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THE MADIGAN ARMY MEDICAL CENTER
CHILDREN WITH DISABILITIES COORDINATED CARE PROGRAM:
A CASE STUDY

A Graduate Management Project
Submitted to the Faculty of
Baylor University
In Partial Fulfillment of the
Requirements for the Degree
of
Master of Health Administration
by
Captain David E. Godfrey, MS
July 1992

Running Head: MAMC Program

Acknowledgments

This project would not have been accomplished without the assistance of many individuals, most of whom will not be named. However, there are several key players in any game and these are the stars of this one.

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In addition, I would be remiss if I did not dedicate this work to my wife and daughter for their unending patience and understanding during the various stages of this endeavor.

Abstract

A case study of the Children with Disabilities Coordinated Care Program at Madigan Army Medical Center (MAMC) was conducted to describe and analyze the program for potential future expansion. The program is a pilot project for a Department of Defense-wide comprehensive support program to families of children with special health care needs. Historically, there has been no standard method for these children and their families to receive available benefits. A variable combination of MAMC providers and several state and federal agencies supplied disabled children with care and funding, but did so with very little coordination. The Children with Disabilities Coordinated Care Program was created to combat these problems and utilizes current developmental pediatrics techniques to improve the quality of care, while applying coordinated care innovations to attempt to provide improved access and family support. Since the MAMC program is a DOD pilot project, a clear description and analysis of the program is necessary prior to expansion to other facilities and agencies.

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APPENDIX

Introduction

The need for the Children with Disabilities Coordinated Care Program was recognized primarily in response to problems with access to adequate care encountered by disabled children who are family members of military personnel. Ambiguous wording of the Department of Defense regulation (DOD 6010.8-R) which governs the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) Program for the Handicapped (PFTH) and recent changes in funding guidance from the Department of Health and Human Services (DHHS) Maternal and Child Health Program has resulted in many disabled military children receiving few or no benefits from either source. CHAMPUS fiscal intermediaries would not act upon applications for PFTH funding, while state and local agencies that are dependent upon DHHS support faced decreased funding and curtailed support to dependents of military personnel. Consequently, if the military Direct Healthcare Service System does not have sufficient numbers of appropriately trained health care professionals to provide necessary services, the DOD cannot fulfill its responsibility to care for these children (Bynum, 1991).

At the local level, evaluation and care (in the form of medical services, supplies and equipment) of children with disabilities has been done by physician and non-physician providers, both military and non-military. Coordination between these providers was on a case by case basis, with no documentation of adequate interaction between involved professionals and agencies. It appears likely that minimal coordination and duplication of effort was routinely accepted as an unavoidable by-product of the system (Kelly, 1991). From the beneficiaries view, the running between providers and filling out of forms must appear as an endless cycle of futility.

Obviously, this situation is not tolerable, either to the DOD or the beneficiary population. Hence, the recent establishment of a DOD pilot program for the timely and efficient provision of health care to dependent children with disabilities. This will be accomplished through coordination of military health resources with civilian and military community resources and federal and state programs that serve disabled children.

Statement of the Management Problem

A lack of coordination and possible duplication of effort in providing services and equipment in the care of children with disabilities appears to be causing impaired patient access to care and a lack of support to the beneficiaries family. A DOD directed pilot project is being initiated in an effort to correct this situation. A description and analysis of this project is key in the determination of its level of effectiveness in the provision of better care.

Review of the Literature

The PFTH, which represents a major source of support for dependent children with special health care needs, is one of two major programs under CHAMPUS. In 1977, the first federal regulations governing CHAMPUS established the Basic Program for general medical funding, as well as the Program for the Handicapped. The PFTH was limited to military dependents with moderate or severe mental retardation or serious physical handicap and has different cost sharing and benefits than the Basic Program (OCHAMPUS, 1991).

However, it was only when the CHAMPUS budget was combined by Congress into the three military departments allocations for each fiscal year that DOD became officially involved (Badgett, 1990). Prior to October 1988, the military direct health care system and the CHAMPUS system were separate entities. This was followed in 1989 by the allocation of the CHAMPUS budget into catchment areas. These actions were an attempt by Congress to improve the quality and cost effectiveness of care in the DOD health care system and appear to be the beginnings of coordinated care in the military system.

Since that time, DOD has initiated several demonstration projects to integrate coordinated care into the Military Health Service System (MHSS). These reforms have been manifested in the form of the CHAMPUS Reform Initiative (CRI), Catchment Area Management (CAM), and other coordinated care projects. These projects are all currently being evaluated to determine the extent to which they actually contain costs, while maintaining or expanding access to care (Braendel, 1990). While Madigan Army Medical Center is not currently the site of one of the major demonstration projects mentioned above, the Children with Disabilities Coordinated Care Program can be considered a microcosm of the larger projects with its own unique situation to be evaluated.

