regions, and with the CSHCN Program. This position is reviewed annually by the membership of each region and each region may decide to elect a new representative(s) or maintain the current one(s). The CSHCN Program is notified of the Regional Rep decision each year so a Statement of Work and funding can be added to the Federal Fiscal Year (October to September) Consolidated Contract for that LHJ.

Roles and contractual responsibilities of CSHCN Regional Representatives include the following:

- Schedule, organize, and facilitate CSHCN regional meetings based on the needs and requests of local CSHCN Coordinators and/or the CSHCN Program;
- Organize guest speakers for special interest topics specific to children with special health care needs.
- Distribute minutes of CSHCN regional meetings to members of the regional network, the CSHCN Program, and others as appropriate;
- Advise and make recommendations to the CSHCN Program based on input from representative's region;
- Act as a resource to CSHCN Coordinators within their region;
- Participate in regularly scheduled Communication Network meetings with staff from the CSHCN Program and other regional representatives; and
- Provide a report of their activities during the time period they serve as Regional Representatives to the CSHCN Program.

## 3250 Regional Meetings

Regional meetings are scheduled to complement the Communication Network Meeting schedule. These meetings provide members with the opportunity, via the regional representative, to hear and respond to information from other regions and from the CSHCN Program. The regional meetings also provide a forum for sharing information, problem-solving local and regional issues, incorporating information from local resources, and education.

## 3260 CSHCN Communication Network Meetings

The statewide Communication Network Meeting occurs quarterly and complements the CSHCN regional meeting schedules. Attendees include: CSHCN Regional Representatives, representatives from parent organizations, Medicaid managed care plans, neurodevelopmental centers, University of Washington's Medical Home Partnerships Project and Nutrition Program, the Center for Children with Special Needs (at Seattle Children's), state agencies such as the Department of Early Learning's Early Support for Infants and Toddlers (ESIT) Program, Health Care Authority (HCA), other entities involved with children with special health care needs, and CSHCN Program staff.

The Communication Network Meeting provides for the exchange of information among the programs and statewide entities and facilitates opportunities to learn about statewide policies, programs and issues critical to this unique population, to children with special health care needs and their families. A variety of on-going technical assistance, consultation and training opportunities are made available through the Communication Network meetings. A separate time is set aside for the CSHCN Regional Representatives to meet with the CSHCN Program staff to ask questions, brainstorm solutions and share issues related to the role local CSHCN Coordinators fill for children and families in their community.

Communication Network Meeting Minutes are distributed to a statewide audience. Minutes include current reports from participants and the entities they represent, and website address links. These are posted on the DOH Children with Special Health Care Needs Program home page at:

<http://www.doh.wa.gov/YouandYourFamily/InfantsChildrenandTeens/HealthandSafety/ChildrenwithSpecialHealthCareNeeds/CommunicationNetwork>

## 3300 CSHCN Services

Children with special health care needs benefit from services such as:

- screening and/or assessment of the child and family's concerns, priorities and resource,
- early identification of health or developmental problems,
- tracking or monitoring,
- therapeutic intervention(s) including family education and support,
- resource identification and referral, and
- care coordination.

These services are provided by a range of agency and services providers including: prenatal and well child clinics, WorkFirst/TANF activities, home-based, center-based, or school based therapy services, neurodevelopmental and early intervention centers, local public health departments and health care providers, community health centers and providers, private physicians and other health professionals, schools, and hospitals. Funding for the development and provision of these services requires multiple payment sources, such as Title V, Title XIX

(Medicaid), local tax dollars, TRICARE, private insurance, Developmental Disabilities Administration, Title XX, client fees, and other private funds.

### ***3310 Local CSHCN Services***

The CSHCN Program contracts with LHJs and, in limited cases, hospitals, and clinics, if approved by the CSHCN Program, to administer services to children with special health care needs at the local level. CSHCN core service activities include:

- Early identification through screening and assessment.
- Assuring diagnostic and treatment services and necessary interventions through resource acquisition and referrals.
- Data management including collecting, entering data into the Child Health Intake Form (CHIF) Automated System, and submitting the data to the state CSHCN Program.
- Administering diagnostic and treatment funds as needed.
- Facilitating access to comprehensive, community-based, and family-centered care.
- Coordination of services.

CSHCN Coordinators work with local agencies and communities to provide leadership in promoting or developing coordinated, family-centered, culturally competent services for children with special health care needs and their families. *(See Appendices for CSHCN Coordinators list.)*

Staff in local agencies may consist of public health nurses, social workers, registered dietitians, occupational therapists, physical therapists, speech therapists, dental hygienists, and administrative staff. Together they carry out a combination of clinical and administrative activities for children with special health care needs.

CSHCN Coordinator decisions to authorize use of CSHCN funds to pay for client services such as respite and specialty camps, therapy, diagnostic evaluations, medical treatment, and equipment or supplies are based on many factors, including the family's financial status, the child's special health or developmental need, the expected outcome with intervention, other available sources of payment, the number and magnitude of requests for CSHCN funds, and the availability of CSHCN funds. See Section 6000, Authorization and Payment.

### ***3320 Neurodevelopmental Center Services***

CSHCN contracts with 18 Neurodevelopmental Centers (NDCs) located in 11 counties through a DOH granting process. The centers are located across the state, each one meeting needs specific to its community.

The NDCs provide evaluation, diagnosis, and coordinated speech, occupational and physical therapies for eligible children. At the discretion of the child's primary care provider, referral for additional medical specialty consultation is also available. Other services may include nursing, nutrition, social work, educational services, adaptive equipment, computer augmented communication therapy, hydro-therapy, and more.

The NDCs also promote statewide capacity for quality, community-based, early intervention services for children with special health care needs of all ages, emphasizing the needs of low income and Medicaid-eligible children, 0-36 months of age. CSHCN grants support NDC infrastructure and service system development. Direct client services are paid from other funding sources including Title XIX (Medicaid) and private insurance. *See Appendices for a list of Neurodevelopmental Centers.*

For more information about NDCs, go to:

<http://www.doh.wa.gov/YouandYourFamily/InfantsChildrenandTeens/HealthandSafety/ChildrenwithSpecialHealthCareNeeds/Partners/NeurodevelopmentalCenters>

### ***3330 Provider Information***

DOH's CSHCN Program supports training and technical assistance to a variety of health care providers in collaboration with the University of Washington (UW), Seattle Children's, local county agencies, and others. The CSHCN Program also collaborates with several training programs. Examples of program and training collaborative activities include:

- *The Center for Children with Special Needs at Seattle Children's*: This program improves statewide systems of care by informing and educating providers in local communities, policy makers and others about medical specialty services for children with special health care needs and their families.
- *The Medical Home Partnerships Project for Children and Youth with Special Health Care Needs* at the UW: This partnership is a joint effort between CSHCN and the UW. A Medical Home is an approach to delivering primary health care through a "team partnership" that ensures health care services are provided in a high-quality, cost effective and comprehensive manner. The Medical Home Leadership Network within the Medical Home Partnerships Project at the UW, and the CSHCN Program, work to create more medical homes for children in WA.
- *The Pediatric Pulmonary Training Grant*: Provides leadership training for health care providers for children using pulmonary conditions to model systems of care that are interdisciplinary, family centered, and culturally competent. Recognition of MCH priorities, access, and disparities are emphasized.
- *The University of Washington Leadership Education in Neurodevelopmental Disabilities (LEND)*: Provides leadership training for health care providers using neurodevelopmental conditions to model systems of care that are interdisciplinary, family centered, and culturally competent. Recognition of MCH priorities, access, and disparities are emphasized.

### ***3340 Nutrition Services***

The UW Center on Human Development and Disability (CHDD) supports a statewide network of community-based, interagency, interdisciplinary feeding teams for feeding assessment and treatment services to children with nutrition and feeding concerns. The CHDD also trains and supports a statewide network of certified dietitians who provide nutrition assessment and follow-up to children with special health care needs.

Funding through the diagnostic and treatment funds to the Newborn Screening Program supports provision of low protein foods to children with specific metabolic conditions such as PKU.

### ***3350 Maxillofacial Services***

Services for children with maxillofacial conditions are available through multidisciplinary team review boards in four regions of the state and are organized by Regional Maxillofacial Team Coordinators. The DOH CSHCN Program divides the state into four service regions. The Department provides partial funding for review boards in three of the regions: 1) East Region in Spokane through the Maxillofacial Program at Providence Sacred Heart Children's Hospital, 2) Central Region in Yakima through Children's Village, and 3) Southwest Region in Tacoma at Mary Bridge Children's Hospital. In the NW region, Seattle Children's provides most maxillofacial services. DOH provides funding to public health in this region to assure coordination of services in collaboration with the NW region maxillofacial team at Seattle Children's and the other Regional Teams.

The purpose of the Maxillofacial Review Boards is 1) To ensure that care for children with craniofacial disorders such as cleft lip and palate is provided in a coordinated, consistent manner with the proper sequencing of evaluations and treatments within the framework of the patients overall developmental, medical, and psychological needs as described in the *Critical Elements of Care for Children with Cleft Lip and Palate (CEC)* and *Parameters for Evaluation and Treatment of Patients with Cleft Lip/Palate or other Craniofacial Anomalies and consistent with American Cleft Palate-Craniofacial Association (ACPCA) Team Standards* ([http://www.acpa-cpf.org/team\\_care/standards/#standard1](http://www.acpa-cpf.org/team_care/standards/#standard1)) and 2) To ensure that interdisciplinary care coordination occurs in the context of *Standards for Systems of Care for Children and Youth with Special Health Care Needs* established by the Association of Maternal and Child Health Programs (AMCHP) to include the following system outcomes:

- a. Families of children with special health care needs partner in decision making at all levels and be satisfied with the services they receive.
- b. Children and youth with special health care needs receive coordinated ongoing comprehensive care within a medical home.
- c. Families of children with special health care needs have adequate private and/or public insurance to pay for the services they need.
- d. Children are screened early and continuously for special health care needs.
- e. Services are organized for children and youth with special health care needs (CYSHCN) and their families in ways that families can use them easily and include access to patient and family-centered care coordination.
- f. Youth with special health care needs receive the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.
- g. CYSHCN and their families will receive care that is culturally and linguistically appropriate.

The Team coordinator works with the Review Board Members, providers (locally as well as statewide) families, and the network of CSHCN coordinators to assure families access needed resources and so that the proper sequencing of care and treatment will occur.

A minimum core team must be present for a Maxillofacial Team Review. According to the ACPCA, minimum core team composition includes: Speech-Language Pathology, Surgery, Orthodontics, and Patient Coordinator.

Inclusion of other specialists in a Team Review is desirable for a comprehensive assessment and development of a plan of care. Examples of other specialists who would help promote comprehensive care include:

- nurse
- social worker
- psychologist
- geneticist or genetic counselor
- pediatrician
- prosthodontist
- plastic surgeon(s)
- orthodontist
- otolaryngologist
- dietitian / nutritionist
- feeding therapist or feeding team

Families are partners in developing shared plans of care with the rest of the team.

The regional CSHCN Coordinator collaborates with the maxillofacial team coordinator in these activities and may act as a liaison between family, team, and local resources and services. They authorize payment for team evaluation and treatment and provide their child-specific data to the LHJ where the child resides for entry into the Child Health Intake Form (CHIF) Automated System.

*A list of CSHCN Maxillofacial Teams and coordinators is in the appendices.*

### ***3360 Family Leadership and Engagement Services***

The CSHCN Program supports family-professional partnerships and culturally responsive, family-centered systems of care by connecting trained family leaders to leadership and advisory opportunities in planning, policy, program development and continuous quality improvement. These partnerships include ongoing collaboration with Washington State Parent to Parent, Washington State Fathers Network, Family to Family Health Information Center, Medical Home Leadership Network teams, and many others across the state. CSHCN relies on parents, caregivers and youth to identify strengths and areas of concern as well as priorities from a family perspective. The Program supports opportunities to develop personal networking systems with other families and organizations, as well as training and leadership opportunities at the local, regional, state and national levels.

### ***3370 Other Services***

- The WithinReach Family Health Hotline and Answers for Special Kids (ASK) Line services are supported by CSHCN. ASK Line Information and Resource Specialists provide local and state resource information on health care coverage, specialty services, recreational opportunities, peer support, basic needs and more to families of children with special health care needs who call this toll-free information service (1-800-322-2588 and 711 for TTY relay).
- CSHCN assessment activities establish a systematic approach to using and developing data about children with special health care needs. This approach includes determining prevalence, identifying the needs of the population and promoting inclusion of data in state and local health assessments. In collaboration with families and our other partners, these methods help paint the picture of children with special health care needs and identify the needs and priorities for the service system of care.

# Section 4000 - Program Eligibility

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## 4100 Introduction

*This section continues to use a number of acronyms that are listed in the Appendices.*

CSHCN client service eligibility is defined in the WA State Administrative codes (WAC 246-710). These policies are the foundation of the CSHCN Program and where client service decisions start.

## 4200 Client Eligibility Policies

Children are eligible to receive CSHCN services if they have: (see Target Population in Section 3000.)

- disabilities and handicapping conditions;
- chronic illnesses and conditions;
- health-related educational or behavioral problems; or
- risk of developing disabilities, chronic conditions, and health-related educational and behavioral problems.

## 4300 Age Eligibility Policies

1. Children 17 years of age or younger are eligible for CSHCN services.
2. Some diagnostic and treatment services may be considered for **established** CSHCN clients who are 18 to 21 years of age, provided:
  - the service was previously planned as a continued stage of treatment required to achieve goals;
  - such treatment was initiated before the client became 18;
  - the treatment has a definable treatment course and termination point; and
  - such services will not be authorized after a client's 21st birthday.

## 4400 Residency Policies

1. Families who intend to establish residency in WA State are eligible for CSHCN services. The length of residency in the state is not a factor in determining eligibility. Visitors who come to the state only for medical services are not considered residents.
2. Members of the military and their dependents are considered WA State residents when they live in WA. CSHCN diagnostic and treatment funds cannot be used to pay for services for dependents of active duty military personnel who claim WA as "home," but are stationed and live outside of the state.

## 4500 Financial Eligibility Policies

1. Financial eligibility must be established before services are funded from diagnostic and treatment (DX/TX) allocations. Medicaid eligibility, with or without premiums, is an appropriate way to determine financial eligibility. Additionally, you can use a financial means test based on federal poverty levels. Section 5000 contains policies and procedures for determining financial eligibility.

2. The current level of financial eligibility for CSHCN is at or below 210% of the federal poverty level.

Clients for whom current eligibility has been approved by the Health Care Authority (Medicaid); Supplemental Security Income (SSI); or Women, Infants and Children (WIC), will be considered financially eligible for CSHCN funding of DX/TX services.

Note: Children eligible for the Children's Health Insurance Program (CHIP) in the Health Care Authority, where financial eligibility is above 210% of the federal poverty level, are not eligible for services paid from CSHCN diagnosis and treatment funds. This is represented as Medicaid with premiums. Refer to Section 6113 Determination of Financial Eligibility for Medicaid. Financial eligibility does not constitute entitlement to CSHCN DX/TX funds. Local agencies will make decisions to use CSHCN DX/TX funds in accordance with policies in Section 4600.

When a family's income exceeds CSHCN financial eligibility guidelines approval can be given for one diagnostic visit within the limits of funds available to each local agency and under the following circumstances:

- Delay in diagnosis could result in deterioration of presumed or suspected condition;
- There are no other resources; and
- The child will not get the service any other way.
- The LHJ has made a decision to serve all children through different revenue streams.

## 4600 Service Eligibility Policies

1. All CSHCN clients regardless of income are eligible for local services as described in Section 3000.
2. Local agencies will make decisions to use CSHCN DX/TX funds to pay for services such as medical or surgical treatment, therapy, and equipment, based on availability of insurance or other public or private third party funding sources, availability of CSHCN funds, and the criteria listed below.
3. Local CSHCN agencies may approve payment from DX/TX funds for children who are financially eligible if the following criteria are met:
  - The child has or is at increased risk for a chronic physical, developmental, behavioral, or emotional condition and also requires health and related services of a type or amount beyond that required by children generally;
  - The child's condition is amenable to treatment;
  - The expected treatment outcome would alleviate, reduce, or prevent handicap or disability;
  - The service is medically appropriate and medically necessary;
  - The service is recognized as an acceptable form of treatment for the condition by a significant portion of the professional community (i.e., is not experimental and is not beyond what is generally considered medically necessary);
  - The prescribed treatment is the least invasive and promotes the best outcome based on generally accepted standards of practice; and
  - Without treatment, there is likely to be a greater functional disability.

## 4700 Service Provider Policies

Providers paid from CSHCN DX/TX funds must meet the qualifications stated below.

Physicians are required to:

- Be licensed to practice medicine in the state where they practice, and
- Have certification under the appropriate American specialty board, or
- Have board certification eligibility as designated by the appropriate specialty board.

Non-physician providers are required to be:

- Licensed or certified in WA or in the state where they practice; or
- Accredited by the appropriate national professional organization when there is no required state licensure or certification process.

Hospitals providing CSHCN sponsored services are required to:

- Be approved by the Joint Commission of Accreditation of Hospitals, and
- Be licensed by the state where the hospital is located.

## 4800 Procedures

<i>Responsibility</i>	<i>Action</i>
CSHCN Program	Determines policy with local CSHCN agencies to clarify WAC requirements.
Local agency	<p>Makes ongoing program eligibility decisions for children with special health care needs in accordance with CSHCN policies and contract responsibilities.</p> <p>Licensing or the law relating to health professionals can be verified by contacting the Department of Health:</p> <p>Department of Health            Health Systems Quality Assurance            (111 Israel Road SE, Tumwater, WA)            Post Office Box 47860            Olympia WA 98504-7860            (360) 236-4700</p> <p>Or by looking up the provider at:  <a href="http://www.doh.wa.gov/LicensesPermitsandCertificates/ProviderCredentialSearch">http://www.doh.wa.gov/LicensesPermitsandCertificates/ProviderCredentialSearch</a></p>

# Section 5000 - Client Intake Management

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## **5100 Introduction**

*This section continues to use a number of acronyms that are listed in the Appendices.*

Local health jurisdictions (LHJ) have contract requirements to collect client information for the Children with Special Health Care Needs (CSHCN) Program. The Child Health Intake Form

(CHIF) Automated System collects this data. CHIF policies, criteria and procedures describe the system, define what is required, and identify what is optional. LHJs are encouraged to utilize the CHIF Automated System to gather information about all children with special health care needs encountered, including those not meeting CSHCN Program criteria of being served, in order to complete reporting activities such as the Department of Health, Maternal Child Health, Consolidated Contract reporting requirements, and other agency-specific, client evaluation and assessment activities.

## **5200 CHIF Automated System**

The Child Health Intake Form (CHIF) Automated System is the client intake process for the data collection system in the CSHCN Program. In January 1995, the CHIF Automated System was implemented statewide by installing a software package into existing LHJ computers and transmitted from LHJs to the CSHCN Program on diskettes. In January 2003, the computer program was converted to a “Windows” application and provided a more convenient way for agencies to use their own data and create reports. In addition, local agency staff established standard reporting criteria at state-wide CHIF trainings that improved CHIF instructional information and became Section 5211.

In September 2007, local agency staff started submitting CHIF client data electronically to the Department of Health through a web-based secure file transfer.

## **5210 Policies**

1. The local CSHCN agency, in the county where the client resides, is responsible for CSHCN client data.
2. Client data must be entered in the CHIF Automated System for all clients served through the Children with Special Health Care Needs Program, regardless of financial eligibility and in accordance with program policies and CHIF criteria.
3. Client data in the CHIF Automated System must be renewed each calendar year for all clients who continue to be served.
4. Client data is sent by direct, electronic transfer from local CSHCN agencies to a secure DOH website depository, approximately every two to three months, or as requested.
5. The CSHCN Program collects and maintains the statewide CSHCN client data system.

## **5211 When to CHIF Criteria**

The purpose of this section is to provide standard reporting criteria for the Child Health Intake Form Automated System. The criteria were developed in 2003 by local CSHCN agency staff.

### **1. Standard Reporting Criteria**

Standard reporting criteria for the CHIF Automated System will provide consistency for CSHCN statewide data collection and give local CSHCN Programs and others the opportunity to improve overall usefulness of client information. The purpose of the CHIF client database is to paint the statewide picture of children served by local CSHCN Programs and reflect the population of those who have the most intensive need for public health involvement.

### **2. Definition of Criteria Elements**

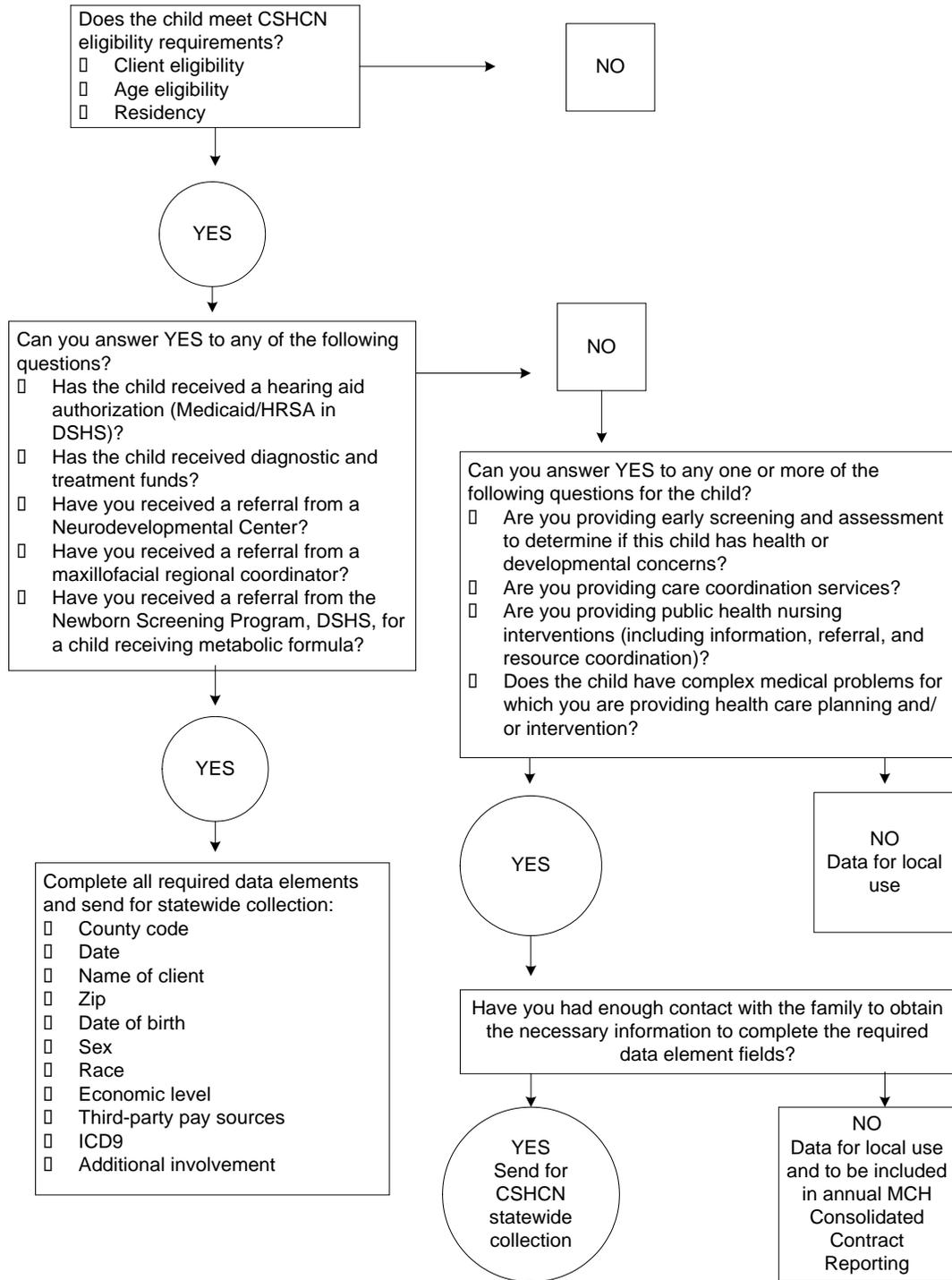
- A. Child meets the CSHCN eligibility policies:
  - Client eligibility
  - Age eligibility
  - Residency eligibility
  
- B. Services are provided which include at least one of the following:
  - Early screening and assessment to determine if child has health or developmental concern;
  - Care coordination services;
  - Public health nursing screening, assessment or intervention (including information, referral and resource coordination);
  - Health care planning and/or interventions;
  - Diagnostic/Treatment funded service;
  - Referrals from Newborn Screening Program, DOH, for child receiving metabolic low protein foods; or
  - Referrals from Maxillofacial Team Coordinators and Neurodevelopmental Centers.
  
- C. All required data elements in the Child Health Intake Form are completed.

### **3. Standard Data Submission Criteria**

CHIF data submitted to the State CSHCN Program by local CSHCN Programs must meet the criteria listed above. The CHIF database may be utilized as a tracking tool for local CSHCN Programs to enter information about any child with a special need in their community. The children who come into contact with the local program, but for whom partial CHIF data is known, may be entered and tracked locally.

In addition to the CSHCN CHIF reporting requirements, all children with special health care needs served by the local health entity should be reported annually as part of the Department of Health, Consolidated Contract reporting requirements (Federal MCH Report 5a and 5b). The number of children served with all required CHIF data elements completed, and the number of children served for which only partial CHIF data is known should be combined for the Consolidated Contract annual reporting requirements.

### CSHCN CHIF Decision Tree

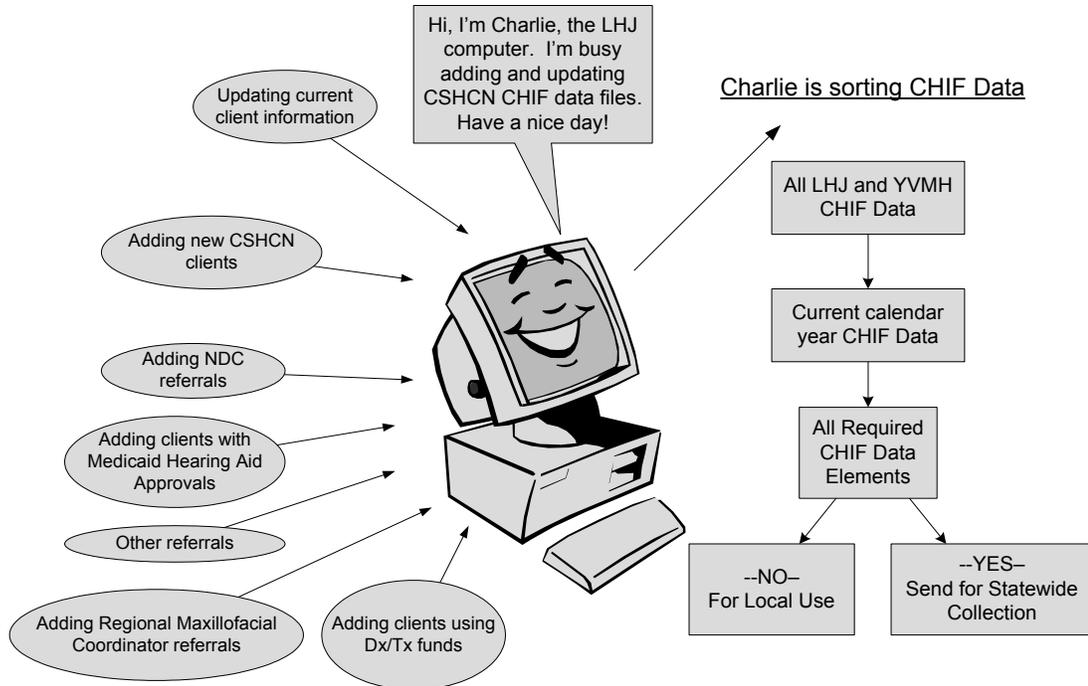
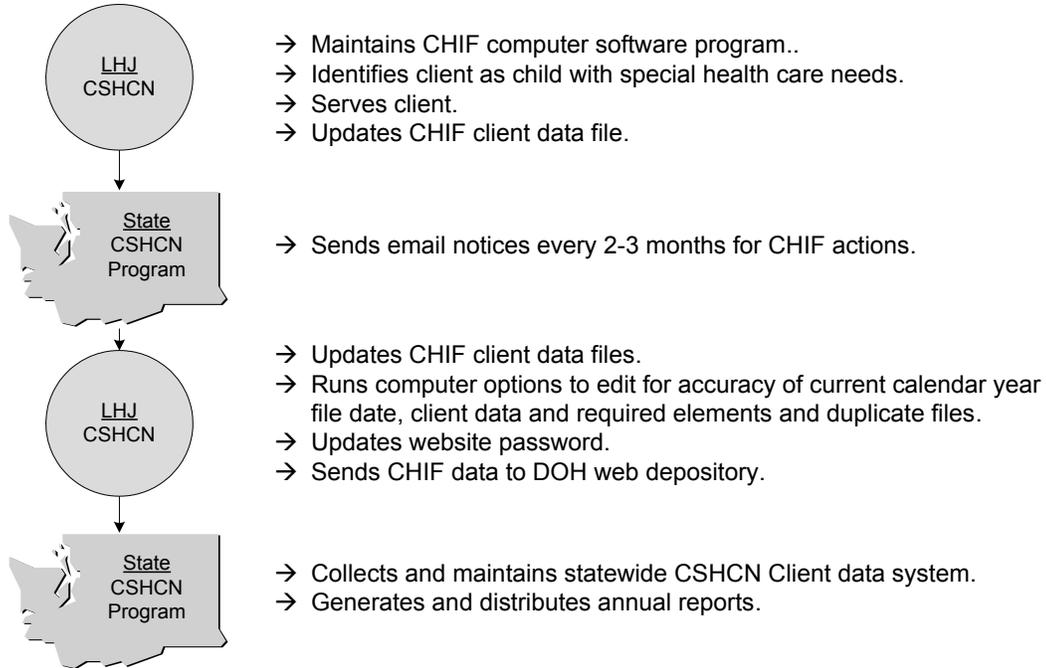


## 5220 Procedures

<u>Responsibility</u>	<u>Action</u>
Local agency (LHJ)	Maintains client data computer system using current CHIF software program.
	Updates client files for renewal and adding new client files for all clients served by CSHCN in a calendar year.
	Coordinates with other contractors to ensure client data is collected on all children served by CSHCN in the county. Examples of other CSHCN contractors are neurodevelopmental centers, regional maxillofacial coordinators and clients receiving metabolic formula from the DOH, Newborn Screening Program.
CSHCN Program	Sends email notifications, instructions and alerts to local agencies for password updates and web-based, client data submission, every 2-3 months, or as instructed. The e-mail subject line will start with "CHIF Assignment".
Local agency	Sends client data by direct, electronic transfer, to a secure DOH website depository, every 2-3 months or as instructed in email notifications, and notify CSHCN when your data has been submitted.  See Section 5240 for additional information and computer instructions.
CSHCN Program	Collects client data from DOH website depository and maintains the statewide CSHCN client data system.
	Generates and distributes annual reports from aggregate client data.
	Maintains and monitors contracts for CHIF computer software technical support and local CSHCN agency CHIF contractual requirements.

5221 CHIF Procedure Flow Chart.

## CSHCN CHIF Procedure Flow Chart



## 5230 CHIF Data Elements

<i>Required Data Elements</i>	<i>Optional</i>	<i>Other</i>
County code Date (file) Name of client Zip Date of birth Sex Race Economic level Third-party pay sources ICD9 Additional involvement	Social security number Case number Status Father Mother Address Family size Referral codes Mom education level Language preference Renew every “__” months	ID Number (CSHCN-CHIF) Local use fields

<i>Data Element</i>	<i>Req Opt Oth</i>	<i>Computer Help Screen = F2 (Those fields with coding choices)</i>	<i>Information</i>
1. ID	OTH		<p>The computer program generates the CSHCN client identification (ID) number when a new client file is first entered into the system. The CSHCN ID number will not change after it is initially created, even if the name or birth date is edited for corrections.</p> <p>The CSHCN client ID number is similar to the DSHS/HRSA ID code (PIC).</p>
2. SSN	OPT	<p>This optional field contains the client's Social Security Number.</p> <p>This field may be left blank.</p>	<p>The SSN is a valuable tool, greatly increasing the number of successful matches to other data bases such as SSI and DSHS/HRSA.</p>

<i>Data Element</i>	<i>Req Opt Oth</i>	<i>Computer Help Screen = F2 (Those fields with coding choices)</i>	<i>Information</i>
3. Case #	OPT	<p>This optional field is for reference purposes only.</p> <p>This field may be left blank.</p>	<p>This field may be used for cross-referencing to other LHJ systems.</p> <p>Prior to the start of the CHIF Automated System in 1995, CSHCN case numbers were assigned a different way. This element was/is a means to connect the old and current LHJ systems.</p>
4. Status	OPT	<p>This optional field contains the current status of this case</p> <p>A = Case is active. I = Case is currently inactive, and will not be included in the “due for renewal” list. D = deceased.</p> <p>This field may be left blank.</p>	<p>Status may be used to sort your client list into three categories. Agencies define active and inactive to suit their individual needs.</p> <p>When loading quarterly disks for a CHIF reporting period, the computer program includes clients regardless of status code.</p>
5. County Code	<b>REQUIRED</b>	<p><b>This field contains a code for the child’s county of residence, and lists all counties and their corresponding code.</b></p> <p><b>A county code is required to produce the CSHCN ID number in item #1.</b></p>	<p><b>When choosing codes for a multiple county agency like Benton-Franklin Health District, use one code for the child’s county of residence.</b></p>

<i>Data Element</i>	<i>Req Opt Oth</i>	<i>Computer Help Screen = F2 (Those fields with coding choices)</i>	<i>Information</i>
6. Date	<b>REQUIRED</b>	<p>This field contains the date the intake form was added to the file, or the date of the latest renewal registration (MM/DD/YY).</p> <p>The system will default to today's date.</p>	<p>Except for date of birth, this is the only date the computer program goes to when a command or menu asks for a date, such as when loading quarterly disks for a CHIF reporting period.</p> <p>This date will change to default (today's date) each time the file is accessed, unless another date is entered. Your agency would be interested in this if you depend on the "due for renewal" list, which starts with (counts from) this date.</p>
7. Name Of Client	<b>REQUIRED</b>	<p><u>Last name:</u> This field holds the child's last name. This may include "Jr," "III," etc. <u>after</u> the last name. You may enter a maximum of 25 characters. The system forces all characters to be upper case.</p> <p><u>First name:</u> This field holds the child's first name. You may enter a maximum of 25 characters.</p> <p><u>Middle initial:</u> This field holds the child's middle initial (one character).</p>	<p>Required for CSHCH ID number (see item #1), using the first five (5) letters of the last name, first letter of the first name, and middle initial, like in the Medicaid system. If the middle initial character is blank, the system will default to a dash in the CSHCN ID number.</p> <p>For the last name, do not insert spaces for names such as McDonald.</p> <p>Also-known-as (AKA) and nicknames can be added to the <u>end</u> of the last or first name, up to the 25 character maximum. A custom data field for AKA names can also be designed in the local use fields (see item #23).</p> <p>If there is a name change in the current reporting year, start a new file and delete the previous one, so the CSHCN ID number (item #1) will reflect the new name.</p>

<i>Data Element</i>	<i>Req Opt Oth</i>	<i>Computer Help Screen = F2 (Those fields with coding choices)</i>	<i>Information</i>
8. Father	OPT	This optional field holds the Father's last and first names.	This information is valuable to the LHJ, but not collected in the state-wide CHIF client data base.
9. Mother	OPT	This field holds the Mother's last and first names.	This information is valuable to the LHJ, but not collected in the state-wide CHIF client data base.
10. Address	OPT	This optional field holds the child's street or mailing address.  This information is valuable to the LHJ, but not collected in the state-wide CHIF client data base.	If there is need for multiple addresses, like a foster family and their caseworker or a contact person, a custom data field could be designed in the local use fields (item #23).  "Washington" is already in this field as a system default. This data element could be edited if your agency wanted to record the out-of-state address of a client who has moved.
Zip	<b>REQUIRED</b>	This field holds the child's zip code.  You may input up to 9 (nine) characters in this field.	<b>The zip code greatly expands possibilities when sorting client location in more detail than by county, and when matching to other client databases.</b>
11. DOB	<b>REQUIRED</b>	This field holds the child's date of birth (MM/DD/YY).  As the date of birth is used to create the CSHCN ID number, you must complete the date of birth field before the record can be saved.	Date of birth is required before the CSHCN ID number and new record is saved.
12. Sex	<b>REQUIRED</b>	This field contains a code for gender:  M = Male F = Female	

<i>Data Element</i>	<b>Req</b> <i>Opt</i> <i>Oth</i>	<i>Computer Help Screen = F2</i> <i>(Those fields with coding choices)</i>	<i>Information</i>
<b>13. Race</b>	<b>REQUIRED</b>	<p><b>This field holds a code which represents the child's ethnicity:</b></p> <p><b>1 = Caucasian</b>  <b>2 = African American</b>  <b>3 = American Indian</b>  <b>4 = Hispanic</b>  <b>5 = Asian/Pacific Islander</b>  <b>6 = Other &amp; Unknown</b>  <b>7 = Multiracial</b></p>	<b>CSHCN categories match those in federally required reports.</b>
14. Family size	OPT	<p>This optional field holds a code which indicates the size of the child's family unit:</p> <p>1 = Child alone/ward/emancipated  2 = Child plus parent (or adult)  3 = Child + 2 parents/child + parent  4 = Child + parent + 2 children or adults  5 = Child + parent + 3 children or adults  6 = Child + parent + 4 children or adults  7 = Child + parent + 5 children or adults  8 = Child + parent + 6 children or adults  9 = Child + 8 or More children/adults  0 = Unknown</p> <p>This field may be left blank.</p>	Agencies would need this number if they were computing financial eligibility using federal poverty level (FPL) guidelines.

<p>15. Economic Level</p>	<p style="text-align: center;"><b>REQUIRED</b></p>	<p>This field holds a code that indicates the economic level of the family unit to which this child belongs.</p> <p>A = Income up to 100% FPL  B = 101% to 133% FPL  C = 134% to 150% FPL  D = 151% to 185% FPL  E = up to 200% FPL (CSHCN &amp; DSHS/HRSA (MAA Level)  F = Income over 200% FPL</p> <p>Note: All economic levels up to 200% of the FPL (A, B, C, D) may be reported as "E".</p>	<p>Reporting documents often require client percentages by income level. To make CHIF reporting easier, economic level can now be reported as over or under 200% of the FPL, using "E" and "F".</p> <p>As a coding option, "E" equals income up to 200% of the FPL, and may be used instead of code choices A, B, C, or D. This is a convenient shortcut when the child/family is financially eligible for DSHS/HRSA/Medicaid, SSI, or WIC because financial eligibility for these programs is at or under 200% FPL.</p>
<p>16. Third Party Pay Sources</p>	<p style="text-align: center;"><b>REQUIRED</b></p>	<p>This field contains the type of third party payment sources (e.g. insurance) for which the child is eligible and enrolled.</p> <p>B = Washington Basic Health Plan  P = Private insurance  C = CHAMPUS  T = Title XIX, Medicaid, HRSA/HO in DSHS  S = CSHCN DX/TX Funds  N = None of the above</p>	<p>Funding sources for child's major medical needs.</p>

<i>Data Element</i>	<b>Req</b> <i>Opt</i> <i>Oth</i>	<i>Computer Help Screen = F2</i> <i>(Those fields with coding choices)</i>	<i>Information</i>
17. Referral Codes	OPT	<p>This optional field contains a code that identifies the referral source of the child to the LHJ.</p> <p>1 = Primary care provider (MD)  2 = Physician specialist  3 = Hospital  4 = Parent  5 = School  6 = PHN/LHJ  7 = DDD  8 = MAA/Medicaid/Title XIX  9 = NDC  0 = Unknown  A = Other  B = FRC  C = PT/OT/Speech therapist  D = WIC  E = Within Reach or ASK Line</p> <p>This field may be left blank.</p>	Identifies how child first became known to LHJ.
18. Mom Ed Level	OPT	<p>The optional field contains a code for education level of the mother in the family unit of which this child is a member.</p> <p>A = At or below 8th grade  B = 9th grade completed  C = 10th grade completed  D = 11th grade completed  E = High school graduate or GED  F = Some college/community college  G = College/university degree  Z = Unknown</p> <p>This field may be left blank.</p>	<p>The original intent of this data was to consider possible risk levels based on mom's educational level at the time of the child's birth. In Washington, that information is now available on birth certificates.</p> <p>Some LHJ agencies use current parent education level as a measure of potential environmental risk.</p>

<i>Data Element</i>	<i>Req Opt Oth</i>	<i>Computer Help Screen = F2 (Those fields with coding choices)</i>	<i>Information</i>
<b>19. ICD-9-CM</b>	<b>REQUIRED</b>	<p>This field contains the ICD-9-CM diagnostic codes for the client. Three diagnosis codes can be entered for each client.</p> <p>An ICD-9-CM code list can be scanned by pressing F2.</p> <p>Also see Section 5231 for a quick-reference tool listing CSHCN commonly diagnosed conditions.</p>	<p>The intent of reporting diagnosis codes is to show who the CSHCN clients are and how they are being served by the LHJ. It is not the intent for the LHJ to diagnose.</p> <p>If your main service to the client and family is based on a secondary or accessory condition, it is important to report that and the primary diagnosis code so there is a complete picture of the client in statewide data.</p> <p>It is okay to insert a broader diagnosis category for an unknown or suspected condition, as long as the code is edited for accuracy later, by the end of December, before annual CHIF data is submitted.</p> <p>The CHIF Automated System accepts numeric IDC-9-CM codes. Two (2), temporary, “V” codes are listed in Section 5231 for children without a specific diagnosis who are referred for special concerns.</p>

<i>Data Element</i>	<i>Req Opt Oth</i>	<i>Computer Help Screen = F2 (Those fields with coding choices)</i>	<i>Information</i>
20. <b>Additional Involvement</b>	<b>REQUIRED</b>	<p><b>This field contains a code for other agencies supplying services to the child.</b></p> <p><b>W = Women, Infants &amp; Children (WIC)</b>  <b>P = OSPI/School District or IEP</b>  <b>S = Supplemental Security Income (SSI)</b>  <b>F = Foster care home (FCH)</b>  <b>I = Infant Toddler Early Intervention Program or IFSP (age 0-3 years)</b>  <b>M = Primary Care Provider (MD)</b>  <b>N = Neurodevelopment Center (NDC)</b></p> <p><b>C = Pediatric Specialty Hospital</b>  <b>D = Division Developmental Disabilities (DDD)</b>  <b>R = Community Resources</b>  <b>B = Maxillofacial Review Board</b></p>	<p><b>This field addresses the client and family involvement in other entities that potentially lead to the creation of a medical home environment.</b></p>
21. Language Preference	OPT	<p>This optional field is for preferred language of client:  EN = English (default)  SP = Spanish  CH = Chinese  TA = Tagalog  KO = Korean  JA = Japanese  VI = Vietnamese  OA = Other Asian  RU = Russian  FA = Farsi  AR = Arabic  OT = Other  Blank = unknown</p> <p>This field may be left blank.</p>	<p>This is a new data field, added in 1999 by LHJ request, to identify the spoken language preference of the client and family.</p> <p>Preferred language, along with the family's ethnicity (item #13), will provide data for LHJs to evaluate ways to serve different cultures in their county, the need for interpreters, client materials development, and broaden the scope of diversity.</p>

<i>Data Element</i>	<i>Req Opt Oth</i>	<i>Computer Help Screen = F2 (Those fields with coding choices)</i>	<i>Information</i>
22. Renew every “___” months	OPT	<p>This optional field indicates how often a case must be renewed. Typically this is every 12 months. You have the option to adjust this number between one month and 36 months if desired.</p> <p>This renewal interval will be used to calculate when the case will appear on the “due for renewal” listing.</p> <p>The system defaults to 12 months</p> <p>This field may be left blank</p>	<p>Agencies have the option of using this tool to fit their needs like a tickler system. This element counts from the date in item #6, the only date recognized in this system besides the date of birth.</p> <p>Some agencies use this tickler system for scheduling home visits, check-backs, or as an alert for other services. The default is set at 12 months as a reminder to update the file for annual CHIF data reporting of all children served.</p>
23. Local use fields	OTH		This location contains multiple areas for LHJ to do custom data elements and text. See computer instructions in Section 5240.

REQ = Required data element. The core group of client data elements for CSHCN statewide data and the reporting requirements of the CHIF Automated System.

OPT = Optional data field. Not used in CSHCN Program statewide data. These fields can be left blank; however, LHJs are encouraged to utilize the CHIF Automated System to gather information about all children with special health care needs encountered, including those not meeting CSHCN Program criteria, in order to complete the Department of Health, Maternal Child Health, Consolidated Contract reporting requirements (Federal Form 5), and other agency-specific, client evaluation activities.

OTH = Other explanation.

## 5231 – Commonly Diagnosed Conditions of CSHCN

Below is a list of common diagnoses among the CSHCN population. The list is only a tool to assist you; it is not a complete listing of ICD 10 codes. It is not required that you use this list; however, a diagnosis is a required data element for the CHIF automated system. There are many other resources to find the appropriate diagnosis code such as your organization's Electronic Medical Record, an ICD 10 book, or professional online resources.

### Important Notes:

1. Coding structure contained in this listing is designed for tracking only; many codes in this listing are not billable in their current structure.
2. Please also note that "0" represents zeros rather than the letter "O".

### Resources:

- World Health Organization - <http://apps.who.int/classifications/apps/icd/icd10training/>
- Centers for Disease Control and Prevention (CDC) - [http://www.cdc.gov/nchs/icd/icd10cm\\_pcs\\_resources.htm](http://www.cdc.gov/nchs/icd/icd10cm_pcs_resources.htm)
- Centers for Medicare and Medicaid (CMS)- <https://www.cms.gov/Medicare/Coding/ICD10/Index.html>

Blood and Blood-Forming Organs	
Anemia, unspecified	D64.9
Coagulation defect, unspecified	D68.9
DiGeorge Syndrome	D82.1
Disease of blood and blood-forming organs, unspecified	D75.9
Disorder involving the immune mechanism, unspecified	D89.9
Hemangioma, unspecified site	D18.00
Lymphangioma, any site	D18.1
Other specified coagulation defects	D68.8
Sickle-cell disease without crisis	D57.1
Thalassemia, unspecified	D56.9
Chromosomal & Congenital Anomalies	
Atresia of foramina of Magendie and Luschka	Q03.1
Atrial Septal Defect	Q21.1
Chromosomal abnormality, unspecified	Q99.9
Cleft palate, unspecified	Q35.9
Congenital deformities of the hip	Q65
Congenital hydrocephalus, unspecified	Q03.9
Congenital malformation of cardiac chambers and connections, unspecified	Q20.9
Congenital malformation of circulatory system, unspecified	Q28.9
Congenital malformation of digestive system, unspecified	Q45.9
Congenital malformation of heart, unspecified	Q24.9
Congenital malformation of musculoskeletal system, unspecified	Q79.9
Congenital malformation of skull and face bones, unspecified	Q75.9

Chromosomal & Congenital Anomalies (cont.)	
Congenital Malformation Syndrome associated with short stature (e.g., Prader Willi Syndrome)	Q87.1
Congenital malformation syndromes predominantly affecting facial appearance	Q87.0
Congenital malformation, unspecified	Q89.9
Craniosynostosis	Q75.0
Deletion from autosomes, unspecified	Q93.9
Discordant ventriculoarterial connection (transposition of great vessels (complete))	Q20.3
Down Syndrome, Trisomy 21, unspecified	Q90.9
Exomphalos	Q79.2
Fetal alcohol syndrome (dysmorphic)	Q86.0
Fragile X Syndrome	Q99.2
Hirschsprung's Disease	Q43.1
Hypertelorism	Q75.2
Hypospadias, unspecified	Q54.9
Klinefelter's Syndrome, unspecified	Q98.4
Malformations of aqueduct of Sylvius	Q03.0
Microcephaly	Q02
Multiple congenital malformations, not elsewhere classified	Q89.7
Neurofibromatosis, type 1	Q85.01
Other congenital hydrocephalus	Q03.8
Other congenital malformations of the abdominal wall	Q79.59
Other deletions of a part of a chromosome (Angelman syndrome)	Q93.5
Patent Ductus Arteriosus	Q25.0

<b>Chromosomal &amp; Congenital Anomalies (cont.)</b>	
Prune Belly Syndrome	Q79.4
Spina Bifida, unspecified	Q05.9
Tetrology of Fallot	Q21.3
Thanatophoric short stature	Q77.1
Torticollis, congenital	Q68.0
Trisomy 13 (Patau's Syndrome), mosaicism	Q91.5
Trisomy 13 (Patau's Syndrome), nonmosaicism	Q91.4
Trisomy 18 (Edward's Syndrome), mosaicism	Q91.1
Trisomy 18 (Edward's Syndrome), nonmosaicism	Q91.0
Turner Syndrome (XO)	Q96
Ventricular Septal Defect	Q21.0
<b>Circulatory System</b>	
Aneurysm, unspecified site	I72.9
Cardiac Arrhythmias, unspecified	I49.9
Essential (primary) hypertension	I10
Heart Disease, unspecified	I51.9
Heart Failure, unspecified	I50.9
Nontraumatic intracerebral hemorrhage, unspecified	I61.9
Other cardiomyopathies	I42.8
Other restrictive cardiomyopathy	I42.5
Peripheral vascular disease, unspecified	I73.9
<b>Diseases of the Eye and Adenxa</b>	
Congenital nystagmus	H55.01
Infantile and juvenile cataract	H26.0
Legal Blindness	H54.8
Retinopathy of prematurity	H35.1
Unspecified visual disturbance	H53.9
<b>Diseases of the Ear and Mastoid Process</b>	
Conductive and sensorineural hearing loss	H90
Sensorineural hearing loss, bilateral	H90.3
Sensorineural hearing loss, unilateral	H90.4
Unspecified hearing loss (Deaf)	H91.9
<b>Digestive System</b>	
Acute and subacute hepatic failure	K72.0
Chronic hepatic failure	K72.1
Chronic hepatitis, unspecified	K73.9
Crohn's Disease, unspecified	K50.9
Dental Caries, unspecified	K02.9
Diseases of Biliary Tract, unspecified	K83.9
Gastroesophageal Reflux Disease with Esophagitis	K21.0
Gastroesophageal Reflux Disease without Esophagitis	K21.9
Gingival and Peridontal Disease	K05
Intestinal Malabsorption, unspecified	K90.9
Irritable Bowel Syndrome with Diarrhea	K58.0

<b>Endocrine, Nutritional &amp; Metabolic Diseases</b>	
Congenital iodine-deficiency syndrome, unspecified	E00.9
Cystic Fibrosis	E84.9
Diabetes, Type I	E10
Diabetes, Type II	E11
Disorders of lysine and hydroxylysine metabolism	E72.3
Galactosemia	E74.21
Hypoparathyroidism, unspecified	E20.9
Hypopituitarism	E23.0
Metabolic Disorder, unspecified	E88.9
Obesity, unspecified	E66.9
Other disorders of tyrosine metabolism	E70.29
Phenylketonuria (PKU)	E70.0
Thyrotoxicosis, unspecified without thyrotoxic crisis or storm	E05.90
Tyrosinemia	E70.21
Unspecified Adrenocortical insufficiency	E27.40
<b>Factors Influencing Health</b>	
Colostomy	Z93.3
Gastrostomy	Z93.1
Ileostomy	Z93.2
Presence of other specified devices (e.g., NG tube)	Z97.8
Tracheostomy	Z93.0
<b>Genitourinary System</b>	
End Stage Renal Disease	N18.6
Renal Failure, unspecified	N19
<b>Infectious Conditions</b>	
Asymptomatic human immunodeficiency virus (HIV) infection status	Z21
Chronic viral hepatitis	B18.1
Congenital cytomegalovirus infection	P35.1
Human immunodeficiency virus (HIV) disease	B20
Necrotizing enterocolitis in newborn, unspecified	P77.9
<b>Injury, Poisoning, &amp; Certain Other Consequence of External Causes</b>	
Tuberculosis of lung	A15.0
Abuse and Neglect, confirmed	T74
Abuse and Neglect, suspected	T76
Allergy, unspecified	T78.40
Anaphylactic reaction, food	T78.0
Anaphylactic shock, unspecified	T78.2
Concussion	S06.0
Diffuse traumatic brain injury	S06.2
Focal traumatic brain injury	S06.3
Shaken infant	T74.4
<b>Mental, Behavioral &amp; Neurodevelopmental</b>	
Attention Deficit Disorders	F90

<b>Mental, Behavioral &amp; Neurodevelopmental, cont.</b>	
Asberger's Syndrome	F84.5
Autism Disorder	F84.0
Conduct Disorder, unspecified	F91.9
Developmental Disorder of Scholastic Skills, unspecified	F81.9
Encopresis	F98.1
Enuresis	F98.0
Generalized anxiety disorder	F41.1
Other pervasive developmental disorders	F84.8
Pervasive developmental disorder, autism	F84.0
Pervasive developmental disorder, Rhetts syndrome	F84.2
Pervasive developmental disorder, unspecified r	F84.9
Specific developmental disorders of motor function	F82
Specific developmental disorders of speech and language	F80
<b>Musculoskeletal &amp; Connective Tissue Conditions</b>	
Kyphosis	M40
Scoliosis	M41
<b>Neoplasms</b>	
Acute leukemia of unspecified cell type not having achieved remission	C95.00
Disseminated malignant neoplasm, unspecified	C80.0
Malignant (primary) neoplasm, unspecified	C80.1
Malignant neoplasm of brain, unspecified	C71.9
Malignant neoplasm of unspecified kidney, except renal pelvis	C64.9
Malignant neoplasm of unspecified retina	C69.20
Other specified types of non-Hodgkin lymphoma, extranodal and solid organ sites	C85.89
Other specified types of non-Hodgkin lymphoma, unspecified site	C85.80
<b>Nervous System</b>	
Absence epileptic syndrome	G40.A
Cerebral Palsy	G80
Encephalopathy, unspecified	G93.41
Epilepsy and recurrent seizures	G40
Migraine	G43
Muscular Dystrophy	G71.0
<b>Perinatal Conditions</b>	
Bronchopulmonary Dysplasia originating in the perinatal period	P27.1
Cytomegalovirus, congenital	P35.1
Extremely Low Birth Weight, newborn	P07.0

<b>Perinatal Conditions, cont.</b>	
Necrotizing enterocolitis, newborn (NEC)	P77
Neonatal withdrawal symptoms from maternal use of drugs of addiction	P96.1
Newborn affected by slow intrauterine growth, unspecified	P05.9
Newborn small for gestational age, unspecified weight	P05.10
Newborn (suspected) to be affected by maternal use of drugs of addiction	P04.4
Newborn (suspected) to be affected by maternal use of drugs of addiction; cocaine	P04.41
Newborn (suspected) to be affected by maternal use of drugs of addiction; other	P04.49
Other problems with newborn (anoxia, etc.)	P84
Other respiratory distress of newborn	P22.8
Preterm Newborn (see codes for more specificity)	P07.3
Respiratory distress of newborn, unspecified	P22.9
Respiratory distress syndrome in newborn	P22.0
Respiratory Failure of Newborn	P28.5
Transient tachypnea of newborn	P22.1
<b>Respiratory Conditions</b>	
Asthma	J45
<b>Skin Conditions</b>	
Atopic Dermatitis	L20.9
<b>Signs &amp; Symptoms</b>	
Delayed Milestone in Childhood	R62.0
Failure to Thrive (child)	R62.51
Feeding Difficulties	R63.3
Other lack of expected normal physiological development in childhood	R62.59

## **5240 Computer Instructions**

Local Health Jurisdictions can store any additional CHIF instructions and reports in this location.

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Department of Health  
Children with Special Health Care Needs Program

Supplement to CSHCN Manual  
Section 5240

Child Health Intake Form (CHIF)  
Automated System  
Computer Training Instructions

by John Speight  
Strategic Software Services  
(425) 391-0423  
[jspeight@strategicsvs.com](mailto:jspeight@strategicsvs.com)  
[www.strategicsvs.com/cshcn](http://www.strategicsvs.com/cshcn) (CHIF help site)

October 2008

### CSHCN Copy/Download Instructions

There is now the capability to create the CSHCN data file (needed by Olympia) and then transfer it directly to a state web site. The web site may be accessed either through a standard web browser (<https://sft.wa.gov/>) or through options within the CHIF program. To log into the web site, you must have a username and password. Passwords expire every 60 days so typically, you will be creating a new password each time a file transfer is made.

Once logged into the web site, you specify the file to be transferred. You then click the file transfer button on the website and wait for the file to download. After the file is downloaded, you may exit the website.

The CHIF program has the capability to maintain your username, password and file name to be transferred. It also has a utility that will automatically create a random password in a format acceptable to the secure web site.

The basic steps include:

- Select the directory in which to save the file of clients.
- Create the file of clients served.
- Connect to the web. (<HTTPS://SFT.WA.GOV/>)
- Position cursor in 'Name' field of website and input or paste your user name.
- Position cursor in 'Password' field of website and input or paste your user password. (Note: The website may require a new password which can be created by clicking the create password button)
- Click the log in button
- Position cursor in File Name to Download field of website and input or paste the file name to transfer.
- Click the 'Upload File' button
- Once transferred, you may click the Log out button on the website and then close the transfer window

More detailed instructions can be found two additional documents. These are:

- CHIF Data Web Submission.doc : A more complete checklist showing the steps to download the CSHCN data.
- DownloadInstructions.doc. : A complete help text including screen shots.

Both of these documents can be found in the same directory that contains the CHIF program. (Please call for additional help or information)

## CHIF DATA WEB SUBMISSION

SFT Server = website integrated into the CHIF program

1. Open the CHIF program
  2. Click on **CHIF** (First menu option)
  3. Click on **Upload CHIF**. (A **Copy CHIF Data** box will open.)
    - **Select Directory:** (The 'Select Directory' section can be ignored. Contact John for more information if necessary)
    - **Save Data Section**
  4. Dates will be automatically be filled in under **CHIF Dates From** and can be changed. (Use the default dates except when submitting year end data)
  5. Under **Data to Copy** click in the box for your county or leave as all counties, especially if you are part of a multi-county LHJ
  6. Click on  **Copy Data** - A box will appear that states how many records were copied and whether any were omitted because of missing data elements. Click **OK**
- Copy to State Section**

Click the icon next to **Connect to Web**. (This links you to the secure website for CHIF data transfer)

7. Login page will open.
8. Place flashing cursor in the blank box next to **Name**, (upper portion of screen) then click on the icon next to **Paste User Name** (lower portion of screen).
9. Place flashing cursor in the blank box next to **Password** (upper portion of screen), then click on the icon next to **Paste Password** (lower portion of screen)
10. Click on **Log In** - A "Tumbleweed Secure Transport" page will open.
  - **Change Password** (This process is required every 60 days to change your SFT login password)
    - i. Click **Change Password** button. (Upper right)
    - ii. Place flashing cursor in blank box next to **Old Password**, then click on the icon next to **Paste Password**.
    - iii. Click button to the right of password entry box (lower portion of screen) and click Yes to automatically create a new password.
    - iv. Place flashing cursor in blank box next to **New Password**. Then click the icon next to **Paste Password**.
    - v. Place flashing cursor in blank box next to **Retype Password**. Then click the icon next to **Paste Password**.
    - vi. Click the **Set Password** button.
    - vii. Click the Word **'Here'** when it shows, 'Click here to reauthenticate'.
    - viii. Repeat steps 8,9 and 10 from above.
- **End of Password change section**
11. Place the flashing icon in the blank box to the left of the **Browse** button. (upper portion of screen). Then click on the icon next to **Paste File Name**.
12. Click on **Upload File** (upper portion of the screen). The data file will automatically be sent. It won't show how many files were sent but you should see a new file name appear.
13. Click in the upper right hand corner to **Logout**. (You may then exit or continue working in the CHIF program.)
14. When the CHIF file has been sent, send an email to Civillia, Christy and John to alert us.

## **5300 Financial Application**

CSHCN financial eligibility is only required by policy when Diagnostic and Treatment Funds are used to pay for a client service. The CSHCN Financial Application collects family income information to verify financial eligibility. Local agencies are encouraged to use the CSHCN application only when required, and not as a routine procedure for all CSHCN clients served. See Section 2300 for WAC requirements. See Section 6000 for Authorization and Payment.

CSHCN Financial Application forms (DOH 910-003, 11/8/94) can be requested from the CSHCN Program. This form was legally approved in 1994 and remains current.

## **5310 Policies**

1. A Financial Application must be completed for any child receiving services paid from CSHCN Diagnostic and Treatment Funds in order to document financial eligibility and obtain signatures for release of liability, last payment source, and reimbursement.
2. Clients whose eligibility has been approved by the Health and Recovery Services Administration (HRSA/Medicaid/Title XIX in DSHS), Supplemental Security Income (SSI), or Women, Infants and Children (WIC) are considered financially eligible for CSHCN. Documentation of current eligibility for these programs must be obtained and filed with or noted on the application by the local agency.
3. As long as a child is receiving services paid from CSHCN Diagnostic and Treatment Funds, a new Financial Application must be completed at least annually. If there is a change in family income, size, or any area that could affect financial eligibility, an application may need to be done more often or before twelve months.
4. Written notification of eligibility must be provided to all families who complete a CSHCN Financial Application. See Section 5340 for client notification information.
5. Agencies may use the CSHCN Program Financial Application, or a locally designed form that meets the following requirements:
  - The name of the program is printed on the form to identify Children with Special Health Care Needs, Department of Health, and the State of Washington.
  - The form must reflect the intent of language for agreement to no other payment source, and release from liability, as on the CSHCN Financial Application, Part II.
  - The income categories and method of computing financial eligibility must be the same as on the CSHCN Financial Application, Part III and IV.
  - Locally designed forms must be submitted to the CSHCN Program for approval before used. Copies of approval must be maintained by the local agency.

## **5320 Procedures**

<u>Responsibility</u>	<u>Action</u>
Local agency (LHJ)	Provides parent or guardian with a Financial Application according to policies in Section 5310. Assists parents or guardians with completing form as needed.
	See Section 6610 for clients without DSHS, Health and Recovery Services Administration (HRSA/Medicaid) or other DSHS medical coverage. As an alternative to the CSHCN application, local agencies may want to have access to DSHS client applications, especially when family income is below 200% FPL.
Parent or Guardian	Completes and signs the Financial Application (See Section 5334 for Signature and Resource Responsibility Table.)
Local agency	Reviews Financial Application for required information. Determines financial eligibility and signs, per instructions in Section 5330.
	Sends client notification letter per policies and procedures in Section 5340.
	Files current Financial Application and client notification letter in client's record.

### **5330 Financial Application Instructions**

The table below provides instructions for completing the CSHCN Financial Application form, DOH 910-003 (11/8/94). This form was legally approved in 1994 and remains current. See the following pages for a copy of the application and samples of completed forms.

**Please note**, the application form and instructions have areas where “MAA” is used, and repeated here in instructions. MAA is the prior name for Health and Recovery Services Administration (HRSA), the current division in DSHS where Medicaid is located.

<i>Financial Application</i>	<i>Instructions</i>
Part I General Information	Completed by parent.  Routine client data which is also collected in the CHIF Automated System (See Section 5200).  The space for comments can be used by both parent and/or local agency to clarify information.
Part II Signature	One (or two) signature(s) and date by parent(s), legal guardian or self, if client is an emancipated minor.  A <u>MAA approved</u> "needy nonparental caretaker relative" is also permitted when documented (MAA procedure for some foster child situations). “MAA” is prior name of HRSA in DSHS.
Part III Financial Information	<b>If eligibility has been confirmed for DSHS MAA/ Medicaid, SSI, or WIC, skip Part III and go to Part IV, per CSHCN policy (See Section 5310).</b> “MAA” is prior name for HRSA in DSHS.  Parts A-F completed by parent.  The space for comments can be used by both parent and local agency to clarify information.
A. Monthly Income: Monthly household income received from all sources.	Separate areas for two wage earners.  Wage statements or federal income tax forms can be requested when reported information is confusing or needs verification.
B. Monthly Expenses: Monthly expenses paid out of family income and not from any other source including CSHCN.	If expenses fluctuate, use judgment for fair average of monthly amount and enter explanation in space for comments.

<i>Financial Application</i>	<i>Instructions</i>
C. Resources: Total resources not included in III-A above.	Do not include funds reserved for household living expenses, such as food and utilities.  When value, ownership or access to resource is in doubt, use judgment to include or not; enter explanation in comments space.
D. Medical/Dental Costs: Total household expenses paid or owed by family and not paid from any other source including CSHCN.	Costs are from all family members (i.e., Mom's prescriptions).  When reported costs are more than \$2,000 or over the Medical Allowance in the Federal Poverty Guidelines Section 5332, an itemized list is recommended so amounts can be confirmed.
E. Adjusted Gross Income from Federal Income Tax for past two years.	Compare amount earned in past two years to income being computed.
F. I/we state the financial information given above is true and complete.	Same as Part II signature.
Part IV  Financial Computations	Part IV is completed by local agency staff.  If financial eligibility has been confirmed for MAA/Medicaid (DSHS), SSI or WIC, check first approval box, sign and date. Financial Application is finished. See Section 5340 for client notification. "MAA" is prior name of HRSA in DSHS.
	To compute financial eligibility:  Transfer information in spaces 8, 9, 13, 18 and 19 from Part III to corresponding numbers in Part IV.  Enter family size in space 25. Family size can be increased by one for verified unborn child.  Complete spaces 24 and 26 by referring to the federal poverty guidelines in Section 5332.  Compute spaces 20, 21, 22 and 23 (plus, minus, times) as directed on form.
	If Adjusted Family Income (space 23) is more than CSHCN Annual Needs (space 26), deny CSHCN financial eligibility by marking third box, sign and date. Client is eligible for CSHCN, but Diagnostic and Treatment Funds cannot be used. Financial Application is finished. See Section 5340 for client notification.

<i>Financial Application</i>	<i>Instructions</i>
	If Adjusted Family Income (space 23) is at or below CSHCN Annual Needs (space 26), approve CSHCN financial eligibility for diagnostic and treatment funded services by marking second approval box, sign and date. Client is eligible for CSHCN including services paid from Diagnostic and Treatment Funds. Financial Application is finished. See Section 5340 for client notification.



5331 Financial Application Form (DOH 910-003) 11/8/94



**Children with Special Health Care Needs  
Financial Application**

**Part I - General Information**

CLIENT'S FULL NAME		BIRTHDATE	SOCIAL SECURITY NO.	SEX <input type="checkbox"/> M <input type="checkbox"/> F	RACE	TELEPHONE Home
ADDRESS		CITY/STATE/ZIP		COUNTY		Message Work
CLIENT'S PRIMARY MEDICAL PROBLEM				OTHER KNOWN HEALTH PROBLEMS		
CLIENT'S REGULAR PHYSICIAN		ADDRESS/CITY/STATE/ZIP				PHONE
MOTHER/STEPFATHER/GUARDIAN		BIRTHDATE	SOCIAL SECURITY NO.	EMPLOYER	EDUCATION LEVEL	
FATHER/STEPMOTHER/GUARDIAN		BIRTHDATE	SOCIAL SECURITY NO.	EMPLOYER	EDUCATION LEVEL	
OTHER DEPENDENTS LIVING IN HOME	RELATIONSHIP	BIRTHDATE	OTHER DEPENDENTS LIVING IN HOME	RELATIONSHIP	BIRTHDATE	
NAME OF INSURANCE CO.			ADDRESS			
POLICY HOLDER			POLICY NUMBER	DOES THIS INSURANCE COVER YOUR CHILD? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Do not know		

CHECK ALL BOXES INVOLVED WITH YOUR CHILD'S AND FAMILY'S CARE:

<input type="checkbox"/> Additional insurance	<input type="checkbox"/> Foster Care
<input type="checkbox"/> Dental insurance	<input type="checkbox"/> WIC (Women, Infants, and Children)
<input type="checkbox"/> DSHS/Medicaid/Medical Assistance Administration PIC (Patient Identification Code) _____	<input type="checkbox"/> SSI (Supplemental Security Income)
	<input type="checkbox"/> DDD (Division of Developmental Disabilities)

COMMENTS

**Part II - Signature**

- I understand and agree that Children with Special Health Care Needs (CSHCN) funds will be used only when there are no other sources of payment for medical care. If CSHCN has paid a bill and any other source including insurance, court awarded settlements or Medicaid pays the same bill, the amount paid by CSHCN will be reimbursed to CSHCN.
- I agree to release the Department of Health, its agents, employees and local Children with Special Health Care Needs agencies from any and all claims from damages, except for willful injury, in the course of or in connection with services provided.
- I understand all information from my child's records will remain confidential and will only be shared if I sign another authorization form or as otherwise permitted by law.

MOTHER/STEPMOTHER/GUARDIAN/SELF (IF EMANCIPATED MINOR)	DATE	FATHER/STEPFATHER/GUARDIAN	DATE
--	------	----------------------------	------

DOH 910-003 (11/8/94)

**Part III - Financial Information**

<b>A. Monthly Income</b>	<b>1st Wage Earner</b>	<b>2nd Wage Earner</b>	<b>Comments</b>
1) Take home pay (after deductions).....	\$ _____	\$ _____ (not added to total)	
2) Gross (before deductions) salary/wages.....	\$ _____	\$ _____	
3) Public assistance grant.....	\$ _____	\$ _____	
4) Unemployment compensation.....	\$ _____	\$ _____	
5) Disability income (permanent).....	\$ _____	\$ _____	
6) Child support/alimony received.....	\$ _____	\$ _____	
7) Other (specify).....	\$ _____	\$ _____	
• Totals (2 thru 7).....	8) \$ _____	9) \$ _____	

Note: Wage statements, federal income tax forms or a statement of work may be required to verify income.

**B. Monthly Expenses**

10) Child support/alimony you pay.....	\$ _____
11) Day care costs while you work.....	\$ _____
12) Medical/dental insurance premiums you pay.....	\$ _____
• Total (10 thru 12).....	13) \$ _____

**C. Resources**

14) Savings Accounts.....	\$ _____
15) Stocks, bonds, contracts.....	\$ _____
16) Assessed value of real estate other than home.....	\$ _____
17) Value of recreational vehicles, boats, etc.....	\$ _____
• Total (14 thru 17).....	18) \$ _____

**D. Medical/Dental Costs**

Costs NOT covered by insurance, or Medical Assistance Admin. (Medicaid) during the past 12 Months, including carryover from previous Years

• Total.....	19) \$ _____
--------------	--------------

**E. Adjusted Gross Income from Federal Income Tax for past two years**

19 _____	\$ _____
19 _____	\$ _____

NOTE: If over \$2,000.00 an itemized list of medical and dental expenses may be required.

**F. I/we state the financial information given above is true and complete.**

MOTHER/STEPMOTHER/GUARDIAN/SELF (IF EMANCIPATED MINOR)	DATE	FATHER/STEPFATHER/GUARDIAN	DATE

**Do Not Write Below This Line**

\* Refer to Federal Poverty Guidelines in CSHCN Manual.

• 8) _____ + 9) _____ = 13) _____	× 12 months = 20) _____	( + )
• 18) _____ × 12% = 21) _____		( + )
• 19) _____ - * Medical Allowance 24) _____	= 22) _____	( - )
• Adjusted Family Income (AFI) (20 + 21 - 22).....	= 23) _____	( - )
• Family size 25) _____ = * CSHCN Annual Needs = 26) _____		

- Approved: Confirmed WIC/MAA/SSI Eligibility
- Approved: Income at or below CSHCN Financial Eligibility Policy (AFI less than CSHCN Annual Needs)
- Denied: Income above CSHCN Financial Eligibility Policy (AFI more than CSHCN Annual Needs)

COMPLETED BY:	DATE:

DOH 510-003 (11/06/04)

**5332 Economic Level Codes - Federal Poverty Level Guidelines**

**2016  
PERCENT OF FEDERAL POVERTY LEVEL\***

Family Size	F P L Income	A	B		C		D		E		F		G	
		100%	101 - 133%	134 - 193%	194 - 210%	211 - 220%	221 - 260%	261 - 312%						
1	Annual	11,880	11,881	15,800	15,801	22,928	22,929	24,948	24,949	26,136	26,137	30,888	30,889	49,297
	Monthly	990	991	1,317	1,318	1,911	1,912	2,079	2,080	2,178	2,179	2,574	2,575	4,108
2	Annual	16,020	16,021	21,307	21,308	30,919	30,920	33,642	33,643	35,244	35,245	41,652	41,653	66,477
	Monthly	1,335	1,336	1,776	1,777	2,577	2,578	2,804	2,805	2,937	2,938	3,471	3,472	5,540
3	Annual	20,160	20,161	26,813	26,814	38,909	38,910	42,336	42,337	44,352	44,353	52,416	52,417	83,656
	Monthly	1,680	1,681	2,234	2,235	3,242	3,243	3,528	3,529	3,696	3,697	4,368	4,369	6,971
4	Annual	24,300	24,301	32,319	32,320	46,899	46,900	51,030	51,031	53,460	53,461	63,180	63,181	100,835
	Monthly	2,025	2,026	2,693	2,694	3,908	3,909	4,253	4,254	4,455	4,456	5,265	5,266	8,403
5	Annual	28,440	28,441	37,825	37,826	54,889	54,890	59,724	59,725	62,568	62,569	73,944	73,945	118,015
	Monthly	2,370	2,371	3,152	3,153	4,574	4,575	4,977	4,978	5,214	5,215	6,162	6,163	9,835
6	Annual	32,580	32,581	43,331	43,332	62,879	62,880	68,418	68,419	71,676	71,677	84,708	84,709	135,194
	Monthly	2,715	2,716	3,611	3,612	5,240	5,241	5,702	5,703	5,973	5,974	7,059	7,060	11,266
7	Annual	36,730	36,731	48,851	48,852	70,889	70,890	77,133	77,134	80,806	80,807	95,498	95,499	152,415
	Monthly	3,061	3,062	4,071	4,072	5,907	5,908	6,428	6,429	6,734	6,735	7,958	7,959	12,701
8	Annual	40,890	40,891	54,384	54,385	78,918	78,919	85,869	85,870	89,958	89,959	106,314	106,315	169,677
	Monthly	3,408	3,409	4,532	4,533	6,576	6,577	7,156	7,157	7,497	7,498	8,860	8,861	14,140
For each person above a family size of 8 persons, add \$4,160.														

\* Federal register from U.S. Department of Health and Human Services; Federal Poverty Level (FPL).  
<http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-02-09-2016.pdf>

**Washington State Health Care Authority (HCA) Eligibility Levels:**

- 193% FPL is eligibility level for pregnant women's program (unborn is counted in household size).
- 210% FPL is eligibility level for free access to the children's medical program (Washington Apple Health for Kids) program.
- 260% FPL is eligibility level for pre-pregnancy family planning services to help participants take charge of their lives and prevent unintended pregnancies.

The **State Children's Health Insurance Program (CHIP)** is a federal non-entitlement program for children under 19 years of age with a family income between 210% and 312% of the FPL. CHIP is administered through HCA, and is known in Washington as Apple Health for Kids with premiums.

<https://www.medicaid.gov/medicaid-chip-program-information/by-state/washington.html>

### **5333 Complex Income Situations**

a) Self-employed

Financial documentation may be requested from families who are self-employed, receive commissions, or have complex income situations. The documentation can serve as an indicator of fair and reasonable income, by comparing past year earnings with projected income.

b) Medical Expenses

When CSHCN financial eligibility is dependent on the family's medical and dental expenses not covered by any other available resource, an itemized list may be requested when the reported costs are more than the medical allowance on the federal poverty guidelines (see Section 5332), in order to confirm expenses and evaluate family needs.

c) Unemployed

Families, whose adult members are unemployed, shall be eligible, based on income during a period of unemployment if loss of income causes current rate of income to be less than CSHCN eligibility. Financial documentation may be requested as described above in a) Self-employed. Length of eligibility may be shortened to review income more frequently.

**5334 Signature and Resource Responsibility**

The following table shows who must sign a CSHCN Financial Application, whose resources are used and who receives the notification letter when determining financial eligibility for use of Diagnostic and Treatment Funds.

<i>Situation</i>	<i>Signs Application</i>	<i>Resources</i>	<i>Eligibility Letter</i>	<i>Comments</i>
1. Abandoned minor client	-0-	-0-	-0-	See item 10 - "Legal Guardian."
2. Adoptive parents of client	One or both adoptive parents	Adoptive parents	Adoptive parents	Adoptive parent is financially responsible at time of placement.
3. Divorced parent(s) of client: Single parent	Parent with physical custody.	Parent with physical custody.	Parent with physical custody	
4. Divorced parent(s) of client: Remarried	Parent and/or step-parent.	Parent and step-parent.	Parent and step-parent	Financial resources of the current household. <sup>1</sup>
5. Division of Juvenile Rehabilitation (DJR) client	-0-	-0-	-0-	Pursue responsibility of facility to provide medical care.
6. Emancipated minor client	Client	Client	Client	<p>Clients under 18 years of age are considered emancipated when they:</p> <ul style="list-style-type: none"> <li>• are married;</li> <li>• are an unwed mother, living independently or with parents;</li> <li>• have a court decree granting emancipation.</li> </ul>

<sup>1</sup> RCW 26.16.205 Liability for family support. The expenses of the family and the education of the children, including stepchildren, are chargeable upon the property of both husband and wife, or either of them, and in relation thereto they may be sued jointly or separately, provided that with regard to stepchildren, the obligation shall cease upon the termination of the relationship of husband and wife.

<i>Situation</i>	<i>Signs Application</i>	<i>Resources</i>	<i>Eligibility Letter</i>	<i>Comments</i>
7. Foster parent(s) of client: voluntary placement	One or both parents	-0- HRSA accepted as financial eligibility	Parents. Copy to case worker and foster parents	Not ward of court.
	Legal guardian	-0- HRSA accepted as financial eligibility	Legal guardian. Copy to case worker and foster parent	
8. Foster parent(s) of client: involuntary placement	Case worker	-0- MAA accepted as financial eligibility	Case worker. Copy to foster parents	Ward of court.
9. Foster parents of client: out of state foster child	-0-	-0-	-0-	Foster children placed in Washington from another state are not eligible to receive Washington CSHCN funded diagnostic and treatment services.
10. Legal guardians of client	Guardian	Client	Legal guardian	Guardianship is established by the court system.
11. Married parents of client: living together	One or both parents	Both parents	Both parents	
12. Married parents of client: living apart	Parent with physical custody.	Parent with physical custody.	Parent with physical custody	
13. Single parent of client: with physical custody	Single parent	Single parent	Single parent	

5335 Sample Financial Application - Approved: Confirmed WIC/HRSA/SSI



Children with Special Health Care Needs  
Financial Application

**Part I - General Information**

CLIENT'S FULL NAME: Becky Doe BIRTHDATE: 1-3-99 SOCIAL SECURITY NO.: 1234 SEX:  M  F RACE: White

ADDRESS: 123 Main Street CITY/STATE/ZIP: anytown 98000 COUNTRY: Yours

CLIENT'S PRIMARY MEDICAL PROBLEM: hearing OTHER KNOWN HEALTH PROBLEMS: none

CLIENT'S REGULAR PHYSICIAN: J. Smith ADDRESS/CITY/STATE/ZIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

MOTHER/STEPFATHER/GUARDIAN: Cindy Doe BIRTHDATE: 2-1-80 SOCIAL SECURITY NO.: 4567 EMPLOYER: \_\_\_\_\_ EDUCATION LEVEL: HS

FATHER/STEPMOTHER/GUARDIAN: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_ SOCIAL SECURITY NO.: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_ EDUCATION LEVEL: \_\_\_\_\_

OTHER DEPENDENTS LIVING IN HOME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

NAME OF INSURANCE CO.: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

POLICY HOLDER: \_\_\_\_\_ POLICY NUMBER: \_\_\_\_\_ DOES THIS INSURANCE COVER YOUR CHILD?  Yes  No  Do Not Know

CHECK ALL BOXES INVOLVED WITH YOUR CHILD'S AND FAMILY'S CARE:

Additional Insurance  Foster Care

Dental Insurance  WIC (Women, Infants and Children)

DSHS/Medicaid/Medical Assistance Administration  SSI (Supplemental Security Income)

PIC (Paternal Identification Code) BC010399DFA  DDD (Division of Developmental Disabilities)

COMMENTS: DSHS - medicaid eligibility confirmed. Copy attached. Becky on Healthy Options - Group Hth

Authorizing hearing aid batteries.

DSHS - certifications for hearing aids and ear molds from Home Town Hearing Center

**Part II - Signature**

I understand and agree that Children with Special Health Care Needs (CSHCN) funds will be used only when there are no other sources of payment for medical care. If CSHCN has paid a bill and any other source including insurance, court awarded settlements or Medicaid pays the same bill, the amount paid by CSHCN will be reimbursed to CSHCN.

I agree to release the Department of Health, its agents, employees and local Children with Special Health Care Needs agencies from any and all claims from damages, except for willful injury, in the course of or in connection with services provided.

I understand all information from my child's records will remain confidential and will only be shared if I sign another authorization form or as otherwise permitted by law.

MOTHER/STEPMOTHER/GUARDIAN/SELF (IF EMANCIPATED MINOR): Cindy Doe DATE: 11-15-08

FATHER/STEPFATHER/GUARDIAN: \_\_\_\_\_ DATE: \_\_\_\_\_

**Part III - Financial Information**

**A. Monthly Income**

1) Take home pay (after deductions) ..... \$ \_\_\_\_\_ (not added to total)

2) Gross (before deductions) salary/wages ..... \$ \_\_\_\_\_

3) Public assistance grant ..... \$ \_\_\_\_\_

4) Unemployment compensation ..... \$ \_\_\_\_\_

5) Disability Income (permanent) ..... \$ \_\_\_\_\_

6) Child support/alimony received ..... \$ \_\_\_\_\_

7) Other (specify) ..... \$ \_\_\_\_\_

• Totals (2 thru 7) ..... 8) \$ \_\_\_\_\_

Note: Wage statements, federal income tax forms or a statement of work may be required to verify income.

**B. Monthly Expenses**

10) Child support/alimony you pay ..... \$ \_\_\_\_\_

11) Day care costs while you work ..... \$ \_\_\_\_\_

12) Medical/dental insurance premiums you pay ..... \$ \_\_\_\_\_

• Total (10 thru 12) ..... 13) \$ \_\_\_\_\_

**C. Resources**

14) Savings Accounts ..... \$ \_\_\_\_\_

15) Stocks, bonds, contracts ..... \$ \_\_\_\_\_

16) Assessed value of real estate other than home ..... \$ \_\_\_\_\_

17) Value of recreational vehicles, boats, etc. .... \$ \_\_\_\_\_

• Total (14 thru 17) ..... 18) \$ \_\_\_\_\_

**D. Medical/Dental Costs**

Costs NOT covered by insurance, or Medical Assistance Admin. (Medicaid) during the past 12 Months, including carryover from previous years

• Total ..... 19) \$ \_\_\_\_\_

NOTE: If over \$2,000.00 an itemized list of medical and dental expenses may be required.

**E. Adjusted Gross Income from Federal Income Tax for past two years**

• Total ..... 19) \$ \_\_\_\_\_

**F. I/we state the financial information given above is true and complete.**

MOTHER/STEPMOTHER/GUARDIAN/SELF (IF EMANCIPATED MINOR) DATE FATHER/STEPFATHER/GUARDIAN DATE

**Do Not Write Below This Line**

\* Refer to Federal Poverty Guidelines in CSHCN Manual.

• 8) + 8) \* 13) x 12 months = 20) (+)

• 18) x 12% = 21) (+)

• 19) \* Medical Allowance 28) = 22) (-)

• Adjusted Family Income (AFI) ..... (20 + 21 - 22) = 23) (-)

\* Family size 25) = \* CSHCN Annual Needs = 26) (-)

Approved: Confirmed WIC/Medicaid/SSI Eligibility

Approved: Income at or below CSHCN Financial Eligibility Policy (AFI less than CSHCN Annual Needs)

Denied: Income above CSHCN Financial Eligibility Policy (AFI more than CSHCN Annual Needs)

COMPLETED BY: P. Shumway DATE: 12-1-08

DOH 910-000 (1/05/04)

5336 Sample Financial Application - Approved: Income within CSHCN Financial Eligibility



Children with Special Health Care Needs  
Financial Application

**Part I - General Information**

CLIENT'S FULL NAME: Mary Smith BIRTHDATE: 2-5-95 SEX:  M  F RACE: C TELEPHONE: Home 456-1234 Message  Year

ADDRESS: 46 Center Ave CITY: Anytown STATE: 98000 COUNTY: Yours

CLIENT'S PRIMARY MEDICAL PROBLEM: cardiac checkups OTHER KNOWN HEALTH PROBLEMS:

CLIENT'S REGULAR PHYSICIAN	ADDRESS/CITY/STATE/ZIP	PHONE
<u>Good Health Clinic</u>	<u>123 Main Street, Ste B</u>	<u>123-6789</u>
MOTHER'S PARENT/GUARDIAN	BIRTHDATE: <u>1-2-71</u> SOCIAL SECURITY NO.: <u>6789</u> EMPLOYER: <u>babysits</u> EDUCATION LEVEL: <u>HS</u>	
FATHER'S PARENT/GUARDIAN	BIRTHDATE: <u>7-6-70</u> SOCIAL SECURITY NO.: <u>16800</u> EMPLOYER: <u>city</u> EDUCATION LEVEL: <u>HS</u>	
OTHER DEPENDENTS LIVING IN HOME	RELATIONSHIP: <u>Bro</u> BIRTHDATE: <u>1-2-02</u> OTHER DEPENDENTS LIVING IN HOME: <u></u> RELATIONSHIP: <u></u> BIRTHDATE: <u></u>	

NAME OF INSURANCE CO.: Blue Cross ADDRESS: Seattle DOES THIS INSURANCE COVER YOUR CHILD?  Yes  No  Do not know

CHECK ALL BOXES INVOLVED WITH YOUR CHILD'S AND FAMILY'S CARE:

Additional Insurance  Foster Care

Dental Insurance  WIC (Women, Infants and Children)

DSHS/Medicaid/Medical Assistance Administration  SSI (Supplemental Security Income)

PIC (Parent Identification Cards)  DDD (Division of Developmental Disabilities)

COMMENTS: Insurance - father only  
Helped with applications to Medicaid - mother and children, and as a backup, Basic Health inquiry.  
Mary needs regular checkups with cardiologist.

**Part II - Signature**

I understand and agree that Children with Special Health Care Needs (CSHCN) funds will be used only when there are no other sources of payment for medical care. If CSHCN has paid a bill and any other source including insurance, court awarded settlements or Medicaid pays the same bill, the amount paid by CSHCN will be reimbursed to CSHCN.

I agree to release the Department of Health, its agents, employees and local Children with Special Health Care Needs agencies from any and all claims from damages, except for willful injury, in the course of or in connection with services provided.

I understand all information from my child's records will remain confidential and will only be shared if I sign another authorization form or as otherwise permitted by law.

MO/HE/ST/PT/MO/TH/GR/DAN/SELF (IF EMANCIPATED MINOR) DATE: 11/10/09

COMPUTED BY: Cindy Doe DATE: 11/10/09

DOH 610-002 (1/08/04)

**Part III - Financial Information**

**A. Monthly Income**

1st Wage Earner	2nd Wage Earner	Comments
1) Take home pay (after deductions) ..... \$ <u>2,300</u> (not added to total)	\$ <u>600</u>	
2) Gross (before deductions) salary/wages ..... \$ <u>2,500</u>	\$ <u>600</u>	<u>Mom babysits in home about 3-4 days a week for sisters children</u>
3) Public assistance grant..... \$ <u></u>	\$ <u></u>	
4) Unemployment compensation..... \$ <u></u>	\$ <u></u>	
5) Disability Income (permanent)..... \$ <u></u>	\$ <u></u>	
6) Child support/alimony received..... \$ <u></u>	\$ <u></u>	
7) Other (specify)..... \$ <u></u>	\$ <u></u>	
• Totals (2 thru 7)..... 8) \$ <u>2,500</u>	9) \$ <u>600</u>	

Note: Wage statements, federal income tax forms or a statement of work may be required to verify income.

**B. Monthly Expenses**

10) Child support/alimony you pay..... \$ <u></u>	14) Savings Accounts..... \$ <u></u>
11) Day care costs while you work..... \$ <u></u>	15) Stocks, bonds, contracts..... \$ <u></u>
12) Medical/dental insurance premiums you pay..... \$ <u></u>	16) Assessed value of real estate other than home..... \$ <u></u>
• Total (10 thru 12)..... 13) \$ <u></u>	17) Value of recreational vehicles, boats, etc..... \$ <u></u>
	• Total (14 thru 17)..... 18) \$ <u></u>

**C. Resources**

14) Savings Accounts..... \$

15) Stocks, bonds, contracts..... \$

16) Assessed value of real estate other than home..... \$

17) Value of recreational vehicles, boats, etc..... \$

• Total (14 thru 17)..... 18) \$

**D. Medical/Dental Costs**

Costs NOT covered by insurance, or Medical Assistance Admin. (Medicaid) during the past 12 Months, including carryover from previous Years

• Total..... 19) \$ <u>2,400</u>	• Adjusted Gross Income from Federal Income Tax for past two years
	19 2007 \$ <u>32,000</u>
	19 2008 \$ <u>34,000</u>

NOTE: If over \$2,000.00 an itemized list of medical and dental expenses may be required.

**E. Adjusted Gross Income from Federal Income Tax for past two years**

19 2007 \$ 32,000

19 2008 \$ 34,000

**F. I/we state the financial information given above is true and complete.**

MO/HE/ST/PT/MO/TH/GR/DAN/SELF (IF EMANCIPATED MINOR) DATE: 11/10/09

FATHER'S PARENT/GUARDIAN

Do Not Write Below This Line

\* Refer to Federal Poverty Guidelines in CSHCN Manual.