Similarly, a nationwide call has come from interested health care providers in support of coordinated care for handicapped children. From beginnings with the Social Security Act in the 1960's, to Public Law 94-142, The Education For All Handicapped Children Act in the 1970's and ultimately to Public Law 99-457, Education for the Handicapped Act Amendments of 1986 (Part H), the federal government has enacted policy that reflects this same sentiment (Gallagher, 1989; Baker, 1991). In fact, Public Law 99-457 virtually requires state governors to establish agencies for the coordination of case managers, interagency councils, and multidisciplinary intervention assessment means for handicapped children (It should be noted that all states are complying to a greater or lesser extent to this policy of coordinated care)(Gallagher, 1989; Hutchins & McPherson, 1991).

This movement appears to have gained impetus in 1987 when Dr. C. Everett Koop, then Surgeon General of the Public Health Service, published a report on the subject. He called for "a national agenda for families and professionals involved in the care of children with special health care needs (handicapped children) to improve the lives of these children and their families through a system of family-centered, community based, coordinated care" (Brewer, McPherson, Magrab and Hutchins, 1989, p. 1055; Hutchins & McPherson, 1991). Since that time, providers, administrators and politicians at the local, state and national levels have become more involved. Despite these efforts, large gaps remain in the actual funding and provision of care to this segment of the population. State programs that support families of disabled children reach about 130,000 families each year (Karp & Bradley, 1991). With approximately 140,000 children born every year with various handicapping disorders, the burden on already hard-pressed budgets can only increase (Baker, 1991; Karp & Bradley, 1991).

The MHSS is no exception to this dilemma. Problems with beneficiary access to and funding from the PFTH recently prompted a complete review of the administrative structure and subsequent proposed changes to the federal regulations governing the program. Several of these changes were key to the establishment of the Children with Disabilities Coordinated Care Program, as well. Most notable are the proposals that would allow OCHAMPUS to make agreements "when appropriate to secure improvements in the quality, efficiency, convenience, or cost effectiveness of the PFTH" and the local MHSS commanders to make "case-specific nonavailability of public facility resources" decisions (Bynum, 1991, p. 26636).

These types of relatively radical changes to established regulations reflect the urgency with which programs that benefit children with special health care needs are viewed. Given this virtual mandate from both the civilian sector and government to establish such programs, the current piecemeal nature of support and treatment services, and the lack of descriptive research in the area, the need for this project becomes apparent (Perrin, 1990).

Purpose

The purpose of this project is twofold; first, to describe the MAMC Children with Disabilities Coordinated Care Program in sufficient detail to be of help to future implementation efforts and second, to determine whether the program actually increases support for the beneficiaries and their families.

Methods and Procedures

The case study method of research is employed in this project for the purposes of description and exploration of the MAMC Children with Disabilities Coordinated Care Program. According to Marshall & Rossman (1989) this strategy is appropriately utilized in qualitative research for these purposes. In addition, Sypher (1990, p. 4) states that "the purpose of a case study is to describe real-life events in such a way as to enhance our understanding and to bolster our insight in ways that other methods could or normally would not". Consequently, the case study method appears valid for the purposes of this project.

Study Design. The multiple-case design method of case study was utilized to describe and analyze the program. A select number of individual cases from the MAMC Children with Disabilities Coordinated Care Program was identified from care plans on file within the existing program. The individual cases to be studied were selected on the basis of longevity in the program, utilization of the program, and availability and the willingness of the subjects for interview and observation. Evidence for the case studies came from multiple sources, including in-depth interviews, direct observations, and review of records and documentation. Case reports were written for each individual case and the results compared. This allowed for cross-case analysis and enhanced the significance of the overall results (Yin, 1984).

Interviews were conducted at the CHAMPUS Health Benefits Advisor Office at MAMC as this was a familiar place for those being interviewed. A standardized protocol of topics and questions was used (see Table 1). However, a conversational tone was maintained in order to allow the participants to clearly state their views and thus provide more meaningful information (Marshall & Rossman, 1989). Observations of health care providers, health benefits advisors, clerical staff and beneficiaries were conducted during various times to describe events and behaviors surrounding the program. Information was also gleaned from case records, newsclippings, memoranda, reports, operating procedures and miscellaneous administrative documents.

Ethical Considerations. The confidentiality of all information was protected. All documents received from the program staff were properly maintained and not released to any third parties. All results were coded without using names to ensure that no individual can be directly identified from this analysis. All records were returned to the program staff at the conclusion of this project.

Reliability and Validity. Reliability was reinforced by utilizing the standard case study protocols described above for each of the individual cases (Yin, 1984). Enhanced documentation of the procedures used in the cases will result and should help to insure replicability of the methods used.

Construct validity was established by using multiple sources of evidence in the collection of evidence for each case study, as described above. Further reinforcement of construct validity has been accomplished by the use of key subject matter informants to the project as reviewers of the draft case study (Yin, 1984).