• 8) <u>2,500</u> + 9) <u>600</u> = 13) <u>0</u> x 12 months = 20) <u>37,200</u> (+)
• 18) <u>0</u> x 12% = 21) <u>0</u> (+)
• 19) <u>2,400</u> - * Medical Allowance 24) <u>3087</u> = 22) <u>0</u> (-)
• Adjusted Family Income (AFI)..... 20) * 21) = 23) <u>37,200</u> (-)
* Family size 25) <u>4</u> = * CSHCN Annual Needs = 26) <u>44,100</u>

- Approved: Confirmed WIC/MMA/SSI Eligibility
- Approved: Income at or below CSHCN Financial Eligibility Policy (AFI less than CSHCN Annual Needs).
- Denied: Income above CSHCN Financial Eligibility Policy (AFI more than CSHCN Annual Needs)

5337 Sample Financial Application - Denied: Income above CSHCN Financial Eligibility



Children with Special Health Care Needs  
Financial Application

Part I - General Information

CLIENT'S FULL NAME <b>Fred Sample</b>	BIRTHDATE <b>9/1/00</b>	SOCIAL SECURITY NO. ---	SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	RACE <b>C</b>	TELEPHONE Home <b>23-1234</b> Message Work <b>567-8910</b>
ADDRESS <b>1 North Street</b>	CITY/STATE/ZIP <b>Anytown 98000</b>	COUNTY <b>Yours</b>			
CLIENT'S PRIMARY MEDICAL PROBLEM <b>Cleft-Lip-Palate</b>	OTHER KNOWN HEALTH PROBLEMS <b>hearing</b>				
CLIENT'S REGULAR PHYSICIAN <b>Mary Reed, MD</b>	ADDRESS/CITY/STATE/ZIP <b>County Pediatric Center</b>	PHONE <b>345-6789</b>			
MOTHER/STEPFATHER/GUARDIAN <b>Sara Sample</b>	BIRTHDATE <b>1/3/69</b>	SOCIAL SECURITY NO. ---	EMPLOYER <b>Acme Co.</b>	EDUCATION LEVEL <b>BS</b>	
FATHER/STEPMOTHER/GUARDIAN <b>James Sample</b>	BIRTHDATE <b>6/9/69</b>	SOCIAL SECURITY NO. ---	EMPLOYER <b>Anytown Const.</b>	EDUCATION LEVEL <b>BS</b>	
OTHER DEPENDENTS LIVING IN HOME	RELATIONSHIP	BIRTHDATE	OTHER DEPENDENTS LIVING IN HOME	RELATIONSHIP	BIRTHDATE
<b>Tom</b>	<b>Sib</b>	<b>8/3/04</b>	<b>George</b>	<b>Sib</b>	<b>12/5/08</b>
<b>Greg</b>	<b>"</b>	<b>4/4/06</b>			
<b>Patty</b>	<b>"</b>	<b>5/9/07</b>			
NAME OF INSURANCE CO. <b>Citizens Insurance Co.</b>	ADDRESS <b>Boston, MA</b>				
POLICY HOLDER <b>James</b>	POLICY NUMBER <b>81623W</b>	DOES THIS INSURANCE COVER YOUR CHILD? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Do not know			

COMMENTS

Family new in area.  
Need to coordinate services for on-going CL-P needs and get medical records to new specialist Sara (mom) may be returning to work soon. Fred may need surgery this summer. Checking income level for possibilities of additional coverage

Part II - Signature

- I understand and agree that Children with Special Health Care Needs (CSHCN) funds will be used only when there are no other sources of payment for medical care. If CSHCN has paid a bill and any other source including insurance, court awarded settlements or Medicaid pays the same bill, the amount paid by CSHCN will be reimbursed to CSHCN.
- I agree to release the Department of Health, its agents, employees and local Children with Special Health Care Needs agencies from any and all claims from damages, except for willful injury, in the course of or in connection with services provided.
- I understand all information from my child's records will remain confidential and will only be shared if I sign another authorization form or as otherwise permitted by law.

MOTHER/STEPMOTHER/GUARDIAN/SELF (IF EMANCIPATED MINOR) <b>John Doe</b>	DATE <b>11/9/09</b>	FATHER/STEPFATHER/GUARDIAN	DATE
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Part III - Financial Information

A. Monthly Income	1st Wage Earner	2nd Wage Earner	Comments
1) Take home pay (after deductions) .....	\$ <b>4810</b>	\$ <b>0</b>	<i>Mom off work 6/mo. Medical bills verified as after insurance - owed by family.</i>
2) Gross (before deductions) salary/wages .....	\$ <b>5960</b>	\$	
3) Public assistance grant .....	\$	\$	
4) Unemployment compensation .....	\$	\$	
5) Disability Income (permanent) .....	\$	\$	
6) Child support/alimony received .....	\$	\$	
7) Other (specify) .....	\$	\$	
• Totals (2 thru 7) .....	8) \$ <b>5960</b>	9) \$ <b>0</b>	
Note: Wage statements, federal income tax forms or a statement of work may be required to verify income.			
B. Monthly Expenses	C. Resources		
10) Child support/alimony you pay .....	\$ <b>0</b>	14) Savings Accounts .....	\$ <b>3800</b>
11) Day care costs while you work .....	\$ <b>0</b>	15) Stocks, bonds, contracts .....	\$ <b>6000</b>
12) Medical/dental insurance premiums you pay \$ <b>150</b>		16) Assessed value of real estate other than home \$	
• Total (10 thru 12) .....	13) \$ <b>150</b>	17) Value of recreational vehicles, boats, etc. ....	\$
		• Total (14 thru 17) .....	18) \$ <b>9800</b>
D. Medical/Dental Costs	E. Adjusted Gross Income from Federal Income Tax for past two years		
Costs NOT covered by insurance, or Medical Assistance Admin. (Medicaid) during the past 12 Months, including carryover from previous Years			
• Total .....	19) \$ <b>6130</b>	19 <b>2007</b>	\$ <b>83,500</b>
		19 <b>2008</b>	\$ <b>85,000</b>
NOTE: If over \$2,000.00 an itemized list of medical and dental expenses may be required.			

F. I/we state the financial information given above is true and complete.

MOTHER/STEPMOTHER/GUARDIAN/SELF (IF EMANCIPATED MINOR) <b>John Doe</b>	DATE <b>11/9/09</b>	FATHER/STEPFATHER/GUARDIAN	DATE
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Do Not Write Below This Line

\* Refer to Federal Poverty Guidelines in CSHCN Manual.

• 8) **5960** + 9) **0** = 13) **150** x 12 months = 20) **69,720** (+)

• 18) **9800** x 12% = 21) **1176** (+)

• 19) **6130** - \* Medical Allowance 24) **4658** = 22) **1472** (-)

• Adjusted Family Income (AFI) (20 + 21 - 22) = 23) **67,072** (-)

\* Family size 25) **7** = \* CSHCN Annual Needs = 26) **66,540**

Approved: Confirmed WIC/MAA/SSI Eligibility

Approved: Income at or below CSHCN Financial Eligibility Policy (AFI less than CSHCN Annual Needs)

Denied: Income above CSHCN Financial Eligibility Policy (AFI more than CSHCN Annual Needs)

COMPUTED BY <i>Lissa Hunter</i>	DATE <b>11/10/09</b>
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## **5340 Client Notification Letters**

Written notification to families who have completed a Financial Application is required in accordance with policies in Section 5310. The table that follows lists the required components, as well as common components in client letters. Written notification to families who have completed an application was a request from parent organizations so families are notified about the conclusion.

Client notification letters are sent to parents or legal guardians who sign the application. Examples are included in Section 5340, Application Signature and Resources Table. It is no longer necessary to send copies of notification letters to the client's medical providers.

An LHJ information sheet may be enclosed with client letters to provide facts about the program. A sample information sheet is in Section 5350 and can be personalized for your agency.

### 5341 - Components in Client Notification Letters

<i>Financially eligible for CSHCN</i>	<i>Income is over CSHCN financial eligibility levels</i>	<i>Examples</i>
*1. Statement of financial eligibility for CSHCN	*1. Statement of financial eligibility for Children with Special Health Care Needs	1. Your child is financially eligible for the Children with Special Health Care Needs program
*2. Services provided by CSHCN	*2. Services provided by Children with Special Health Care Needs	2. The program provides care coordination and . . .
	*3. Explanation of non-financial eligibility for diagnostic and treatment services based on income level	3. Although we are not able to pay for medical services because your income is too high, these services are available ... (regardless of income)
*4. Time period of financial eligibility not to exceed 12 months	4. Time period of financial eligibility not to exceed 12 months	4. You are financially eligible for the program for twelve (12) months from _____ to _____.
5. Services provided by public health nurse	5. Services provided by public health nurse	5. Public health nurses are available to coordinate services for you and your family.
6. Role of family	6. Role of family	6. We require that you apply for medical coverage through the Health and Recovery Services Administration (Medicaid) in DSHS.
7. Limits on services	7. Limits on services	7. The program does not cover regular or routine medical and dental services.
8. Local agency contact person and phone number	8. Local agency contact person and phone number	8. Insert information in signature block.

\* *Required*

**5342 Sample Client Notification Letter -Probable HRSA Eligibility**

Date

Parent Address

RE: Client Name  
Date of Birth  
CSHCN Case Number or another identifier

Dear Parent:

Thank you for completing a Financial Application for Children with Special Health Care Needs (CSHCN). This program provides care coordination and limited payment for some medical services.

Your application indicates you may be eligible for medical coverage through Health and Recovery Services Administration (HRSA) in the Department of Social and Health Services (DSHS). We require that you apply for HRSA before CSHCN pays for any services. I can help you with that process.

Many services are offered by public health nurses and CSHCN staff in county. We know about children with special health care needs, community resources and can work with you to organize services for your child and family. An information sheet is enclosed with more explanation.

We look forward to getting to know your child and family. Please contact our staff with questions.

Sincerely

Name  
CSHCN Coordinator  
Local Agency  
Phone

Enclosure

cc: Client Record  
Other CSHCN Contracted Agency

**5343 Sample Client Notification Letter - Eligible CSHCN and HRSA**

Date

Parent Address

RE: Client Name  
Date of Birth  
CSHCN Case Number or another identifier

Dear Parent:

Welcome to Children with Special Health Care Needs (CSHCN). We look forward to helping you coordinate  (child's name)  care and getting to know your family.

There are many services offered by public health nurses and CSHCN staff in our county which may be of interest to you. The nurses know about children with special health care needs, community resources and can help arrange your medical coverage through  (i.e., Healthy Options/ Basic Health Plan-Plus/Medicaid, HRSA in DSHS) .

Please contact our staff with any questions.

Sincerely,

Name  
CSHCN Coordinator  
Local Agency  
Phone

cc: Client Record  
Other CSHCN Contracted Agency

**5344 Sample Client Notification Letter - Income Above Guidelines**

Date

Parent Address

RE: Client Name  
Date of Birth  
CSHCN Case Number or another identifier

Dear Parent:

Thank you for completing a Financial Application for Children with Special Health Care Needs (CSHCN). Although we are not able to pay for medical services because your income is too high, many other services are available in     (county)    . Public health nurses and CSHCN staff know about children with special health care needs and community resources. We can work with you to identify needs and coordinate services.

We look forward to getting to know your child and family.

Sincerely,

Name  
CSHCN Coordinator  
Local Agency  
Phone

cc: Client Record  
Other CSHCN Contracted Agency

## **5350 Sample Information Sheet**

Information sheets or brochures of many descriptions are created and used by local agencies as client handouts. The sample that follows is appropriate for a parent who has completed a CSHCN application, and could be an attachment to a client notification letter.

### ***SAMPLE INFORMATION SHEET***

(Local Agency Name)

#### **CHILDREN WITH SPECIAL HEALTH CARE NEEDS**

(Please read carefully and keep for reference)

#### **SERVICES:**

1. You are expected to apply for medical coverage through Health and Recovery Services Administration (HRSA) in the Department of Social and Health Services (DSHS).
2. Before your medical appointment, call the Children with Special Health Care Needs (CSHCN) office if you need help coordinating payment of the service. See the back of this sheet for a name and phone number.
3. Limited funds are available from the Children with Special Health Care Needs Program to pay for some medical services which are not covered by any other source. You must get approval from CSHCN before the services happens.
4. When the CSHCN Program pays for a service, the provider cannot bill you for additional charges. However, you may be billed for services which were not approved by the CSHCN Program. If you receive such bills and have questions, call our office.
5. Payment for services may be stopped if money for this program runs out or is reduced.

#### **ELIGIBILITY:**

Your eligibility will be updated at least once a year. Contact our office if there is a change in your:

- |                                      |                                       |   |
|--------------------------------------|---------------------------------------|---|
| <input type="checkbox"/> income      | <input type="checkbox"/> phone number | <input type="checkbox"/> insurance coverage |
| <input type="checkbox"/> family size | <input type="checkbox"/> address      | <input type="checkbox"/> Medicaid coverage  |

#### **INSURANCE AND OTHER THIRD-PARTY COVERAGE:**

1. You are expected to apply for medical coverage through Health and Recovery Services Administration (HRSA) in the Department of Social and Health Services (DSHS).

2. Insurance, Medicaid, Healthy Options, Basic Health Plan-Plus, Health Maintenance Organization, and other third-party coverage must be used before the CSHCN Program will make payment.
3. Send all medical bills to your insurance company.
4. Send all insurance checks to those who provided the service.
5. The CSHCN Program will make payment for approved services if the insurance payment is less than the CSHCN fee for the service(s) or after an insurance company refuses payment. If you have a question about a bill, call our office.
6. If your coverage is with Healthy Options or a Health Maintenance Organization (for example, Group Health or Kaiser), all services covered under the plan must be obtained through the designated facility or provider. A statement saying the requested services are not provided by the policy covering your child, must be obtained before CSHCN can consider payment.
7. CSHCN payments are made directly to the doctor (or facility) who provided the service.

YOUR LOCAL CSHCN OFFICE IS THE \_\_\_\_\_ HEALTH DEPARTMENT.

Phone: \_\_\_\_\_

Nurse: \_\_\_\_\_

Phone: \_\_\_\_\_

Other: \_\_\_\_\_

Phone: \_\_\_\_\_

## 5400 Authorization to Release and Obtain Information

The CSHCN Authorization to Release and Obtain Information form is an approved form to release and/or obtain confidential health care information restricted in use and access by law. The form was legally approved in 1994 and remains current (DOH 970-002 (10/25/94)).

Other consent forms used by local health agencies and medical providers can be used if they comply with the legal requirements. A valid authorization for disclosure must:

- Identify the client;
- Identify the nature of the information to be disclosed;
- Identify the name, address and institutional affiliation of the person to whom the information is to be disclosed;
- Identify the provider who is to make the disclosure;
- Be in writing and be dated and signed by patient (parent or legal guardian).

It is recommended a consent be processed whenever requested as a courtesy to the comfort of clients, client families and medical providers, even in situations where not required by law.

The CSHCN Authorization to Release or Obtain Information form can be requested from the CSHCN Program.

## 5410 Policy

A statement of authorization must be completed and signed for consent to release or obtain confidential health care information and comply with federal and state laws.

## 5420 Procedures

<u>Responsibility</u>	<u>Action</u>
Local agency (LHJ)	Provides parent or guardian with consent form when a request is made to authorize the release or obtain confidential health care information.
Parent or Guardian	Completes and signs form.
Local agency	Reviews form for complete information and signature. Processes the authorization for requested service. Retains form in client's record. Renews signature after 90 days if needed.

**5421 Instructions for Completing Authorization to Release and Obtain Information**

The table that follows provides instructions for completing the CSHCN Authorization. Each section is for a different consent and can be used alone.

See Section 5422 for a copy of the form.

<i>Authorization Form</i>	<i>Instructions</i>
1. Authorization to Release Information	Purpose: Local CSHCN agency <u>gives</u> information to another health provider.  Parent completes all spaces with assistance from local agency staff.  Parent signs.
2. Authorization to Obtain Information	Purpose: Local CSHCN agency <u>obtains</u> information from another health provider. This also clarifies that the health provider has permission to give the information.  Parent completes all spaces with assistance from local agency staff.  Parent signs.
3. Specific Release Related to Treatment	Purpose: Special release relating to treatment of specific protected areas.  Parent completes all spaces with assistance from local agency staff.  Parent signs.

**5422 Authorization to Release and Obtain Information (form)**



**CHILDREN WITH SPECIAL HEALTH CARE NEEDS  
AUTHORIZATION TO RELEASE AND OBTAIN INFORMATION**

**1. AUTHORIZATION TO RELEASE INFORMATION:**

I give my consent for \_\_\_\_\_ to release \_\_\_\_\_  
(Name and Address of CSHCN Agency) (Health Care Information)  
 for \_\_\_\_\_ to the following professionals:  
(CSHCN Client)

NAME <small>(Doctor/Hospital/Agency/Institutional Affiliation)</small>	ADDRESS	CONTACT PERSON

This authorization expires **90** days after the last date it was signed. It can be renewed. A copy of this document may be considered the same as the original

DATE	SIGNATURE <small>(Parent/Guardian/Self if imancipated minor)</small>	CSHCN Agency Contact Person

**2. AUTHORIZATION TO OBTAIN INFORMATION:**

I give my consent for \_\_\_\_\_ to obtain \_\_\_\_\_  
(Name and Address of CSHCN Agency) (Health Care Information)  
 for \_\_\_\_\_ from the following professionals. I further give my consent to  
(CSHCN Client)  
 the below named professional to disclose and release health care information for \_\_\_\_\_  
(CSHCN Client)  
 to \_\_\_\_\_  
(CSHCN Agency)

NAME <small>(Doctor/Hospital/Agency/Institutional Affiliation)</small>	ADDRESS	CONTACT PERSON

This authorization expires **90** days after the last date it was signed. It can be renewed. A copy of this document may be considered the same as the original

DATE	SIGNATURE <small>(Parent/Guardian/Self if imancipated minor)</small>	CSHCN Agency Contact Person

3. SPECIFIC RELEASE RELATED TO TREATMENT:

I give my consent for \_\_\_\_\_ to release specific health care information relating to  
(Name and Address of CSHCN Agency)  
 treatment to the following programs to help the agencies provide \_\_\_\_\_ with service:  
(CSHCN Client)

HEALTH CARE TREATMENT	NAME (Doctor/Hospital/ Agency/Institutional Affiliation)	ADDRESS	CONTACT PERSON
Alcohol/Other Drug Treatment			
STD Diagnosis & Treatment			
Mental Health & Psychiatric Disorders Treatment			
HIV/AIDS Testing, Diagnosis & Treatment			

This authorization expires **90** days after the last date it was signed. It can be renewed. A copy of this document may be considered the same as the original

DATE	SIGNATURE (Parent/Guardian/Self if imancipated minor)	CSHCN Agency Contact Person

I understand that alcohol/other drug treatment information relating to me is protected under federal law and cannot be disclosed to anyone else without my written consent unless permitted by law. I also understand I may **cancel** my consent to release alcohol/other drug treatment information at any time except to the extent that action has already been taken on it as allowed.

I understand that health care information, STD and HIV/AIDS information, and mental health information relating to me is protected by state law and cannot be disclosed to anyone else without my written consent unless permitted by law. I understand that I may **cancel** this consent at any time.

## **5500 Referral and Intake for Supplemental Security Income (SSI) Applicants**

Title V requires "provision of rehabilitation services for blind and disabled individuals under the age of 16 who are receiving benefits under Title XVI, to the extent medical assistance for such services is not provided under Title XIX". To meet this federal requirement, the CSHCN Program has developed a system for outreach and referral of SSI applicants and clients to local CSHCN agencies. The CSHCN Program refers available information about SSI applicants to local agencies. Local agencies notify SSI applicants of the availability of CSHCN services and refer potentially eligible clients to Social Security Administration (SSA) for SSI application.

### **5510 Policies**

1. The CSHCN Program will ensure that SSI applicants and/or clients receive information about CSHCN services.
2. Local CSHCN agencies will ensure CSHCN applicants are referred to the Social Security Administration (SSA) for application for SSI.
3. The CSHCN Program will ensure that local CSHCN agencies have access to information about the SSI status of CSHCN clients.
4. Policies and procedures adopted by the Department of Health (DOH) and SSA will be used to ensure that information contained in their respective records and obtained from each other or from others in carrying out their functions will be disclosed solely as provided in Section 1106 of the Social Security Act, the Privacy Act of 1974 and the Freedom of Information Act, and regulations promulgated there under.
5. Local CSHCN agencies must refer children with special health care needs applicants to SSA to apply for SSI.
6. Local CSHCN agencies must notify SSI applicants, who may be eligible for CSHCN services, of the availability of services through the local CSHCN agency.

## 5520 Procedures

<u>Responsibility</u>	<u>Action</u>
CSHCN Program	Maintains linkages with the Social Security Administration, the Disabilities Determination Unit in the Department of Social and Health Services (DSHS), and other agencies and organizations interested in CSHCN/SSI issues.
	Receives applicant referrals from the Disabilities Determination Unit, in DSHS, on an intermittent basis.
	Forwards information on SSI applicants to the local CSHCN agency in the child's county of residence.
	Maintains aggregate data on CSHCN/SSI clients and applicants.
Local agency	<p><u>Receives</u> referrals of SSI applicants <u>from</u> the CSHCN Program and reviews for appropriate action. Note: SSI “applicant” means those that applied for SSI, not necessarily those approved, and there is also the possibility that an applicant has died.</p> <p><u>Refers</u> CSHCN applications <u>to</u> SSI when appropriate. See Appendix for list of Social Security contacts.</p>
	Sends letter about CSHCN services to the SSI applicants who may be eligible for CSHCN services and are not current CSHCN clients. (See Section 5521 for sample outreach letter)
	Provides services to individuals eligible through CSHCN program, and completes a CHIF in accordance with policies and procedures in Section 5200.
SSI	Refers information about SSI applicants to the CSHCN Program.
CSHCN Program and Local agencies	Restrict access to the data to only those authorized employees and officials who need it to perform their official duties in connection with the intended programs, following legal requirements for confidentiality of data.
	Store the data in an area that is physically safe from access by unauthorized persons during duty hours as well as non-duty hours or when not in use.
	Process the data under the immediate supervision and control of authorized personnel in a manner which will protect the confidentiality of the data and in such a way that unauthorized persons cannot retrieve the data by means of computer, remote terminal or other means.

<u>Responsibility</u>	<u>Action</u>
	Advise all personnel who will have access to the data of the confidential nature of the information, the safeguards required to protect the information and civil sanctions for noncompliance.
(continued)	Permit SSA to make on site inspections to ensure that adequate safeguards are being maintained.
	Disclose information outside the agency only with the written consent of the individual, the legal guardian or parent of a minor. The written consent must be signed and dated and must specify the items of information to be redisclosed and the period of time to which the consent applies, in compliance with the provisions of 45CFR 5b.9 (a). The consent may be included as part of an application or other document and will contain language approved by the SSA. The consent statement will be retained by the agency for a minimum of 2 years beyond the life of the consent.

**5521 Sample SSI/CSHCN Outreach Letter**

Date

Address

RE: (Patient Name)  
(SS#)

Dear (Primary Addressee):

The Social Security Administration notifies our agency of children who apply for Supplemental Security Income (SSI). We have been notified that you applied for SSI for your child.

Services for children with special health care needs are provided through the Local Health Department. We may be able to assist you or your child with:

- information about other services or resources that may be available for your child or your family.
- care coordination services
- financial assistance with the cost of specialized medical care not covered under Title XIX Medical coupons/cards.

If you are interested in our program, please contact us at:

Contact name  
Contact address  
Phone number

Sincerely,

CSHCN Coordinator  
Local Agency

# Section 6000 - Authorization and Payment

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**Alert!** Each section listed in this table of contents has been created with a built-in link to take you directly to it—simply hover over the line item and Ctrl and Click to go directly to the page. As an Adobe (.pdf) document, the guide also is easily navigated by using bookmarks on the left side of the document. (If you don't immediately see the bookmarks, right click on the document and select Navigation Pane Buttons. Click on the bookmark icon on the left of the document.)



## 6100 Introduction

*This section continues to use a number of acronyms that are listed in the Appendices.*

This section describes the system of monitoring, authorizing and paying for services from CSHCN Diagnostic and Treatment (DX/TX) funds. Understanding this process helps local CSHCN agencies including local health jurisdictions (LHJs) budget diagnostic and treatment allocations, promotes positive provider partnerships, and provides a way to pay for medical services which are not covered by Health Care Authority (HCA), or other funding sources responsible and available for the child's care.

Key elements of eligibility and process are described in the Washington Administrative Codes (WAC) in Section 2000 (WAC 246-710-0010 to 246-710-090), Program Eligibility Policies in Section 4000, and the policies here in Section 6000.

The scope of services paid from DX/TX funds fluctuates depending on what state service systems are currently in place. Medicaid, also known as Washington Apple Health, covers medically necessary services for eligible children. DX/TX funds are intended for those medically-related services, beyond the scope of routine care common to most children, which are not the responsibility of, nor covered by Medicaid or other funding sources. DX/TX funds are not intended for those items that are part of usual daily living expenses and are the responsibility of parents and caregivers. Examples include food, clothing, shelter, and entertainment. DX/TX funds are intended to provide services or treatments to benefit the eligible child. In some cases, they may be used to provide services to family members when those services will directly impact the care of the eligible child.

Decisions about the use of DX/TX funds are made on a case-by-case basis, according to CSHCN policies, which are protected by law. Use of these funds are subject to Title V requirements under section 503 and 504 of the Social Security Act, Washington Administrative Codes (WAC 246-710), and DOH policies. DX/TX funds are not entitlement funds and take into consideration a number of variables. Based on these variables:

- Use of DX/TX funds can be different from one LHJ or other local CSHCN agency to the next.
- Allocation of DX/TX funds may vary on a case-by-case basis.
- The decision may be not to use DX/TX funds.

## 6110 Decision Tools for Use of CSHCN Diagnostic and Treatment Funds

The process and requirements for accessing DX/TX funds for payment of medically necessary equipment, treatment, and services is described below and includes the following:

1. Does the child have special health care needs?
2. Does the family meet financial eligibility requirements?
3. Is the service medically necessary? (See definition and Tool for Determining Medical Necessity on page 6-5.)
4. Is the service or treatment evidence-based and standard of care?
5. Are there other available funding sources?

**6111 Decision Process for Use of DX/TX Funds**

Decision Process	True?	
<b>1. The Child</b> a) The child has special health care needs. b) The client is 17 years of age or younger. c) The client and family are Washington residents. d) The client’s family is financially eligible for DX/TX services.	Yes	No
<b>2. The Child’s Medical Service</b> a) The service is beyond the scope of routine care common to most children. b) The service is medically necessary and appropriate for the child. c) The service is evidence-based, an accepted form of treatment for the condition, and recognized by the medical community. d) The service is not covered by any other public or private funding source available to child. (For questions about service coverage, see Section 6112.) e) The service is not the responsibility or component of any other public or private funding source available to child.	Yes	No
<b>3. The Local CSHCN Agency Diagnostic and Treatment Fund Allocation</b> a) This payment will be within the limits of the unspent allocation balance available to the local health agency (your agency).	Yes	No
<b>4. The Provider of Service</b> a) The provider is qualified to accept payment. b) The provider agrees to accept CSHCN payment process and fees.	Yes	No
If <b>ALL</b> statements (1-4) above are true, DX/TX funds may be used to cover the service. Use of DX/TX funds are governed by federal and state regulations. DX/TX funds are not entitlement funds and take into consideration a number of variables. Therefore, individual local CSHCN agency or DOH may decide not to use the funds based on other considerations.		

**6112 Determination of Medical Necessity**

Determination of Medical Necessity based on the Health Care Authority – Medicaid Program  
 WAC 182-500-0070

**“Medically necessary is a term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, “course of treatment may include mere observation or, where appropriate, no treatment at all.”**

Requested services must meet the above definition of medical necessity. The following checklist tool may be useful in determining if the requested service meets the above definitions:

Figure 1: Tool for Determining Medical Necessity

## Tool for Determining Medical Necessity

Please Check if Applicable:

- Children with Special Health Care Needs (CSHCN)
- Meets financial eligibility
- Service not covered by health insurance or other resource

If all 3 are checked, move to determination of medical necessity.

Service Requested:

**Definition of Medical Necessity**  
*Requested service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions that endanger life, cause suffering or pain, or result in an illness or infirmity or threaten to cause or aggravate a handicap or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service.*

Will

1

	Please Select
<input type="checkbox"/>	Prevent
<input type="checkbox"/>	Diagnose
<input type="checkbox"/>	Correct
<input type="checkbox"/>	Cure
<input type="checkbox"/>	Alleviate

2

	Please Select
<input type="checkbox"/>	Worsening
<input type="checkbox"/>	Suffering/Pain
<input type="checkbox"/>	Illness
<input type="checkbox"/>	Infirmity
<input type="checkbox"/>	Aggravation
<input type="checkbox"/>	Physical Deformity
<input type="checkbox"/>	Malfunction

The Medical Condition the service is being requested for:

Of or due to:

At least 1 Item checked in boxes 1 and 2, and all 4 items checked in box 3, see supplemental fee schedule for rates and further instructions for use of DX/TX funds. If unsure, contact the CSHCN Program.

3

and there is....

	Please Select All That Apply
<input type="checkbox"/>	No other equally effective treatment
<input type="checkbox"/>	No other less costly treatment
<input type="checkbox"/>	No other suitable treatment for family
<input type="checkbox"/>	Evidence to support the use of this service

Provide explanation as needed for items checked in box 3. Include statement related to source of evidence.

### **6113 Determination of Financial Eligibility for Medicaid (as of April 1, 2013)**

Children are eligible to access the DX/TX funds when the child's (if on SSI) or their families' income is < 200% of the federal poverty level (FPL) and they are Medicaid eligible ([see Section 5332 for the most current FPL table](#)). Medicaid eligibility is determined based on Modified Adjusted Gross Income (MAGI). Children are eligible for the following programs:

- Households with income <200% FPL; Medicaid with no monthly premium
- Households with income 200-300% FPL; Medicaid with a monthly premium

Income eligibility can be determined using the following:

1. Client states they are on Medicaid (this can be verified by ProviderOne) or,
2. Family is paying a monthly Medicaid premium, then they exceed 200% FPL and are not eligible or,
3. Income can be entered into the Washington Health Benefit Exchange Web Portal and percentage of federal poverty level and Medicaid eligibility will be determined (see link below).

<http://wahbexchange.org/news-resources/calculate-your-costs>

### **6114 Accessing and Troubleshooting Coverage for Medical Services**

DX/TX funds are intended for medically necessary services and treatments not covered by an individual's health care plan. The following list of questions will help in determining if a service is covered by an individual's health care plan.

Identifying and Accessing Coverage for Medical Services:

- What health care plan does the family have?
- What service is being requested?
- Is the requested service covered?
  - If not covered by the plan, is it covered directly by Medicaid (i.e., interpreter services, transportation, glasses, hearing aids, etc.)?
- Does the service meet medical necessity criteria?
- What are the required conditions for this service to be covered?
- Does the client meet these conditions?
- Does the service require prior authorization? Was prior authorization obtained?
- Was there an exception to rule filed with the insurance company or Medicaid (add WAC) for a non-covered service?
- Does the client have a primary and secondary insurance?

It may be necessary to do some troubleshooting when a service is denied. The following questions may help determine the reason for denial and/or find alternate means of accessing coverage. This information will also be needed when completing an HSA form (see Section 6500).

Troubleshooting denial of service coverage:

- Was the service appropriately billed for by the vendor/provider but denied?
- If the service was denied, what is the reason for denial?
  - Billing error
  - Medical necessity questioned
  - Covered service questions
  - Question related to eligible condition
  - Other
- What does it say on provider HCA billing or billing statement?
- What does it say on denial letter?
- Can you work with the plan to support medical justification?
- Can services be coordinated with other payment sources?
- What is the appeal process?
- Has an appeal been filed?
- Will another service or product work just as well?



- Maintains understanding of authorization and payment system.
- Maintains on-going contractual responsibility to track and monitor Diagnostic and Treatment fund allocations within limits of available funding.
- Follows Decision Process described in the manual Section 6000 shown in Section 6110.
- Coordinates services and payment process with provider of service:
  - Check that requested service clearly meets the requirements described in Section 6110.
  - Contact DOH CSHCN Program prior to submitting the HSA form if you have questions or need clarification of eligibility.
  - If you submit the HSA to determine service eligibility and CSHCN Program payment (i.e. for clarification) it may be necessary to wait for DOH approval before providing and paying for service.
- Completes HSA form, signs, and sends original to provider.
- Provider adds the appropriate provider information and billing code(s) (e.g., CPT/HCPCS) in Box #15, signs original HSA in Box #21, and returns to local CSHCN agency with claim or invoice attached.
- Sends original signed copy of HSA and billing to CSHCN Program.
- Records action in internal tracking log.



- Reviews HSA request and adjudicates fees to determine payment.
- Processes payment through agency/state systems.
- Maintains statewide allocation reports showing allocations, payments, obligations, and balances.
- Distributes allocation reports to local CSHCN agency.
- Requests report of obligations from local CSHCN agency.



- Coordinates services and payment process with provider of service after getting approval from state office.
- Reviews allocation reports for accuracy.
- Provides obligations as requested.

## 6200 Fee Schedules

Payments made by CSHCN come from the CSHCN Supplemental Fee Schedule and Medicaid program specific fee schedules from HCA. These fee schedules establish standards so there is consistency in payments and process across the state.

### 6210 Policies

1. In most cases, fees paid by CSHCN will be in accordance with Medicaid rates using national billing codes. CSHCN rates shown in the fee schedule below will be used when:
  - The Medicaid rate is too complex and/or will not accurately reflect the service provided (for example: bundled or team services);
  - A service does not have a rate;
  - The service is not listed on a HCA fee schedule;
  - The HCA fee is "by report", as billed by the provider; or
  - There is a negotiated rate where a provider agrees to a lower rate or two or more parties agree to share cost (see Section 6320).
2. Medical providers or vendors will accept the fees provided by these schedules or by negotiation as full payment for services rendered.
3. Clients cannot be billed for the service provided.

### 6220 Procedures

<i>Responsibility</i>	<i>Action</i>
Local CSHCN Agency	<u>Maintains</u> ongoing understanding of authorization and payment process and responsibilities to support provider relations, payment of services, and budgeting of DX/TX funds.
DOH – CSHCN Program	<u>Monitors</u> ongoing process of reviewing services and identifying appropriate fees.

### 6230 Fee Schedules

#### ***6231 Health Care Authority (HCA) Fee Schedules***

The HCA uses a reimbursement methodology based on federal rates and state calculations to determine fees for health care. Procedure codes are defined using the physician's "Current Procedural Terminology (CPT)" codes of the American Medical Association.

The HCA document, "Physician-Related Services", contains provider billing instructions, policy guidelines and procedure codes for services such as office visits, surgeries, radiology, laboratory and anesthesia. HCA billing instructions and fee schedules by procedure code are located in separate documents. Each Medicaid-covered program has a fee schedule showing covered and non-covered codes as well as a provider guide which outline policies.

See Appendix for HCA web sites.

Specific HCA provider billing instructions are available at the following link:

<http://www.hca.wa.gov/medicaid/billing/Pages/bi.aspx>

**6232 CSHCN Supplemental Fee Schedule**

The supplemental fee schedule is a list of procedures, services and fees for the CSHCN Program. Procedures and services must meet the requirements described in Section 6100 and in the comments section. This is not an all inclusive listing of procedure codes and services. In most cases, CSHCN Program pays using national billing codes and Medicaid rates. CSHCN rates will be used if there is no Medicaid rate or under circumstances listed in section 6210. These rates are included in the Supplemental Fee Schedule. Local health agencies may use a negotiated payment process to leverage community funds (see Section 6320).

<i>Description</i>	<i>Source of Code (HCPCS/ CPT or DOH-code)</i>	<i>CSHCN Fee</i>	<i>Comments</i>
Clinics and teams sponsored by CSHCN: <ul style="list-style-type: none"> <li>▪ Physician</li> <li>▪ Non-physician</li> </ul>	HCA  HCA	\$100/hr maximum per MD for team meeting time  \$80/hr maximum per non-physician for team meeting time	Interdisciplinary Evaluations and Services. See Section 6330 for clinic policies.  Need to negotiate the request in advance. Limited to one team evaluation per day per client. Up to a maximum allowable amount of \$1,200 per team per child per year.
Health Care Authority (HCA) – Medicaid Program <ul style="list-style-type: none"> <li>▪ Medical service</li> <li>▪ Durable medical equipment (e.g., rental of breast pumps, adaptive therapy equipment)</li> <li>▪ Disposable supplies</li> </ul>	HCA HCA HCA	65% of billed charges  85% of billed charges  100% or Medicaid rate if available.	Most of these services/supplies are covered by Medicaid and can be obtained through a limitation extension. Providers need to request items through Medicaid using CPT or HCPCS codes rather than brand name products; e.g., Arch or foot supports (L3000, L3050 etc.) versus “chipmunks” or compression garments (A4466) versus SPIOS, and provide the medical necessity for the requested items.

<i>Description</i>	<i>Source of Code (HCPCS/ CPT or DOH-code)</i>	<i>CSHCN Fee</i>	<i>Comments</i>
Health Education Trainings and Materials	DOH-4000	Up to 100%	In general, to be used for education and training of the eligible child. In some cases, may be used for family members when the activity will directly impact the eligible child.  Documentation of denials from other sources are not a requirement to access. Need to submit justification on the HSA form.  Local CSHCN Agencies cannot be paid for this activity if it is already a consolidated contract responsibility.
Health Education – Life Skills training (e.g., camps, conferences)	DOH-5000	Up to 100%	Specific to children with special health care needs. Child needs to participate.  Need to negotiate the request in advance; might include negotiation in scholarship amounts.  Up to a maximum allowable amount of \$1,000 per child per year.  Documentation of denials from other sources are not a requirement to access. Need to submit justification on the HSA form.
Hospital, inpatient and outpatient	HCA	HCA	Determined on a case by case basis.
Interpreter: spoken language or hearing	HCA	65% of customary charge or HCA brokerage rate	For a CSHCN covered health care service.  Negotiate fee in advance.  Be alert to agencies or providers who should fund interpretation as part of their service to comply with state and federal regulations.
Maxillofacial Review Board	HCA	See "clinics and teams" above.	See "clinics and teams" above.
Nutrition Products:			Nutrition supplements are described in Section 6241.
<ul style="list-style-type: none"> <li>▪ Special Formulas &amp; Supplements</li> <li>▪ Inborn errors of metabolism</li> </ul>	HCA N/A	100% billed charge N/A	Supplied by DOH Newborn Screening Program. See Section 6242.

<i>Description</i>	<i>Source of Code (HCPCS/ CPT or DOH-code)</i>	<i>CSHCN Fee</i>	<i>Comments</i>
Orthodontic and dental	HCA	HCA	Clients with complex maxillofacial or craniofacial conditions should be referred to the Maxillofacial Team. Other orthodontia procedures should be negotiated in advance.
Out-of-state provider [*WAC 246-710-050]	HCA	HCA	Fees are determined and payments made the same as for licensed in-state providers with documented need/referral by a local primary health care provider. Negotiate in advance.
Pharmaceutical prescriptions and over-the-counter drugs	HCA or DOH-2000	85% of retail charge	Specific to children with special health care needs, beyond routine care.
<b>UNDER CONSIDERATION,</b> Respite services (TBD)	<b>HCA or DOH-1000</b>  Will use HCPCS codes to track the different time frames for respite, i.e., hourly versus daily, etc.	<b>TBD</b>	Using Lifespan Respite Voucher System and Qualified Respite Providers  Individual families in need of respite services  Specific to children with special health care needs and medical necessity  Child is not eligible for other systems of respite services  Up to a maximum allowable amount of \$500 per child per year.
Social work	HCA	65% of billed charge.	Roles might include case management; generally the social worker is a member of the interdisciplinary team. This is not for otherwise billable mental health therapy.
Surgery, surgeon	HCA	HCA Medicaid rate if available (or 65% of medical service charges)	Specific to children with special health care needs, beyond routine care.
Surgical suites—non-hospital	HCA	HCA Medicaid rate if available (or 65% of medical service charges)	Ambulatory Surgery Fee Schedule or CSHCN 65%

<i>Description</i>	<i>Source of Code (HCPCS/ CPT or DOH-code)</i>	<i>CSHCN Fee</i>	<i>Comments</i>
Therapies: <ul style="list-style-type: none"> <li>▪ Physical, occupational, speech</li> <li>▪ Other therapies recognized by the medical community and provided by a qualified health care providers (i.e. vision, behavioral, acupuncture, massage, etc.)</li> </ul>	HCA	HCA Medicaid rate or \$20 flat fee per service maximum or \$80/hr maximum	For children, HCA currently pays for all medically necessary therapy.  Annual allowable maximum of \$3,000 per therapy service per child per calendar year.  Requires a referral by the primary care provider.
Therapeutic activities, other <ul style="list-style-type: none"> <li>▪ Recognized by the medical community and provided by qualified providers, e.g., specialty recreation therapy; specialty exercise classes.</li> </ul>	HCA	HCA	Determined on a case-by-case basis using the Tool for Determining Medical Necessity. See Section 6110.  Annual allowable maximum of \$3,000 per therapy service per child per calendar year.  Requires a referral by the primary care provider.
Travel, provider	DOH-3000	Current state rate	Payable only when in conjunction with a CSHCN-sponsored clinic or team, and travel is in excess of 50 miles one way to service site.

Services and eligibility requirements are regulated by federal Title V Maternal and Child Health Block Grant funding requirements, WAC, liability and Children with Special Health Care Needs policy.

Authorization for services paid for with CSHCN funds will be accomplished in accordance with the following:

- 1) Financial eligibility for a client has been determined.
- 2) A request for services to be paid for with CSHCN funds has been reviewed for consistency with program directions. Services must be recognized as an acceptable form of treatment by a significant portion of the professional community.
- 3) No services will be authorized for out-of-state providers if an equivalent service is available within the state of Washington. However, use of resources in bordering states will be authorized when appropriate.

Services that are **not** covered by CSHCN include, but are not limited to, the following examples, per federal Title V Maternal and Child Health Block Grant funding requirements, liability, and/or CSHCN policy:

- Client travel and/or lodging for client and/or family in connection with any medical health care service (potential duplication of Medicaid).
- Equipment, used medical (per Medicaid rule)
- Equipment, medical, installed to a building, structure or vehicle (per federal rules).
- Insurance or Warranty payments (per Medicaid rule)

**6241 CSHCN Special Formulas**

Infants and children with special health care needs may receive formulas or nutritional supplements through several government programs. Children with PKU and other rare inborn errors of metabolism may receive metabolic formula through DOH Newborn Screening Program (see Section 6242). Infants and children with special health care needs who are financially eligible may access formula, food, and/or nutritional supplements through one of three government programs in the following order of responsibility:

1. Washington State Women, Infants, and Children's Nutrition Program (WIC)
2. Washington State Health Care Authority (HCA)
3. Washington Department of Health, Children with Special Health Care Needs (CSHCN) Program (may provide as a last resort)

WIC provides food and formula to eligible families according to WIC policies and procedures. WIC does not provide medical/metabolic formula, specialty foods, or supplements. These include low-protein specialty foods and vitamins. The Medicaid Enteral Program will provide medically necessary formula or nutrient supplements according to the HCA policies when:

1. Client is not eligible for the WIC Program.
2. Client is eligible for the WIC Program but requires a product not available through WIC or in excess of WIC allowable amounts.

DX/TX funds may be accessed as a last resort.

**6242 Policies**

1. All special formulas and nutrition supplements (including small amounts to determine tolerance of a product) must be prescribed by a physician.
2. Clients must have an evaluation by a certified registered dietitian (RD) within 30 days of initiation of an enteral nutrition product and periodic reassessments (at the discretion of the certified RD while receiving the product).
3. Additional formula prescribed to address a medical need beyond the maximum level allowed by WIC may be provided by CSHCN according to the above order of responsibility.
4. Clients who reside in institutions are not eligible for special formulas and nutrition supplements through CSHCN.

**6243 Procedures**

<i>Responsibility</i>	<i>Action</i>
Vendor/Provider	<p><u>Obtain</u> a nutrition plan based on a RD assessment. An initial nutrition assessment must be within 30 days of formula initiation. Periodic nutrition re-assessments must be done at least every four months for infants to age three years and at least every six months for children over age three years while the client is receiving the special formula.</p> <p><u>Completes</u> prescription specifying indication for and amounts of special formula or nutrition supplements.</p>
Vendor/Provider and Local CSHCN Agency	<p><u>Adheres</u> to policies of WIC and HCA for purchase of formula for clients with eligibility in those programs, including pre-authorization, required request forms, and other possible funding sources.</p>

<i>Responsibility</i>	<i>Action</i>
Local CSHCN Agency	<p><u>Reviews</u> requests for special formulas and nutrition supplements in accordance with CSHCN policies and procedures.</p> <p><u>Coordinates</u> economical purchase of products by comparing prices from available providers.</p> <p><u>Completes</u> HSA form (see Section 6500) using HCPCS code, including the product name and quantity.</p>
CSHCN Nutrition Consultant	<p><u>Responds</u> to inquiries regarding nutrition services including information about HCA and WIC.</p> <p><u>Maintains</u> ongoing process of reviewing special formula and nutrition supplement expenditures.</p> <p><u>Assists</u> local agencies in identifying a registered dietitian.</p>
DOH – CSHCN Program	<p><u>Adjudicates</u> fees and processes payments in accordance with CSHCN policies, procedures, and first payer/last payer instructions above.</p>

***6244 Procedures for Tracking CSHCN Special Formula Use***

The form “CSHCN Nutrition Tracking for Special Formulas,” on the next page, is recommended to help organize the information required for payment through CSHCN, but is not required. The tracking form should be completed by the RD involved with the client or the local CSHCN coordinator and attached to the HSA form.

*CSHCN Nutrition Tracking for Special Formulas*

Date of Request: \_\_\_\_\_ County: \_\_\_\_\_

Client's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

ProviderOne ID: \_\_\_\_\_ CHIF ID: \_\_\_\_\_

Recent Weight: \_\_\_\_\_ Date Measured: \_\_\_\_\_

Recent Height: \_\_\_\_\_ Date Measured: \_\_\_\_\_

Medical Problem/Diagnosis and Nutritional Risk:

\_\_\_\_\_  
\_\_\_\_\_

Product Requested: \_\_\_\_\_

New Request                      Intended for:     Oral Feeding  
 Request to Continue                       Tube Feeding

Rationale/Treatment Goal: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Quantity Needed: \_\_\_\_\_ per day \_\_\_\_\_ per month

Duration: \_\_\_\_\_

Medicaid:	<input type="checkbox"/> Enrolled	<input type="checkbox"/> Ineligible	<input type="checkbox"/> Coverage Denied
WIC:	<input type="checkbox"/> Enrolled	<input type="checkbox"/> Ineligible	<input type="checkbox"/> Coverage Denied
Insurance:	<input type="checkbox"/> Enrolled	<input type="checkbox"/> Ineligible	<input type="checkbox"/> Coverage Denied

CSHCN Contact Person: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Dietitian RD/CD \_\_\_\_\_ Phone Number: \_\_\_\_\_

Attach this to a HSA form and send by mail or FAX to CSHCN:

Children with Special Health Care Needs Program  
DOH/Prevention and Community Health  
PO Box 47880  
Olympia, WA 98504-7880  
FAX 360-586-7868

## 6245 *Metabolic Products*

Children with phenylketonuria (PKU) and other rare inborn errors of metabolism who reside in Washington receive contracted clinical care and evaluation services through the DOH, Newborn Screening Program. Metabolic formula and low protein foods are purchased by the Newborn Screening Program, supplied to the client from a central distribution site, and the appropriate agency/insurance is billed. Low protein specialty foods are not covered by Medicaid. The DX/TX funds reimburses the Newborn Screening Program for low protein food supplied to financially eligible children with special health care needs receiving care through this program.

CSHCN is last dollar to HCA, while HCA is last dollar to WIC for products covered by WIC. All other resources, such as private insurance, must be used before CSHCN makes payment, in accordance with CSHCN policies and procedures.

## 6246 *Policies*

1. All metabolic formulas must be prescribed by the Medical Director of the PKU and Biochemical Genetics Clinic at the University of Washington, Biomedical Genetics Clinic at Seattle Children's or the Metabolic Clinic at the Oregon Health Sciences University, or other qualified physician.
2. All clients must be followed by registered dietitians with the PKU and Biochemical Genetics Clinic at the University of Washington, the Biomedical Genetics Clinic at Seattle Children's or the Metabolic Clinic at the Oregon Health Sciences University, according to established clinic protocols.

## 6247 *Procedures*

<i>Responsibility</i>	<i>Action</i>
Local CSHCN Agency	<u>Refers</u> clients with PKU and other inborn errors of metabolism to the Newborn Screening Program at:  1610 NE 150th Street Shoreline, WA 98155-9701  Phone: (206) 418-5400; see Appendix for web site.
Newborn Screening Program	<u>Determines</u> CSHCN financial eligibility for those clients being considered for receipt of metabolic formula. Sends completed application to local CSHCN agency where the client resides. (Also <b>determines</b> eligibility for subsidized low-protein food products.)  <u>Provides</u> metabolic formula to CSHCN financially eligible clients from a central distribution site and bills appropriate resource.  <u>Submits</u> a monthly expenditure report to CSHCN listing formula and low protein foods supplied to CSHCN clients and maintains records of those transactions.
DOH – CSHCN Program	<u>Reviews</u> the Newborn Screening Program monthly expenditure report and approves payment for low protein foods.
Local CSHCN Agency	<u>Receives</u> client information and referrals from Newborn Screening Program.  <u>Completes</u> client intake for CHIF Automated System (Section 5000).  <u>Coordinates</u> any additional services with the client and family.

## 6300 Payments

This section explains how payments to medical providers are determined after the fee is identified by the fee schedules in Section 6200. The fee may be reduced by factors such as insurance payments, provider charges, or negotiated agreements. The CSHCN Program adjudicates the fee and determines the payment. As previously noted, policies in this area work in combination with all other CSHCN policies and WAC.

### 6310 Standard Payments

#### 6311 Policies

1. Medical providers will accept the fees determined by these schedules or by negotiation as full payment for services rendered.
2. DX/TX funds may not be used for payments to clients, which is in accordance with federal Maternal and Child Health Block Grant requirements.
3. All other resources, such as insurance or HCA, applicable for the service and available to the client, must be used before CSHCN makes payment to medical providers.
4. Based on HCA policies, the following policies also apply to CSHCN:
5. When the provider's charge is less than the CSHCN established fee, payment is made at whichever is less.
6. When the Medicaid payment is less than the CSHCN established fee, the claim is considered paid in full.

#### 6312 Procedures

<i>Responsibility</i>	<i>Action</i>
Local CSHCN Agency	<u>Considers</u> payment for service in accordance with CSHCN policies, including client's HCA medical coverage (fee-for-service or Medicaid managed care). If decision is made to pay for the service, <u>completes and processes</u> HSA form in Section 6500.
Vendor or Provider	<u>Provides</u> service, equipment, therapies, treatment or supplies. <u>Submits</u> billing and explanation of benefits from insurance or HCA during the HSA billing process.
Local CSHCN Agency	<u>Continues</u> HSA process. Sends HSA form and appropriate information to CSHCN.
DOH – CSHCN Program	<u>Adjudicates</u> fees and processes payment in accordance with CSHCN policies and procedures.

### 6320 Negotiated Payments

There may be times when a local CSHCN agency wants to negotiate a reduced or shared payment with a provider. This option may be considered when there is a clear willingness for a provider to accept a reduced payment or when two or more parties are willing to share the expense (see Section 6230).

In accordance with CSHCN policies and WAC, this option would not be used when HCA or other third party resources are responsible for the services.

### 6321 Policies

A local CSHCN agency may negotiate payment for a service with the provider for less than the established CSHCN fee.

### 6322 Procedures

<i>Responsibility</i>	<i>Action</i>
Local CSHCN Agency	<u>Negotiates</u> payment with provider before service is given, at an amount which is less than the provider's usual charge. <u>Verifies</u> any question regarding established CSHCN fee and amount negotiated with CSHCN. <u>Describes</u> negotiated agreement on HSA form so local CSHCN agency, provider, and CSHCN all understand what will be paid.
Vendor/Provider	<u>Agrees</u> to negotiated payment by signing HSA form.
DOH – CSHCN Program	<u>Responds</u> to local CSHCN agency negotiated payment questions.

### 6323 Negotiated Payment Examples

1. Diabetes Camp (currently not covered by HCA). CSHCN fee is 100% of cost to maximum of \$1000 per child per year. Payment could be negotiated to be any amount or percentage lower than full cost of camp. For example: Community group provides a scholarship that covers 50% of the camp cost (\$800). CSHCN funds are accessed to cover the remaining \$400. (See Section 6231)
2. Parenting Skills training class that is not covered by HCA for parents of a child with Autism. CSHCN fee for Health Education is up to 100% of cost (see Section 6231). Payment could be negotiated for CSHCN to cover cost of books and materials with a local non-profit agency paying registration, food and travel costs. CSHCN cannot pay for client/family food and travel.

## 6330 Clinic and Team Payments

CSHCN clinics or team evaluations are CSHCN facilitated meetings which bring together a group of interdisciplinary health professionals to conduct screenings and/or an evaluation, develop a plan, and review the progress for clients.

When a local CSHCN agency is paying for a team evaluation, clinic, or maxillofacial review board using DX/TX funds, payment to the provider is one amount for the meeting or an amount per hour for the team meeting time. A list of children and their ProviderOne or unique CHIF identification number is required. Any one-on-one evaluations, done in conjunction with the team meeting, are not part of the team payment and are billed to the client's medical funding source.

CSHCN payment is not made if team members attend as part of their employment. CSHCN payment is not made if the service is the responsibility or component of another payment source such as HCA or in any way substitutes or supplements reimbursement from other payment sources. There are circumstances when team members donate their time as a community service or when this type of service is funded by local CSHCN agency contracted activities.

As previously noted, policies in this section work in combination with other CSHCN policies and WAC.

### 6331 Policy

1. CSHCN clinic and team payments are made in accordance with the CSHCN Supplemental Fee Schedule.
2. A list of client names and ProviderOne or unique CHIF identification numbers is required.
3. CSHCN payment is not made to team members who attend and/or participate as a part of their employment.
4. CSHCN payment is not made if the service is the responsibility or component of another payment source such as HCA or private insurance.

### 6332 Procedures

<i>Responsibility</i>	<i>Action</i>
Local CSHCN Agency	<u>Facilitates</u> clinic or team review activity. <u>Determines</u> provider payment per CSHCN Supplemental Fee Schedule, Section 6230, Clinics. <u>Prepares</u> HSA form in accordance with Section 6500. Leaves client information blank. Indicates payment amount in "Description" (i.e., how much per hour). <u>Enters</u> required data fields, for all clients served in clinics or teams, into CHIF Automated System (see Section 5200). <u>Attach</u> a list of client names and ProviderOne or unique CHIF identification numbers to submit with the HSA form.
Provider	<u>Agrees</u> to payment by signing HSA Form and provides the service.
DOH – CSHCN Program	<u>Responds</u> to local agency clinic and team payment questions.

### 6333 Team Payment Example for Community-Based Feeding Team

DX/TX funds may be used to pay for components of feeding team services to support and develop systems of care under the following circumstances:

1. The community-based feeding team has a working relationship with the local CSHCN Program.
2. The child being served is enrolled and meets CSHCN financial eligibility.
3. Medicaid or other third party payers responsible for the service are used to pay for the direct service components of the feeding team services.
4. The team member seeking reimbursement works in private practice, part-time, or beyond his/her normal work hours and is not being paid by any other source to participate in the feeding team conference.
5. No other early intervention or grant funds are available to support the feeding team.
6. CSHCN funds are not used to pay for team member travel or per diem.

### 6334 Process

1. Local CSHCN Coordinator will determine if any other financial resources are available to support the feeding team member, such as Medicaid, health insurance, early intervention service funds, or grant funds.
2. A non-physician hourly rate (\$80/hr/maximum) will be negotiated with the feeding team member in advance.

- An HSA form, listing the feeding team member as the "Vendor/Provider," must be completed and submitted using the appropriate CPT code with a date and description of the service provided to the child and the number of hours billed (see Section 6530).

### 6335 Scenario

A child is referred to a community-based feeding team that includes a CSHCN Coordinator as the team nurse, a registered dietitian/nutritionist in private practice, a speech therapist from an early intervention center, and a parent with Parent to Parent. The team meets to first review a videotape of the child being fed by his parents at home and plan the interdisciplinary evaluation, then again to review results of the evaluations and develop an integrated intervention plan.

The separate "hands-on" evaluation components are individually charged to the correct payment sources. The nurse and speech therapist can participate in the team conferencing as part of their salaried jobs. The parent consultant on the team gets reimbursed through Parent to Parent. The private practice registered dietitian/nutritionist has no one to bill for her team conferencing time. DX/TX funds are used to support the nutritionist's conferencing time at a pre-negotiated non-physician rate per hour.

## 6340 Payment Reimbursement to CSHCN

When third-party payments are received by local CSHCN agencies for payments made from diagnostic and treatment funded services, refunds are sent directly to DOH to comply with state reimbursement policies. In most cases, these refunds do not get credited back to CSHCN because policies and WAC are in place to prevent such reimbursement situations, and the fiscal budget period for the service is usually past. (See Section 6350 for Legal Requests and Subrogation Claims.)

### 6341 Policies

- Repayment to the DOH is required when a provider receives an overpayment for services previously paid from DX/TX funds.
- Repayment to the DOH is required when a provider or client's family receives insurance benefits, court-awarded damages, or like funds for services previously paid by DX/TX funds.

### 6342 Procedures

<i>Responsibility</i>	<i>Action</i>
Family	<u>Assigns</u> or gives insurance payments to the provider.
Vendor or Provider	<p><u>Refunds</u> CSHCN payment (through local CSHCN agency) by making check payable to the <u>Department of Health</u>.</p> <ul style="list-style-type: none"> <li>Per state policy, reimbursement checks made payable to the local CSHCN agency, or any entity other than DOH, cannot be processed and will be returned for re-issue.</li> <li>The state payment received by the vendor/provider can also be returned.</li> </ul>
Local CSHCN Agency	<p><u>Sends</u> reimbursement check and copy of HSA form that paid the service to:</p> <p>Children with Special Health Care Needs Program DOH/Prevention and Community Health PO Box 47880 Olympia, WA 98504-7880</p>

<i>Responsibility</i>	<i>Action</i>
DOH – CSHCN Program	<u>Records</u> receipt of reimbursement in diagnostic and treatment payments and allocation ledger. Prepares check-log with appropriate coding related to local CSHCN agency. Sends reimbursement to:  DOH Revenue Section MS 47901
DOH Revenue Section	<u>Credits</u> reimbursement.
DOH – CSHCN Program	Responds to payment reimbursement questions.

## 6350 Legal Requests and Subrogation Claims

The local CSHCN agency or CSHCN may receive inquiries from legal authorities about client payment information. These requests must be handled in an official way to assure compliance with legal and contractual responsibilities.

### **6351 Policies**

1. All requests for payment information must be forwarded to CSHCN.
2. CSHCN will provide client payment information to legal authorities when requested in writing and accompanied with a current release of information statement signed by the client's legal parent/guardian.
3. Repayment to DOH from the vendor/provider, family or other source is required should insurance benefits, trusts, court awarded damages or like funds become available, and where payments have been made to the family or provider for services paid for by CSHCN (WAC 246-710-090).

### **6352 Procedures**

<i>Responsibility</i>	<i>Action</i>
Legal authority	<u>Provides</u> written request to local CSHCN agency or CSHCN for client payment information, including a current release of information statement signed by the client's legal parent or guardian.
Local CSHCN Agency	<u>Forwards</u> request and release of information to CSHCN.  <u>Reviews</u> client records to collaborate with CSHCN and confirm payments made from DX/TX funds.
DOH – CSHCN Program	<u>Notifies</u> DOH Assistant Attorney General of requests.  <u>Researches</u> requested client payment history and confirms with local CSHCN agency.  <u>Provides</u> requested payment information to legal authority.  <u>Maintains</u> file on legal requests. Provides copies of correspondence to local CSHCN agency.
Legal authority	<u>Determines</u> refund and makes payment to DOH.

## 6400 State Administration of CSHCN Diagnostic and Treatment Funds

Funds for DX/TX services are allocated to local CSHCN agencies at the beginning of the state biennium (July 1, 2013, July 1, 2015). CSHCN supervises the central adjudication system for locally authorized services paid from these funds. Administration of the allocated funds is an agency contracted responsibility (Section 7000). The allocated funds are maintained separately and not included in local CSHCN agency contract funding. All available funds not previously allocated to a local CSHCN agency are maintained by the state in the Central Treatment Fund (see Section 6420). The policies in this section work in combination with other CSHCN policies and WAC.

### 6410 Obligating Funds and Tracking Payments

Local CSHCN agencies manage and track diagnostic and treatment allocations by reviewing their allocation fund balance like a check book or Excel spreadsheet: total initial allocation, minus payments made, minus obligated amount of payments in process or future planned expenditures. An estimate of obligations is the amount of DX/TX funds needed to pay a provider for a service and is determined each time a HSA form is issued.

There are many ways local agencies can estimate obligations. Some suggestions are:

1. Determine fee from provider estimate.
2. Estimate the average payment for common services.
3. Refer to CSHCN Supplemental Fee Schedule in Section 6232.
4. Call CSHCN for assistance.

CSHCN manages and tracks diagnostic and treatment allocated funds by maintaining and distributing quarterly State Summary of Diagnostic and Treatment Allocations report, which show individual agency and statewide balances.

#### **6411 Policies**

1. CSHCN and local CSHCN agencies have an individual and mutual responsibility for monitoring DX/TX fund status and for taking actions necessary to manage within the limits of available funding.
2. Local CSHCN agencies must keep records accounting for HSA forms issued, by sequential county-assigned form number, and the funds obligated. Local agencies develop their own internal system to log or track allocations. At a minimum the log must include:
  - DX/TX initial allocation amount
  - County-assigned sequential number, Box 11 on HSA
  - Amount obligated for each HSA
  - Conclusion (amount paid, payment cancelled, allocation balance)
3. Local CSHCN agencies must report the total outstanding obligations to CSHCN periodically, as requested by CSHCN.

**6412 Procedures**

<i>Responsibility</i>	<i>Action</i>
Local CSHCN Agency	<p><u>Maintains</u> an internal system to track diagnostic and treatment allocation balance and obligations in accordance with CSHCN policies and contract responsibilities.</p> <p><u>Submits</u> Estimates of Obligations to CSHCN when requested and when required at the end of the state biennium.</p>
DOH – CSHCN Program	<p><u>Maintains</u> a tracking system that records diagnostic and treatment allocation actions to monitor local CSHCN agency and statewide fund status, including the Central Treatment Fund.</p> <p><u>Distributes</u> state summary report to local agencies quarterly (see Section 6414).</p> <p><u>Provides</u> technical assistance and consultation.</p>
Local CSHCN Agency	<p><u>Compares</u> agency records to CSHCN state summary report and consults with CSHCN to reconcile if there are differences.</p>

Children with Special Health Care Needs Program  
Diagnostic and Treatment Allocations

Estimate of Obligations Form  
Next Due Date: \_\_\_\_\_

Obligations are defined as:

- The estimated amount of known services the local CSHCN agency has obligated or expects to pay from CSHCN Diagnostic and Treatment funds, that have not been processed for payment to the CSHCN Program, and
- Health Services Authorization forms you have written that have not been returned to you by the provider, and so have not been processed for payment to the CSHCN Program.

Estimate of obligations are used to:

- Project statewide expenditures,
- Track expenditure patterns to identify increased use of funds,
- Prepare for decisions involving use of the Central Treatment Fund, and
- Determine if end-of-biennium balance estimates are within required funding limits (CSHCN Manual Section 2330, WAC 246-710-030).

\*\*\*\*\*

Period being reviewed: July 1, \_\_\_\_\_ through June 30, \_\_\_\_\_ (dates of service)

Total Outstanding Obligation (current): \$ \_\_\_\_\_

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*Signature* *Date* *Local Agency*

Submit to: Children with Special Health Care Needs Program  
DOH/Prevention and Community Health  
PO Box 47880  
Olympia WA 98504-7880

Or: Email: [cshcn.support@doh.wa.gov](mailto:cshcn.support@doh.wa.gov)  
FAX: (360) 586-7868

Reporting obligation estimates is a contractual requirement.  
See CSHCN Manual, Section 6411, for Policy.

2013-15 STATE BIENNIUM SUMMARY

CHILDREN WITH SPECIAL HEALTH CARE NEEDS											
STATE SUMMARY OF DIAGNOSTIC AND TREATMENT ALLOCATIONS											
1	2	3	4	5	6	7	8	9	10	11	12
REGION	CO#	AGENCY	SUBMITTED EST OF OBLIG	ALLOCATIONS			TOTAL EXPENDED TO DATE	UNSPENT BALANCE	TOTAL OUTSTANDING OBLIGATIONS	CURRENT ESTIMATED BALANCE	PERCENT EXPENDED TO DATE
				INITIAL	CTF	CURRENT					
E	01	ADAMS		2,000	-	2,000	-	2,000		2,000	0%
E	02	ASOTIN		500	-	500	-	500		500	0%
C	03	BEN-FRANK		500	-	500	-	500		500	0%
C	04	CHEL-DOUG		500	-	500	-	500		500	0%
NW	05	CLALLAM		3,000	-	3,000	-	3,000		3,000	0%
SW	06	CLARK		2,000	-	2,000	-	2,000		2,000	0%
E	07	COLUMBIA		500	-	500	-	500		500	0%
SW	08	COWLITZ		3,000	-	3,000	-	3,000		3,000	0%
E	12	GARFIELD		500	-	500	-	500		500	0%
C	13	GRANT		500	-	500	-	500		500	0%
SW	14	GRAYS HARB		1,000	-	1,000	-	1,000		1,000	0%
NW	15	ISLAND		1,000	-	1,000	-	1,000		1,000	0%
NW	16	JEFFERSON		500	-	500	195	305		305	39%
NW	18	KITSAP		500	-	500	-	500		500	0%
C	19	KITTITAS		1,000	-	1,000	-	1,000		1,000	0%
SW	20	KLICKITAT		500	-	500	-	500		500	0%
SW	21	LEWIS		500	-	500	-	500		500	0%
E	22	LINCOLN		500	-	500	-	500		500	0%
SW	23	MASON		500	-	500	-	500		500	0%
E	33	NE TRI		2,000	-	2,000	-	2,000		2,000	0%
C	24	OKANOGAN		500	-	500	-	500		500	0%
SW	25	PACIFIC		500	-	500	-	500		500	0%
NW	28	SAN JUAN		500	-	500	-	500		500	0%
NW	17	SEA-KING		8,000	-	8,000	1,001	6,999		6,999	13%
NW	29	SKAGIT		500	-	500	-	500		500	0%
SW	30	SKAMANIA		500	-	500	-	500		500	0%
NW	31	SNOHOMISH		7,000	-	7,000	581	6,419		6,419	8%
E	32	SPOKANE		14,000	-	14,000	1,000	13,000		13,000	7%
SW	27	TAC-PIERCE		4,000	-	4,000	141	3,859		3,859	4%
SW	34	THURSTON		5,000	-	5,000	-	5,000		5,000	0%
SW	35	WAHKIAKUM		500	-	500	-	500		500	0%
C	36	WALLA WALLA		500	-	500	-	500		500	0%
NW	37	WHATCOM		9,000	-	9,000	-	9,000		9,000	0%
E	38	WHITMAN		500	-	500	-	500		500	0%
C	39	YVMH		3,000	-	3,000	1,136	1,864		1,864	38%
		SUBTOTAL		75,000	-	75,000	4,055	70,945		70,945	
		CTF*		13,000	-	13,000	-	13,000		13,000	
		Metabolics**		12,000	-	12,000	2,329	9,671		9,671	19%
		TOTAL		100,000	-	100,000	6,383	93,617		93,617	6%
		* Central Treatment Fund									
		** Newborn Screening Program Medical Foods and Formulas									

**Column explanations:**

Column 1 = **REGION** is the CSHCN region to which the county is assigned. (4 regions: Northwest, Southwest, Central, East)

Column 2 = **CO#** is the assigned county number. All HSA requests should be numbered using this county number along with a unique sequential number (field #10 on HSA)

Column 3 = **AGENCY** is the local health jurisdiction or agency with CSHCN contract responsibility to manage the diagnostic and treatment allocation.

Column 4 = **ESTIMATE OF OBLIGATION** is a Yr/No field used at the end of the fiscal period to tracking the receipt of estimate worksheets. (The estimate reporting is recorded in Column 10.) Reporting obligations is a contract responsibility and reported periodically by local health jurisdictions when requested by the CSHCN Program, to verify that expenditures, obligations and balances are within available funding limits, which is required by law. Obligations are usually requested every 6-12 months.

Column 5 = **INITIAL** allocations are diagnostic and treatment amounts allocated at the beginning of the biennium (July 1, 2013)

Column 6 = **ACTIVITY** is any change in allocation amounts throughout the biennium, most commonly being approvals for Central Treatment Funds

Column 7 = **CURRENT** allocation is the sum of the initial allocation (Column 5) and any additional activity (column 6)

Column 8 = **TOTAL EXPENDED TO DATE** is the total amount of all Health Service Authorization payments-to-date per processing by the CSHCN Program. (See agency-specific detail by month in the companion document titled "2013-15 Treatment Allocation Report")

Column 9 = **UNSPENT BALANCE** is the amount remaining in current allocation (Column 7) after expenditures (Column 8)

Column 10 = **TOTAL OUTSTANDING OBLIGATIONS** is the estimated amount of all report services the agency has obligated to pay from diagnostic and treatment funds which have not been processed for payment to the CSHCN Program. This amount is periodically reported by agencies when requested.

Column 11 = **CURRENT ESTIMATED BALANCE** is the balance remaining in current allocation after expenditures and obligations.

Column 12 = **PERCENT EXPENDED TO DATE** is periodically included as a tool agencies can use to measure the total firm amount expenditures to date against the initial allocation.

**The 2013-15 State Biennium effective dates are July 1, 2013 through June 30, 2015 (dates of the service).**  
 CSHCN policies and additional information about Diagnostic and Treatment Allocations are located in the CSHCN Manual, Section 6000.

April 1, 2014  
 Months remaining in the biennium = 15



## 6420 Central Treatment Fund

At the beginning of the state biennium, a portion of the total statewide DX/TX funds is held in reserve for local CSHCN agencies that may have needs beyond their allocated amount. Central treatment funds (CTF) are used to:

1. Fund an unusual or extraordinary medically related client service that would deplete a local CSHCN agency's diagnostic and treatment allocation.
2. Supplement a local CSHCN agency's depleted diagnostic and treatment allocation when it appears the remaining funds will not be adequate to provide services through the end of the state biennium.

CTF requests come from the local CSHCN agency and go through an approval process that includes the CSHCN Regional System and CSHCN.

### 6421 Policies

1. The CTF will be used to allocate additional funds to local CSHCN agencies that are projected to be out of DX/TX allocations before the end of the biennium.
2. Local CSHCN agencies must request central treatment funds when their DX/TX allocation has been depleted, or expected to be depleted, and additional expenses or obligations are anticipated before the close of the state biennium.
3. Local CSHCN agencies will request central treatment funds by submitting a CTF Request Form and supporting information through the CTF approval process.
4. The CTF approval process consists of review and approval by both the appropriate CSHCN region and CSHCN.
5. The amount of funding designated for approved CTF requests is determined by CSHCN.
6. If the CTF becomes depleted, funds will be transferred to the CTF from local CSHCN agency allocations where unspent funds are projected.

### 6422 Procedures

<i>Responsibility</i>	<i>Action</i>
Local CSHCN Agency	<p><u>Monitors</u> county diagnostic and treatment fund status in accordance with CSHCN policies and WAC.</p> <p><u>Completes</u> Central Treatment Fund Request form and attaches supporting information, when it appears agency allocation will be depleted. (Print copy of form from Section 6423.)</p> <p><u>Forwards</u> form to appropriate CSHCN Regional Representative and presents request to membership at next regional meeting or conference call.</p>

<i>Responsibility</i>	<i>Action</i>
CSHCN Regional Representative	<p><u>Facilitates</u> CTF request discussion at regional meeting to assure:</p> <ul style="list-style-type: none"> <li>▪ CSHCN policies and WAC are met</li> <li>▪ CTF Request form issues are addressed</li> <li>▪ Alternative strategies, ideas and experiences are shared.</li> </ul> <p><u>If region does not recommend approval</u>, indicate denial on the CTF Request form with an explanation of the decision. Return CTF request to local CSHCN agency and send a copy to CSHCN.</p> <p><u>If region recommends approval</u>, sign CTF Request form. Forward form and agency supporting information to CSHCN Manager, adding comments that would be helpful to CSHCN, including recommended amount of funding.</p>
DOH – CSHCN Program and Manager	<p><u>Reviews</u> CTF requests with staff.</p> <p><u>If request is denied</u>, indicate denial on the CTF Request form with an explanation of the decision. Return copy of form to local CSHCN agency and regional representative.</p> <p><u>If request is approved</u>, manager signs CTF request form and indicates dollar amount. Sends approved copy to local CSHCN agency and regional representative.</p> <p><u>Transfers</u> funds from CTF to local CSHCN agency's allocation.</p> <p><u>Maintains</u> system that monitors CTF and requests.</p>



## 6430 End-of-Biennium Fund Management

The budget for the State of Washington is approved for a biennium, a two-year period beginning July 1 and ending June 30. State and federal funding policies govern the Department of Health (DOH), Children with Special Health Care Needs (CSHCN) Program. The policies and procedures in this section are intended to facilitate effective management and promote maximum utilization of DX/TX allocated funds at the end of the state biennium. Reporting of Obligations will be requested by CSHCN during this time.

### 6431 Policies

1. Services provided in a current biennium must be paid from funds allocated for that biennium.
2. CSHCN funds will not be carried over to pay for services provided after the end of the biennium.
3. Payment for services will not exceed the sum of all county allocations and the CTF.
4. Time lines established by CSHCN will govern procedures for processing authorizations at the end-of-biennium.

### 6432 Procedures

<i>Responsibility</i>	<i>Action</i>
DOH – CSHCN Program	<u>Distributes</u> end-of-biennium instructions and timelines. Maintains and distributes quarterly state summary reports to agencies until payments for services provided during the previous biennium have been made.
Local CSHCN Agency	<u>Ensures</u> that current biennium allocations are authorized for use only for services provided during that biennium. This means, at the end of one biennium, and the beginning of another, the date of service is what determines which biennium allocation pays for the service. Adheres to end-of-biennium instructions and timelines received from CSHCN.

## 6500 Health Services Authorization

A Health Services Authorization (HSA) form must be completed to access DX/TX funds to pay for service, treatment, or equipment. If the request meets established eligibility criteria outlined in Section 6000, the HSA form will be processed for payment.

The HSA form is a one-page electronic form that can be filled out on the computer. A sample HSA form can be found in Section 6540.

### 6510 Policies

1. All services paid with DX/TX funds must be authorized on a HSA form.
2. Local CSHCN agencies must designate authority to individual(s) to approve payment for services and sign HSA form.
3. Payment can only be made from a copy of the HSA form with an original signature by the provider or provider's designee.

## 6520 Procedures

<i>Responsibility</i>	<i>Action</i>
Local CSHCN Agency	<p><u>Approves</u> service in accordance with CSHCN policies and WAC.</p> <p><u>Coordinates</u> service and payment process with provider.</p> <p><u>Completes</u> the HSA form, according to instructions in Section 6530.</p> <p><u>Assigns</u> a local CSHCN agency-assigned sequential form number. This number includes the county code. For example, Pierce would start with 27-001; the next would be 27-002.</p> <p><u>Signs</u> HSA form.</p> <p><u>Sends</u> signed copy to provider. Retains file copy.</p> <p><u>Records</u> estimate of obligations to maintain and track diagnostic and treatment allocation balance and agency-assigned sequential form number. See Section 6510 for obligations and tracking payments.</p> <p><u>Verifies</u> that client data is updated and entered into the CHIF Automated System. See Section 5200 for CHIF.</p>
Vendor or Provider	<p><u>Provides</u> item or service.</p> <p>Completes Box #7 Vendor/Provider's Federal Tax ID No. and if applicable, completes Box #8 Vendor/Provider's NPI, Box #9 Vendor/Provider's Taxonomy, and Box #15 to include CPT/HCPCS code(s).</p> <p><u>Signs</u> HSA form and returns copy with original signature to local CSHCN agency, including Health Insurance Claim Form (1500) and/or invoice as requested and explanation of benefits (EOB) from insurance or HCA correspondence (e.g., letter of denial) as appropriate.</p> <p><u>Retains</u> copy for file.</p>
Local CSHCN Agency	<p><u>Sends</u> original signed HSA form by mail or FAX to CSHCN with provider billing, insurance or HCA/Medicaid denial or explanation of benefits as appropriate. (Original signatures are required on documents and electronic signatures cannot be processed for payment.)</p> <p>Children with Special Health Care Needs Program DOH/Prevention and Community Health PO Box 47880 Olympia, WA 98504-7880 FAX 360-586-7868</p>
DOH – CSHCN Program	<p><u>Adjudicates</u> fees and determines payments in accordance with CSHCN policies and WAC.</p> <p><u>Assigns</u> an "Authorization No." as official form and invoice number used in DOH disbursement system.</p> <p><u>Processes</u> HSA form for payment through DOH and State of Washington disbursement system.</p> <p><u>Retains</u> copy of HSA form for permanent payment file.</p>

<i>Responsibility</i>	<i>Action</i>
	<p><u>Returns</u> copy of HSA form, billings and any attachments to local CSHCN agency.</p> <p><u>Maintains</u> computer system that records diagnostic and treatment payments and allocation balances. Distributes quarterly Diagnostic and Treatment State Summary Allocation report to local CSHCN agencies. Monthly detailed reports are distributed upon request by county.</p>

## 6530 Instructions for Preparing the HSA Form

The table below provides instructions for completing the HSA form (DOH 910-002). This form was revised in 2014. The numbered items in the instruction table correspond to the numbers on the form. Procedures in Section 6520 explain how the HSA form is processed.

One asterisk (\*) = Required data for payment or for the CHIF Automated System.

<i>Item</i>	<i>Instructions</i>
AUTHORIZATION NO.	<p><b><u>LEAVE THIS AREA BLANK.</u></b></p> <p>The electronic HSA form does not have a form number. A form number will be assigned at the CSHCN state office when the form is processed for payment.</p>
* 1. PATIENT	Enter client's legal name: Last name, first and middle initial
* 2. PROVIDERONE ID	Enter client's Medicaid ID number (also known as ProviderOne). If no ProviderOne ID, see Box #3.
3. CHIF ID	Enter client's unique identifier if client does not have a ProviderOne ID. Use CSHCN unique client identification ID number generated by the Child Health Intake Form (CHIF) Automated System. (See Section 5000)
4. ADDRESS	Enter address of family.
* 5. DIAGNOSIS	Enter the child's diagnosis related to requested service followed by the applicable diagnostic code (ICD-9 or ICD-10).
* 6. VENDOR or PROVIDER **	<p>Enter name and address of vendor or provider providing supplies or service(s). Payments are issued using this information.</p> <p>The provider or vendor name on first line should be the official way the TAX ID number is registered (i.e., if this is a "group" TAX ID number, the first line should be the group or business name, not an individual doctor or billing person).</p> <p>**If new vendor or provider, a Statewide Payee Registration form needs to be completed and submitted to Department of Enterprise Services. (<a href="http://www.des.wa.gov/about/FormsPubs/Pages/Forms.aspx">http://www.des.wa.gov/about/FormsPubs/Pages/Forms.aspx</a>)</p>
* 7. VENDOR OR PROVIDER'S FEDERAL TAX ID NUMBER	Enter information in accordance with state and federal requirements. Payments are reported to the Internal Revenue Service.
8. VENDOR OR PROVIDER'S NPI	Vendor or Provider enters National Provider Identifier (NPI) number if applicable.

<i>Item</i>	<i>Instructions</i>																																							
9. VENDOR OR PROVIDER'S TAXONOMY	Vendor or Provider enters their taxonomy code if applicable.																																							
* 10. BIRTH YEAR	Enter birth year of client.																																							
* 11. COUNTY OF RESIDENCE & CODE	<p>Enter one (1) numeric county code, for where the client resides, followed by a county-assigned sequential number to identify each HSA form you prepare in a calendar year.</p> <p><u>For example</u>, the first electronic HSA form, prepared by Adams County, would be 01-001, the next would be 01-002.</p> <table border="0"> <tr> <td>01 Adams</td> <td>14 Grays Harbor</td> <td>27 Pierce</td> </tr> <tr> <td>02 Asotin</td> <td>15 Island</td> <td>28 San Juan</td> </tr> <tr> <td>03 Benton</td> <td>16 Jefferson</td> <td>29 Skagit</td> </tr> <tr> <td>04 Chelan</td> <td>17 King</td> <td>30 Skamania</td> </tr> <tr> <td>05 Clallam</td> <td>18 Kitsap</td> <td>31 Snohomish</td> </tr> <tr> <td>06 Clark</td> <td>19 Kittitas</td> <td>32 Spokane</td> </tr> <tr> <td>07 Columbia</td> <td>20 Klickitat</td> <td>33 Stevens</td> </tr> <tr> <td>08 Cowlitz</td> <td>21 Lewis</td> <td>34 Thurston</td> </tr> <tr> <td>09 Douglas</td> <td>22 Lincoln</td> <td>35 Wahkiakum</td> </tr> <tr> <td>10 Ferry</td> <td>23 Mason</td> <td>36 Walla Walla</td> </tr> <tr> <td>11 Franklin</td> <td>24 Okanogan</td> <td>37 Whatcom</td> </tr> <tr> <td>12 Garfield</td> <td>25 Pacific</td> <td>38 Whitman</td> </tr> <tr> <td>13 Grant</td> <td>26 Pend Oreille</td> <td>39 Yakima</td> </tr> </table>	01 Adams	14 Grays Harbor	27 Pierce	02 Asotin	15 Island	28 San Juan	03 Benton	16 Jefferson	29 Skagit	04 Chelan	17 King	30 Skamania	05 Clallam	18 Kitsap	31 Snohomish	06 Clark	19 Kittitas	32 Spokane	07 Columbia	20 Klickitat	33 Stevens	08 Cowlitz	21 Lewis	34 Thurston	09 Douglas	22 Lincoln	35 Wahkiakum	10 Ferry	23 Mason	36 Walla Walla	11 Franklin	24 Okanogan	37 Whatcom	12 Garfield	25 Pacific	38 Whitman	13 Grant	26 Pend Oreille	39 Yakima
01 Adams	14 Grays Harbor	27 Pierce																																						
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12 Garfield	25 Pacific	38 Whitman																																						
13 Grant	26 Pend Oreille	39 Yakima																																						
* 12. AUTHORIZATION DATE	Enter the month, day, and year the HSA form is being prepared by the county.																																							
* 13. AUTHORIZATION EXPIRES	<p>Enter the date a vendor or provider should return HSA form to the local CSHCN agency for payment. This date should not exceed 1 month from the date of service or 2 months from authorization date (see examples). Date consists of month, day and year and is always the last day of the month.</p> <p>Examples:</p> <ul style="list-style-type: none"> <li>• #12 - Today's authorization date = October 1, 2014 <ul style="list-style-type: none"> <li>○ Ex: Date of service scheduled for October 10, 2014</li> </ul> </li> <li>• #13 - Authorization expires (no more than one month later) = November 10, 2014</li> <li>• #12 - Today's authorization date = March 1, 2014 <ul style="list-style-type: none"> <li>○ Ex: Date of service is future receipt of ordered item</li> </ul> </li> <li>• #13 - Authorization expires (no more than two months later) = May 1, 2014</li> </ul> <p>End-of-biennium year: In an odd year in which the biennium ends (2015, 2017), all HSA forms expire on June 30, or you can also enter "immediately" in this space. (See Section 6530 for end-of-biennium procedures.)</p> <p>This date sets limits, is used to track payments, and can be changed by the local CSHCN agency whenever appropriate.</p>																																							

<i>Item</i>	<i>Instructions</i>
* 14. INSURANCE/ POLICY NO./NAME	<p>Enter health insurance company name regardless of payment or denial, and</p> <p>Attach Explanation of Benefits, billing statement or letter of denial from insurance company or Medicaid.</p> <p>Enter "Not Available" for clients who do not have private insurance.</p> <p>Enter HCA explanations for denial here or in item #16 "Description/Dates(s) of Service(s)" if more room is needed, or indicate if HCA denial document is attached.</p> <p>This information confirms CSHCN policies and WAC requirements.</p>
* 15. CPT/HCPCS/DOH	<p>Local CSHCN agency leaves this area blank.</p> <p>Vendor or provider completes the Current Procedural Technology/Healthcare Common Procedure Coding System (CPT/HCPCS) if applicable.</p> <p>CSHCN state office will enter DOH code.</p>
* 16. DESCRIPTION/ DATE(S) OF SERVICE(S)	<p>Enter a description of service or supplies that includes:</p> <ul style="list-style-type: none"> <li>▪ Brief but complete statement of service authorized. For example, if this is a nutrition supplement, list name of product and quantity.</li> <li>▪ Date(s) of service(s) -- If one time service, begin and end date are the same.</li> </ul> <p>Also enter additional information if applicable that may include:</p> <ul style="list-style-type: none"> <li>▪ Explanation of denial from #14 above</li> <li>▪ Billing instructions for vendor or provider, such as due dates for billings, reports, limiting services, negotiated fees, or deadlines for billing at end of the biennium.</li> <li>▪ Special information for CSHCN, such as for nutrition supplements, Central Treatment Fund approved requests, or additional insurance or HCA information.</li> <li>▪ Attach documentation of medical necessity.</li> </ul>
17. AMOUNT AUTHORIZED	<p>Local CSHCN agency leaves this area blank.</p> <p>The amount authorized will be completed at state office.</p> <p>Do not enter the vendor or provider's charge or the obligated amount on the original or second copy (sent to vendor/provider) because that amount could be a mistake and misinterpreted to be the expected payment.</p>
18. FOR AGENCY USE	<p>Local CSHCN agency leaves this area blank.</p> <p>It will be completed at state office.</p>
19. VENDOR OR PROVIDER SIGNATURE	<p>Local CSHCN agency leaves this area blank.</p> <p>Vendor/provider or vendor/provider designee will sign in this space, agreeing to CSHCN policies, which are summarized on the HSA form.</p>

<i>Item</i>	<i>Instructions</i>
20. ACCOUNT CODE -FOR AGENCY USE	Local CSHCN agency leaves this area blank. It will be completed at state office.
21. RETURN TO	Enter address of local CSHCN agency issuing HSA and paying for this service.
22. PREPARED BY	Enter name of local CSHCN agency designee who prepared HSA, if different from Box 23.  Local CSHCN agency contact person and phone number may also be helpful information for the vendor.
23. AUTHORIZED BY	Enter name of local CSHCN agency designee who is authorized to approve services and funding. This person signs or initials HSA.

Procedures in Section 6520 explain processing.

### Children with Special Health Care Needs (CSHCN) HEALTH SERVICES AUTHORIZATION

Asterisk (\*) = Required Data for Payment

AUTHORIZATION NO.

1. PATIENT*:		2. PROVIDER ONE (P1) ID*	
		3. CHIF ID (if P1 not available)	
4. ADDRESS:			10. BIRTH YEAR*
5. DIAGNOSIS*:			11. COUNTY OF RESIDENCE & CODE*
6. VENDOR OR PROVIDER*	RETURN AUTHORIZATION BY		12. AUTHORIZATION DATE*
			13. AUTHORIZATION EXPIRES*
			14. INSURANCE/POLICY No./NAME*

7. VENDOR/PROVIDER FEDERAL TAX ID No.*	8. VENDOR/PROVIDER NPI	9. VENDOR/PROVIDER TAXONOMY	
--	------------------------	-----------------------------	--

You are authorized to perform the following services for which CSHCN will be obligated to pay their fee, according to currently established payment policy or fee schedule. For payment questions and additional services not specified nor ordinarily included as a part of the description, contact local agency indicated at bottom.

15. CPT/HCPCS/DOH*	16. DESCRIPTION/DATE(S) OF SERVICE(S)*	17. AMOUNT AUTHORIZED	18. FOR AGENCY USE
	DESCRIPTION:  BEGIN DATE OF SERVICE(S) END DATE OF SERVICE(S)		

Vendor/Provider of Service agrees to accept CSHCN fee as payment in full and that no additional charge will be made to the patient or his/her family for these services.

19. I certify that all services represented by this voucher have been provided without discrimination on the grounds of race, color, or national origin.  VENDOR/PROVIDER SIGNATURE X	Instructions to receive payment: Mail this signed "Voucher Copy," billing, and report of service (if requested) to local agency indicated at bottom. Medicaid and insurance must be billed prior to making claim to CSHCN. Payment will only be made upon receipt of documented proof of denial or amount of reimbursement from other payment sources.
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**20. ACCOUNT CODE – FOR AGENCY USE**

PREPARED BY			TELEPHONE NUMBER			DATE			AGENCY APPROVAL			DATE			
DOC DATE		PMT DUE DATE		CURRENT DOC NO.		REF. DOC. NO.		VENDOR NUMBER			VENDOR MESSAGE		USE TAX	UBI NUMBER	
MASTER INDEX				WORDCLASS				COUNTY		CITY/TOWNSHIP					
REF DOC SUF	TRANS CODE	M O D	APPN INDEX	PROGRAM INDEX	SUB OBJ	SUB SUB OBJ	ORG INDEX	ALLOC	BUDGET UNIT	MOS	PROJECT	SUB PROJ	PROJ PHAS	AMOUNT	INVOICE NUMBER
ACCOUNTING APPROVAL FOR PAYMENT								DATE				WARRANT TOTAL		WARRANT NUMBER	

21. RETURN TO:	22. PREPARED BY:
	23. AUTHORIZED BY:



## *6541 Instructions for Using Electronic Form*

Children with Special Health Care Needs (CSHCN) Program  
**Health Services Authorization (HSA)**

**Local CSHCN Agency**  
**Instructions for Using Electronic Form**  
June 2014

### **A. Form Mechanics**

1. You can fill out this form electronically and save it on your computer.
2. You can click in a box to begin typing, or you can tab from box to box. If you cannot put your cursor inside a box (# 20, for example), you are not meant to fill it out.
3. To save your completed form, select File/Save As and give the document a new name. Consider using the new county document number in B-2 below.
4. Please do a test to be sure the mechanics of the electronic form can be accomplished with your computer system.
5. If you have difficulties with the mechanics of this form, contact the CSHCN state office for assistance.