Results

Program Description. The first step in the process of providing care to children eligible for this program is identification of a significant disability in the beneficiaries aged birth to 5 years. The term "significant disability" is defined for the purpose of this project, as a 25% or greater delay in any area of development or a clinical diagnosis that could result in such a delay during the first five years of life (DOD, 1991, p. 6-1). Any child suspected of meeting this definition should be referred to the program using the form found at Appendix A. Sources for referral are most commonly clinical, but occasionally educational and social work services or various local agencies participate.

Following a full medical evaluation by the primary care provider and any required evaluative consultations, the child is assigned a case manager. The case manager ensures that a complete developmental assessment is done in order to establish the child's level of functioning, recommended treatment and prognosis. The case manager then schedules an interdisciplinary case conference (commonly referred to as a "staffing"), which consists of the case manager and primary care provider with representation from developmental pediatrics, pediatric psychology, speech and language pathology, physical therapy and early childhood education, as a minimum. A proposed comprehensive care plan is developed at this time. A sample care plan can be found at Appendix B. Essential elements of the care plan include functional goals, time frames and duration of services, and location and sources of funding for provision of services. The case manager is responsible to discuss the care plan with the parents of the beneficiary, insure their understanding, and obtain their input and approval. A request for modification of the plan by the parents is negotiated by the case manager and a subsequent case conference attended by some or all of the regular attendees may be required.

Once approved, the care plan is implemented by the case manager. Any required assistance in utilization of the most cost effective and appropriate funding agencies is supplied by a designated health benefits advisor from the facility Coordinated Care Division. Direct care at the local MHSS facility is preferred, but publicly provided services also are used to the greatest extent possible. Memoranda of understanding have been established with local agencies such as the Washington State Department of Social and Health Services (DSHS) and the Social Security Administration (SSA) in order to effect access to these services by integrating the involved agencies actions. Sample memoranda can be found at Appendices C through F. Other, less preferred sources of funding are CHAMPUS or supplemental care.

Close coordination with the beneficiaries parents is essential to their continued involvement and input to the program. Education, communication and reduction of barriers to access are used to improve parent satisfaction and compliance. Automated systems for centralized processing of patient clinical and administrative data allows integration of entry into both the MAMC program and local agencies. The potential for reduction in paperwork and required appointments for coordination has made implementation and expansion of automation capabilities a priority within the MAMC program.

Case Study A. Subject A was born in January of 1985 with a rare genetic disease called Nager Acrofacial Dystosis Syndrome. This has resulted in numerous disabling afflictions which include deafness, cleft palate, microcephaly and a gastrostomy for feeding. Treatments and medical equipment that have been required in the seven years since his birth include numerous surgical procedures, speech, feeding and physical therapy, hearing aids, suction equipment, and a cardio-respiratory monitor. He has been case managed by MAMC health benefits advisors since five days after his birth, but was only recently enrolled in the Children with Disabilities Coordinated Care Program.

As a military beneficiary, Subject A has been eligible for CHAMPUS PFTH since birth. His parents have not found this program very accessible, however. OCHAMPUS has denied payment on much of his medical equipment and care, despite attestations from physicians as to the necessity of them. Quite normally, after weeks or even months of negotiation, OCHAMPUS will pay the claims, only to stop payment a few months later. A nearly constant communication with this agency is required to keep continued support. Recent attempts by OCHAMPUS to more closely manage the case has resulted in tighter restrictions on where Subject A may receive care, which has further alienated his parents in their endeavors to obtain assistance for the care and equipment required for his improvement.

Similar problems have been encountered with the Social Security Administration (SSA) in attempts to receive those benefits, as well. As an example, it took SSA three reviews and one years time to approve payment for the purchase of hearing aids for Subject A. Luckily, state and county agencies have been more accommodating in their approach to supporting this disabled child. The state Children's Coordinated Services (CCS) Division has been particularly helpful in arranging medical "coupons" to help defray the cost of medical care for this child. Nonetheless, Subject A's mother foresees no overall improvement in the various agencies provision of support services for her son. She is resigned to the fact that "getting the run around" will continue to be the standard for accessing these programs until she can begin to more fully realize the benefits from enrollment in the Children with Disabilities Coordinated Care Program.

Case Study B. Subject B was born with spina bifida at a military hospital on the east coast in August of 1986. The nature of this disease is such that he has required mainly medical equipment such as braces, crutches, wheelchairs and bowel management items, with a small amount of therapy services involved. Unfortunately, for the first two years of his life, during which the majority of health care services were required, his family was stationed on the east coast and the standard CHAMPUS was inadvertently utilized for payment of claims with the standard copayment and deductible amounting to much more each year than the PFTH costs would have. Also, along with the higher costs, his parents were forced to drive several hundred miles from their home in order to get the necessary care.