### **B. Form Content**

1. The "Authorization No." box is now blank (top right). Do not use this space. The number will be assigned at the CSHCN state office when the form is processed for payment.
2. Box 11: Insert a number after your county code. This sequential number will be for your internal county log to identify each form you prepare. For example, Pierce would start with 27-001, the next would be 27-002.
3. The HSA form cannot be processed with electronic signatures. For that reason, you will need to complete the form, print it, sign it (Box 23), then process for payment according to CSHCN Policies and Procedures, including provider signatures.
4. CSHCN Contact: CSHCN Program (360-236-3571)  
DOH/Prevention and Community Health  
PO Box 47880  
Olympia, WA 98504-7880  
Email: [cshcn.support@doh.wa.gov](mailto:cshcn.support@doh.wa.gov)

### Children with Special Health Care Needs (CSHCN) HEALTH SERVICES AUTHORIZATION

Asterisk (\*) = Required Data for Payment

AUTHORIZATION NO.

1. PATIENT*: Martha A Washington	2. PROVIDERONE (P1) ID*: 123456789WA	
4. ADDRESS: 2014 Cherry Blossom Lane, Olympia, WA 98501	3. CHIF ID (if P1 not available)	
5. DIAGNOSIS*: 734	10. BIRTH YEAR*: 2014	
6. VENDOR OR PROVIDER*: Olympia Orthotics 2014 Capitol Boulevard Olympia, WA 98501	11. COUNTY OF RESIDENCE & CODE*: 34-001	
	12. AUTHORIZATION DATE*: 5/1/2014	
	13. AUTHORIZATION EXPIRES*: 7/1/2014	
7. VENDOR/PROVIDER FEDERAL TAX ID NO.*: 91-9000000	8. VENDOR/PROVIDER NPI: 909090909	9. VENDOR/PROVIDER TAXONOMY: 335E0000X
14. INSURANCE/POLICY NO./NAME*: Not covered by Medicaid		

RETURN  
AUTHORIZATION  
By

You are authorized to perform the following services for which CSHCN will be obligated to pay their fee, according to currently established payment policy or fee schedule. For payment questions and additional services not specified nor ordinarily included as a part of the description, contact local agency indicated at bottom.

15. CPT/HCPCS/DOH*	16. DESCRIPTION/DATE(S) OF SERVICE(S)*	17. AMOUNT AUTHORIZED	18. FOR AGENCY USE
L3060	DESCRIPTION: Bilateral Foot Orthotics  BEGIN DATE OF SERVICE(S) 5/15/15 END DATE OF SERVICE(S) 6/15/14		

Vendor/Provider of Service agrees to accept CSHCN fee as payment in full and that no additional charge will be made to the patient or his/her family for these services.

19. I certify that all services represented by this voucher have been provided without discrimination on the grounds of race, color, or national origin.

**VENDOR/PROVIDER SIGNATURE** X George Entwistle

**Instructions to receive payment:** Mail this signed "Voucher Copy," billing, and report of service (if requested) to local agency indicated at bottom. Medicaid and insurance must be billed prior to making claim to CSHCN. Payment will only be made upon receipt of documented proof of denial or amount of reimbursement from other payment sources.

20. ACCOUNT CODE – FOR AGENCY USE															
PREPARED BY			TELEPHONE NUMBER			DATE			AGENCY APPROVAL			DATE			
DOC DATE		PMT DUE DATE		CURRENT DOC NO.		REF. DOC. NO.		VENDOR NUMBER		VENDOR MESSAGE		USE TAX	UBI NUMBER		
REF DOC SUF		TRANS CODE	M O D	APPN INDEX	PROGRAM INDEX	SUB OBJ	SUB SUB OBJ	ORG INDEX	ALLOC	BUDGET UNIT	MOS	PROJECT	SUB PROJ	PROJ PHAS	AMOUNT
INVOICE NUMBER															
ACCOUNTING APPROVAL FOR PAYMENT								DATE				WARRANT TOTAL		WARRANT NUMBER	

21. RETURN TO: Local CSHCN Agency  
PO Box 2014  
Olympia, WA 98501

22. PREPARED BY:

23. AUTHORIZED BY: Christy Polking



## 6600 CSHCN Health Care Coverage and Services

### 6610 CSHCN and Medicaid Coverage

CSHCN and Health Care Authority (HCA) collaborate to improve and expand services to children. This section explains policies for potential clients and procedures developed for approval of specific services. It is important to have an understanding of Medicaid medical service categories, payment systems and ways to problem solve client issues because the majority of children served by CSHCN have Medicaid coverage.

All of Medicaid's child health services are combined into one streamlined program now called Washington Apple Health. The majority of children enrolled in Apple Health will be assigned to one of five Medicaid managed care plans. Children who are not in or are otherwise exempted from enrollment in a Medicaid managed care plan will receive their health services through the Fee-For-Service Medicaid payment system. Some very specific benefits for children with special health care needs may be covered by the Fee-For-Service system even while the child is in managed care. (Examples include applied behavior therapy for children with autism and dental care.) Overall, children should be able to access the same benefits through either the Fee-For-Service system or Medicaid managed care, or a combination of the two.

All children enrolled in Apple Health will be assigned a ProviderOne number. ProviderOne is the technology system at HCA that coordinates the health plans and sends client and billing data to the state. Health care providers, including state and local CSHCN agencies can use ProviderOne to see whether children are enrolled in Apple Health. Some higher income families will be eligible for a subsidized version of Apple Health where they pay monthly premiums and co-payments. The DX/TX fund **can only** be used for children in Apple Health whose family income is so low that they do not pay premiums.

If children are not financially eligible for Apple Health, they may qualify for subsidies with other health insurance. With the implementation of the Affordable Care Act, all families can apply for Apple Health and other private insurance through Washington Healthplanfinder (<https://www.wahealthplanfinder.org>). In addition, some families may be eligible for Medicaid as a secondary insurance. They should be also encouraged to apply through the Healthplanfinder even if they have private insurance through their employer.

Medicaid information is available in a variety of ways. Local CSHCN agencies and other medical providers can sign-up to receive on-going client and payment news and information directly from HCA. HCA updates are also provided through the CSHCN Regional System and Communication Network meetings (Section 3200). HCA representatives participate in these activities and may attend CSHCN Regional Meetings upon invitation. In addition, anyone can sign up for the Apple Health email list at <https://fortress.wa.gov/hca/listsrvsignup/>.

### 6620 CSHCN Clients Without Medicaid

#### *6621 Policy*

Local CSHCN agencies must refer clients to Healthplanfinder (<https://www.wahealthplanfinder.org>) for insurance coverage if the family is eligible for Medicaid as either a primary or secondary insurance. To qualify for Medicaid children to age 18 years is currently at 200% of the Federal Poverty Level (effective 2014, see <http://www.hca.wa.gov/hcr/me/Pages/eligibility.aspx>).

## 6622 Procedures

<i>Responsibility</i>	<i>Action</i>
Local CSHCN Agency	<p><u>Refers</u> clients and their families to <a href="https://www.wahealthplanfinder.org">https://www.wahealthplanfinder.org</a> to apply for Medicaid or other insurance coverage when the client appears to be financially eligible or when extensive medical care is possible.</p> <p>Web-based information and on-line application opportunities are also available. See Appendix for HCA web addresses.</p>
Local CSHCN Agency	<p><u>Follow-up</u> with family regarding outcome of medical coverage application.</p> <ul style="list-style-type: none"><li>• Review application approval for medical program coverage (fee-for-service or managed care plan) and scope of care.</li><li>• Review application denial for possible resolution.</li></ul>

## 6630 TRICARE

TRICARE provides coverage of some health care costs for dependents of active duty military personnel. It is the responsibility of the State Title V Program to ensure access to quality health care services for all children. This responsibility requires maximum utilization of all funding sources. The State Title V Program must ensure that the CSHCN policy relating to TRICARE does not discriminate against any children, including those who may or may not be dependents of active duty military personnel.

Previous CSHCN policies and procedures for TRICARE clients were developed to clarify first payer/last payer issues, particularly when a client was financially eligible for CSHCN and TRICARE, but not Medicaid, in HCA. This situation was resolved in 1994, when HCA increased children's financial eligibility to 200% of the federal poverty level.

To qualify for TRICARE benefits provided through Program for Persons with Disabilities, previously called Program for the Handicapped (PPTH), TRICARE requires military families to first use public funds and facilities, to the extent they are available and adequate. Interaction with CSHCN, to verify that services or funding are not available through the CSHCN program, is done in a variety of ways depending on the military facility. This may involve filling out a federal form and preparing a letter to provide clarifying information, such as the requested services are covered by HCA, and the child has that coverage or is eligible and should apply.

Policies and procedures in this section work in combination with all other CSHCN policies and WAC. These policies are repeated in other sections and apply to any CSHCN client.

### 6631 Policies

1. Local CSHCN agencies must refer clients to HCA, when income or medical needs appear to be within HCA eligibility limits.
2. All other resources, such as insurance or HCA, applicable for the service and available to the client, must be used before CSHCN makes payment to medical providers.

## 6632 Procedures

<i>Responsibility</i>	<i>Action</i>
Local CSHCN Agency	<u>Provides</u> a statement of non-availability of CSHCN funding for services when requested by active duty military families to fulfill TRICARE requirements.
Local CSHCN Agency with military facility in county	<u>Facilitates</u> communication and access to care with military staff serving children with special health care needs.
DOH – CSHCN Program	<u>Reviews</u> issues of concern.

### 6640 HCA Hearing Aid Services

After years of advocating for a more efficient process for providing hearing aids to children, the Washington legislature was influenced to revise the WAC requirements. Effective July 1, 2009, local CSHCN agencies no longer need to approve children's hearing aids for Medicaid eligible children.

### 6650 HCA Neurodevelopmental Therapy Services

A cooperative agreement was initiated in January 1991 between the Department of Health (DOH) and the Department of Social and Health Services (DSHS) (now known as the Health Care Authority) to address the concern of unmet therapy needs for Medicaid-eligible children, and facilitate reimbursement to Medicaid therapy providers in communities not served by a CSHCN neurodevelopmental center. A quality assurance procedure was developed whereby CSHCN coordinators would facilitate prior authorization for Medicaid services by certifying additional physical, occupational and speech therapy when the medical need was above the limits allowed by Medicaid.

This successful process influenced change in Medicaid-covered therapy services for children. DSHS (now known as HCA) revised therapy billing instructions and Washington Administrative Codes (WAC) to reflect unlimited, medically necessary therapy services for clients under 20 years of age through Medicaid Fee-For-Service. CSHCN approval responsibilities are no longer required for Medicaid Fee-For-Service therapy services. With the transition of children into Medicaid managed care plans, plans are able to limit therapy visits and require prior authorization for services, but ultimately need to support unlimited, medically necessary therapy services for clients under 20 years of age. If experiencing issues with plans, contact the plan; if unresolved, you can contact HCA through [hcameprograms@hca.wa.gov](mailto:hcameprograms@hca.wa.gov) or contact DOH for assistance.

### 6660 HCA Orthodontic and Maxillofacial Services

A cooperative agreement was initiated in October 1990 between the Department of Health (DOH) and the Department of Social and Health Services (DSHS - now known as HCA) to approve orthodontic treatment for Medicaid eligible children with complex craniofacial problems, whose treatment plan had been developed and approved by a CSHCN maxillofacial team (Section 3000).

A quality assurance procedure was developed whereby CSHCN coordinators would facilitate prior authorization for Medicaid services by approving an orthodontic information sheet containing required details. This was a time when most orthodontic procedures required prior authorization. The CSHCN maxillofacial teams were instrumental in getting children's services through the Medicaid approval and payment process.

This successful process influenced change in Medicaid-covered dental and orthodontic services for children and improved Medicaid policies and procedures. CSHCN approval responsibilities are no longer required. Dental and orthodontic services for children on Medicaid continue to be reimbursed through Medicaid Fee-For-Service outside of the managed care system.

# Section 7000 - Fiscal and Contract Management

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## **7100 Introduction**

*This section continues to use a number of acronyms that are listed in the Appendices.*

This section gives a brief overview of consolidated contracts with local health agencies. Management of these contracts is at an agency level, with Office of Maternal and Child Health (MCH) Regional Team involvement for MCH-wide activities and selected activities.

The Consolidated Contract is an interagency, cost reimbursement, client service contract between the Department of Health (DOH) and the 35 Local Health Jurisdictions (LHJs) in Washington State. Each LHJ has a five-year contract, currently effective January 1, 2007 through December 31, 2011, that combines many program activities and funding sources into one contract. By combining statements of work for many programs into one contract, the number of contracts between the DOH and the LHJs is minimized. Yakima Valley Memorial Hospital is the contractor for MCH consolidated contract activities in Yakima County.

Management of and information about consolidated contracts is coordinated by other sources in DOH. See Appendix for the DOH Consolidated Contract website used by Local Health Jurisdictions.

## **7200 MCH Regional Teams**

Representatives from all programs in MCH comprise the membership of four (4) teams in the state: East, Central, Northwest, and Southwest. Members of each MCH Regional Team and representatives from LHJs in the region, meet on a regular basis. Regional meetings provide collaborative planning opportunities, contract management assistance with activities, and exchange of LHJ and MCH program information and updates.

## **7300 Statement of Work and Funding**

The MCH Statement of Work (SOW) and Local Health Jurisdiction funding formula is coordinated through MCH Regional Teams. The purpose of these MCH-wide activities is to provide maternal and child health focused public health services as described in the activity plan developed by each LHJ.

The MCH-wide SOW includes required responsibility for CSHCN reporting of client data and management of diagnostic and treatment funds, and refers to this CSHCN Manual for additional guidance.

Individual programs in MCH may have program-specific activities listed separately outside the MCH-wide SOW. The CSHCN Regional Representative responsibilities, in four (4) LHJs, are examples of CSHCN program-specific activities.

# Section 8000 - Information and Data Management

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## **8100 Introduction**

*This section continues to use a number of acronyms that are listed in the Appendices.*

The Information and Data Management Section consists of all information, both written and electronic, which is used in the CSHCN Program, including:

- data collection and reporting;
- data resources and needs assessment; and
- confidentiality.

This section will be expanded as current data collection systems are improved.

## **8200 Policies**

1. Reporting requirements for data will be in accordance with the terms of the consolidated contract or in procedures contained in other sections of this manual.
2. Security of data will be in accordance with all established rules concerning confidentiality and right to privacy. CSHCN programs will take whatever measures they deem appropriate to safeguard any information gathered and to share this information with only those individuals or agencies with a legitimate need to know. Consent to share client information, individuals or agencies outside the local CSHCN office will require a separate release of information form signed by the parent(s).
3. Information of a statistical nature, not connected to a client's name, may be shared freely without restriction to any person or agency interested in such information.

## **8300 Data and Reports**

Reports showing client caseload, demographics, and diagnostic data are generated from CHIF data and distributed to local agencies on a quarterly basis. The reports reflect cumulative data for each quarter within the calendar year, with the fourth quarter report serving as an annual summary. The data can be used at both the state and local levels for:

- program planning and evaluation
- responding to requests for information
- providing information to funding sources and authorities
- meeting federal Title V requirements

Reports are run automatically on the third week of the month following the end of the quarter (April, July, November, and January). CHIFs for the prior calendar year should be processed by

the first week in January to be included in the annual summary. See Appendix 8000 for sample reports.

# Section 9000 - Service System Development

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## **9100 Introduction**

*This section continues to use a number of acronyms that are listed in the Appendices.*

The MCH Block Grant mandates Title V agencies to assume a leadership role in assuring the development of community-based systems of services for children with special health care needs and their families (see Section 1000). Developing these systems involves the creation of an organizational infrastructure for the delivery of health services and a variety of other services needed for this population and assures their continuance over time.

## **9200 Essential Qualities of the Service Delivery System**

### **9210 Broad Population**

The service delivery system should serve children of all ages, including infants, toddlers, school-age children, adolescents, and young adults. The system should reflect a generic (or functional), rather than disease-specific or condition-specific, orientation. From the standpoint of available personnel and cost, it is not feasible to have separate service delivery systems for children with different diseases and conditions. Even when children with different diseases and conditions do need disease-specific or condition-specific services, they have common life experiences and problems.

It may be necessary or desirable for one or more types of children with special health care needs to be the initial target of the system, and then expand the system to encompass other children with special health care needs.

### **9220 Community-Based**

Children with special health care needs deserve to live with their own families in their own communities. They deserve to share in the everyday experiences most of us take for granted. All too often needed services are not available or accessible in or near home communities. Delivery of needed services near home communities facilitates the families' ability to care for their children at home and promotes normal patterns of living.

### **9230 Family-Centered**

A family-centered system responds to the needs of children and their families, rather than requiring them to adapt to the system. A family-centered system supports and assists families in their natural care-giving roles, promotes normal patterns of living, and ensures family collaboration and choice in the planning and provision of services to the child.

Family-centered care is described in a publication of the Association for Care of Children's Health entitled *Family-Centered Care for Children With Special Health Care Needs*. Other resources on family-centered care and family involvement are found in the Resource section.

## **9240 Culturally competent**

Family-centered services are culturally competent services. Cultural competence refers to a system's ability to honor those beliefs, interpersonal styles, attitudes and behaviors both of families who are clients and the multicultural staff who are providing services. It also implies skills which help translate beliefs, attitudes, and orientation into action and behavior within the context of daily interaction with families and children. Other resources on cultural competence are found in the Resource section.

## **9250 Comprehensive**

A wide array of prevention, treatment, and support services is an essential element of comprehensive service delivery. Children with special health care needs and their families often have a variety of problems and need a broad range of health, educational, social, and related services. Such children, at least as a group, require three levels of care:

- preventive and primary care involving basic care;
- secondary care, involving somewhat less complex specialty care, and;
- tertiary care, involving very complex subspecialty and specialty care.

The service system should make as many services as possible (and practical) available and accessible in the community, including:

- information and referral services;
- health promotion activities and preventive services (services directed at preventing the occurrence of health problems among children through the delivery of personal health services, health education, regulation of behavior affecting health status, and changes in environmental factors affecting health status. Ex: injury prevention activities, genetic counseling, immunizations);
- early identification services (services aimed at the early detection of health problems, often prior to their clinical manifestation, for the purpose of early intervention, such as newborn screening, HPIT, Child Find, well-child clinics, etc.);
- primary care services;
- diagnostic and evaluation services;
- treatment services (intervention directed at curing a health problem, alleviating its symptoms, or minimizing its effects.);
- dental services (preventive and restorative oral health care);
- nutrition services (nutrition screening, assessment, intervention, and support, such as therapeutic diets, special dietary products, special feeding equipment, and monitoring);
- emergency medical services;
- habilitation and rehabilitation services (interventions directed at assisting children with health problems to attain the maximum possible

functioning and independence; includes therapies and adaptive/assistive devices and equipment);

- educational and vocational services;
- mental health services;
- family support and other social services (includes respite care and parent-to-parent support);
- recreational and arts programs; and
- other economic and social support services.

This spectrum of services is frequently not available at the community level. Large medical centers, generally located in major urban areas, are often the source of high quality tertiary medical care for children with special health care needs. Some secondary level care and primary care can and should be provided by community physicians and other community health professionals. Strong linkages are needed among providers to create the needed continuum of care for children with special health care needs.

Since CSHCN programs are public health programs, they should direct their efforts to the organization of the health component of systems of comprehensive services. However, state and local CSHCN programs must interact with service sectors that provide services other than health services to assure that the established systems of services provide truly comprehensive services. Due to limited resources, priorities should be set within the framework of a community needs assessment.

A sample list of comprehensive community services is found in the Resource section.

## **9260 Coordinated**

Children with special health care needs often require a variety of services that are usually provided by different sources. The many public and private programs serving these children and their families may have differing mandates, eligibility requirements, and overlapping and inconsistent policies. Gaps, fragmentation, and duplications in services often result. Furthermore, it is not uncommon for programs to serve only a particular age group. Linkages between programs serving infants and young children, school age children, and adolescents and young adults are all too often lacking. Families often find it very difficult to locate and use appropriate services.

Coordination among multiple community agencies and providers, as well as among informal community resources (church, relatives, friends, scouts, etc.), is necessary to plan and implement quality care for children with special health care needs and their families. In addition, coordination among all levels of health care, including secondary and tertiary levels (specialized consultant and direct services for unusual/complex health problems) is essential. The care coordinator/case manager plays a pivotal role in facilitating this coordination.

On the community level, the local CSHCN agency, as a recipient of MCH Block Grant funds, should take the lead in coordinating services and fostering the creation of linkages among providers serving children with special health care needs and their families.

## **9300 State Role**

State Title V CSHCN agencies have a central and crucial role in the development of community-based service systems. State agencies can assist in the development of community-based systems through:

- establishing a planning process for service system development at the state level;
- facilitating collaboration among state agencies to promote community-based services;
- providing leadership in defining the role of tertiary and secondary service providers in community-based systems;
- providing financial resources to communities for service system development;
- establishing policies to facilitate the development of these systems;
- providing and facilitating technical assistance, consultation, education, and training to help communities in service system development; and
- establishing minimum standards for an evaluation of these systems.

## **9400 Community Role**

Communities should assume major responsibility for planning, designing, and implementing local service delivery systems. Local agencies receiving MCH Block Grant funds should provide leadership in the development and maintenance of these community-based systems.

## **9500 Community Process**

A process for service system development should be developed and implemented at the local level involving representatives from a variety of groups, including:

- community health care providers;
- providers of other community services needed by children with special health care needs and their families;
- families of children with special health care needs;
- civil, religious, and child advocacy organizations;
- local public officials; and
- community leaders.

This process should include the following steps as they relate to children with special health care needs and their families:

- needs assessment; including:
- an assessment of community organizational structure and the service environment;
- the identification of problems and needs;
- prioritization and analysis of these problems; and
- an inventory and analysis of currently available services, resources, and personnel.
  - the development of a plan which includes intervention strategies and priorities (in light of local resources);
  - implementation of the plan; and
  - monitoring and evaluation of progress.

### **9510 Needs Assessment**

Good information about needs is a cornerstone for developing a responsive service delivery system. Needs assessment should go beyond facts and figures to the analysis of a problem within the social context of the values, beliefs, and attitudes held by members of the community.

The purpose of needs assessments is to determine whether existing resources are sufficient to address certain problems.

The focus of a "systems development" needs assessment is the identification of:

- gaps in and duplication of services at the community level;
- barriers to accessing needed services;
- where there is the most need to devote additional resources to existing services;
- lack of coordination and collaboration among service providers;
- ways in which services are not responsive to family needs and cultural diversity, and;
- federal, state, and/or local laws and regulations governing programs and agencies which encourage or hinder coordination efforts.

The following list of considerations is helpful in assessing the service system:

- Does the system reflect its own needs more than the needs of the family?
- Must families be identified by each service individually, or is there a central intake system that will coordinate or refer families to services as needed?
- Is the present referral system effective, or are families left to "shop around" for the services they need due to lack of coordination?

- Are service providers aware of other services within the community and what they consist of in order to facilitate referral and collaboration?
- Are there collaborative activities between service providers in regard to any of the service delivery components, such as intake and screening? Do agencies share resources such as facilities, staff, transportation, equipment, or others?
- Are all components of the service system being implemented?

A variety of sources and methods can be used in collecting the information necessary for a needs assessment. None of these sources of information about need may be sufficient by itself. The most valid and reliable information may be obtained by a combination of sources, all contributing to the needs assessment process. Some of these sources and methods are listed below:

1. Existing surveys and expert judgment address where existing services are compared to mandated standards.

**Advantages:** economical.

**Disadvantages:** data from existing surveys may be derived from populations that are not comparable to those under consideration.

2. Service statistics are based on the periodic accumulation of service reports from direct service agencies. These statistics address expressed need and provide a rough measure of resources expended.

**Advantages:** the statistics are available, accessible, and economic. Such statistics are valuable in maintaining support for activities and for establishing monitoring procedures. They are useful for extracting trends in caseloads and patient characteristics, and developing profiles of users.

**Disadvantages:** service statistics will not provide data about categories of need that are unmet and may leave unassessed the needs of clients and families who are waiting to receive services or who cannot receive services due to access barriers.

3. Resource Inventory and Analysis: A resource inventory describes the services available to a target population. A resource analysis provides information about the current system of services for families. It may point to underutilized sources and may reveal gaps in services. It can be used to obtain policy, population, collaboration, and service issue information. The analysis considers as community resources all formal services available to families, including services designed specifically to help children with special needs and their families, and services available to all community citizens, such as city and recreational activities for young children. The following types of information about community services is often collected:

- Who is presently providing services
- Eligibility criteria, including income guidelines, age of clients, and types of clients served

- A description of what each service provides, and the identification, intake, referral, service, follow-up, and evaluation procedures
- The number of children and families served by each service
- Cooperative agreements between service providers
- Identification of barriers to service provision or collaboration
- Responsibilities of each service provider according to written laws, policies, and guidelines
- Funding sources and restrictions of each service provider

**Advantages:**

**Disadvantages:** Resource inventories are constrained by the need to convince those inside and outside of agencies that data should be generally available and in a common format. This problem can be minimized by involving agencies in the planning of the inventory and making the results known to them. A further limitation is that the results mirror demand, not need. A more difficult problem from the standpoint of an objective needs assessment is overcoming the commitment of agencies to the services they already provide and vested interest in existing service networks.

4. Social surveys attempt to determine what people want or perceive their needs to be. Social surveys derive their power from their dual focus—they identify available services and provide information about consumers knowledge of these services.

**Advantages:** can act to legitimize change and can serve as a stimulus for support of change.

**Disadvantages:** the cost and the time required to design and implement the social surveys.

5. Focus groups and other group techniques involve the collection of data through group interviews and discussions. Focus groups entail in-depth interviewing of a selected group of individuals and may take a variety of forms.

**Advantages of focus groups:**

- they allow for the collection of data quickly and at less cost than many other data collection methods;
- they allow direct interaction between the moderator and participants and among participants;
- they are flexible and easy to understand.

**Disadvantages:**

- the relatively small number of participants may not be representative of the target population, the interaction of participants with each other, and with the moderator can produce biased results;

- the "open-ended" nature of responses can make interpretation and generalization of results a problem.

(See the Resource section for literature on focus groups.) Other group techniques can be used, including the nominal group technique, the Delphi technique, brainstorming, and others.

6. Public hearings invite members of the public to present testimony and to hear the testimony of others.

**Advantages:** compatibility with democratic decision making, economy compared to formal surveys, and encouragement, clarity and exchange of ideas through open discussion.

**Disadvantages:** attendance at such meetings may not be representative of the target population.

### **9520 Community Plan**

The assessment of service needs and identification of current resources are essential for good planning. The discrepancy between service needs and resources provides a sound basis for planning for services.

The focus of a "systems development" community plan is to develop and implement strategies to:

- address elimination of gaps and duplications in services;
- target additional resources to existing services;
- address ways in which barriers to accessing services can be eliminated or minimized;
- foster coordination and collaboration among service providers;
- enhance the responsiveness of services to family needs and cultural diversity.

### **9530 Evaluation**

to be developed

### **9600 Strategies**

A number of strategies can be used to develop or enhance service delivery systems. Communities are most likely to experience progress in developing their service system when they take concerted action at both the service delivery and service system levels.

At the service delivery level, there should be focus on meeting the needs of individual children and families. Initiatives are designed to improve access, availability, and the quality of services that participating organizations provide to their clients.

At the system level, efforts should be focused on creating a set of policies and practices that can help build a community-wide network of comprehensive service delivery. Ultimately, service delivery efforts must be joined by system-wide policy changes to ensure that all children with special health care needs and their families routinely receive comprehensive services. Strategies will vary depending upon community needs, resources, and overall environment

### **9610 Develop administrative, personnel, and organizational policies**

There are a number of ways in which agency policies can promote and facilitate interagency coordination, constituency development, and a collaborative approach to service delivery for children with special health care needs and their families. Examples include policies that:

- ensure development of a system or process that actively involves individuals and groups affected by the agency's planning of services, its methods of service delivery, and its service results;
- ensure collaboration and cooperation with other community agencies that have similar or overlapping missions or deliver similar programs in the same service area;
- ensure, in all cases in which a potential duplication of activities exists between the agency and another organization, establishment of a written agreement that clarifies functional relationships and identifies areas of collaboration;
- allow and encourage staff to participate in or serve on councils, boards, or committees of organizations at the state and community level, such as Interagency Coordinating Councils;
- ensure that all staff have structured, routine, group opportunities to discuss program methods and procedures, current levels of demand for services, and information about community resources and services.

### **9620 Build Coalitions**

Coalitions bring people together to facilitate cooperative planning and to exchange information. By their very nature, coalitions are informal alliances of different individuals or agencies, often with differing points of view. The joint recognition of a common need or common mission allows coalition members to tap their varying capabilities and achieve a common goal. Coalitions can facilitate networking, information sharing, community awareness, project development, grantsmanship, and problem solving. They can create an environment for social change, provide community education, and serve as an information clearinghouse. (See Resource Section, Tips for Successful Coalitions.)

### **9630 Facilitate Community Forums**

Community forums provide an opportunity for families and community, civic, health, education, and social service leaders to meet and identify problems and issues impacting children with special health care needs and their families, and to begin to develop solutions.

In addition, community forums can:

- "spotlight" existing services providers;
- facilitate outreach to families in need of service;
- facilitate increased coordination among services and service providers; and
- highlight innovative services and methods developed in other parts of the state or region.

### **9640 Facilitate Parent/Professional Collaboration at All Levels**

Parents should be involved in all levels of health care, including:

- planning and implementing direct services for their child;
- program development, implementation, and evaluation; and
- policy development.

### **9650 Facilitate Use of Formal and Informal Resources that Support Families**

An effective family support system includes both formal and informal resources. Informal networks are the primary resources for meeting most family needs. Informal support refers to family, friends, relatives, neighbors, churches, clubs, and organizations with whom a person voluntarily interacts. Usually these ties are more intimate, the relationships are more equal, and are characterized by more mutual exchange than is found in formal support. In addition to natural networks that may have existed previously, informal networks may include new friends and acquaintances who are coping with chronic illness or disability. Parent-to-parent networks are a prime example of how effective and powerful this kind of informal support can be.

Formal support refers to those professional persons and groups to whom families turn for specific kinds of help and service. Both formal and informal support are important in meeting the needs of children with special health care needs and their families.

### **9660 Develop or Strengthen Interagency Partnerships and Facilitate Mechanisms for Collaboration Among Providers**

No single organization can adequately address all the service needs of children with special health care needs and their families. Increasingly, community agencies are realizing that by working together, the needs of the community can be better met. Interagency partnerships offer an opportunity to bring together a broad range of professional expertise and agency services on behalf of children and families. In addition, these initiatives have the capacity to harness and combine the financial resources available within several budgets.

Collaboration enables providers to get as much mileage as possible out of available resources and to improve the quality and range of services. It can also:

- increase communication among agencies;
- promote continuity between agencies when staff changes occur;

- reduce duplication of services by clarifying roles and responsibilities.

These efforts may also create positive spin-off effects such as:

- increased understanding and respect between agencies with differing philosophies;
- an opportunity to confront and resolve negative stereotypes about programs;
- stimulation of new ideas.

### **9661 Ways agencies can collaborate**

The many ways that agencies can work together can be grouped under service delivery and administrative categories.

Examples of collaboration in service delivery include:

- referrals between agencies,
- case conferences,
- care coordination/case management, and
- interdisciplinary teams from multiple agencies.

Examples of administrative collaboration include:

#### A. Fiscal

- joint funding: several organizations agree to jointly fund a project.
- purchase of services: one organization contracts to provide services that are paid for by another organization.

#### B. Personnel practices

- joint use of staff: staff provides services for more than one organization.
- staff out-stationing: organizations place some of their staff closer to the client or where the coordinated work is to be done.
- co-location: staff from two or more organization are located in the same facility.

#### C. Planning and programming

- joint development of policies: administrators from several organizations jointly agree on policies for clients.
- joint planning: administrators from several organizations jointly plan for programs and services.
- joint programming: administrators from several organizations jointly develop program services.

- joint evaluation: personnel from several organizations work together to jointly evaluate services provided.

D. Administrative support services

- central support: services needed by several organizations, such as typing and printing, are provided by each organization contributing funds for the services provided.
- grants management: activities funded through grants and records of fund allocations are supervised and maintained by staff in one location for all of the participating organizations.

**9662 Types of collaboration agreements**

Collaboration activities may be supported by methods ranging from informal verbal agreements to formal written agreements and contracts.

The appropriate type of agreement will depend on the complexity of the effort, whether it will be a one-time effort or ongoing, the number of agencies involved and whether or not money is exchanged for a service. Written agreements, letters, or contracts give greater legitimacy to a project and clearly define the responsibilities of each party. However, verbal agreements may evolve into written agreements once the activity has proven successful and parties are willing to make deeper commitments.

The agreement should be drafted by one or two people, although all relevant agencies should participate in reviewing the agreement and refining it until it is acceptable to all concerned. (See table on the following page.)

It is recommended that local CSHCN agencies collaborate with the following agencies, programs, or services. Other agencies may be equally important in a particular community:

Social Service Agencies

DSHS Community Service Offices (CSO)

Mental Health

WIC and other nutrition services

Family Planning

Hospitals (including out-of-county hospitals where infants are transferred)

Schools, preschools, Head Start/ECEAP

Developmental Disabilities Office

Neurodevelopmental Centers

Child care sites

Primary care physicians and clinics

Genetic counseling

Health and parenting education

Birth to Six Interagency Coordinating Council

Parent Support Groups

## Types of Agreements

<i>Type of Agreement</i>	<i>Description</i>	<i>Examples</i>	<i>When to Use</i>
1. Informal	A verbal commitment to work together on a specific project.	<ul style="list-style-type: none"> <li>▪ Workshop for parent advocates on group process.</li> <li>▪ Agree to send representative to Board Meeting.</li> <li>▪ Informal information and referral service.</li> <li>▪ Co-sponsor a workshop.</li> </ul>	<ul style="list-style-type: none"> <li>▪ For a one time exchange of service.</li> <li>▪ When specificity is neither necessary or desired.</li> <li>▪ Early stages of a possible working relationship.</li> <li>▪ For a specific event.</li> </ul>
2. Letter of agreement	A document, i.e., letter or memorandum, that describes a specific commitment between two or more parties.	<ul style="list-style-type: none"> <li>▪ Cooperative production of a brochure.</li> <li>▪ Memo about a meeting and issues identified for further attention.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Simple exchange of services.</li> <li>▪ Initial stages of linking to another agency to document progress.</li> </ul>
3. Formal Written Agreement	A document that is written to specify the exchange of goods or services and the procedures for making this exchange.	<ul style="list-style-type: none"> <li>▪ Describes services from Public Health Department.</li> <li>▪ Explains relationship to Neurodevelopmental Centers.</li> <li>▪ Defines communication procedures with Child Protection Services.</li> </ul>	<ul style="list-style-type: none"> <li>▪ With agencies where procedures are complex or not clear.</li> <li>▪ With agencies that offer a number of different services.</li> <li>▪ To spell out specifics of a new arrangement.</li> </ul>
4. Contract	A written agreement to supply goods or services at a fixed price.	<ul style="list-style-type: none"> <li>▪ Professional consultant.</li> <li>▪ Ongoing training program.</li> <li>▪ Individual therapy services.</li> </ul>	<ul style="list-style-type: none"> <li>▪ When money is exchanged for a service.</li> </ul>

Adapted from *Head Start Linkages*, Parents in Community Action, Inc., Minneapolis, Minn., 1983.

## **9663 Assessing the Need for Interagency Partnerships**

Agencies and communities can take the first steps toward improving outcomes for the children and families they service by asking themselves tough questions. The following inventory is presented to stimulate reflection and to assist organizations to make the case for change. We trust that the conversations begun by these inquiries will lead to action on behalf of more comprehensive services for children and families.

### **I. How are we doing on our own?**

1. Are the lives of the children, youth and families we serve improving? If not, why not?
2. Have we reassessed our mission recently in light of the overlapping economic, education, health, employment and social services needs of our clients?
3. Are services to clients well-integrated within our agency?
  - a. Do staff working with the same clients communicate frequently?
  - b. Do staff and clients work together to set personal and family goals?
  - c. Does our agency measure the impact of its services on the lives of children and families or do we simply tabulate the number of services we provide?
  - d. Do we offer preventive supports and services to help our clients avoid more serious problems?
  - e. Are our services organized in response to client needs or are the kinds of services we offer constrained by the limitations of available funding and administrative rules?

How well are we connected with other agencies offering services which our clients need?

- a. Do our line workers have effective working relationships with their counterparts in other agencies?
- b. When our clients are referred elsewhere for services are we kept informed of their progress and changing needs?

### **II. Do we need to change?**

1. How effective will we be in ten years if the needs of our client population continue to increase and we continue to do "business as usual"?
2. What resource limitations do we face in bringing more comprehensive services to our clients?
3. How might closer relationships with other agencies help us improve outcomes for the families we serve?

### **III. How ready are we to engage in interagency partnerships?**

1. Do the agencies serving children and families in our neighborhood, our school community, our city, our county, have a common vision of what they are trying to accomplish?
2. What is the history of cooperation and collaboration in our neighborhood, community, city/county? What lessons can we learn from past experience (or lack of it?)
3. Do we have close working relationships with the directors of other agencies that deliver services to the same clients? What do we know about other agency's current needs and priorities that might encourage them to discuss common problems and potential solutions on behalf of our clients?
4. Who are the leaders from outside the direct service community who are interested in the well-being of the community and who might take a leadership role in a collaborative effort or assist with the expansion and improvement of ongoing activities?
5. What are we willing to pay in terms of tangible resources and loss of unilateral control to formulate common goals with other agencies and to better serve our shared clients?

#### **9664 Guidelines for New Partners**

##### **INVOLVE ALL KEY PLAYERS**

Commitment to change must be broad-based and include all key players. In both service delivery and system level efforts, participation that involves representatives from appropriate levels of all the sectors and services necessary to achieve the initiative's goals and objectives is essential. Participants should include not only those with the power to negotiate change, but also representatives of the children and families whose lives will be affected by the results.

##### **CHOOSE A REALISTIC STRATEGY**

Partners need to choose an interagency strategy that accurately reflects the priorities of service providers, the public, and key policy makers, the availability of adequate resources, and local needs. In situations where potential partners are not yet ready to undertake the financial commitment and degree of change inherent in collaboration, a cooperative strategy to coordinate existing services is a realistic starting point. Down the road, the trust and sense of accomplishment built up in these initial efforts will make it easier for agencies to accept the greater risks and more ambitious goals of collaboration. By the same token, when conditions already bode well for change, partners who never move beyond cooperation toward collaboration waste resources and pass by an important window of opportunity.

##### **ESTABLISH A SHARED VISION**

Cooperative ventures are based on a recognition of shared clients. Collaborative partnerships must create a shared vision of better out-comes for the children and families they both serve. It will be far easier to agree on common goals and objectives if participants work to understand the issues, priorities, and perspectives that partners bring to the table and demonstrate a willingness to incorporate as many of these as possible.

## **AGREE TO DISAGREE IN THE PROCESS**

Participants need to establish a communication process that gives them permission to disagree and uses conflict and its resolution as a constructive means of moving forward. Interagency initiatives that circumvent issues about how, where, why, and by whom services should be delivered and resources allocated, in an effort to avoid turf issues and other conflicts, are likely to result in innocuous objectives that do little to improve the status quo.

## **MAKE PROMISES YOU CAN KEEP**

Setting attainable objectives, especially in the beginning, is necessary to create momentum and a sense of accomplishment. At the same time, sufficiently ambitious long-term goals will ensure that momentum is maintained.

## **"KEEP YOUR EYE ON THE PRIZE"**

It is easy for collaborative initiatives to become so bogged down in the difficulty of day-by-day operations and disagreements that they lose sight of the forest for the trees. Particularly in system level efforts, a leader from outside the direct service community who is committed to the goals of the initiatives and able to attract the attention of key players, policy makers, and potential funders can ensure that a sufficiently ambitious agenda is devised and stays on track.

## **BUILD OWNERSHIP AT ALL LEVELS**

The commitment to change must extend throughout the organizational structure of each participating agency. Include staff representatives in planning from the earliest possible moment and keep all staff members informed. In-service training should allow staff time to air feelings about proposed changes and identify the advantages changes are likely to bring. Cross-agency training is essential to provide staff with the specific information, technical skills, and abilities necessary to meet new expectations.

## **AVOID "RED HERRINGS"**

Partners should delay the resolution of the "technical difficulties" that impede the delivery of comprehensive services to shared clients until partners have: 1) had the opportunity to develop a shared vision and 2) assessed whether specific impediments result from policies and operating procedures that can be changed or from statutory regulations that must be maintained. The bulk of the differences that emerge usually result from misunderstandings or from policies that can be changed or otherwise accommodated. They should not be allowed to become "red herrings" that provide convenient excuses for partners who are not fully committed to working together.

## **INSTITUTIONALIZE CHANGE**

No matter how useful or well-designed, the net effect of interagency initiatives that are here today but gone tomorrow is minimal. If changes in programming, referral arrangements, co-location agreements, and other initiatives are to endure, both service delivery and system level efforts will need facilities, staff, and a continuing source of financial support. Participants must incorporate partnership objectives into their own institutional mandates and budgets and earmark the permanent flow of adequate resources to keep joint efforts up and running.

## PUBLICIZE YOUR SUCCESS

Interagency partnerships are a promising conduit for the large scale creation and delivery of comprehensive services to children and families, but, even when resources are reconfigured and used more wisely, current funding levels are insufficient to meet the level of need. Partnerships must demonstrate the ability to improve outcomes for children and families and express their success in future dollars saved and taxpayer cost avoided. Well-publicized results that consistently meet reasonable objectives will go far to attract the funding necessary to replicate and expand innovation.

### 9663 *Assessing the Need for Interagency Partnerships*

Formation	Conceptualization	Development	Implementation
Capable person selected to conceptualize and to provide leadership for a project of this scope	Written mission statement (discussed/agreed to in Formation)	Development of work groups/selection of chairs with adequate skills to facilitate and lead work groups	Meaningful interagency agreement developed which includes use of resources
Selection/recruitment/ approval of appropriate group members	Assessment of current systems, development of goals, objectives, and working strategies for change	Development of an adequate system of communication among work groups to facilitate successful completion of tasks, as well as input and ownership by the entire group	Policy changes made to eliminate former barriers to cooperative service delivery
Selection/recruitment/ approval of appropriate group members	Understanding and selection of a decision making model	Communication with key decision makers concerning essence of plan and get their approval	Attitudes of agency personnel more positive and cooperative
Selection of appropriate facilitator/leader for interagency group activities	Definition of tasks, roles, responsibilities, and timelines for planning changes	Work groups and large group productively working-raising issues and conflicts and resolving them	Services improved
Development of adequate structure for group to function and communicate with relevant decision makers and other groups	Development of a system of communication within work groups	Examination of all relevant agency policies/concerns concerning specific changes needed in policies, including interagency agreements	More children/families served
Development of a climate which encourages active participation and attendance	Determination of administrative structure for future interagency efforts and delivery of services	Plans are of the quality and adequacy to facilitate revising and/or expanding the system	Contacts and communication among agencies as expected bases on plans
Delineation and understanding of roles/responsibilities	Approval of plans by this group and by high level decision makers	Approval of plans by the group as a whole as well as key decision makers	Strategies selected to enhance interagency functioning are in place and working
Understanding and acceptance of level of group authority by membership and agency decision makers	Public awareness and support for group and the plan	Frequent communication and negotiation with work groups and large group	Those agencies and people who are supposed to participate/interact do so productively resolving conflicts as they arise
Members acquainted with one another and their	Active participation by membership and		

Formation programs	Conceptualization	Development	Implementation
Discussion of/knowledge of agreement to a global mission	development of a strong group identification Mechanism established for coordination with other groups with similar mission and target group		
Potential conflicts identified			

## 9700 Quality Assurance

There are several references which include standards and assessment tools related to the service system and the community agency's capacity to take a leadership role in its development. Some of these are listed below.

Enhancing Quality, Standards and Indicators of Quality Care of CSHCN, New England Serve, Chapter V: Guidelines for Community and Societal Supports. Provides guidelines and indicators that reflect community awareness of and support for children with special health care needs and their families and the degree to which they are integrated into community life.