Luckily, the family moved to Fort Lewis several years ago and were started on CHAMPUS PFTH, CCS and SSA programs immediately. In September 1991, Subject B became one of the first cases enrolled in the Children with Disabilities Coordinated Care Program. Additionally, all necessary medical care can be provided at MAMC (with the exception of physical therapy). His parents report that this has resulted in less distance travelled to get care, less paperwork to complete in filing claims, improved access because appointments are scheduled well in advance, and better treatment because of more individualized care. They also state that they like the multispecialty panel that evaluates Subject B because it is more efficient than seeing each physician individually over a longer period of time.

On the other hand, the change from dealing totally with civilian care providers to mainly military care, has not been easy. Despite the fact that the personal cost was greater, Subject B's mother stated that civilian hospitals "give you everything" needed for care, while military medicine is sometimes oriented toward adult care. But overall, these beneficiaries are very satisfied with the MAMC program and more confident about their ability to cope with future challenges in dealing with a disabled child.

Case Study C. Subject C was born in September 1986 at a military hospital in Hawaii with no apparent disabilities. Approximately two years later, his parents became concerned with a lack of development and initiated medical evaluation. Subject C was eventually diagnosed with opsismodisplasia/nephropathy complicated by ricketts and tibial bowing. This is a rare form of skeletal dyplasia which has caused developmental and kidney problems that have restricted him totally to a wheelchair. Support programs in Hawaii had been working on the purchase of a suitable wheelchair for almost a year when the family was transferred to Fort Lewis. Records concerning the wheelchair were sent to MAMC prior to the move, but due to an unfortunate administrative oversight the paperwork had to be completely redone upon arrival.

Sadly enough, this was not the end of problems for this family. State programs denied payment of claims until SSA approved them. SSA denied payment twice, but approved the wheelchair on the third attempt. Each time the required SSA form had to be filled out in its entirety (the form is 49 pages). Finally, action was taken and Subject C is currently benefiting from the support of CCS, SSI and OCHAMPUS programs in the form of case management, equipment and home health care. He will soon be enrolled in the Children with Disabilities Coordinated Care Program at MAMC and his mother believes that improved access to care is "inevitable."

She further states that "sharing the load" with the program personnel will be a great help, particularly assistance in filling out the paperwork. She believes that someone to share those endeavors could prevent the hopelessness that comes from struggling so long against the large bureaucracy that is currently in place and looks forward to that benefit of the program.

Discussion

Despite the variation of circumstances surrounding the cases described above, there is much that can be drawn from both the diversity and the similarity of them. For instance, all are at different stages of the enrollment process into the Children with Disabilities Coordinated Care Program (one soon to be enrolled, one recently enrolled and one enrolled for some time), but all expressed similar attitudes towards the program. The belief that this program will improve their personal situations may be based in the emotional distress that these people face, but all are cognizant of the potential strengths and weaknesses, as well as the functional aspects of the program.

This becomes even more significant when one considers these peoples past experiences with "the system" used to provide services to disabled children. The most noteworthy example of this, and one that all of these families were involved in, concerns a situation that occurred only a few years ago in this area. This situation arose when local health care facilities refused to treat any more military beneficiaries without prepayment, because of problems collecting claims from state and federal agencies whose main purpose it is to support disabled children. CHAMPUS would not pay if public programs were available and adequate. Similarly, state managed programs, such as Washington's CCS, considered CHAMPUS to be the first payer (Brown, 1989; Roth, 1989). Only when a public outcry prompted congressional intervention and a subsequent decision to authorize CHAMPUS as first payor was the situation defused (Bynum, 1991). But that was only after many months of political and bureaucratic haggling, with military beneficiaries caught in the middle. This dilemma alone makes it a wonder that these families would place much faith in a new federal program that proposes to assist the handicapped child.

The situation described above gets to the heart of why the Children with Disabilities Coordinated Care Program is viewed by these people with such optimism. Any program that offers to attempt an organized and coherent approach to the provision of care, services and equipment to these beneficiaries is considered a boon to their ongoing efforts. As stated by a parent directly involved in the above situation, "I can deal with my daughter's problems...but financial problems - that really scares me" (Brown, 1989, p. 1). And there should be no doubt that it is, in fact, the parents that make the difference between a successful program and just another federal effort to affect the welfare of the beneficiary. That the parents of disabled children put such faith in this program should push DOD toward the conclusion that it is worth the effort and should be expanded to other facilities.

The innovative use of agreements (Appendices C through F) with local state and federal agencies to coordinate care and funding is notable, as well. Not only does this share resources among the various levels of government and further communication of those involved, but it facilitates the use of all available services by those that need it most - the disabled and their families. The acceptance of MAMC computer generated forms by the Washington State Department of Social and Health Services is particularily worthy of emulation in other related coordinated care programs (see Appendix E). This simple innovation is the first step toward obtaining the pertinent information a single time and generating the necessary forms for application to all support agencies. This could relieve a tremendous amount of appointment and travel time from these beneficiaries and their families.

Another aspect to be considered is the current mandate throughout the military for implementation of quality management and quality improvement and how this general theme relates to the expansion of the Children with Disabilities Coordinated Care Program as a DOD pilot project. It appears that the program as described above correlates nicely to generally accepted quality concepts. The basic implementing body of the program is the multidisciplinary staffing team that coordinates and approves the proposed care plans. This team is virtually analogous to process action teams that are so common in recent quality improvement attempts. The quality precepts of communication and participation are readily apparent in the exchange between the providers, the case manager and the parents in this process, as well. The basic orientation of this program is focused on providing better support to the customer (beneficiary), which also parallels the quality improvement approach. And finally, given that the Children with Disabilities Coordinated Care Program is eventually expanded throughout DOD health care facilities, the quality management precept of long-range focus will be met, to the benefit of all involved.

Conclusions and Recommendations

This project has described the Children with Disabilities Coordinated Care Program at MAMC and determined through the case study process that support of these beneficiaries is perceived as improved under this program. This indicates that the program should be expanded throughout DOD in order to more fully support this segment of the beneficiary population.

What this project did not determine however, was the financial benefits to DOD that should be realized from the expansion of such a program. One can intuitively surmise that a program that closely manages how and where a patient population is evaluated and treated should save health care dollars. But, until the systems are in place to collect such data, no definitive statement as to the cost effectiveness can be made. As there are currently efforts being made to enroll all individuals in the program into a single data processing system (as well as to track costs according to usage), the information necessary to make such a determination should be available within the next few years. This data, when available, constitutes the foundation of further study in this area and will no doubt be necessary to aid in efforts to make this program a DOD priority. This is especially true in this time of extremely restrained resources.

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Table 1.

Standardized Protocol of Topics and Questions

A. Past involvement with various services

  1. Service names
  2. Method of access to services
  3. Problems or benefits of services

B. Present situation with various services

  1. Description of services
  2. Access improvements or problems
  3. Observations of service interaction

C. Future access to services

  1. Perceived problems or benefits

Appendix A

Request for Case Management

REQUEST FOR CASE MANAGEMENT

Date_______________

Patient's Name ____________________________________

Sponsor's Name ____________________________________

Sponsor's SSN ____________________________________

Home Phone ____________________________________

Work PHone ____________________________________

Presumptive Diagnosis ______________________________________

____

____

CONSULTATIONS:

SPECIALTY	** LOCATION
__________________________	__________________________
__________________________	__________________________
__________________________	__________________________
__________________________	__________________________
__________________________	__________________________
__________________________	__________________________

____

The above child is less than 3 years and I have confirmed or strongly suspect that he/she has at least a 25% delay in some area of development and will require services of a medical, developmental, educational or family nature outside the MAMC direct care system.

______________________________ PRINTED NAME OF PHYSICIAN

__________________________ SIGNATURE

** IF MAMC PLEASE INDICATE

Appendix B

Sample Care Plan

CARE PLAN

This Care Plan is for ______________. It was developed at ______________ on ___ DD ___ MM ___ YY

Birth date of child: ___ DD ___ MM ___ YY Service Coordinator: ______________ Review date: ___ DD ___ MM ___ YY

Medical Diagnoses

1 ______________
2 ______________
3 ______________
4 ______________

Developmental Diagnoses

1 ______________
2 ______________
3 ______________
4 ______________

Care Plan Team present at meeting

Name	Specialty	Agency

Parent: ______________

I give my permission to implement this Care Plan.

Signature ___ *DD* ___ *MM* ___ *YY*

Comments

Medical Stamp Plate

Arrangements for family members when the sponsor is deployed:

Pilot Form 1 (Care Plan) JUN 91

CARE PLAN Continuation Sheet

Page ___ of ___

Service Delivery Area: ______________________

____
Child

____
Service Coordinator

Functional Goal(s)	Duration/ Frequency/ Location	Provider (Agency/Name)	Source of Funding

Pilot Form 2 (Care Plan) JUN 91

Appendix C

Memorandum of Understanding

Social Security Administration

MEMORANDUM OF UNDERSTANDING
between
SOCIAL SECURITY ADMINISTRATION
REGION X, TACOMA DISTRICT OFFICE
and
MADIGAN ARMY MEDICAL CENTER
DEPARTMENT OF THE ARMY, TACOMA WASHINGTON

The purpose of this document is to facilitate access to Social Security Administration (SSA) and Supplemental Security Income (SSI) benefits for individuals who are dependents of Armed Forces personnel who reside in the Madigan Army Medical Center (Madigan) catchment area. This encompasses the counties of King, Kitsap, Lewis, Mason, Pierce and Thurston and extends to those eligible for the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) including Program for the Handicapped (PFTH), Military Health Care System (MHCS) and the Washington State Children with Special Health Care needs (CSHCN) Program. This Memorandum of Understanding will be effective on the first day of the month following the month in which this agreement is completed. This agreement can be amended at any time with 30 days written notice and mutual approval by SSA and Madigan Army Medical Center.