Assessment Protocol for Excellence in Public Health (APEX/PH). Provides a process for organizational and community self-assessment and evaluation for local public health agencies. While the framework provided is intended to cover the broad spectrum of public health, it can be applied to and adapted for issues related to children with special health care needs and their families.

Model Standards: A Guide for Community Preventive Health Services. Section on Administrative and Supporting Services includes indicators on program evaluation, health planning and development, and consumer involvement and awareness. Section on Maternal and Child Health includes objectives and indicators regarding health status of this population, as well as the service system. Focuses on prevention and access to care.

Additional standards specific to community-based service systems for CSHCN are found in the Resource section.

### OTHER RESOURCES:

(to be developed)

## 9800 Policies

Agencies receiving MCH Block Grant funds through CFH (Office of Children With Special Health Care Needs) must use a portion of their allocated contract funds for activities that facilitate and promote the development and maintenance of a community-based system of services for children with special health care needs and their families.

Since contract funds are used for this purpose, appropriate local work methods (in the consolidated contract) or language in the statement of work must reflect these activities.

## **9900 Procedures**

The contract between the Department of Health (Office of Children With Special Health Care Needs) and the local agency provides the mechanism for receiving funds for use in service system development. The statement of work includes several methods that specifically address development of service delivery systems for children with special health care needs and their families. The contract application indicates whether these are required or optional and specifies reporting requirements. (See Section 7421 and Appendix 7000.)

# Section 1000 -Early Identification Services

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## **10100 Early Identification Services**

*This section continues to use a number of acronyms that are listed in the Appendices.*

This section contains **recommended guidelines** for Early Identification services. It should be noted that no one agency could provide all of the suggested Early Identification services. To develop a system of services similar to the one presented in this section, it would be necessary to coordinate and collaborate with families and other community providers.

## **10200 Responsibility of the CSHCN Program**

Title V programs that serve children with special health, nutritional, oral, or developmental needs have an important and evolving role to play in maximizing and coordinating existing community services. In cases where gaps in services are identified, the Title V agency should take a leadership role in facilitating community problem solving to address the unmet need. For more details about the leadership role and community and service system development, see Sections 1000 and 9000 of this manual. Examples of some of the roles that the Title V agency could assume in developing Early Identification services include:

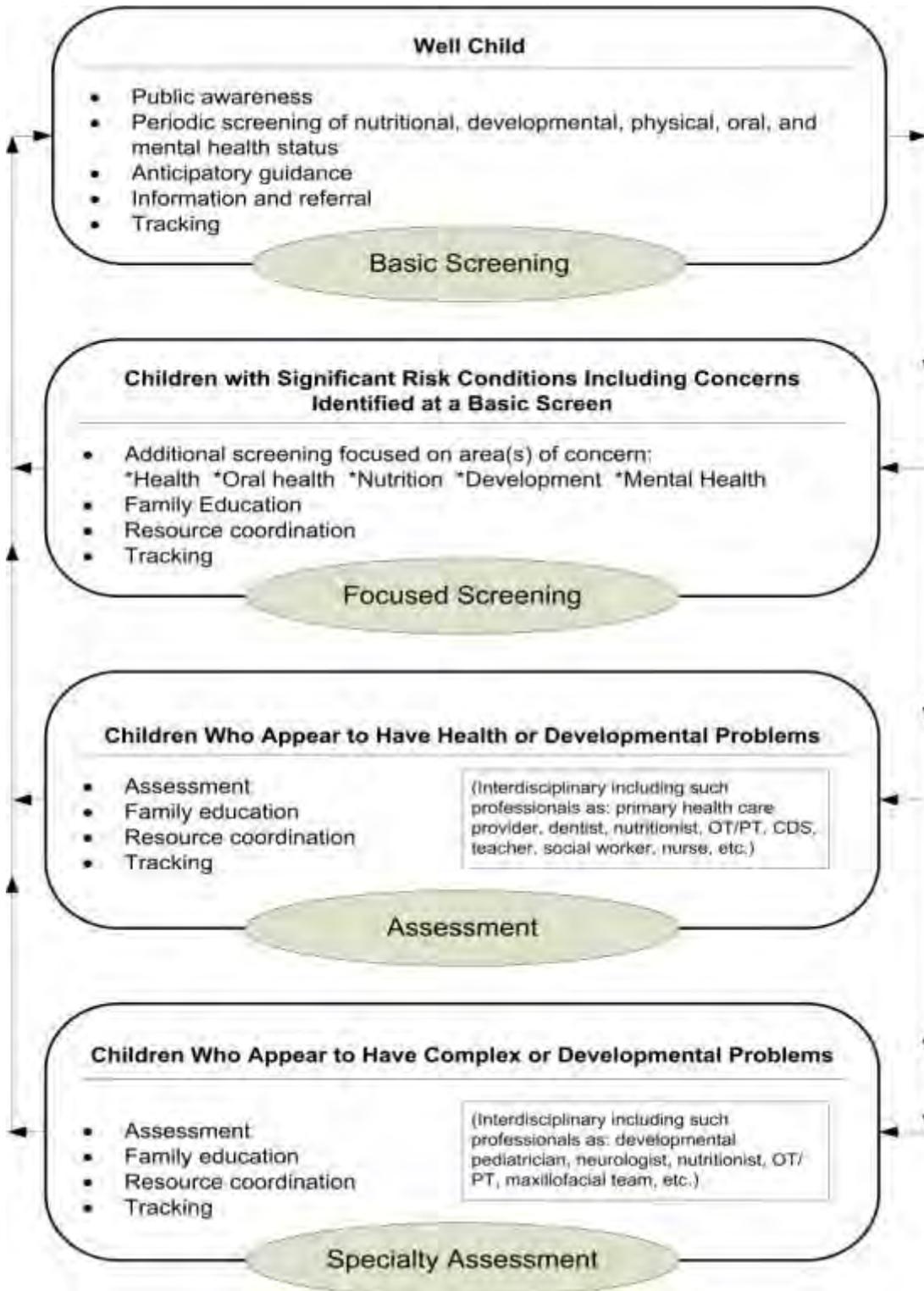
- working with families and other community providers to identify gaps and duplication in current Early Identification services;
- assisting and encouraging private providers, parents, child care providers, and others to identify and refer children who are at risk;
- providing Early Identification services through activities such as Well Child Clinics, WIC, and HPIT;
- assuring that currently available Early Identification services are family-centered, community-based, culturally competent, affordable, and effective.
- developing Early Identification services where the need exists

## **10300 The Purpose of Early Identification Services**

The purpose of Early Identification services is to identify those children who have or are at risk of having a poor nutritional, developmental, physical, oral or mental health outcome. This section describes four levels of Early Identification services:

- Basic Screening (Section 10131)
- Focused Screening (Section 10132)
- Assessment (Section 10133)
- Specialty Assessment (Section 10134)

## Early Identification Services



B. Woodward, CTR, MPH  
Washington State Department of Health

## **10310 Early Identification Services Model**

Please refer to the early identification services diagram on the previous page. The arrows in the margins describe the flow between the different service levels. If a problem is suspected, many children will progress from the basic screening level to a focused screening, and then if needed, on to assessment level services. However, it is just as likely that a child's problems may be readily apparent to the professional performing the basic screen and that a referral directly to an assessment or specialty assessment would be appropriate.

Decisions to refer for further screening or assessment should never be based solely upon the results of a screening or assessment tool. The results of the tool should always be accompanied by 1) parent concern, 2) health and developmental history, and 3) professional judgment.

The arrows in the left margin of the diagram depict the fact that a child should go back to the basic level of screening as part of ongoing primary health care. HPIT<sup>1</sup> can provide a tracking tool to assist children with, or at risk for, health or developmental problems to remain in primary health care.

## **10320 General Guidelines for Screenings and Assessments**

The following are general guidelines for all screening and assessment procedures. Screening and assessment processes should:

- incorporate parents' concern and perceptions of the child's development
- incorporate multiple sources of information (for example, parent report, medical records, screening tool)
- not be performed without informed consent of the parent
- be performed by persons trained in the appropriate testing procedures and in typical and atypical infant/child development
- use instruments as they are intended to be used, that are reliable and valid, and have a high predictive value
- be voluntary on the part of the family (unless court-ordered for the protection of the child)
- be communicated in the child and family's primary language and be culturally sensitive and relevant
- include discussion with the parents about the child's current and anticipated development
- take place within the family's community and in a setting that is comfortable for the child and family whenever possible
- consider the child and family's cultural background when interpreting the results<sup>1</sup>

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<sup>1</sup> *The analysis and interpretation of the results of any screening or assessment tool should be combined with knowledge about the child's cultural background. Few, if any, currently available tests have been adequately normed for children from minority cultural and racial backgrounds.*

## **10400 Basic Screening Level Services**

- Public Awareness
- Basic Screening
- Anticipatory Guidance/Family Education
- Information and Referral

### **10410 Public Awareness**

The purpose of an ongoing public awareness program is to increase the level of awareness in a community about the importance of early identification of children who may have a nutritional, developmental, physical, oral, or mental health problem. Information about community resources and services for these children should be readily available to families and service providers alike. Ultimately, the goal of a public awareness program is to make it easy for families to access services.

Ideally, a public awareness program should:

- be ongoing and varied in order to reach all target audiences, especially families
- provide information about nutrition, development, physical, oral, and mental health, including early warning signs of possible problems
- provide information about the early identification and early intervention services in the community

Some examples of a public awareness program include:

- the provision of educational or informational sessions for parents, child care providers, physicians, and other service providers
- public service announcements on television or radio
- resource guides with listings of telephone numbers and addresses
- handouts on child development for parents which list telephone numbers and addresses of resources in the community.

### **10420 Basic Screening of Nutritional, Developmental, Physical, Oral, and Mental Health Status**

The purpose of basic level screening of infants and children is to detect as early as possible specific problems or conditions and factors that increase the risk of poor outcomes. The purpose of early identification is to prevent the progression of a health or developmental problem by intervening as early as possible. Infants and children should be screened for problems or risk factors related to physical, oral, and mental health as well as nutrition, and development. Due to time constraints, generally none of these can be reviewed in great depth at the basic screen. The information gathered, however, can indicate the need for a more focused look at one or more of the health or developmental areas.

### **10421 Target Population**

The target population for basic screening are all infants and children, including children who are well and children with special needs. Well children are screened in order to detect conditions before the child develops sign or symptoms. Similarly, children with special needs must be screened for the same conditions, even though they may be experiencing a specific health or developmental problem. The American Academy of Pediatrics recommends that all children be screened at the following ages: birth; 2 weeks; 2, 4, 6, 9, 12, 15, and 18 months; 2, 3, 4, 5, and 6 years; and every other year thereafter.

### **10422 Guidelines**

Standards or guidelines for what is screened and how the screening is performed are available from several sources. The American Academy of Pediatrics' *Guidelines for Health Supervision* is a standard of practice in most communities. In addition, other agencies have published guidelines tailored to the needs of their community. The Washington State Department of Health, Community and Family Health, has printed *Child and Adolescent Health Screening Guidelines* for use by health departments and other health care providers in Washington. These guidelines recommend specific tools and methods for basic screening and are written as a companion to this manual.

If there are positive findings during the basic screening visit, the decision to refer for focused screening or assessment should be based upon:

- parent concern
- history, including high risk factors
- observation, screening exam, and tests
- professional judgement
- results of standardized developmental screening tool

### **10423 Providers**

Basic screening, ideally, should be provided by the primary health care provider, who may an advanced registered nurse practitioner, physician assistant, or physician, and in some settings, a specially trained registered nurse.

### **10424 Tools**

Some basic level developmental screening tools include the Infant Monitoring Questionnaire, the Developmental Profile, the Denver II and the CAT-CLAMS. (See the Resource section for a more complete list.)

### **10425 Funding**

Funding for basic screening is available from various sources. For children eligible for Medicaid, basic level screening is covered under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT/Healthy Kids) funding. Some private insurance companies will reimburse for this service. All health maintenance plans or organizations cover basic screening for children. For

families without one of these benefits, community clinics and local health departments offer screening which is funded through various state and federal sources, or available on a sliding fee scale.

### **10430 Anticipatory Guidance/Family Education**

The education/training component is probably the single most important aspect of an early identification program. With adequate information and support the family will be better able to foster a healthy developmental course for their child, prevent some of the adverse sequelae of high risk conditions, and possibly attenuate the early signs of a health or developmental problem.

The purpose of anticipatory guidance and family education at the Basic screening level of service is to educate families about developmental achievements expected in the coming months, risk factors to poor health, and ways to reduce risk and promote healthy growth and development. It is appropriate to prioritize topics and address only a few on a single visit. Priorities should be based on the following criteria:

- parent interest and concerns
- findings from the screening visit
- preventable causes of morbidity and mortality based on age and risk factors
- effectiveness of recommended prevention strategy
- developmental stages and strategies to support progress

Priority should be given first to areas of parent concern or interest. Secondly, the results of the screening of the child should determine areas for education. For example, if the child is experiencing sleep problems, this area should be addressed.

A third priority area for discussion are age-specific causes of preventable morbidity and mortality. For example, teaching the family of a four month old about choking prevention is more appropriate than teaching this family about bicycle safety.

A fourth priority issue is the effectiveness of the recommended prevention strategy. For example, the use of car seats and seat belts have been shown to reduce the risk of injury and death dramatically, in contrast to pedestrian safety curriculums whose gains have been less significant.

### **10431 Guidelines for Routine Anticipatory Guidance**

Anticipatory guidance should occur at every screening encounter, and is a requirement of EPSDT/Healthy Kids. The information and guidance provided to the family should include:

- feedback about what the family is doing well (for example, positive parent-child interaction, good questions and observations by family, helpful strategies already used by family)
- descriptions of the anticipated developmental stages and the potential impact on the family
- recommended responses to anticipated behaviors

- suggestions for developmentally-appropriate experiences and activities that promote healthy growth and development
- recommendations for the date of the next health screening visit and immunizations

**10432 Guidelines for Anticipatory Guidance When Adverse Health Conditions Exist**

When specific risk factors or health problems are identified during the screening visit it is essential to discuss them with the family. Health education should be provided and may include:

- information about the specific health or developmental concern and strategies to reduce risk factors. For example, for a family of a 4 month old infant who is not gaining weight, who turns away from the bottle, and who falls asleep frequently during feeding, information might include:
  - acknowledgement about how frustrating and worrisome this is,
  - appropriate foods/beverages and amounts necessary
  - information on how to prepare formula appropriately
  - recognizing stages of development indicating readiness for progression in feeding behavior and appropriate foods and textures to match developmental readiness
  - the value of knowing when an infant is ready to eat (i.e., infant state of wakefulness) and ways to recognize cues of hunger and satiation
  - the importance of positioning the infant for the caregiver's and infant's comfort and ability to make eye contact and respond to each others' cues.
- information related to family members' concerns (for example, the family may be getting conflicting advice from relatives or friends) and
- follow-up recommendations and possible referral for follow-up of the health or developmental concern

<b>10440 Information and Referral</b>
---------------------------------------

The purpose of a well-administered information and referral component of the early identification system is to promote informed decision making by helping families find out about and access services which may enable them to optimally support their child.

It is most effective to provide critical information during the screening visit. Parents of all infants and children seen for basic screening should be provided information about resources relevant to their indicated concerns, needs, and interests. In addition, resource information related to identified health or developmental concerns, the role of other professionals, and information about parent support and financial assistance can also be offered at this time if appropriate. With this information, the family is better able to understand the child's risk factors and/or health or

developmental concern, and make informed decisions about accessing resources. Referral to resources the family desires and information about how to access a service is also needed. Written resource lists or brochures are helpful for families to take home for future reference.

Information and referral services are usually provided by the professional administering the screening. In some settings social workers, family resource coordinators, or assistants may provide the service.

## **10441 Resources**

The ability to provide information and referral services requires a commitment to keeping abreast of available community resources. Many Washington communities now have telephone information and referral services for child care, social services and/or health care providers. Parent crisis lines are usually available locally. In addition, there are some statewide toll-free numbers for accessing information including:

IFRC (Interim Family Resources Coordinator) for a developmental concern

Healthy Mothers/Healthy Babies

Pregnancy Information Line 1-800-322-2588

Medicaid 1-800-562-3022

WIC 1-800-841-1410

Basic Health Plan 1-800-826-2444

Domestic Violence Hotline 1-800-562-6025

Food Stamp Hotline 1-800-882-5333

The *Regional Resource Directory for People with Developmental Disabilities and their Families* was developed by the Birth to Six State Planning Project and the Division of Developmental Disabilities. A copy is located at your local DSHS Community Service Office and Region Developmental Disabilities Field service Office.

### **10442 Characteristics of an Effective Information and Referral System**

Both families and professionals benefit when communities develop a comprehensive information and referral system. Ideally, a community's information and referral system should:

- be well publicized and accessible;
- include information about available social, health and developmental services, such as child care programs, parent support/education programs, crisis lines, and specialty and primary care providers;
- be continually updated;
- be available at no cost to families.

## 10500 Focused Screening Level Services

### Focused Screening

- health
- oral health
- mental health
- nutrition
- development

### Tracking

- Anticipatory Guidance/Family Education
- Resource Coordination

**Focused Screening** services are intended to:

- gather additional information regarding the child's nutritional, developmental, physical, oral, and mental health status;
- provide ongoing surveillance of a child's status and progress with special attention to areas for which a concern exists;
- prevent the adverse sequelae of untreated high risk conditions through early detection and family education.

Focused screening services are appropriate for children for whom there is an indication of a possible problem identified at a basic screen. The professional providing the basic screen may feel that the presenting problem(s) are not severe enough to warrant a referral for an assessment, but that a more thorough focused screen to gather additional information about a specific area of concern may be beneficial to the child and family. The consulting professionals can help the family with the presenting problem(s) and assist the basic screener to determine if and when the child may need a referral for an assessment and intervention services.

Focused screenings should be available as needed, and can be provided on a periodic basis as a means of monitoring or re-checking a nutritional, developmental, physical, oral, or mental health concern.

Focused screenings should be professionally-administered, optimally using the services of the professional(s) most closely related to the area(s) of concern. These professionals may be in private practice in the community, at local school districts, Developmental Disability Centers or Neurodevelopmental Centers, hospitals, public health departments, or community or Indian health clinics.

Depending upon the training of the primary health care provider, and with time permitting, the basic and focused screen could take place at the same visit. An example of where this might happen would be a child who presents with indication of a developmental delay and some

unusual physical findings. The provider may suspect that a syndrome may be the reason for these findings and begin a more indepth genetic history of the family. This additional information added to the basic screen results assists the provider in determining whether a referral to a geneticist would be appropriate.

## **10510 Focused Nursing Screening**

The purpose of nursing screening is to identify a child's possible health problems and family strengths, concerns, priorities, and resources. The ultimate goal of nursing screening is to identify problems as early as possible and to determine interventions that will be most effective.

### **10511 Target Population**

A focused nursing screening should be considered for infants, children, and adolescents who have been identified with possible health or developmental problems during a basic screening.

### **10512 Guidelines**

Nursing screening expands upon information collected in the basic screen so that at least cursory information is collected in each of the functional health patterns. Functional health patterns include:

- health perception and health management practices
- nutritional needs and metabolic functioning
- activity, exercise and self-help
- elimination patterns
- cognitive/perceptual functioning
- roles, relationships and social supports
- coping and stress responses
- self-perception/self-concept
- sleep/rest patterns and needs
- sexuality/reproductive functioning
- family values and beliefs

Included in the information collected in the eleven functional health patterns are observations of parent-child interaction. Parent-child interaction reflects the nature of the child's on-going environment. Environmental factors are important in determining child health and developmental outcomes. Observing parent-child interaction involves 1) looking at the child's ability to produce clear cues and respond to her/his care giver, and 2) parent ability to recognize the child's cues, respond, alleviate distress, and provide the child with growth fostering situations.

Upon completion of the screen, the nurse, child and family have identified the family's concerns, priorities and resources related to the focused screen. This creates an initial data base and establishes the beginning of a parent-professional partnership. Specific interventions might include:

- referring the child/family back to the basic screener for routine health care;
- monitoring health patterns;
- gathering additional information in health patterns where possible health problems have been identified (this will begin the nursing assessment process);
- discussing identified areas of concern and areas of strength;
- identifying professional providers and helping the family understand the role and/or value of additional screening or assessment by other professionals;
- referring the child to others for screening and/or assessment; and
- sharing information about family support and financial resources.

### **10513 Providers**

Focused nursing screening is provided by public health nurses and/or other registered nurses who have training and experience in nursing screening.

### **10514 Tools**

The Region X Child Health Standard Screen is a tool which facilitates completion of a nursing screen. Nursing Child Assessment Satellite Training (NCAST) tools are specific for assessment of parent-child interaction. Nurses trained to use NCAST tools may incorporate concepts from these tools as they gather information for the nursing screen. The nurse will use NCAST tools, as they were designed to be used, as she moves from nursing screening to nursing assessment. Use of an ecomap or a tool such as the Family Network Survey will help the nurse and family identify existing sources of support.

### **10515 Funding**

Information related to funding for nursing screening is described in Section 10615.

<b>10520 Focused Dental Screening</b>
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The purpose of focused dental screening is to identify potential oral and or maxillofacial problems.

#### **10521 Target Population**

Infants and children who have been identified with possible dental or oral problems should have a focused dental screening.

#### **10522 Guidelines**

A focused dental screening should include:

- Intra-oral screening
- A visual inspection of the oral cavity is conducted. Soft and hard tissues are inspected to observe growth and developmental delay patterns. Retarded eruption of teeth, severe

periodontal disease, cleft lip and palate, severe malocclusion, gross speech behaviors such as tongue thrust, malformation of enamel, are noted for referral to other professionals.

- Extra-oral screening
- A visual inspection of the face and jaws is conducted. Facial deformities, macro or micro gnathic conditions, cleft lip, gross speech patterns are noted for referral to other professionals.

### **10523 Providers**

The screen should be completed by a dental hygienist.

### **10524 Tools**

Screening tools include the American Dental Association Guidelines for Oral Health Screening.

### **10525 Funding**

Funding for focused dental screenings is available through Medicaid or private insurance.

<b>10530 Focused Nutritional Screening</b>
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The purpose of a focused nutritional screening is to further evaluate children identified as having or at risk for developing a feeding or nutrition problem. Once a nutrition concern has been identified, during a basic screening, the child can be referred to a registered/certified dietitian for the more thorough focused nutritional screening.

### **10531 Target Population**

A focused nutritional screening is appropriate for children for whom a significant nutritional risk condition has been identified at a basic screening. For example, a child who is diagnosed with baby bottle tooth decay might benefit from a referral for a focused nutritional screen. In addition, a focused nutritional screening may be appropriate when common nutritional concerns can not be adequately addressed during the basic screen.

A focused nutritional screening should be available as needed and can be provided on a periodic basis as a means of monitoring a nutritional or feeding concern.

### **10532 Guidelines**

A focused nutritional screening involves the collection of data from one or more of the following categories:

- anthropometric
- clinical,
- biochemical,
- dietary,

- socioeconomical,
- developmental (related to feeding skills), and
- behavioral (related to feeding).

A major component of the focused nutritional screening may be the provision of education to the child and/or family. As information collected during a focused nutritional screening may be similar to that collected during a nutritional assessment. Please refer to the Nutritional Assessment section for a more thorough description of this process.

### **10533 Providers**

A focused nutritional screening should be provided by a registered/certified dietitian.

### **10534 Tools**

Examples of focused screening forms can be found in the Resource section.

### **10535 Funding**

Funding sources for a focused nutritional screening include EPSDT funds, CSHCN treatment dollars, and private insurance.

<b>10540      Focused Developmental Screening</b>
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The primary purpose of focused developmental screening is to assist the basic screener and family to determine, at an early stage, whether the child may have a developmental disorder. Of equal importance is the provision of guidance to the family to assist them in encouraging their child's optimal development and prevent subsequent developmental delays.

### **10541 Target Population**

Focused developmental screening should be available to children who appear to have some early signs of a possible developmental problem.

### **10542 Guidelines**

Focused developmental screening procedures should include:

- a formal method of eliciting parent's concern and perceptions of their child's development,
- a review of developmental history,
- a review of health and social histories,
- observation of the child's behavior and appearance,
- an examination of orthopedic status (age-appropriate),
- an examination of reflex behavior and muscle tone (age-appropriate),
- a review of eating practices and feeding behaviors if feeding has been identified as an area of concern,

- the administration of a standardized developmental screening tool,
- the measurement of the motor domain of development that includes the evaluation of the quality of movement as well as the determination of milestone achievement,
- the determination of the child's ability to hear and his or her functional communication skills when screening for language problems.

### **10543 Providers**

Focused developmental screenings can be provided by professionals from several disciplines, including occupational and physical therapists, physicians, communication disorders specialists (CDS), and early childhood special educators. The developmental area(s) of concern dictate the developmental specialist that should be consulted. For example, if motor appears to be a concern, an occupational or physical therapist should provide the focused developmental screening.<sup>2</sup>

### **10544 Tools**

Appropriate focused developmental screening tools include the Motor Assessment for Infants (MAI) screening tool, Infant Motor Screen, Early Language Milestones (ELM), and the Gesell Developmental Inventory. For a more complete listing, see the Resource section.

### **10545 Funding**

Funding for focused developmental screening services is available through Title XIX Healthy Kids Program for Medicaid-eligible children. CSHCN funds can also support focused screening services. Local school districts are mandated to provide Childfind services, although there are few guidelines to that requirement. They, as well as other local providers of early intervention, may be interested in collaborating to provide focused screening and assessment services.

<b>10550</b>	<b>Tracking</b>
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The purpose of a tracking system is to: 1) assist families to maintain their child in ongoing health care; 2) facilitate the early identification of potential developmental or health disorders; and 3) assist local and state health, education and social service agencies to plan for future service needs.

### **10551 HPIT**

In counties where the High Priority Infant Tracking (HPIT) program is available, infants may be enrolled in the tracking program if:

- the family agrees to have their child tracked, and
- the child has one or more significant risk conditions (environmental, biological, or established).

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<sup>2</sup> *It is important that all focused screeners have knowledge and experience in pediatrics. Occupational and physical therapists, in most cases, function similarly in the pediatric setting. For further information about the roles of occupational and physical therapists, see the Resource section.*

The HPIT program is designed to track all children with risk factors in a county, and it receives referrals from numerous sources (for complete information on HPIT refer to the HPIT Reference Guide).

### **10552 Alternative Methods of Tracking**

Individual agencies or health care providers will benefit from developing their own tracking system to monitor a child's care. The tracking system will provide information about the outcome of a referral. It is helpful to keep a copy of the referral form in the child's chart, and request the professional to whom the client was referred to return a copy with the diagnosis and outcome. This could be used with a tickler file which reminds the screener to contact the client and/or professional if the referral form is not returned in the expected time frame.

The CHIF (Child Health Intake Form—refer to section 5200 for specific information about CHIF and its required use) can be used as a tool for tracking. The CHIF must be renewed annually. Used in conjunction with a tickler file, the CHIF will provide a reminder to check back with the family. This would be especially useful for children/families who receive only periodic services from the CSHCN agency. For example, information about services and support a child/family is receiving may be obtained through a telephone call to the family at the time a CHIF needs to be renewed. The CHIF would not need to be renewed if the child is no longer receiving any services from the local CSHCN agency. The CHIF would have served as an aid in tracking and validating this information.

## **10560 Anticipatory Guidance/Family Education**

The purpose of anticipatory guidance and family education/training at the Focused screening level is to inform families about significant risk factors, identified health or developmental problems, and learn about resources which may help. As noted previously, this education component is critical for families to find out about their child's needs, how to promote growth and development, and/or prevent adverse sequelae. The educational component is also influential in the on-going development of the parent-professional relationship. It is important to remember that, at this level of service, families may not have much knowledge or experience with health or developmental risk factors or problems, the specific roles of health care professionals, or available resources.

### **10561 Anticipatory Guidance Specific to an Area of Concern**

Information and guidance specific to an area of concern should include information about the results of the focused screen and how results from this screen relate to findings and concerns identified on the basic screen.

For example, if a health or developmental concern identified during a basic screen was ruled out, the family should know why and understand what kind of health care is indicated for their child.

If the health or developmental concern warrants monitoring, but no further assessment, the family should know why and what 'monitoring' means (i.e., how often the child should be seen and by whom). It is important for the family to understand and be comfortable with the idea of monitoring so they will know they are getting what they need at this time.

If additional screening or assessment is indicated, the family needs to know what the assessment entails, who can do it, and what resources are available.

- suggestions for developmentally-appropriate experiences and activities to promote the child's growth and development.
- information on strategies to reduce factors that put the child at risk for poor health, nutritional, and developmental outcomes.
- instructions on specific methods of handling and care that address the identified area of concern.
- information related to family feelings and responses. The family should know that their feelings and responses are normal and are important in the care of their child.
- information about available services including those for therapeutic intervention, parent support, and financial assistance. Information about how to access these services is also indicated (see Resource Coordination).
- information about the value of sharing and coordinating information among all services.

## **10570 Resource Coordination**

Resource coordination activities incorporate and expand activities included in the information and referral component of the Basic screen level of service.

The purpose of resource coordination, at the focused screening level, is to promote positive child and family outcomes by helping families get the services they need. The family is provided with information about services and assisted in gaining timely access to services. In addition, effective and efficient communication and coordination of activities among all resources is promoted.

Resource coordination activities should be available to all families who have been involved in a focused screen and when families become involved with several services.

### **10571 Resource Coordination Guidelines**

Some resource coordination activities include:

- discussion with the family about available resources. This discussion includes reviewing and expanding upon information the family received previously.
- referring the child/family to resources  
For example, some children will need only Well Child care and will be referred back to the basic screener. For others, an interdisciplinary assessment may be indicated. In this case the child may be referred to a Neurodevelopmental Center or to a specific clinic in a Tertiary Care Center. In addition, the family may want services for family support and/or financial assistance.
- assisting the family and helping them understand how to communicate with and access resources
- working to coordinate roles and activities of all resources, including the family

- follow-up on referrals and re-screening, if necessary

### **10572 Providers of Resource Coordination**

Resource coordination activities are frequently performed by a professional involved in the focused screen (eg., public health nurse, nutritionist, occupational therapist), or others such as social workers, Interim Family Resource Coordinators, or assistants. Clear, direct, and reciprocal communication among all resources, including the family, is essential. A process for communication should be established and roles of all participants identified. A lead person should be named to assume overall responsibility for resource coordination.

## **10600 Assessment Level Services**

- Assessment
- Family Education
- Resource Coordination

The purpose of an assessment is to determine the presence and extent of a nutritional, developmental, physical, oral, or mental health disorder. Assessment services should be available to all children when the results of a basic or focused screening examination are **indicative** of a problem.

Assessments should be interdisciplinary, involving the services of such professionals as occupational or physical therapists, nurses, physicians, special educators, dentists, social workers, and nutritionists. Assessment services should be available to the family on a timely basis.

### **10610 Nursing Assessment**

The purpose of nursing assessment is to identify and/or validate a child's human response to potential or actual health problems as well as family strengths, concerns, priorities and resources. Nursing assessment data enables the nurse and family to identify appropriate goals and interventions and develop a plan of care.

#### **10611 Target Population**

Any infant, child, or adolescent for whom possible health problems have been identified on a basic or focused screen and those children identified with health or developmental problems by others should be considered for a nursing assessment.

#### **10612 Guidelines**

Nursing assessment is an on-going process and an in-depth collection of health information over time. The data base from a nursing screen is expanded to include more information from all or selected health patterns. Data are collected through multiple sources of information (eg., individual family members, professionals), by multiple methods (eg., interview, questionnaires, observation, records, screening and assessment tools), and in multiple settings (eg., clinic, home,

school). This assures a variety of perspectives and promotes accurate identification of health information.

### **10613 Providers**

Nursing assessments are completed by public health nurses and other registered nurses who have training and experience in nursing screening and assessment. Content within the assessment will vary depending upon nurses' education, skill, and experience.

### **10614 Tools**

Assessment tools/protocols such as the Region X Child Health Standards, NCAST, NSTEP-P, Nursing Standards for Children with Special Health Care Needs, and tools which identify family resources and assess family functioning (eg., Family Network Survey, Coping Health Inventory for Parents, Family Inventory of Life Events and Changes) are valuable in completing a nursing assessment for children with special health care needs. More examples of nursing screening and assessment tools are available in the Resource section.

### **10615 Funding**

Information related to funding nursing assessment is described in section 7000.

<b>10620      Dental Assessment</b>
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The purpose of an oro-facial assessment is to determine the presence and extent of dental as well as oro-facial problems.

### **10621 Target Population**

Assessment services should be available to all children identified through basic or focused screening with probable oral or maxillofacial problems.

### **10622 Guidelines**

Assessment should include intra- and extra-oral examinations. These should include examination of soft and hard tissues of the mouth for caries as well as for growth and developmental problems. Retarded eruption of teeth, periodontal and orthodontic problems, and speech patterns should be assessed for follow-up.

### **10623 Providers**

The assessment is completed by a dentist.

### **10624 Tools**

Screening tools include the American Dental Association Guidelines.

### **10625 Funding**

Funding is provided through Medicaid or private insurance.

## **10630 Nutrition Assessment**

The purpose of a nutritional assessment is to provide a comprehensive and detailed examination of a child's nutritional status. A nutritional assessment serves to rule out or confirm the presence of a feeding or nutrition problem.

### **10631 Target Population**

Children with identified nutritional risks or those with documented nutrition related health problems should be referred to a registered/certified dietitian for a nutritional assessment. For example, a referral for a nutritional assessment would be appropriate for a child who presents at a basic screening with a weight for height greater than the 95th percentile or a weight for length less than the 5th percentile, on NCHS growth grids. Children presenting with the above concerns warrant a comprehensive assessment of their nutritional status.

### **10632 Guidelines**

A nutrition assessment consists of the collection and evaluation of data from the following categories as appropriate:

#### *Anthropometric*

Measure and plot on the appropriate growth chart:

- height or length for age
- weight for age
- weight for height or length
- head circumference (below three years of age)

Measure (if appropriate):

- triceps skinfold
- mid-upper arm circumference
- subscapular skinfold

Calculate

- arm muscle area
- arm fat area

Compare current measures to reference data and previous measurements.

#### *Clinical*

Obtain pertinent health history information from client/caregiver. Pertinent information may include:

- perinatal history

- family health history
- family growth history
- client growth history
- caregiver concerns about child
- reason for referral—who referred child and the concerns
- client health history

Review medical records to obtain health history and present medical conditions and diagnoses and treatment plans.

#### *Biochemical*

Review pertinent laboratory data from medical records. Order further laboratory work as indicated by anthropometric, clinical, and dietary data.

#### *Dietary*

Assess present dietary intake. A variety of methods may be used to collect dietary intake information, including the following:

- three- to seven-day food records,
- 24-hour dietary recall, or
- food frequency method.

#### *Developmental (Feeding Skills) and Behavioral*

Complete a feeding history by interviewing caregiver and/or client and reviewing medical records. If possible, observe while the child is eating. When there are oral/motor concerns, an occupational or speech therapist should be consulted.

#### *Socioeconomic*

Obtain information from the caregiver and/or client regarding the following:

- family size and composition,
- food resources,
- family concerns and problems, and
- educational level.

### **10633 Providers**

Nutrition assessments should be provided by registered/certified dietitians.

## **10634 Tools**

For examples of nutrition assessment forms, see the Resource section.

## **10635 Funding**

Funding sources for nutritional assessments include Medicaid and CSHCN funds.

<b>10640</b>	<b>Developmental Assessment</b>
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The purpose of a developmental assessment is to determine the presence and extent of a developmental delay or condition.

### **10641 Target Population**

Assessment services should be available to all children when there is an indication of a developmental delay or condition identified through a basic or focused level screen.

### **10642 Guidelines**

Developmental assessments should:

- include a formal method of eliciting the parent's concern and perception of their child's development;
- include a review of the child's developmental history;
- incorporate multiple sources of information, including a review of pertinent records related to the child's health status and medical condition, vision and hearing, nutrition and growth parameters
- be communicated in the child's typical mode of communication and primary language, with regard to the family's racial and ethnic background;
- be provided by an interdisciplinary team comprised of appropriately qualified professionals having expertise and knowledge in the area of child development;
- include professional's informed clinical opinion based upon observation of the child's behavior in formal and informal settings;
- be interpreted with regard to the child's ability to meet the physical, sensory, behavioral, and language demands of the testing situation. (for example, when testing a child who has cerebral palsy, items on the test may need to be modified in order that his motor impairment does not obscure his real abilities in non-motor related items);
- include the administration of a standardized, assessment tool addressing all developmental areas;
- include the measurement of the motor domain of development for the quality of movement, reflex behavior, orthopedic status, muscle tone, and sensorimotor functioning, if age appropriate;
- include a speech and language assessment that evaluates the child's hearing and functional communication skills.
- include a medical examination.

### **0643 Providers**

Developmental assessments should be multidisciplinary or interdisciplinary and include the services of the professional(s) most closely related to the child's developmental area(s) of concern.

### **10644 Tools**

Some of the recommended developmental assessment tools include the Bayley Scales of Infant Development, the Motor Assessment of Infants, the Battelle Developmental Inventory, and the McCarthy Scales of Children's Abilities. For others, see the Resource section.

### **10645 Funding**

The costs of assessment services can be supported by Medicaid and CSHCN for those children meeting the respective eligibility guidelines for the two programs. Reimbursement may also be available through private insurance providers. Developmental assessments may be available through some local school districts, at no cost.

<b>10650</b>	<b>Anticipatory Guidance/Family Education</b>
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The purpose of anticipatory guidance and family education at the assessment level of services is to help families understand the health or developmental problem being assessed. An additional purpose is to help families understand and cope with their own thoughts and feelings related to the child's health or developmental concern.

It is well known that the impact of the diagnosis of a special health or developmental need is a powerful stressor for families. It is important to remember that the assessment process is also stressful for families. In addition to the unfamiliarity of the assessment process and people involved, the family often fears that concerns about their child will be validated. Information and support are critical at this time.

All children and families involved in an interdisciplinary assessment should be provided information before, during and at the conclusion of the assessment.

### **10651 Pre-Assessment Family Education Guidelines**

Guidance provided before the assessment should include:

- information about how identified concerns will be assessed
- information about who will perform each assessment
- information about how parents participate in the assessment

Guidance provided during each assessment should include:

- an explanation about the process and procedures used
- preliminary feedback about parent concerns, observations, and strategies they use with the child

- preliminary feedback related to professional observations

### **10652 Post-Assessment Family Education Guidelines**

Guidance provided after all assessments are completed should include:

- a discussion about the results of each assessment
- a discussion about the relationship of problems identified. For example, an infant assessed for a feeding problem may have feeding difficulty due to low tone. His feeding problem may influence his nutritional status and could also influence the quality of parent-child interaction.
- more information about specific services, how to access them, and role(s) of professionals involved
- elaboration about the need for coordination of information between the family and all resources
- recommendations regarding the need for continual screening or assessment of child/family strengths, concerns, and family resources and priorities.
- information related to family feelings and responses and the impact of the child's diagnosis on the family
- information about the family's partnership with professionals and family decision making. The assessment process frequently results in the development of an Individual Family Service Plan (IFSP). It is essential that the family understand this process and their role in developing and maintaining the plan.

### **10660 Resource Coordination**

The purpose of resource coordination, at the assessment level of services, is to assure the family's timely access to services, promote information sharing and effective and efficient communication and to insure on-going screening and/or assessment of the child/family's needs concerns, priorities and resources.

Families of children who have been involved in the assessment process and those for whom an IFSP has been written should have resource coordination services.

Family resource coordination activities at the Assessment level of service are similar to those described in the Focused screening level of service. As noted previously, an Individualized Family Service Plan (IFSP) is frequently developed as a result of an interdisciplinary assessment. This plan should include activities for coordinating information between the family and all resources. The plan should also identify a lead person to assume responsibility for resource coordination.

### **10700 Specialty Assessments**

- Specialty Assessments

- Family Education
- Resource Coordination

The purpose of specialty assessments is to determine the presence and extent of a complex nutritional, developmental, physical, oral, or mental health disorder and its etiology.

### **10710 Providers**

These services are appropriate for children who appear to have a condition that is complex in nature and requires the expertise of professionals such as geneticists, pediatric neurologists, orthopedists, and other medical specialists. In addition, other professionals such as nutritionists, psychologists, social workers, therapists, and nurses frequently comprise the specialty team. These services are not available in many communities and often must be obtained through such facilities as the Child Development and Mental Retardation Center (CDMRC) at the University of Washington and tertiary care centers such as Children's Hospital and Medical Center.

### **10720 Tools**

Frequently the assessments that are performed are complex and require special technology. An example is a child who is experiencing feeding problems. A specialty assessment may include the use of video-fluoroscopy to view the oral mechanism and the pharyngeal phases of swallowing to rule out aspiration during oral feedings.

### **10730 Funding**

Funding for these services is available through the Medicaid and CSHCN programs and other third party reimbursement sources.

## **10800 Outcomes of a Well-Coordinated Early Identification System**

A well coordinated early identification system will have positive outcomes for families, communities, and service providers. Some potential outcomes include:

- Families who have concerns about their child's health, nutrition, or development can easily identify and access information and assistance.
- Community service providers, (for example, physicians, child care providers, social workers) will understand where and how to obtain early identification services.
- Families who have a child who is at risk for a poor health, nutritional, or developmental outcome will have the opportunity to receive tracking services to help them maintain their child in ongoing health care.
- Children will be able to receive periodic nutritional, developmental, physical, oral, and mental health screenings to facilitate the early identification of a potential problem.

## APPENDICES

Commonly Used Web Sites

CSHCN Acronyms

CSHCN Coordinators

CSHCN Maxillofacial Teams

CSHCN Neurodevelopmental Centers of Washington

CSHCN Regions Map

Organizational Charts:

Department of Health

Division of Prevention and Community Health

Office of Healthy Communities

Access, Systems and Coordination Section

Healthy Starts and Transitions Unit (includes Children with

Special Health Care Needs Program)

Parent Support Programs:

Washington State Fathers Network

<http://www.fathersnetwork.org>

Washington State Parent to Parent

[http://www.arcwa.org/getsupport/parent\\_to\\_parent\\_p2p\\_programs](http://www.arcwa.org/getsupport/parent_to_parent_p2p_programs)

Send appendices updates and changes to:

Children with Special Health Care Needs Program

PO Box 47880

Olympia WA 98504-7880

360-236-3571

FAX: 360-586-7868

Email: [CSHCN.Support@doh.wa.gov](mailto:CSHCN.Support@doh.wa.gov)

## Commonly Used Web Sites

Web site addresses and links to external resources are provided as a public service and do not imply endorsement by the Washington State Department of Health.

This is not a complete list of entities noted in the CSHCN Manual.  
Web site address and links are subject to change.