I. Background

Madigan's coordinated care effort will provide service coordination services to help diminish any perceived barriers in the SSA/SSI application process. Eligibility to any and all benefits for potential recipients will be pursued as part of that effort. This expands long standing procedures between SSA and Madigan Army Medical Center.

II. Social Security Administration agrees to:

A. Develop with Madigan procedures for filing for SSA/SSI benefits for military families in the Madigan catchment area who have children, age birth to five, with special health care needs.

B. Accept application and eligibility information for applicants from Madigan service coordinators.

C. Advise families of military dependents (age birth to 5) of Madigan's service coordination services.

D. Contact Madigan service coordinator if additional information is needed, or if problems are noted.

E. Provide initial training to Madigan service coordination staff and refresher/follow-up training as needed.

F. Participate in quarterly meetings for the purpose of facilitating communication between SSA and Madigan staff.

G. Assist Madigan in implementing standard appeal procedures for military dependent clients to address eligibility and benefit payment issues.

III. **Madigan agrees to:**

A. Develop and implement a process for a family-centered, multi-disciplinary team assessment and development of a care plan outlining services needed for children with special health needs who are military dependents and their families.

B. Develop with the Social Security Administration procedures for filing for SSA/SSI benefits for military families in the Madigan catchment area who have children, age birth to five, with special health care needs.

C. Provide information (to include necessary available medical records) for SSA/SSI application and eligibility determinations to the SSA Tacoma District Office. SSA/SSI eligibility determinations will be the sole responsibility of the Social Security Administration.

D. Assist SSA in securing additional information from applicant families if needed.

E. Participate in quarterly meetings for the purpose of facilitating communication between SSA and Madigan staff.

F. Assist with SSA in implementing standard appeal procedures for military dependent clients to address eligibility and benefit payment issues.

IV. Dispute Resolution

Disputes about the terms of this agreement, or anything related to it but not covered here, will be resolved between the Tacoma District Manager (or his/her designee) and the Commander of Madigan Army Medical Center (or his designee).

Signed:

Pat Hailey

Pat Hailey
District Manager
Social Security Administration
Tacoma WA District Office

Date May 14, 1992

LMBurger

Leslie M. Burger, MD
Brigadier General, U.S.Army
Commander
Madigan Army Medical Center

Date May 14, 1992

Appendix D

Memorandum of Understanding

Parent-Child Health Services

DEPARTMENT OF HEALTH SERVICES
MEMORANDUM OF UNDERSTANDING
between
PARENT-CHILD HEALTH SERVICES (PCHS)
DEPARTMENT OF HEALTH
and
MADIGAN ARMY MEDICAL CENTER

The purpose of this document is to facilitate access to necessary reimbursable services for individuals and families who are dependents of active duty Armed Forces personnel (excluding dependents of retirees) who reside in the Madigan Army Medical Center (MAMC) catchment area encompassing the counties of King, Kitsap, Lewis, Mason, Pierce, and Thurston, who are eligible for the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) (including the Program for the Handicapped (PFTH)), Military Health Care System (MHCS) and the Washington State Children With Special Health Care Needs (CSHCN) Program. This Memorandum of Understanding will be effective on the first day of the month following the month in which this agreement is completed. This agreement governs the duration of the pilot and can be amended or terminated at any time with 30 days written notice and mutual approval by PCHS and MAMC.

I. Background

Eligibility for the PFTH requires that local public resources be used to the extent they are available and adequate before any PFTH benefits can be allowed. Determining when CSHCN funds are available or are not available to CSHCN-PFTH eligible has been problematic. CSHCN-PFTH beneficiaries have been subjected to inconsistent benefit acquisition requirements and unreliable coverage outcomes depending upon the various interpretations by state and local CSHCN staff, Office of CHAMPUS staff, and CHAMPUS fiscal intermediaries.

II. Basic agreement

To develop and pilot a mechanism which will facilitate CHAMPUS eligible beneficiaries with special health needs and their families access to coordinated family-centered, community-based services and allow the MHCS or CHAMPUS-PFTH and CSHCN to share the cost of services to eligible beneficiaries in a standardized, reliable manner.

III. PCHS agrees to:

A. Refer all children with special health care needs who are dependents of active duty military personnel, to MAMC for intake, assessment and coordination of services if that dependent's family is in agreement with such referral.

B. Accept information from MAMC service coordinator for purposes of CSHCN intake and eligibility determination.

C. Contact MAMC service coordinator if additional information is needed, or if problems are noted.

D. Encourage local CSHCN agencies to participate in service coordination meetings to determine payment source and where the family will receive services.

E. Reimburse only those services preauthorized by the MAMC multi-disciplinary team and approved by the family and local agency.

F. Utilize a formula updated biennially to determine available funds for CHAMPUS eligible children (see Attachment 1).

G. Participate in quarterly meetings for the purpose of facilitating communication between State and local CSHCN and MAMC staff.

H. Collaborate with MAMC to develop and implement a grievance procedure for CSHCN/active duty military dependent clients and providers to address eligibility and benefit payment issues.

IV. MAMC agrees to:

A. Develop and implement a process for a family-centered, multi-disciplinary team assessment and development of a care plan outlining services needed for children with special health needs who are dependents of active duty military personnel.

B. Provide information for CSHCN intake and eligibility determination to county CSHCN agencies.

C. Collaborate with local CSHCN agencies to determine what services for military dependents will be reimbursed by CSHCN.

D. Develop procedures for and provide coordination of services to military families in the MAMC catchment area who have children with special health care needs.

E. Accept local certification of the non-availability of CSHCN benefits based upon the exhaustion of the military dependent set-aside amount when adjudicating PFTH eligibility.

F. Participate in quarterly meetings for the purpose of facilitating communication between State and local CSHCN and MAMC staff.

G. Collaborate with CSHCN to develop and implement grievance procedures for care providers and CSHCN/active duty military dependent clients to address eligibility and benefit payment issues.

V. Dispute Resolution

Disputes about the terms of this agreement or anything related to it but not covered here will be resolved between the Assistant Secretary of Parent-Child Health Services and the Commander of Madigan Army Medical Center.

Signed:

Maxine Hayes, MD, MPH
Assistant Secretary
Parent-Child Health Services
Department of Health

Date 2/7/92

John E. Hutton Jr. B.G.U.S.A.
Commanding
Madigan Army Medical Center

Date 24 Feb 92

ATTACHMENT 1

CHAMPUS POLICIES AND PROCEDURES

Introduction

The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) 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 CSHCN policy relating to CHAMPUS does not discriminate against any children, including those who may or may not be dependents of active duty military personnel.

CHAMPUS benefits are available through two programs: the Basic Program, which generally covers acute/emergent conditions, and the Program for the Handicapped (PFTH). The CHAMPUS information in this manual deals only with PFTH and excludes dependents of retirees.

To qualify for benefits provided through PFTH, families are required to use public funds and facilities to the extent they are available and adequate. Documentation that other funds are unavailable or insufficient is required by CHAMPUS. A benefit may not be paid under PFTH if the client is eligible for coverage through any other health insurance, health maintenance organization, or publicly funded programs, including Title V (CSHCN), but excluding Title XIX (Medicaid).

The policies and procedures that follow describe a mechanism that allows PFTH and CSHCN to share, in a standardized and reliable manner, the cost of services for children eligible for both programs. A pilot project is being developed to facilitate access to care for children who are military dependents in a six-county catchment area covered by Madigan Army Medical Center (MAMC). Separate agreements are being developed by Madigan Army Medical Center, the state OCSHCN, and local CSHCN agencies in the catchment area.

First Payer/Last Payer Issue

CSHCN (Title V) is last dollar to Medicaid, but is first dollar to CHAMPUS, while Medicaid is last dollar to CHAMPUS. This results in the following eligibility groups:

- children eligible for CSHCN, CHAMPUS, and Medicaid
- children eligible for CSHCN and CHAMPUS

Policies and Procedures

Clients Who Are CSHCN/CHAMPUS/Medicaid Eligible

Policies:

When the client is eligible for all three programs, CHAMPUS is first payer. These clients are excluded from CHAMPUS regulations that require CSHCN funds to be used prior to payment of CHAMPUS PFTH benefits because CHAMPUS has agreed to recognize CSHCN as second payer to Title XIX. No statement of Title V CSHCN denial is required if the claim is accompanied by proof of Title XIX eligibility.

Procedures:

Responsibility	Action
Local CSHCN agency	Advises providers to furnish a copy of the Medicaid coupon when submitting billings to CHAMPUS in behalf of Medicaid eligible clients.

Clients Who Are CSHCN/CHAMPUS (but not Medicaid) Eligible

Policies:

1. Local CSHCN agencies will pay for services for children who are eligible for both CSHCN and CHAMPUS, based upon availability of funds.

2. "Availability" of CSHCN funds will be based upon the balance remaining of the CHAMPUS set-aside, a portion of each local CSHCN agency's or neurodevelopmental center's funds that is set-aside monthly for services for children who are CHAMPUS eligible.