### CSHCN Program:

<http://www.doh.wa.gov/YouandYourFamily/InfantsChildrenandTeens/HealthandSafety/ChildrenwithSpecialHealthCareNeeds.aspx>

The CSHCN Program web site includes categories for:

- Current Collaborative Activities
- Our Partners
- CSHCN Publications
- Referrals for Services
- Autism

### CSHCN Manual and Orientation Notebook:

<http://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/PublicHealthSystemResourcesandServices/Funding/ConsolidatedContracts/FormsReportsandProgramInformation.aspx>

### CSHCN County and State Specific Data:

<http://www.doh.wa.gov/DataandStatisticalReports/DiseasesandChronicConditions/ChildrenwithSpecialHealthCareNeeds.aspx>

### Section 1000

ADA	<a href="http://www.ada.gov/">http://www.ada.gov/</a>
DHHS	<a href="http://www.hhs.gov/about/">http://www.hhs.gov/about/</a>
IDEA	<a href="http://idea.ed.gov/">http://idea.ed.gov/</a>
Healthy People 2010	<a href="http://healthypeople.gov/">http://healthypeople.gov/</a>
HRSA (U.S. DHHS)	<a href="http://www.hrsa.gov/">http://www.hrsa.gov/</a>
MCHB	<a href="http://www.mchb.hrsa.gov/">http://www.mchb.hrsa.gov/</a>
Title V	<a href="http://mchb.hrsa.gov/programs/">http://mchb.hrsa.gov/programs/</a>

### Section 2000

Revised Code of Washington	<a href="http://apps.leg.wa.gov/rcw/">http://apps.leg.wa.gov/rcw/</a>
Washington Administrative Code	<a href="http://apps.leg.wa.gov/wac/">http://apps.leg.wa.gov/wac/</a>
Washington State Legislative Home Page	<a href="http://www.leg.wa.gov/legislature">http://www.leg.wa.gov/legislature</a>

### Section 3000

DOH	<a href="http://www.doh.wa.gov">http://www.doh.wa.gov</a>
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LHJ

<http://www.doh.wa.gov/AboutUs/PublicHealthSystem/LocalHealthJurisdictions.aspx>

### **Section 4000**

WIC Nutrition Program

<http://www.doh.wa.gov/YouandYourFamily/WIC.aspx>

Health Care Authority

<http://www.hca.wa.gov/Pages/index.aspx>

<http://www.hca.wa.gov/medicaid/Pages/index.aspx>

<http://wahbexchange.org/news-resources/calculate-your-costs>

DOH Health Professionals

<http://www.doh.wa.gov/AboutUs/ProgramsandServices/HealthSystemsQualityAssurance.aspx>

### **Section 5000**

Health Care Authority

<http://www.hca.wa.gov/Pages/index.aspx>

<http://www.hca.wa.gov/medicaid/Pages/index.aspx>

Newborn Screening

<http://www.doh.wa.gov/YouandYourFamily/InfantsChildrenandTeens/NewbornScreening.aspx>

Disabilities Determination Services

<http://www.dshs.wa.gov/dds/>

Social Security Administration

<http://www.socialsecurity.gov/>

Supplemental Security Income

<http://www.ssa.gov/ssi/text-understanding-ssi.htm>

### **Section 6000**

Washington Administrative Code

<http://apps.leg.wa.gov/wac/>

Newborn Screening Program

<http://www.doh.wa.gov/YouandYourFamily/InfantsChildrenandTeens/NewbornScreening.aspx>

Health Care Authority (HCA)

<http://www.hca.wa.gov/Pages/index.aspx>

<http://www.hca.wa.gov/medicaid/Pages/index.aspx>

<http://www.hca.wa.gov/medicaid/billing/pages/bi.aspx>

<http://wahbexchange.org/news-resources/calculate-your-costs>

### **Section 7000**

DOH Consolidated Contracts

<http://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/PublicHealthSystemResourcesandServices/Funding/ConsolidatedContracts.aspx>

**CSHCN Acronyms**  
 (Key terms used in this document)

ADA	Americans with Disabilities Act
ASK	Answers for Special Kids Toll-Free Hotline
CHDD	Center on Human Development and Disability at University of Washington
CHIF	CSHCN Child Health Intake Form
CHIP	Children’s Health Insurance Program
CSHCN	Children with Special Health Care Needs (cshcn) Children with Special Health Care Needs Program (DOH)
DDA	Developmental Disabilities Administration (DSHS)
DEL	Department of Early Learning (Washington State)
DOH	Department of Health (Washington State)
DSHS	Department of Social and Health Services (Washington State)
DX/TX	CSHCN Diagnostic and Treatment Allocations/Funds
ESIT	Early Support for Infant Toddler Program (DEL)
FRC	Family Resources Coordinator (ESIT/DEL)
HCA	Health Care Authority (Washington State)
HHS	U.S. Department of Health and Human Services
HRSA	Health Resources and Services Administration (federal)
HSA	Health Services Authorization Form
IDEA	Individuals with Disabilities Education Act
IEP	Individualized Education Program
IOM	Institute of Medicine
LEND	Leadership Education in Neurodevelopmental Disabilities

LHJ	Local Health Jurisdiction(s)
MCH	Maternal and Child Health
MCHB	Maternal and Child Health Bureau (federal)
NDC	Neurodevelopmental Center(s)
NICU	Neonatal Intensive Care Unit
OBRA	Omnibus Budget Reconciliation Act
OSPI	Office of Superintendent for Public Instruction (Washington State)
PCH	Prevention and Community Health Division
PHIP	Public Health Improvement Plan
RCW	Revised Code of Washington
SSA	Social Security Administration
SSI	Supplemental Security Income
Title V	
Title XX	
Title XIX	
TRICARE	Military managed-care health system (previously CHAMPUS)
WAC	Washington Administrative Code
WIC	Women, Infants and Children Nutrition Program

## CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN) LOCAL AGENCY COORDINATORS AND SUPPORT STAFF

(Street addresses in parenthesis are only used for package deliveries by carriers other than the U.S. Postal Service.)

Please review for edits and respond to Christy Polking  
at (360) 236-3571 or email [christy.polking@doh.wa.gov](mailto:christy.polking@doh.wa.gov)

County	Contact/Address	Communications
<p><b>Adams County Health Department</b></p> <p><a href="http://www.co.adams.wa.us">www.co.adams.wa.us</a></p>	<p>Leslie Spencer, RN, CSHCN Coordinator</p> <p>Main Health Department Number 108 West Main Ritzville, Washington 99169</p>	<p>509-659-3319</p> <p>509-659-3315 FAX 509-659-4109</p> <p>Internet: <a href="mailto:leslies@co.adams.wa.us">leslies@co.adams.wa.us</a></p>
<p><b>Asotin County Health District</b></p> <p><a href="http://www.ac-hd.org">www.ac-hd.org</a></p>	<p>Diane Rousseau, RN Director/CSHCN Coordinator PO Box 306 (102 1<sup>st</sup> Street) Asotin, Washington 99402</p>	<p>509-243-3344 FAX 509-243-3345</p> <p>Internet: <a href="mailto:drousseau@ac-hd.org">drousseau@ac-hd.org</a></p>
<p><b>Benton-Franklin Health District</b></p>	<p>Carla Prock, RN, BSW, CSHCN Coordinator 7102 W Okanogan Place Kennewick, Washington 99336</p>	<p>509-460-4225 FAX 509-585-1525</p> <p>Internet: <a href="mailto:carlap@bfhd.wa.gov">carlap@bfhd.wa.gov</a></p>
<p><b>Chelan-Douglas Health District</b></p> <p><a href="http://www.cdhd.wa.gov/ParentandChildHealthServices.htm">www.cdhd.wa.gov/ParentandChildHealthServices.htm</a></p>	<p>Carol McCormick <b>** Central CSHCN Regional Representative (2016)</b> Assistant Administrator/Personal Health</p> <p>Cari Hammond, RN, BSN, CSHCN Coordinator 200 Valley Mall Parkway East Wenatchee, Washington 98802</p>	<p>509-886-6423</p> <p>509-886-6411 FAX 509-886-6478</p> <p>Internet: <a href="mailto:Carol.McCormick@cdhd.wa.gov">Carol.McCormick@cdhd.wa.gov</a> <a href="mailto:cari.hammond@cdhd.wa.gov">cari.hammond@cdhd.wa.gov</a></p>
<p><b>Clallam County Department of Health &amp; Human Services</b></p>	<p>Tina Moody, CSHCN Coordinator Post Office Box 1612 (140 C Street) Forks, Washington 98331</p> <p><i>Main Health Department:</i> 223 East Fourth Street, Suite 14 Port Angeles, Washington 98362-3015</p>	<p>360-374-3121 FAX 360-374-5418</p> <p>Internet: <a href="mailto:tmoody@co.clallam.wa.us">tmoody@co.clallam.wa.us</a></p>
<p><b>Clark County Public Health</b></p>	<p>Connie Callahan, RN, CSHCN Coordinator Jan Schmalenberger, Admin. Support Post Office Box 9825 (1601 E 4<sup>th</sup> Plain Road, 3<sup>rd</sup> Floor, Zip 98661) Vancouver, Washington 98666-8825</p>	<p>360-397-8472 360-397-8440 FAX 360-397-8442</p> <p>Internet: <a href="mailto:connie.callahan@clark.wa.gov">connie.callahan@clark.wa.gov</a> <a href="mailto:Jan.Schmalenberger@clark.wa.gov">Jan.Schmalenberger@clark.wa.gov</a></p>

\*\* Indicates Regional Representative  
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<b>County</b>	<b>Contact/Address</b>	<b>Communications</b>
<b>Columbia County Public Health District</b>	Kathleen Juris, RN, CSHCN Coordinator 270 E Main Street Dayton, Washington 99328	509-382-2181 FAX 509-382-2942 Internet: kathleen_juris@co.columbia.wa.us
<b>Cowlitz County Health Department</b>	Doreen Wadsworth, RN, CSHCN Coordinator 900 Ocean Beach Hwy, Suite 1-B Longview, Washington 98632	360-414-5599, x6437 FAX 360-425-7531 Internet: wadsworthd@co.cowlitz.wa.us
<b>Garfield County Health District</b>	Leta Travis, RN Director/CSHCN Coordinator Post Office Box 130 (121 South 10 <sup>th</sup> Street) Pomeroy, Washington 99347	509-843-3412 FAX 509-843-1935 Internet: ltravis@co.garfield.wa.us
<b>Grant County Health District</b>	Carol Schimke, RN, BA, CSHCN Coordinator 1038 W Ivy (Suite 1) Moses Lake, Washington 98837	509-766-7960, ext. 22 FAX 509-766-6519 Internet: cschimke@granthealth.org
<b>Grays Harbor County Public Health and Social Services</b>	Julie Zambas, RN, CSHCN Coordinator 2109 Sumner Avenue Aberdeen, Washington 98520	360-500-4051 FAX 360-533-6272 Internet: jzambas@co.grays-harbor.wa.us
<b>Island County Health Department</b>	Loretta Bezold, RN, CSHCN Coordinator Post Office Box 5000 (410 North Main Street) Coupeville, Washington 98239	360-678-7940 FAX 360-221-8480 Internet: LorettaB@co.island.wa.us
<b>Jefferson County Public Health</b> <a href="http://www.jeffersoncountypublichealth.org">www.jeffersoncountypublichealth.org</a>	Marti Haley, RN, CSHCN Coordinator 615 Sheridan Port Townsend, Washington 98368	360-385-9442 FAX 360-385-9401 Internet: mhaley@co.jefferson.wa.us
<b>Kitsap Public Health District</b>	Linda Tourigny, CSHCN Coordinator Lori Werdall, Admin. Support 345 6 <sup>TH</sup> Street, Suite 300 Bremerton, Washington 98337-1866	360-337-5633 360-337-4821 FAX 360-337-4851 Internet: Linda.tourigny@kitsappublichealth.org Lori.Werdall@kitsappublichealth.org
<b>Kittitas County Public Health</b>	Michele Cawley, RN, Program Manager Community Health of Central Washington 607 East Mountain View Avenue Ellensburg, Washington 98926  <i>Main Health Department:</i> 507 North Nanum Street, Suite 102 Ellensburg, Washington 98926	509-962-1414, ext. 3905 Cell: 509-306-1740 FAX 509-962-1408 Internet: michele.cawley@chcw.org

County	Contact/Address	Communications
<b>Klickitat County Health Department</b>	Penny Andress, RN, Co-CSHCN Coordinator Angie Kaley, Admin. Support 228 West Main Street, MS: CH-14 Goldendale, Washington 98620	Goldendale 1-888-291-3521 509-773-2365 509-773-2490 FAX 509-773-5991
	-and-	Internet: pennya@klickitatcounty.org angiek@klickitatcounty.org
	Kristyn Pardo, Co-CSHCN Coordinator Post Office Box 159 (501 NE Washington Street) White Salmon, Washington 98672	White Salmon 1-888-267-1199 509-493-6207 FAX 509-493-4025 Internet: kristynp@klickitatcounty.org
<b>Lewis County Public Health and Social Services</b>	Donna Muller, RN, CSHCN Coordinator 360 NW North Street MS HSD03 Chehalis, Washington 98532	360-740-1236 FAX 360-740-1145 Internet: donna.muller@lewiscountywa.gov
<b>Lincoln County Health Department</b>	Jolene Erickson, RN Director/CSHCN Coordinator 90 Nichols Street Davenport, Washington 99122	509-725-9213, ext. 27 FAX 509-725-1014 Internet: jerickson@co.lincoln.wa.us
<b>Mason County Public Health</b>	Elizabeth Custis, RN-BC, Maternal Child Health Lead PO Box 1666 (415 N 6 <sup>th</sup> Street) Shelton, Washington 98584	360-427-9670, ext. 407 FAX 360-427-7787 Internet: elizac@co.mason.wa.us
<b>N.E. Tri-County Health District Ferry County</b>	Judy Hutton, PHN, CSHCN Coordinator/Community Health Supervisor Post Office Box 584 (147 North Clark) Republic, Washington 99166	509-775-3111 FAX 509-775-2858 Internet: jhutton@netchd.org
<b>N.E. Tri-County Health District Pend Oreille County</b>	Jan Steinbach, PHN <b>** East CSHCN Co-Regional Representative (2016)</b> Community Health Supervisor  605 Highway 20 Newport, Washington 99156	509-447-3131 1-800-873-6162 FAX 509-447-5644 Internet: jsteinbach@netchd.org
<b>N.E. Tri-County Health District Stevens County</b>	Kay Scamahorn, PHN, CSHCN Coordinator/Community Health Supervisor 240 East Dominion Street Colville, Washington 99114	509-685-2622 1-800-827-3218 FAX 509-684-9878 Internet: kscamahorn@netchd.org
<b>Okanogan County Public Health</b>	Lauri Jones, RN Director/CSHCN Coordinator Post Office Box 231 (1234 South Second) Okanogan, Washington 98840	509-422-7158 FAX 509-422-7384 Internet: ljones@co.okanogan.wa.us

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County	Contact/Address	Communications
<b>Pacific County Public Health and Human Services</b>	Alycia Johnson, RN, CSHCN Coordinator 7013 Sandridge Road Long Beach, Washington 98631	360-642-9300, ext. 2628 FAX 360-642-9352
	Wendy Hamlin, Admin. Support Post Office Box 26 (1216 W Robert Bush Drive) South Bend, Washington 98586	360-875-9343 FAX 360-875-9323 Internet: ajohnson@co.pacific.wa.us whamlin@co.pacific.wa.us
<b>San Juan Health and Community Services</b>	Tamara Joyner, RN, CSHCN Coordinator Wayne Totten, Admin. Support Post Office Box 607 (145 Rhone Street) Friday Harbor, Washington 98250-0607	360-378-4474  FAX 360-378-7036 Internet: tamaraj@sanjuanco.com waynet@sanjuanco.com
<b>Public Health – Seattle &amp; King County</b>	Katharine Besch, RN <b>** Northwest CSHCN Co-Regional Representative (2016)</b> CSHCN Coordinator	206-263-1244
<a href="http://www.kingcounty.gov/healthservices/health/child/cshcn.aspx">www.kingcounty.gov/healthservices/health/child/cshcn.aspx</a>	Nona Chitwood, Admin. Support 401 Fifth Avenue; Suite 1000 Seattle, Washington 98104	206-263-8379  <b>Preferred contact #: 206-296-4610 (main line)</b>
		FAX 206-296-4679 Internet: katharine.besch@kingcounty.gov nona.chitwood@kingcounty.gov
<b>Skagit County Public Health Department</b>	Stephanie Peterka, RN, CSHCN Coordinator 700 South Second, Room 301 Mount Vernon, Washington 98273	360-416-1526  FAX 360-336-9401 Internet: speterka@co.skagit.wa.us
<b>Skamania County Health Department</b>	Amanda Cole, RN, CSHCN Coordinator Post Office Box 369 (710 SW Rock Creek Drive) Stevenson, Washington 98648	509-427-3883 FAX 509-427-0188  Internet: cole@co.skamania.wa.us
<b>Snohomish Health District</b>	Judy Ward, RN, <b>** Northwest CSHCN Co-Regional Representative (2016)</b> CSHCN Coordinator	425-339-8686
<a href="http://www.snohd.org">www.snohd.org</a>	Carol Furness, Program Specialist 3020 Rucker Avenue, #203 Everett, Washington 98201	425-339-8652 FAX 425-339-5255 Internet: jward@snohd.org cfurness@snohd.org

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County	Contact/Address	Communications
<b>Spokane Regional Health District</b> <a href="http://www.srhd.org/services/nursing.asp">www.srhd.org/services/nursing.asp</a>	Colleen O'Brien, RN Manager, CSHCN Program  Melissa Charbonneau, RN <b>** East CSHCN Co-Regional Representative (2016)</b> Public Health Nurse, Education Coordinator  1101 West College Avenue (Suite 240) Spokane, Washington 99201	-509-324-1657  509-324-1665 FAX 509-324-1699 Internet: cbobrien@srhd.org mcharbonneau@srhd.org
	Laurie Vessey, RN Eastern Washington Maxillofacial Coordinator Providence Sacred Heart Maxillofacial Program PO Box 2555 (101 W Eighth Avenue) Spokane, Washington 99220-2555	509-474-3106 FAX 509-474-2801 Internet: laurel.vessey@providence.org
<b>Tacoma-Pierce County Health Department</b>	Andrea (Ryker) Sander, RN <b>** Southwest CSHCN Regional Representative (2016)</b> CSHCN Coordinator	253-798-4576 FAX 798-4599
	Maggi Milam, Admin. Support and Intake 3629 South "D" Street (MS 1100) Tacoma, Washington 98418-6813	253-798-6490 FAX 253-798-3522 Internet: asander@tpchd.org mmilam@tpchd.org
	Angela Kitzmiller SW Washington Maxillofacial Coordinator Mary Bridge Children's Health Center PO Box 5299 (1220 Division Avenue, MS: 1220-1-SP) Tacoma, Washington 98415-98406	253-792-6640 FAX 253-627-5004 Internet: angela.kitzmiller@multicare.org
<b>Thurston County Health Department</b>	Bonnie Peterson, RN, CSHCN Coordinator 412 Lilly Road NE (MS: 0947) Olympia, Washington 98506-5132	360-867-2543 FAX 360-867-2601 Internet: petersb@co.thurston.wa.us
<a href="http://www.co.thurston.wa.us/health/personalhealth/womenchildren/CSHCN.html">www.co.thurston.wa.us/health/personalhealth/womenchildren/CSHCN.html</a>		
<b>Wahkiakum County Health and Human Services</b>	Danelle Barlow, CSHCN Coordinator Post Office Box 696 (64 Main Street) Cathlamet, Washington 98612	360-795-6207 FAX 360-795-6143 Internet: barlowd@co.wahkiakum.wa.us
<b>Walla Walla County Health Department</b>	Valerie Remboldt, RN, CSHCN Coordinator Post Office Box 1753 (314 West Main) Walla Walla, Washington 99362-0346	509-524-2650 (Main #) 509-524-2658 FAX 509-524-2642 Internet: vremboldt@co.walla-walla.wa.us
<b>Whatcom County Health Department</b>	Gail Bodenmiller, MSW, CSHCN Coordinator 1500 North State Street Bellingham, Washington 98225	360-676-6762, ext. 32119 FAX 360-676-6783 Internet: GBodenmi@whatcomcounty.us

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County	Contact/Address	Communications
<b>Whitman County Health Department</b>	Vicky Cochran, CSHCN Coordinator Noel Christiansen, Admin Support (Colfax Office) 310 N Main Street Colfax, Washington 99111	509-397-6280
	-and-	
	Meghan Johns, Admin Support (Pullman Office) 1205 SE Professional Mall Boulevard (Suite 203) Pullman, Washington 99163	509-332-6752 FAX 509-334-4517 Internet: vickyc@co.whitman.wa.us noel.christiansen@co.whitman.wa.us meghan.johns@co.whitman.wa.us
<b>Children's Village - Yakima</b>	Cindy Carroll Child Health Services Manager	509-574-3228
	Tracie Hoppis Child and Family Services Supervisor Cathy Buchanan, Cleft Lip and Palate Program Coordinator	509-574-3263 509-574-3268
	Carrie Schilperoot, Fiscal Coordinator Amanda McMurray, CSHCN Program Support 3801 Kern Road Yakima, Washington 98902	509-574-3201 509-574-3283 FAX 509-574-3210 Internet: cindycarroll@yvmh.org traciehoppis@yvmh.org cathybuchanan@yvmh.org carrieschilperoot@yvmh.org amandamcmurray@yvmh.org

## CHILDREN WITH SPECIAL HEALTH CARE NEEDS MAXILLOFACIAL TEAMS

Maxillofacial Teams are located in Spokane, Tacoma, Yakima, and Portland, Oregon. Children are usually seen by the team serving their area of residence, however parents may choose to continue to be seen by the team initially providing service if they move to another region in the state.

- The Northwest Washington Region includes the following counties:

Clallam	King	Skagit
Island	Kitsap	Snohomish
Jefferson	San Juan	Whatcom

The CSHCN maxillofacial coordinator for this region is:

Donna Borgford-Parnell, RN, MBA  
CSHCN Coordinator  
Public Health Seattle & King County  
401 Fifth Avenue; Suite 1000  
Seattle, Washington 98104  
206-296-4610  
FAX 206-296-4679  
Email: [donna.borgford-parnell@kingcounty.gov](mailto:donna.borgford-parnell@kingcounty.gov)

- Spokane's Maxillofacial Program serves counties in the East Region:

Adams	Ferry	Pend Oreille	Whitman
Asotin	Garfield	Spokane	
Columbia	Lincoln	Stevens	

The team coordinator for this region is:

Laurie Vessey, RN, BSN  
Providence Sacred Heart Children's Hospital  
PO Box 2555  
(101 W Eighth Avenue)  
Spokane, Washington 99220-2555  
509-474-3106  
FAX 509-474-2801  
Email: [laurel.vessey@providence.org](mailto:laurel.vessey@providence.org)  
Website:  
<http://washington.providence.org/hospitals/sacred-heart-childrens-hospital/services/maxillofacial-program/>

- Tacoma’s Southwest Washington Maxillofacial Team serves counties in the Southwest Region:

Clark	Lewis	Pierce	Wahkiakum
Cowlitz	Mason	Skamania	
Grays Harbor	Pacific	Thurston	

The team coordinator for this region is:

Patricia Mahaulu-Stephens  
Mary Bridge Children’s Hospital & Health Center  
PO Box 5299, MS: 316L-1-CHN  
(311 South “L” Street  
Tacoma, Washington 98415-0299  
253-403-1559  
FAX 253-403-4700  
Email: [patricia.mahaulu-stephens@multicare.org](mailto:patricia.mahaulu-stephens@multicare.org)

- Yakima’s Central Washington Cleft Palate team serves counties in the Central Region:

Benton	Franklin	Klickitat	Yakima
Chelan	Grant	Okanogan	
Douglas	Kittitas	Walla Walla	

The team coordinator and case manager for this region is:

Cathy Buchanan, MSW, Case Manager  
Children’s Village  
3801 Kern Road  
Yakima, Washington 98902  
509-574-3260  
FAX 509-574-3210  
Email: [cathy.buchanan@ymh.org](mailto:cathy.buchanan@ymh.org)

- The CSHCN maxillofacial coordinator for the Northwest Region works with Children's Craniofacial Center staff at Seattle Children's to serve children in the Northwest Region. The Craniofacial Center director is Michael Cunningham, MD, PhD, attending physicians are Anne Hing, MD, Carrie Heike, MD, and Charlotte Lewis, MD, and nurse clinicians are Marsha Ose, RN, MS, Bay Sittler, RN, MS, and Suzanne Siegel, RN. They may be reached at:

Children's Craniofacial Center  
Seattle Children's  
4800 Sand Point Way NE  
Seattle, Washington 98105  
206-987-2208  
FAX (206) 987-3824  
Toll free: 1-866-987-2000  
Email: [marsha.ose@seattlechildrens.org](mailto:marsha.ose@seattlechildrens.org)  
Website: <http://www.seattlechildrens.org/clinics-programs/craniofacial>

- Portland serves children residing in Southwest Washington through:

Cleft Palate and Craniofacial Program  
Oregon Health and Science University  
Child Development and Rehabilitation Center  
PO Box 574  
Portland, Oregon 97207-0574  
503-494-2741  
FAX 503-494-4447  
Website: <http://www.ohsu.edu/cdrc/clinical/portland/craniofacial.html>

Clinic director is Janet Brockman, MS-CCC-FP

# Neurodevelopmental Centers of Washington

## Birth to Three Developmental Center

Maryanne Barnes, Executive Director

[mbarnes@birthtothree.org](mailto:mbarnes@birthtothree.org)

35535 6<sup>th</sup> Place SW (physical address)

PO Box 24269 (mailing address)

Federal Way, Washington 98093-1269

PH No. (253) 874-5445

FAX No. (253) 874-0687

Web [www.birthtothree.org](http://www.birthtothree.org)

## Boyer Children's Clinic

Michael Stewart, Executive Director

[Mike.Stewart@boyercc.org](mailto:Mike.Stewart@boyercc.org)

1850 Boyer Avenue East

Seattle, Washington 98112

PH No. (206) 325-8477, ext. 202

FX No. (206) 323-1385

Web [www.boyercc.org](http://www.boyercc.org)

## Children's Developmental Center

Cathryn Tames, Executive Director

[cathyt@childrensdc.org](mailto:cathyt@childrensdc.org)

1549 Georgia Avenue SE

Richland, Washington 99352

PH No. (509) 735-1062

FX No. (509) 737-8492

Web [www.childrensdevelopmentalcenter.org](http://www.childrensdevelopmentalcenter.org)

## Children's Therapy Center

Jon Botten, Executive Director

[jon@ctckids.org](mailto:jon@ctckids.org)

10811 SE Kent Kangley Road

Kent, Washington 98030

PH No. (253) 854-5660

FX No. (253) 854-7025

Web [www.ctckids.org](http://www.ctckids.org)

## ChildStrive

Terry Clark, Executive Director

[terry.clark@childstrive.org](mailto:terry.clark@childstrive.org)

14 East Casino Road

Everett, Washington 98208

PH No. (425) 353-5656, ext. 7132

FX No. (425) 513-2807

Web [www.ChildStrive.org](http://www.ChildStrive.org)

## Good Samaritan Hospital

Children's Therapy Unit

Marianne Bastin, Director

[Marianne.bastin@multicare.org](mailto:Marianne.bastin@multicare.org)

402 15<sup>th</sup> Avenue SE, Suite 100

Puyallup, Washington 98372

PH No. (253) 697-5220

FX No. (253) 697-5145

Web [www.goodsamhealth.org](http://www.goodsamhealth.org)

## Infant Toddler Program of Holly Ridge Center

Connie Zapp, Program Director

[czapp@hollyridge.org](mailto:czapp@hollyridge.org)

5112 Northwest Taylor Road

Bremerton, Washington 98312

PH No. (360) 373-2536

FX No. (360) 373-4934

Web [www.hollyridge.org](http://www.hollyridge.org)

## Innovative Services NW

Launda Carroll, President/CEO

Susan Lehr, Director of Health Programs and Early Intervention

[lcarroll@innovativeservicesnw.org](mailto:lcarroll@innovativeservicesnw.org)

[slehr@innovativeservicesnw.org](mailto:slehr@innovativeservicesnw.org)

9414 NE Fourth Plain Road

Vancouver, Washington 98662

PH No. (360) 823-5175

(360) 823-5142

FX No. (360) 823-2157

Web [www.innovativeservicesnw.org](http://www.innovativeservicesnw.org)

## Kindering Center

Maxine Siegel, Executive Director

[mimi.siegel@kinding.org](mailto:mimi.siegel@kinding.org)

16120 NE 8<sup>th</sup> Street

Bellevue, Washington 98008

PH No. (425) 747-4004, ext. 4333

FX No. (425) 747-1069

Web [www.kinding.org](http://www.kinding.org)

# Neurodevelopmental Centers of Washington

Mary Bridge Children's Health Center  
Angela Kitzmiller, Program Supervisor  
[angela.kitzmiller@multicare.org](mailto:angela.kitzmiller@multicare.org)  
1220 Division Avenue (MS: 1220-1-SP)  
(PO Box 5299, Tacoma, 98415)  
Tacoma, Washington 98403  
PH No. (253) 792-6640  
FX No. (253) 627-5004  
Web  
[www.multicare.org/marybridge/developmental-services/](http://www.multicare.org/marybridge/developmental-services/)

PeaceHealth Medical Group  
PeaceHealth Children's Therapy  
Debbie Taylor, Director  
Kris Sandholm, Manager  
[KSandholm@PeaceHealth.org](mailto:KSandholm@PeaceHealth.org)  
4545 Cordata Parkway LL4  
Bellingham, Washington 98225  
PH No. (360) 752-5622  
FX No. (360) 752-5624  
Web  
[www.peacehealth.org/phmg/bellingham-lynden](http://www.peacehealth.org/phmg/bellingham-lynden)

Progress Center  
Kara Harris, Interim Executive Director  
[KHarris@theprogresscenter.org](mailto:KHarris@theprogresscenter.org)  
1600 3<sup>rd</sup> Avenue  
Longview, Washington 98632  
PH No. (360) 425-9810  
FX No. (360) 425-1053  
Web [www.theprogresscenter.org](http://www.theprogresscenter.org)

Providence Everett Medical Center  
Providence Children's Center  
Christine Tipton, Manager  
[christine.tipton@providence.org](mailto:christine.tipton@providence.org)  
Pavilion for Women and Children  
900 Pacific Avenue, First Floor  
PO Box 1067  
Everett, Washington 98206-1067  
PH No. (425) 258-7069  
FX No. (425) 258-7618  
Web [www.providence.org/everett/](http://www.providence.org/everett/)

Skagit Preschool and Resource Center  
Pat Holloran, Executive Director  
[pat@sparckids.org](mailto:pat@sparckids.org)  
320 Pacific Place  
Mount Vernon, Washington 98273  
PH No. (360) 416-7570  
FX No. (360) 416-7580  
Web [www.sparckids.org](http://www.sparckids.org)

Skagit Valley Hospital  
Children's Therapy Program  
Erin Kauai, Lead Therapist, Children's  
Therapy Program  
[ekauai@skagitvalleyhospital.org](mailto:ekauai@skagitvalleyhospital.org)  
1415 Kincaid Street  
Mount Vernon, Washington 98274  
PH No. (360) 814-2699  
FX No. (360) 416-8390  
Web [www.skagitvalleyhospital.org](http://www.skagitvalleyhospital.org)

Spokane Guilds' School & Neuromuscular Center  
Richard Boysen, Executive Director  
[dickb@guildschool.org](mailto:dickb@guildschool.org)  
2118 W Garland Avenue  
Spokane, Washington 99205  
PH No. (509) 326-1651  
FX No. (509) 326-1658  
Web [www.guildschool.org](http://www.guildschool.org)

Valley Medical Center  
Children's Therapy Department  
Kari Tanta, PhD, OTR/L, FAOTA, Rehab  
Supervisor  
[Kari\\_Tanta@valleymed.org](mailto:Kari_Tanta@valleymed.org)  
3600 Lind Avenue, Suite 160 (physical address)  
PO Box 50010 (mailing address)  
Renton, Washington 98058  
PH No. (425) 228-3440, ext. 3560  
FX No. (425) 656-5075  
Web  
<http://www.valleymed.org/childrenstherapy>

Yakima Valley Memorial Hospital  
Children's Village  
Cindy Carroll, Child Health Services Manager  
[CindyCarroll@yvmh.org](mailto:CindyCarroll@yvmh.org)  
3801 Kern Road  
Yakima, Washington 98902  
PH No. (509) 574-3228  
FX No. (509) 574-3210  
Web [www.yakimachildrensvillage.org](http://www.yakimachildrensvillage.org)

# Neurodevelopmental Centers of Washington

## Associated Tertiary Centers\*

Center on Human Developmental and  
Disability Clinical Training Unit, High Risk  
Follow-up

Beth Ellen Davis, MD, MPH, CTU Director  
F. Curt Bennett, MD, HRIF

[bedavis@uw.edu](mailto:bedavis@uw.edu)

[fbennett@uw.edu](mailto:fbennett@uw.edu)

Box 357920

Seattle, Washington 98195-7920

PH No. (206) 685-1350 (Davis)

(206) 685-1356 (Bennett)

FX No. (206) 598-7815

CHDD Website:

<http://depts.washington.edu/chdd/index.html>

LEND Website:

<http://depts.washington.edu/lend/>

Seattle Children's Hospital  
Neurodevelopmental Program

William Walker, Jr. MD, Chief  
Division of Developmental Medicine

[william.walker@seattlechildrens.org](mailto:william.walker@seattlechildrens.org)

4800 Sand Point Way NE (M/S A 7938)

Seattle, Washington 98105

PH No. (206) 987-3664

FX No. (206) 987-3824

Web <http://www.seattlechildrens.org/clinics-programs/neurodevelopmental/>

Madigan Army Medical Center  
Developmental-Behavioral Pediatrics

Bradley Hood, MD, Program Director

[Bradley.s.hood2.civ@mail.mil](mailto:Bradley.s.hood2.civ@mail.mil)

Department of the Army, MCHJ-P

Tacoma, Washington 98431

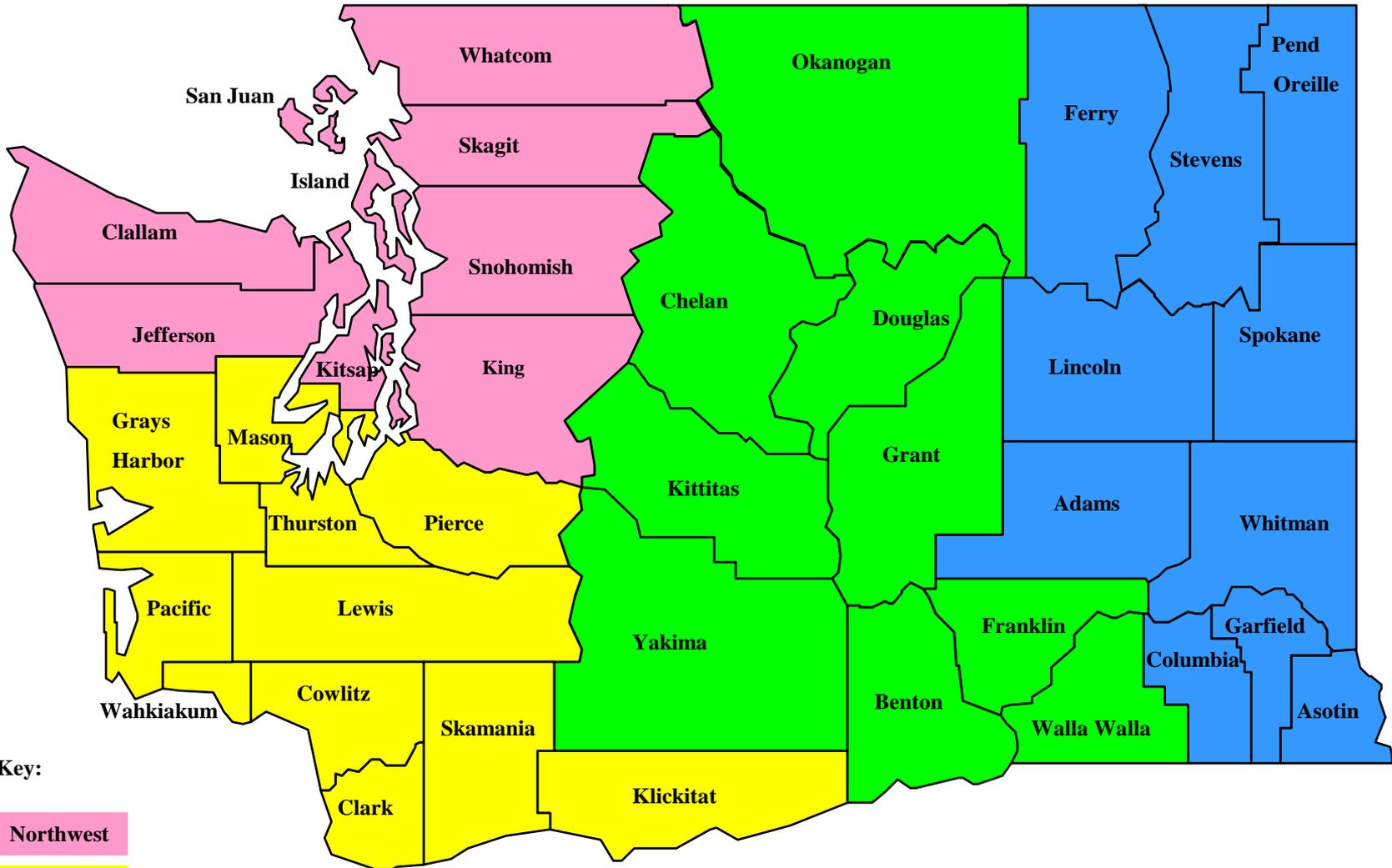
PH No. (253) 968-2477

FX No. (253) 968-5274

Web <http://www.mamc.amedd.army.mil/>

\*DOH does not contract for direct services with these associated tertiary centers.

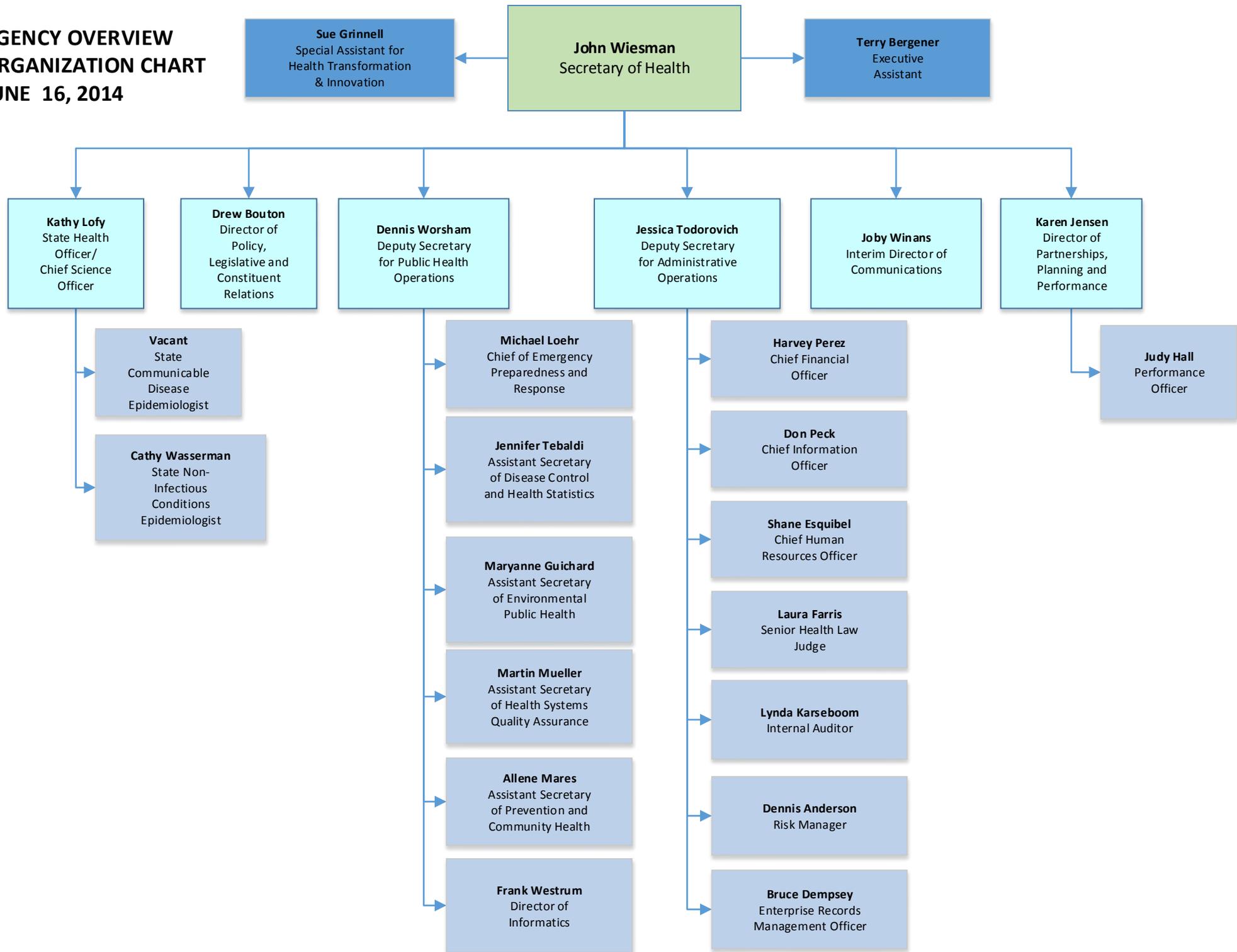
# CSHCN Regions



Key:

- Northwest
- Southwest
- Central
- East

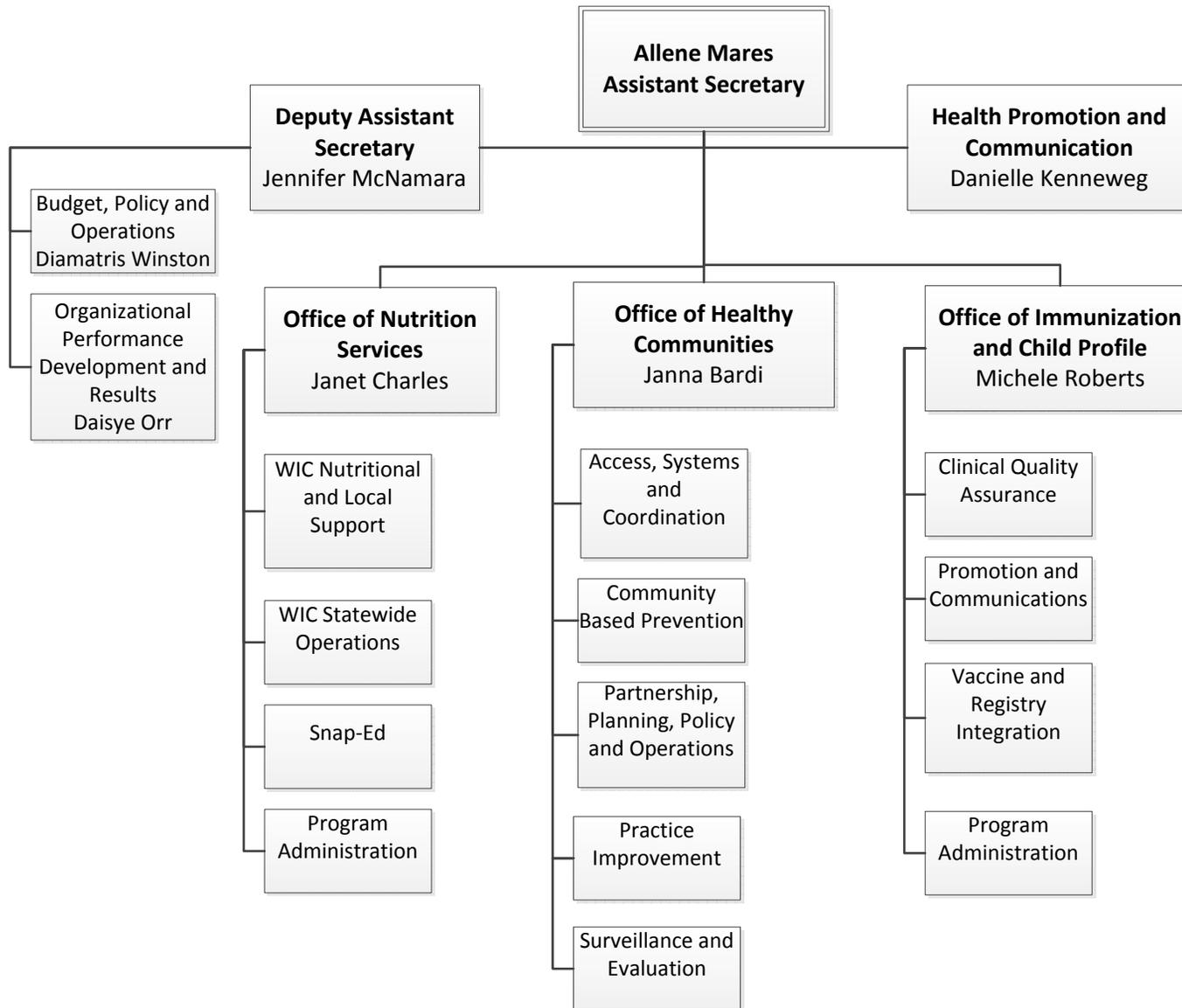
**AGENCY OVERVIEW  
ORGANIZATION CHART  
JUNE 16, 2014**



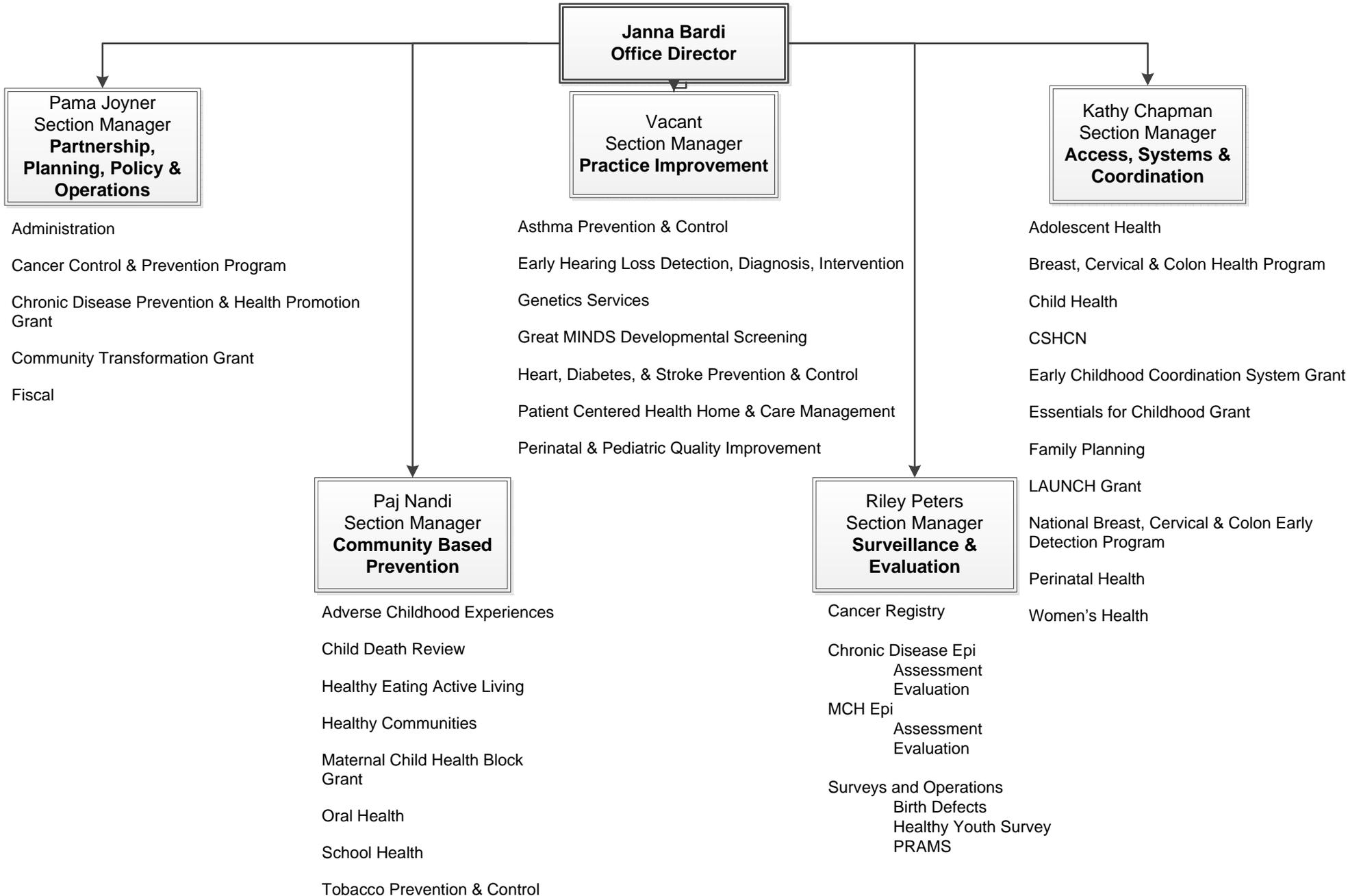
# Prevention and Community Health Division

Washington State Department of Health

June 2014



Prevention and Community Health Division  
**Office of Healthy Communities**  
 Washington State Department of Health  
 June 2014



**Janna Bardi**  
Office Director

Vacant  
Section Manager  
**Practice Improvement**

- Asthma Prevention & Control
- Early Hearing Loss Detection, Diagnosis, Intervention
- Genetics Services
- Great MINDS Developmental Screening
- Heart, Diabetes, & Stroke Prevention & Control
- Patient Centered Health Home & Care Management
- Perinatal & Pediatric Quality Improvement

**Kathy Chapman**  
Section Manager  
**Access, Systems & Coordination**

- Adolescent Health
- Breast, Cervical & Colon Health Program
- Child Health
- CSHCN
- Early Childhood Coordination System Grant
- Essentials for Childhood Grant
- Family Planning
- LAUNCH Grant
- National Breast, Cervical & Colon Early Detection Program
- Perinatal Health
- Women's Health

**Pama Joyner**  
Section Manager  
**Partnership,  
Planning, Policy &  
Operations**

- Administration
- Cancer Control & Prevention Program
- Chronic Disease Prevention & Health Promotion Grant
- Community Transformation Grant
- Fiscal

**Paj Nandi**  
Section Manager  
**Community Based  
Prevention**

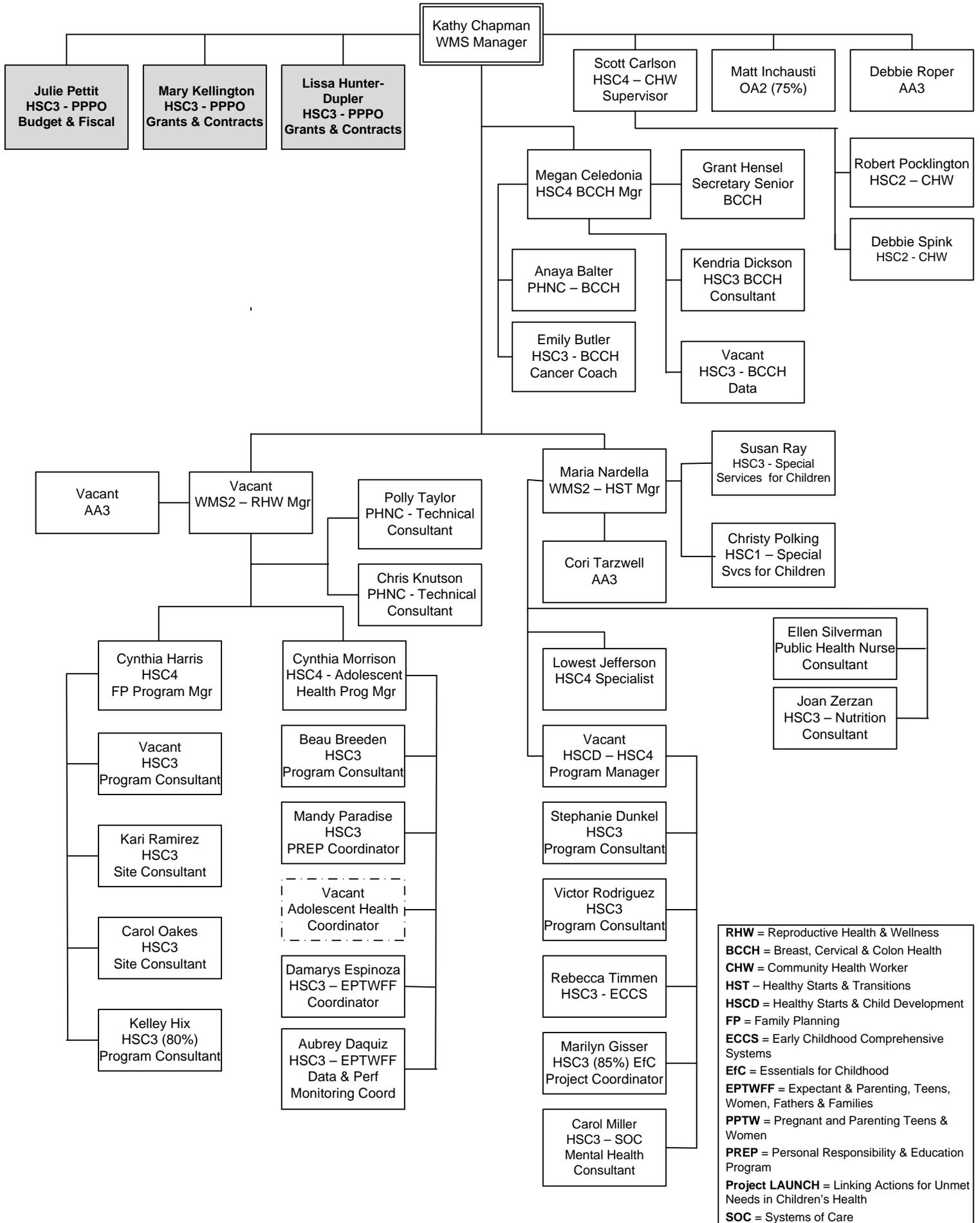
- Adverse Childhood Experiences
- Child Death Review
- Healthy Eating Active Living
- Healthy Communities
- Maternal Child Health Block Grant
- Oral Health
- School Health
- Tobacco Prevention & Control

**Riley Peters**  
Section Manager  
**Surveillance &  
Evaluation**

- Cancer Registry
- Chronic Disease Epi Assessment Evaluation
- MCH Epi Assessment Evaluation
- Surveys and Operations
- Birth Defects
- Healthy Youth Survey
- PRAMS

# Access, Systems and Coordination

## June 2014



**RHW** = Reproductive Health & Wellness  
**BCCH** = Breast, Cervical & Colon Health  
**CHW** = Community Health Worker  
**HST** = Healthy Starts & Transitions  
**HSCD** = Healthy Starts & Child Development  
**FP** = Family Planning  
**ECCS** = Early Childhood Comprehensive Systems  
**EfC** = Essentials for Childhood  
**EPTWFF** = Expectant & Parenting, Teens, Women, Fathers & Families  
**PPTW** = Pregnant and Parenting Teens & Women  
**PREP** = Personal Responsibility & Education Program  
**Project LAUNCH** = Linking Actions for Unmet Needs in Children's Health  
**SOC** = Systems of Care

# Healthy Starts and Transitions Unit

June 2014

Maria Nardella  
Unit Manager



Promote integrated systems that improve access, linkages, and coordination directed towards health, early and ongoing learning and development, and safe environments for all children and their families.

Vacant  
Supervisor



Carol Miller  
SOC/UDS



Marilyn Gisser  
EFC



Rebecca Timmen  
ECCS



Stephanie Dunkel  
Child Health Consultant



Victor Rodriguez  
Child Health Consultant



Cori Tarzwell  
AA3



Susan Ray  
Family Involvement



Ellen Silverman  
PHNC



Christy Polking  
Special Services  
Consultant



Lowest Jefferson  
Environmental  
Health Consultant



Joan Zerzan  
Nutrition



# WASHINGTON STATE FATHERS NETWORK-PROGRAMS

## **BELLEVUE — FATHERS NETWORK**

Kindering Center  
16120 N.E. Eighth Street  
Bellevue, WA 98008-3937  
Contact: **Greg Schell**, facilitator (425) 653-4286  
E-mail: [greg.schell@kindering.org](mailto:greg.schell@kindering.org)  
Contact: **Mark Gabarra**, facilitator  
E-mail: [mgabarra@hotmail.com](mailto:mgabarra@hotmail.com)

## **CHELAN –FATHERS NETWORK**

Contact: **Merick Hill**, facilitator  
311 West Columbia Avenue, Chelan, WA 98816  
509-682-8759-cell  
E-mail: [mervsebikerentals@gmail.com](mailto:mervsebikerentals@gmail.com)

## **CLALLAM COUNTY — FATHERS NETWORK**

The Arc of Olympic Peninsula  
P.O. Box 3129  
Port Angeles, WA 98362  
Contact: **George Stuber** (360) 681-2709, (360) 461-6780  
E-mail: [geosanta2001@yahoo.com](mailto:geosanta2001@yahoo.com)

## **ISLAND COUNTY — FATHERS PROGRAM**

Island County Human Services  
P.O. Box 5000  
Coupeville, WA 98239  
Contact: **Mike Etzell**, facilitator  
(360) 678-7883 (day), (360) 678-0559 (evenings)  
E-mail: [mikeet@co.island.wa.us](mailto:mikeet@co.island.wa.us)

## **SOUTH KING COUNTY FATHERS NETWORK**

Children's Therapy Center  
10811 SE Kent-Kangley Road  
Kent, WA 98030  
Contact: **Jason Maji**, facilitator (425) 766-7479  
E-mail: [jlmaji@comcast.net](mailto:jlmaji@comcast.net)

## **KITSAP COUNTY — FATHERS NETWORK**

7669 Colony Court NE  
Bremerton, WA 98311  
Contact: **Doug Stauner**, facilitator (360) 692-4670  
E-mail: [Doug\\_st@hotmail.com](mailto:Doug_st@hotmail.com)

## **LYNNWOOD –FATHERS NETWORK**

Little Red School House  
3210-200<sup>th</sup> Place SW  
Lynnwood, WA 98036  
Contact: **David Calhoun**, facilitator (425) 328-4528  
E-mail: [david.calhoun@littlered.org](mailto:david.calhoun@littlered.org)

## **MOSES LAKE/OTHELLO — FATHERS NETWORK**

Grant/Adams Parent to Parent  
605 Coolidge St.  
Moses Lake, WA 98837  
Contact: **Jennifer Newhouse** (509) 764-7424  
E-mail: [jnewhouse@mlchc.org](mailto:jnewhouse@mlchc.org)

## **SEATTLE — FATHERS NETWORK EEU**

University of Washington  
Experimental Education Unit  
Box 357920  
Seattle, WA 98195-7920 (Facilitator: **Bill Scott**)  
Contact: (Front desk) (206) 543-4011

## **SEATTLE — FATHERS PROGRAM BOYER CLINIC**

Boyer Child Clinic  
1850 Boyer Avenue North  
Seattle, WA 98112  
Contact: **Bill Scott**, facilitator (206) 325-8477  
E-mail: [bill.scott@boyercc.org](mailto:bill.scott@boyercc.org)

## **SNOHOMISH COUNTY — FATHERS NETWORK**

Arc of Snohomish County  
2500 Hewitt Avenue  
Suite 300  
Everett, WA 98201  
Facilitators: **Jeff Atkins & James Loaris**  
E-mail: [fathersnetwork@arcosno.org](mailto:fathersnetwork@arcosno.org)

## **SPOKANE - FATHERS NETWORK**

Arc of Spokane  
320 East 2<sup>nd</sup> Avenue  
Spokane, WA 99202  
Contact: **Brian Holloway**, facilitator  
(509) 789-8321-office  
Email: [bholloway@arc-spokane.org](mailto:bholloway@arc-spokane.org)

## **TACOMA – FATHERS NETWORK**

PAVE  
6316 South 12th Street  
Tacoma, WA 98465  
(253) 565-2266

## **THURSTON COUNTY — FATHERS NETWORK**

Contact: **Gregg Osborne**, facilitator – 360-878-7518  
E-mail: [fathersnetwork@gmail.com](mailto:fathersnetwork@gmail.com)

## **YAKIMA FATHERS NETWORK**

1116 S. 8<sup>th</sup> Avenue  
Yakima, WA 98902  
**John Mahaney** (509) 248-0843(hm.); 509-307-0403  
E-mail: [MahaneyJohn@aol.com](mailto:MahaneyJohn@aol.com)

## **WALLA WALLA — FATHERS NETWORK**

Contact: **Alan Schroeder**, facilitator (509) 520-8012 (cell)  
(509) 529-9260 (office)  
E-mail: [aschroeder@andersonperry.com](mailto:aschroeder@andersonperry.com)

## **WENATCHEE — FATHERS NETWORK**

Children's Home Society  
1014 Walla Walla Street  
Wenatchee, WA 98801  
Phone: (509) 663-0034  
Contact: **Ignacio Chavez**, facilitator (509) 662-8249

6-9-14



# WASHINGTON STATE PARENT TO PARENT SUPPORT PROGRAMS SITES AND COORDINATORS – May, 2014

**STATE PARENT TO PARENT OFFICE**  
**SUSAN ATKINS, State Coordinator**  
 Washington State P2P Programs  
 4738 172nd Ct. S.E.  
 Bellevue, WA 98006  
 VOICE: (425) 641-7504, CELL: (425) 269-3267  
 Toll Free: (800) 821-5927  
 E-MAIL: [statep2p@earthlink.net](mailto:statep2p@earthlink.net)  
 SPONSORING AGENCY: The Arc of Washington State  
 2638 State Ave. NE, Olympia, WA 98506  
 Cathy Davis, Administrative Assistant  
 E-MAIL: [cathy@arcwa.org](mailto:cathy@arcwa.org)  
 VOICE: (360) 357-5596 Toll Free: (888) 754-8798  
 Fax: (360) 357-3279 website: [www.arcwa.org](http://www.arcwa.org)  
 Facebook: Parent to Parent of Washington State

## State Resources

**GINGER KWAN**  
 Open Doors for Multicultural Families  
 VOICE: (206) 372-1072  
 E-MAIL: [gingerk@multiculturalfamilies.org](mailto:gingerk@multiculturalfamilies.org)  
 Website: [www.multiculturalfamilies.org](http://www.multiculturalfamilies.org)

## Parent Support Program Seattle Children's

**LAWRIE WILLIAMS, Coordinator**  
 MS-W3636  
 P.O. Box 5371  
 Seattle, WA 98105  
 VOICE: (206) 987-1119  
 E-MAIL: [lawrie.williams@seattlechildrens.org](mailto:lawrie.williams@seattlechildrens.org)  
 Website: <http://cshcn.org/support-connection/parent-support-program/>

## PENINSULA REGION

### Thurston/Mason Counties

**SYLVIA HEISER, Coordinator**  
 South Sound Parent to Parent  
 1012 Homann Dr. SE  
 Lacey, WA 98503  
**Program Activities:** Spanish Language Line, Helping Parent, Parent to Parent Support Groups, Autism Support, Online Autism Support, Down Syndrome Support and activities, Mom to Mom, Sibshops, Family Activities, Annual Family Picnic, Buddy Walk, Infant/Toddler Early Intervention Program (ESIT), Transition/IEP Support, Toy/Equipment/Book lending program, Information and referral, website, monthly newsletter  
 VOICE: (360) 352-1126 (main line & Spanish Language Line), Toll Free: (877) 352-1126  
 FAX: (360) 352-0761  
 E-MAIL: [sheiser@ssp2p.org](mailto:sheiser@ssp2p.org)  
 SPONSORING AGENCY: 501(C) 3 Parent to Parent of Thurston County  
 Website: [www.ssp2p.org](http://www.ssp2p.org)  
 Facebook: South Sound Parent to Parent (<http://www.facebook.com/#!/pages/South-Sound-Parent-to-Parent/107941882604130>)

### Kitsap/Jefferson/Clallam Counties

**HOLLY PATTON, Coordinator**  
 3243 North Perry Avenue  
 Bremerton, WA 98310  
**Program Activities:** newsletter, workshops, resources  
 VOICE: (360) 377-3473  
 E-MAIL: [holly@arckj.org](mailto:holly@arckj.org)  
 SPONSORING AGENCY: The Arc of Kitsap & Jefferson Counties  
 Website: [www.arckj.org](http://www.arckj.org)

### Grays Harbor/Pacific Counties

**CHARLENE McCARTY- P2P/Sr. Parent Caregiver Coordinator**  
 523 West First St.  
 Aberdeen, WA 98520  
**Program Activities:** Support, Informational & Referral via phone, e-mail, list serve, Informational & Educational Newsletter and website, Educational workshops on schools I.E.P. (Individual Education Plan) and 504 plans, Love & Logic Parenting Classes, Autism 200 Videoconference series, etc., Inclusive Family Winterfest, Summer Picnic and Informational Navigating Your Way gatherings.  
 VOICE: (360) 537-7000 Toll Free 1-866-537-7272  
 FAX: (360) 537-8816  
 E-MAIL: [charlenem@arcgh.org](mailto:charlenem@arcgh.org)  
 SPONSORING AGENCY: The Arc of Grays Harbor  
 Website: [www.arcgh.org](http://www.arcgh.org)  
 Facebook: The Arc of Grays Harbor (<http://www.facebook.com/#!/pages/The-Arc-of-Grays-Harbor/140300235985061>)

## PIERCE / KING REGION

### Pierce County

**MICHELE LEHOSKY, Coordinator, ext. 104**  
**SUSAN JACKSON, Co-Coordinator, ext. 107**  
 6316 S. 12th St.  
 Tacoma, WA 98465  
**Program Activities:** Community Inclusion Program, List serve support, Information and Referral, Down Syndrome Support group, Mom's Night Out, Person Centered Planning workshops, Spanish Support Group, Conversations & Coffee  
 VOICE: (253) 565-2266, ext. 104, Mon.-Fri. 1:00 – 4:30  
 V/TTY: (253) 565-2266 OR 1-800-5PARENT  
 FAX: (253) 566-8052  
 E-MAIL: [MLEhosky@wapave.org](mailto:MLEhosky@wapave.org), [sjackson@wapave.org](mailto:sjackson@wapave.org)  
 SPONSORING AGENCY: Washington PAVE  
 Website: <http://piercecountyparent2parent.org>, <http://communityinclusionprogram.org>  
 Facebook: Parent to Parent and Community (<http://www.facebook.com/#!/washingtonpave>)

### King County

**CATHY MURAHASHI, Coordinator**  
 233 6th Avenue North  
 Seattle, WA 98109  
**Program Activities:** Parent Support groups, Information and referral, Email support and information groups, Spanish Support group, Senior Family Caregiver project, Parent education, Multicultural Information and Support; Spanish, Vietnamese, & Somali  
 VOICE: (206) 364-6337  
 To contact Cathy Murahashi: (206) 829-7039  
 FAX: (206) 364-8140  
 E-MAIL: [cmurahashi@arcofkingcounty.org](mailto:cmurahashi@arcofkingcounty.org)  
 SPONSORING AGENCY: The Arc of King County  
 Website: [www.arcofkingcounty.org](http://www.arcofkingcounty.org)





# WASHINGTON STATE PARENT TO PARENT SUPPORT PROGRAMS SITES AND COORDINATORS – May, 2014

## NORTHWEST REGION

### Skagit County

HEATHER MILLIREN, Coordinator, ext. 401  
AMANDA SLOAN, Assistant Coordinator, ext. 402  
KIM IRISH, Assistant Coordinator, ext. 402  
GABBY LOPEZ, Hispanic Outreach Specialist, ext. 414  
320 Pacific Place  
Mt. Vernon, WA 98273

**Program Activities:** Resources, lending library, support meetings, educational workshops, recreational activities, annual Helping Parent Training, Legos in the Libraries, annual moms' and dads' events, bi-monthly Autism parent support brunches, quarterly Down syndrome family events and annual Buddy Walk, semi-annual newsletters (English & Spanish), annual Hispanic family event (support, education and/or social), and Spanish translation available.

VOICE: (360) 416-7570, ext. 401

FAX: (360) 416-7580

E-MAIL: [p2p@sparckids.org](mailto:p2p@sparckids.org), [amanda@sparckids.org](mailto:amanda@sparckids.org), [kim@sparckids.org](mailto:kim@sparckids.org), [hispanicp2p@sparckids.org](mailto:hispanicp2p@sparckids.org)

SPONSORING AGENCY: SPARC

Website: [www.skagitp2p.org](http://www.skagitp2p.org)

### Snohomish County

JAMIE COONTS, Coordinator, ext. 104  
ALAINA KUBE, Co-Coordinator, ext. 111  
SUGELY SANCHEZ, Hispanic Outreach Coordinator, ext. 106  
2500 Hewitt Ave Suite 300  
Everett, WA 98201

**Program Activities:** Helping Parent, Mothers Network, Fathers Network, Mom n Me Group, Autism Support Group, English & Spanish Parent Groups, Monthly Parent Speaker Night, Lego Club, Family Activities, Sibshops, Special Education Speakers & Support, Caregiver Support Group, Weekly/Bi-weekly Arc Happenings e-mail Newsletter with events & resources, Website Calendar, Book & Video Lending Library

VOICE: (425) 258-2459

FAX: (425) 252-8232

E-MAIL: [jamie@arcsno.org](mailto:jamie@arcsno.org), [alaina@arcsno.org](mailto:alaina@arcsno.org), [sugely@arcsno.org](mailto:sugely@arcsno.org)

SPONSORING AGENCY: The Arc of Snohomish County

Website: [www.arcsno.org](http://www.arcsno.org)

### Whatcom County

CHRISTINE GRIFFIN, Coordinator, ext. 1  
KARLENE UMBAUGH, Community Outreach, ext. 3  
MARCELA JIMENEZ, Latino Community Coordinator, ext. 2  
2001 H Street  
Bellingham, WA 98225

**Program Activities:** Bi-Monthly Newsletter, Monthly Support Meetings, Family Inclusive Events, Parent Workshop, Super Sitter Training, Helping Parent Training, Quarterly Sibshops, Hispanic Outreach Family Events, Book & Video Lending Library, and Parent Matches.

VOICE: (360) 255-2056

FAX: (360) 650-9411

E-MAIL: [christine@p2pwhatcom.org](mailto:christine@p2pwhatcom.org), [karlene@p2pwhatcom.org](mailto:karlene@p2pwhatcom.org), [familia@p2pwhatcom.org](mailto:familia@p2pwhatcom.org)

SPONSORING AGENCY: Whatcom Center for Early Learning

Website: [www.p2pwhatcom.org](http://www.p2pwhatcom.org)

### Island/San Juan Counties

**NO PROGRAM  
FUNDING ELIMINATED**

## SOUTHWEST REGION

### Lewis County

ANGELA NAILLON, Coordinator  
AMBER WHITE, Co-Coordinator  
P.O. Box 870  
203 W. Reynolds Ave.  
Centralia, WA 98531

**Program Activities:** Quarterly parent support meetings, newsletter, resource & referral service, video & book lending library, Helping Parent Training, educational trainings and family events

VOICE: (360) 880-0672 or (360) 736-9558; (360) 269-4828

FAX: (360) 736-1436

E-MAIL: [anailon@reliableenterprises.org](mailto:anailon@reliableenterprises.org), [awhite@reliableenterprises.org](mailto:awhite@reliableenterprises.org)

SPONSORING AGENCY: Reliable Enterprises

Website: [www.reliableenterprises.org](http://www.reliableenterprises.org)

### Clark County

BRENDA TYRRELL, Coordinator  
MARIA RANGEL, Spanish Speaking Outreach Coordinator  
P.O. Box 2608  
Vancouver, WA 98668

**Program Activities:** Social Gatherings, Support Groups, Lending Library

VOICE: (360) 953-1597

FAX: (360) 759-4921

E-MAIL: [brendat@arcswwa.org](mailto:brendat@arcswwa.org), [maria@ccparentcoalition.org](mailto:maria@ccparentcoalition.org)

SPONSORING AGENCY: The Arc of Southwest Washington

Website: [www.arcswwa.org](http://www.arcswwa.org)

Facebook: Parent to Parent of SW Washington  
(<http://www.facebook.com/pages/Parent-to-Parent-of-SW-Washington/183154595037015>)

### Cowlitz County

LACEY CAIRNS, Coordinator  
906 New York Street  
Longview, WA 98632

**Program Activities:**

VOICE: (360) 425-5494

FAX: (360) 577-9137

E-MAIL: [laceycairns@lifeworkswa.org](mailto:laceycairns@lifeworkswa.org)

SPONSORING AGENCY: LifeWorks WA

Website: <http://www.lifeworkswa.org/wb2/index.php>

## EAST REGION

### Walla Walla/Columbia/Garfield/Asotin Counties

ANGELA BEAM, Coordinator  
YSABEL FUENTES, Hispanic Parent Outreach  
P.O. Box 1595  
Walla Walla, WA 99362

**Program Activities:** Parent Support Group, Educational & Teleconference Events, Family Events, Newsletter in English & Spanish, Lending Library, Sr. Family Caregiver Project, Sr. Care Provider's Monthly Dinner Meetings, Annual Legislative Tea, Annual Employment Fair, Children's Day in the spring, Translation services, Transitions, Housing, Requesting Transportation, Support for Parents at IEP Meetings, Guardianship Workshops, Whitman Buddy Program

VOICE: (509) 525-5433

FAX: (509) 525-5484

E-MAIL: [angelab@lilliericecenter.org](mailto:angelab@lilliericecenter.org), [ysabelf@lilliericecenter.org](mailto:ysabelf@lilliericecenter.org)

SPONSORING AGENCY: Lillie Rice Center, Inc.

Website: [www.lilliericecenter.org](http://www.lilliericecenter.org)



# WASHINGTON STATE PARENT TO PARENT SUPPORT PROGRAMS SITES AND COORDINATORS – May, 2014

## Benton/Franklin Counties

MELISSA BROOKS, Coordinator  
MARIA RAMOS, Hispanic Outreach Coordinator  
1455 Fowler St.  
Richland, WA 99352

**Program Activities:** Parent Support group with Educational classes, Activities for families, quarterly newsletter with The Arc of Tri-Cities, Senior Caregiver Project, work with the Northwest Epilepsy Foundation Grant, provide education and social activities for parents and youth.

VOICE: (509) 783-1131, ext. 108

FAX: (509) 735-7706

E-MAIL: [p2p@arcofricitities.com](mailto:p2p@arcofricitities.com), [archispanic11@yahoo.com](mailto:archispanic11@yahoo.com)

SPONSORING AGENCY: The Arc of Tri-Cities

Website: [arcofricitities.com](http://arcofricitities.com)

## Spokane/Lincoln/Whitman Counties

ROZ BETHMANN, Coordinator  
320 E. 2<sup>nd</sup> Ave.  
Spokane, WA 99202

**Program Activities:** Parent Support Group & Workshops, Parents 4 Life monthly meetings, Newsletter, Lending Library, Transition Support, Guardianship & IEP referrals, Annual Holiday Party & Summer Picnic, Annual Family Support Conference in the spring

VOICE: (509) 328-6326, ext. 8322

FAX: (509) 328-6342

E-MAIL: [rbethmann@arc-spokane.org](mailto:rbethmann@arc-spokane.org)

SPONSORING AGENCY: The Arc of Spokane

Website: [www.arc-spokane.org](http://www.arc-spokane.org)

## Stevens/Ferry/Pend Oreille Counties

**NO PROGRAM**

**FUNDING ELIMINATED**

## Yakima County

TRACIE HOPPIS, Coordinator  
AMY BERKHEIMER- Program Specialist  
LIZ CRUZ, Program Specialist  
JOHN MAHANEY, Event Support  
MARIA PULIDO, Hispanic Outreach  
3801 Kern Road  
Yakima, WA 98902

**Program Activities:** English and Spanish Parent Group, Hispanic Outreach, Sibshops, Recreational Program, Youth Group, Disability Awareness, Neonatal Intensive Care Unit Support Project, Newsletter, Autism Support Group, Family Social Events, New Diagnosis Support Group,

VOICE: (509) 574-3263

FAX: (509) 574-3210

E-MAIL: [traciehoppis@yvmh.org](mailto:traciehoppis@yvmh.org), [lizcruz@yvmh.org](mailto:lizcruz@yvmh.org),

[amyberkheimer@yvmh.org](mailto:amyberkheimer@yvmh.org)

SPONSORING AGENCY: Yakima Valley Memorial Hospital

Website: [www.yakimachildreenvillage.org](http://www.yakimachildreenvillage.org)

## Okanogan County

**NO PROGRAM**

## Chelan/Douglas Counties

**NO PROGRAM**

**FUNDING ELIMINATED**

## CENTRAL REGION

## Kittitas County

MICHELLE WILLIAMS, Coordinator  
P.O. Box 837  
111 E. University Way  
Ellensburg, WA 98926

**Program Activities:** Kittitas County - Parent Support Meetings, Autism/Asperger's Support Meetings, Family Social Events, Newsletters, Workshops, Information and Referral

Chelan/Douglas Counties - Support, Information and Referral

VOICE: (509) 929-7277

E-MAIL: [kittitascountyparent2parent@gmail.com](mailto:kittitascountyparent2parent@gmail.com)

SPONSORING AGENCY: Kittitas Valley Opportunities

## Grant/Adams Counties

JENNIFER NEWHOUSE, Coordinator  
CHRISTI DIERINGER, Outreach Coordinator  
ANNA ALVAREZ, Hispanic Outreach Coordinator  
605 Coolidge St.  
Moses Lake, WA 98837

**Program Activities:** Family Social Events, Mom's Night Out, Café Chat, Quarterly Parent Meetings, Kidtivity, Home Equipment Loan Program, Lending Library, Quarterly Newsletter, Disability Awareness Training, Lego Groups

VOICE: (509) 764-7424

FAX: (509) 765-5838

E-MAIL: [jnewhouse@mlchc.org](mailto:jnewhouse@mlchc.org), [cdieringer@mlchc.org](mailto:cdieringer@mlchc.org)

SPONSORING AGENCY: Moses Lake Community Health

Website: [www.mlchc.org](http://www.mlchc.org)



# WASHINGTON STATE PARENT TO PARENT SUPPORT PROGRAMS SITES AND COORDINATORS – September 2009

**STATE PARENT TO PARENT OFFICE**  
**SUSAN ATKINS, State Coordinator**  
 Washington State P2P Programs  
 4738 172nd Ct. S.E.  
 Bellevue, WA 98006  
 VOICE: (425) 641-7504, CELL: (425) 269-3267  
 Toll Free: (800) 821-5927  
 E-MAIL: [statep2p@earthlink.net](mailto:statep2p@earthlink.net)  
 SPONSORING AGENCY: The Arc of Washington State  
 2638 State Ave. NE, Olympia, WA 98506  
 Cathy Davis, Administrative Assistant  
 E-MAIL: [cathy@arcwa.org](mailto:cathy@arcwa.org)  
 VOICE: (360) 357-5596 Toll Free: (888) 754-8798  
 Fax: (360) 357-3279 website: [www.arcwa.org](http://www.arcwa.org)

### State Resources

**YVONE LINK**  
 Parent to Parent Power for Asian Families  
 1118 S. 142nd St., Suite B  
 Tacoma, WA 98444  
 VOICE: (253) 531-2022  
 FAX: (253) 538-1126  
 E-MAIL: [yvone\\_link@yahoo.com](mailto:yvone_link@yahoo.com)  
 Website: [www.p2ppower.org](http://www.p2ppower.org)

### Parent Support Program Children's Hospital

LAWRIE WILLIAMS, Coordinator  
 MS-W3636  
 P.O. Box 5371  
 Seattle, WA 98105  
 VOICE: (206) 987-1119  
 E-MAIL: [lawrie.williams@seattlechildrens.org](mailto:lawrie.williams@seattlechildrens.org)

## PENINSULA REGION

### Kitsap/Jefferson/Clallam Counties

**SHERRY CHARLOT (REGIONAL REP.)** Kitsap Coordinator  
**JENELL DEMATTEO**, Jefferson/Clallam Coordinator  
 3243 North Perry Avenue  
 Bremerton, WA 98310  
**Program Activities:**

VOICE: (360) 377-3473  
 E-MAIL: [sherry@arckj.org](mailto:sherry@arckj.org), [jenell@arckj.org](mailto:jenell@arckj.org)  
 SPONSORING AGENCY: The Arc of Kitsap & Jefferson Counties  
 Website: [www.arckj.org](http://www.arckj.org)

### Thurston/Mason Counties

SYLVIA HEISER, Coordinator  
 MATT GRAFFAGNINO, Coordinator  
 South Sound Parent to Parent  
 1012 Homann Dr. SE  
 Lacey, WA 98503  
**Program Activities:**

VOICE: (360) 352-1126, Toll Free: (877) 352-1126  
 FAX: (360) 352-0761  
 E-MAIL: [sheiser@ssp2p.org](mailto:sheiser@ssp2p.org), [mgraffagnino@ssp2p.org](mailto:mgraffagnino@ssp2p.org)  
 SPONSORING AGENCY: 501(C) 3 Parent to Parent of Thurston County  
 Website: [www.ssp2p.org](http://www.ssp2p.org)

### Grays Harbor/Pacific Counties

ANGIE LARSEN, Coordinator  
 LORETTA MARLOW, Pacific Coordinator  
 LESLIE GADWA, Ethnic Outreach Coordinator  
 CHERI GOERES & CHERYL GRUBER, Sr. Parent Caregiver Coordinators  
 P.O. Box 1794  
 Aberdeen, WA 98520  
**Program Activities:**

VOICE: (360) 537-7000  
 FAX: (360) 537-8816  
 E-MAIL: [p2pgh@techline.com](mailto:p2pgh@techline.com)  
 SPONSORING AGENCY: The Arc of Grays Harbor  
 Website:

## PIERCE / KING REGION

### Pierce County

**MICHELE LEHOSKY (REGIONAL REP.)** Coordinator  
**SUSAN JACKSON**, Co-Coordinator  
 6316 S. 12th St.  
 Tacoma, WA 98465  
**Program Activities:**

VOICE: (253) 565-2266 Mon.-Fri. 1:00 – 4:30  
 V/TTY: (253) 565-2266 OR 1-800-5PARENT  
 FAX: (253) 566-8052  
 E-MAIL: [mmlehosky@wapave.org](mailto:mmlehosky@wapave.org), [sjackson@wapave.org](mailto:sjackson@wapave.org)  
 SPONSORING AGENCY: Washington PAVE  
 Website: [www.washingtonpave.com](http://www.washingtonpave.com)

### King County

CATHY MURAHASHI, Coordinator  
 XOCHITL GONZALES, Spanish Liaison  
 233 6th Avenue North  
 Seattle, WA 98109  
**Program Activities:** Parent Support groups, Information and referral, Email support and information groups, Spanish Support group, Senior Family Caregiver project, Parent education, Recreation activities.  
 VOICE: (206) 829-7039 (T/Th), (425) 643-4048 (W/F)  
 To Contact Xochitl Gonzalez: (206) 829-7004, ext. 7043  
 FAX: (206) 364-8140  
 E-MAIL: [cmurahashi@arcofkingcounty.org](mailto:cmurahashi@arcofkingcounty.org), [xgonzalez@arcofkingcounty.org](mailto:xgonzalez@arcofkingcounty.org)  
 SPONSORING AGENCY: The Arc of King County  
 Website: [www.arcofkingcounty.org](http://www.arcofkingcounty.org)



# WASHINGTON STATE PARENT TO PARENT SUPPORT PROGRAMS SITES AND COORDINATORS – September 2009

## NORTHWEST REGION

### Skagit/Island/San Juan Counties

HEATHER MILLIREN, (REGIONAL REP.) Coordinator, ext. 401  
CINDY HUBERT, Birth to Three Consultant, ext. 406  
ALMA LOPEZ, Hispanic Outreach Specialist, ext. 414  
320 Pacific Place  
Mt. Vernon, WA 98273

#### Program Activities:

VOICE: (360) 416-7570  
FAX: (360) 416-7580  
E-MAIL: [p2p@sparckids.org](mailto:p2p@sparckids.org)  
SPONSORING AGENCY: SPARC  
Website: [www.skagitp2p.org](http://www.skagitp2p.org)

### Snohomish County

JAMIE COONTS, Coordinator, ext. 104  
TRACIE DIEMERT, Co-Coordinator, ext. 111  
JESSIE ATKINS, Co-Coordinator, ext. 105  
P.O. Box 13177  
Everett, WA 98206

#### Program Activities:

VOICE: (425) 258-2459  
FAX: (425) 252-8232  
E-MAIL: [jamie@arcsno.org](mailto:jamie@arcsno.org), [tracie@arcsno.org](mailto:tracie@arcsno.org), [jessie@arcsno.org](mailto:jessie@arcsno.org)  
SPONSORING AGENCY: The Arc of Snohomish County  
Website: [www.arcsno.org](http://www.arcsno.org)

### Whatcom County

CHRISTINE GRIFFIN, Coordinator, ext. 1  
ALINA ZOLLFRANK, Hispanic Outreach, ext. 2  
KARLENE CARLSON, Community Outreach, ext. 3  
2001 H Street  
Bellingham, WA 98225

**Program Activities:** Bi-Monthly Newsletter, Monthly Support Meetings, Family Inclusive Events, Parent Workshop, Super Sitter Training, Helping Parent Training, Quarterly Sibshops, Hispanic Outreach Family Events, and Parent Matches.

VOICE: (360) 255-2056  
FAX: (360) 650-9411  
E-MAIL: [christine@p2pwhatcom.org](mailto:christine@p2pwhatcom.org), [alina@p2pwhatcom.org](mailto:alina@p2pwhatcom.org),  
[karlene@p2pwhatcom.org](mailto:karlene@p2pwhatcom.org)  
SPONSORING AGENCY: Whatcom Center for Early Learning  
Website: [www.p2pwhatcom.org](http://www.p2pwhatcom.org)

## SOUTHWEST REGION

### Lewis County

PAULA ZAMUDIO, (REGIONAL REP.) Coordinator  
ANGELA NAILLON, Co-Coordinator  
203 W. Reynolds Rd.  
Centralia, WA 98531

**Program Activities:** Quarterly parent support meetings, newsletter, resource & referral service, helping parent training, educational trainings and family events

VOICE: (360) 880-0672 or (360) 736-9558; (360) 269-4828  
FAX: (360) 736-1436  
E-MAIL: [pzamudio@reliableenterprises.org](mailto:pzamudio@reliableenterprises.org), [anailon@reliableenterprises.org](mailto:anailon@reliableenterprises.org)  
SPONSORING AGENCY: Reliable Enterprises  
Website: [www.reliableenterprises.org](http://www.reliableenterprises.org)

### Clark/Skamania Counties

KATHY WEBER, Coordinator  
P.O. Box 2608  
Vancouver, WA 98668

#### Program Activities:

VOICE: (360) 759-4917, ext. 109  
FAX: (360) 896-7382  
E-MAIL: [kathyw@arcoclarkcounty.org](mailto:kathyw@arcoclarkcounty.org)  
SPONSORING AGENCY: The Arc of Clark County  
Website: [www.arcoclarkcounty.org](http://www.arcoclarkcounty.org)

### Cowlitz/Wahkiakum Counties

NO COORDINATOR  
600 Royal Street, Suite A  
Kelso, WA 98626

#### Program Activities:

VOICE: (360) 425-3264  
E-MAIL:  
SPONSORING AGENCY: The Arc of Cowlitz Valley  
Website: [www.cowlitzarc.org](http://www.cowlitzarc.org)

### Klickitat County

**NO PROGRAM  
FUNDING ELIMINATED**



# WASHINGTON STATE PARENT TO PARENT SUPPORT PROGRAMS SITES AND COORDINATORS – September 2009

## EAST REGION

### Walla Walla/Columbia/Garfield/Asotin Counties

TERI HOUGH, (REGIONAL REP.) Coordinator  
ANGIE WITT, Coordinator  
CARLA L. NIBLER, Sr. Parent Coordinator  
YSABEL FUENTES, Hispanic Outreach  
P.O. Box 1595  
Walla Walla, WA 99362  
**Program Activities:**

VOICE: (509) 524-2920  
FAX: (509) 524-2992, TDD: (509) 524-2994  
E-MAIL: [though@co.walla-walla.wa.us](mailto:though@co.walla-walla.wa.us), [walla2parenttoparent@hotmail.com](mailto:walla2parenttoparent@hotmail.com),  
[yfuentes@co.walla-walla.wa.us](mailto:yfuentes@co.walla-walla.wa.us), [cnibler@co.walla-walla.wa.us](mailto:cnibler@co.walla-walla.wa.us)  
SPONSORING AGENCY: Walla Walla County Dept. of Human Services  
Website: [www.co.walla-walla.wa.us/departments/hrs/index.shtml](http://www.co.walla-walla.wa.us/departments/hrs/index.shtml)

### Benton/Franklin Counties

PATTY CAREY, Coordinator  
MARIA RAMOS, Hispanic Outreach Coordinator  
761 Williams Blvd.  
Richland, WA 99354  
**Program Activities:**

VOICE: (509) 946-5157, ext. 108  
FAX: (509) 946-5346  
E-MAIL: [Arc\\_parenttoparent@yahoo.com](mailto:Arc_parenttoparent@yahoo.com), [archispanic11@yahoo.com](mailto:archispanic11@yahoo.com)  
SPONSORING AGENCY: The Arc of Tri-Cities  
Website: [arcofricities.com](http://arcofricities.com)

### Spokane/Lincoln/Whitman Counties

HELEN BLACK, Coordinator  
W. 127 Boone Ave.  
Spokane, WA 99201  
**Program Activities:**

VOICE: (509) 328-6326, ext. 220  
FAX: (509) 328-6342  
E-MAIL: [hblack@arc-spokane.org](mailto:hblack@arc-spokane.org)  
SPONSORING AGENCY: The Arc of Spokane  
Website: [www.arc-spokane.org](http://www.arc-spokane.org)

### Stevens/Ferry/Pend Oreille Counties

**NO PROGRAM  
FUNDING ELIMINATED**

## CENTRAL REGION

### Kittitas/Chelan/Douglas Counties

MICHELLE WILLIAMS, (REGIONAL REP.) Coordinator  
P.O. Box 837  
111 E. University Way  
Ellensburg, WA 98926  
Program Activities: Kittitas County - Parent Support Meetings, Autism/Asperger's Support Meetings, Family Social Events, Newsletters, Workshops, Information and Referral  
Chelan/Douglas Counties - Newsletters, Support, Information and Referral  
VOICE: (509) 929-7277  
E-MAIL: [rolftw@charter.net](mailto:rolftw@charter.net)  
SPONSORING AGENCY: Kittitas Valley Opportunities

### Grant/Adams/Okanogan Counties

JENNIFER NEWHOUSE, Coordinator  
CHRISTI DIERINGER, Outreach Coordinator  
ANNA ALVAREZ, Hispanic Outreach Coordinator  
605 Coolidge St.  
Moses Lake, WA 98837  
**Program Activities:**

VOICE: (509) 765-5809  
FAX: (509) 765-5838  
E-MAIL: [jnewhouse@mlchc.org](mailto:jnewhouse@mlchc.org)  
SPONSORING AGENCY: Moses Lake Community Health  
Website: [www.mlchc.org](http://www.mlchc.org)

### Yakima County

TRACIE HOPPIS, Coordinator  
MARIA PULIDO, Hispanic Outreach  
MARYLYNNE BREWINGTON, Disability Awareness Coordinator  
MARLA BARSTAD & KRISTI MESSER, Recreation Coordinators  
SANDRA LINDE, Inclusive Community Coordinator: Sunnyside  
3801 Kern Road  
Yakima, WA 98902  
**Program Activities:**

VOICE: (509) 574-3200  
FAX: (509) 574-3210  
E-MAIL: [tracie.hoppis@ymh.org](mailto:tracie.hoppis@ymh.org)  
SPONSORING AGENCY: Yakima Valley Memorial Hospital  
Website: [www.yakimachildrenewillage.org](http://www.yakimachildrenewillage.org)