3. A CHAMPUS set-aside amount will be determined by the state OCSHCN for each agency receiving Title V CSHCN funds.

    a. CHAMPUS set-aside amounts will be applied on a monthly basis and will not carry over to subsequent monthly periods if not used each month.

    b. Under certain circumstances, local agencies may exceed the monthly set-aside. (For example: cost of services slightly exceeds the monthly set-aside.) Approval from the state OCSHCN is required prior to local agency authorization of amounts that exceed the monthly set-aside.

4. When there are continuing unmet treatment needs for a CSHCN/CHAMPUS eligible client after the CSHCN set-aside and the CHAMPUS PFTH monthly benefit have been reached, the local CSHCN agency or neurodevelopmental

center must provide the same level of benefits as it does for non-CHAMPUS eligible children.

5. CHAMPUS will not require clients already being served in one agency to transfer to another in order to utilize available CHAMPUS set-aside funds.

Procedures:

Responsibility	Action
1. State OCSHCN	Determines and publishes the amount of CHAMPUS set-aside for each local CSHCN agency and neurodevelopmental center at the beginning of each state biennial period. (See page 7.) Uses standardized data sources and a formula that calculates a prorated share of each agency's allocated funds. The formula is based upon the proportion of the active duty military and military dependent population to the total population in each county. (See page 6.) A minimum CHAMPUS set-aside of $25 will be allocated within each agency regardless of the agency's total treatment allocation or the size of the active duty military and military dependent population.
2. Local CSHCN agency	Provides CHAMPUS eligible families with a "statement of non-availability of CSHCN funds" when the monthly CHAMPUS set-aside has been expended through the payment of CSHCN treatment funds in behalf of active duty military dependents. The statement shows the inclusive dates of the period of non-availability, which may be up to 30 days. (See page 5.)
3. Local CSHCN agency or Neurodevelopmental center	Coordinates with other agencies receiving OCSHCN funds to minimize problems with competition for reimbursement. For example: If a neurodevelopmental center is delivering services on an ongoing basis and if a local CSHCN agency purchases a wheelchair for the same child, both may be counting on the $1,000 monthly benefit from CHAMPUS PFTH. However, once $1,000 per month is expended, the benefit is exhausted. One provider will not be reimbursed.

Responsibility	Action
4. Local CSHCN agency	Tracks use of the monthly set-aside amount using log (See page 9.) or another method that documents expenditures in behalf of CHAMPUS PFTH eligible clients.

Sample Statement of Non-Availability of CSHCN Funds

Dear Parent(s):

The Children With Special Health Care Needs (CSHCN) program acknowledges your request for assistance with funding for services needed by your child. This letter is to inform you that funds are not available from _______ to _______. At the end of this time period, you may again apply for coverage through the CSHCN program.

Take this letter to your CHAMPUS representative, who will help you submit your medical bills through the CHAMPUS Program for the Handicapped (PFTH) during this time.

If your medical bills are more than the amount allowed by CHAMPUS, you may re-apply to CSHCN for consideration of payment for eligible services not paid by CHAMPUS.

If there is any change in your situation, or if you have questions, call _____________ at ___________.

Sincerely,

CSHCN Coordinator

cc: Client record
Neurodevelopmental Center (if applies)
Children's Hospital and Medical Center (if applies)
CHAMPUS Service Coordinator

Calculation of CHAMPUS Set-Aside

The State OCSHCN determines the CHAMPUS set-aside amount for each local CSHCN agency and neurodevelopmental center using a standardized formula and data sources. New set-aside amounts are distributed at the beginning of each state biennium.

Monthly set-aside =

$$\frac{\text{Active duty military and dependent population for county or jurisdiction}}{\text{Total population}}$$

x biennial treatment allocation

÷ 24

OR

% active duty military and dependent population for county or jurisdiction

x biennial treatment allocation

÷ 24

Example for County X:

Data:
Total population: 168,600
Active duty military and dependent population for county or jurisdiction: 10,720
% active duty military and dependent population: 6.36%
Total CSHCN biennial treatment allocation: $88,650

Formula:

$$\frac{10{,}720}{168{,}600} = 6.36 \times \$88{,}650 = \$5{,}638 \div 24 = \$235$$

Monthly CHAMPUS set-aside = $235

Note: A minimum CHAMPUS set-aside of $25 will be allocated for each agency, regardless of the result of the above formula.

CHAMPUS MONTHLY "SETASIDE"
1991-1993 BIENNIUM

AGENCY CSHCN Agency	TREATMENT $ Initial Allocation	TOTAL POPULATION 91 - 93	MILITARY POPULATION (FY 1989) RESIDENT	TOTAL INCL. DEPENDENTS	PERCENT OF TOTAL POP.	RAW MONTHLY SETASIDE	ADJUSTED MONTHLY SETASIDE
	A	B	C	D	E	F	G
ADAMS	$8,228	13,603	0	0	0.00%	$0	$25
ASOTIN	$12,190	17,605	0	0	0.00%	$0	$25
BENTON-FRANKLIN	$51,404	150,033	40	108	0.07%	$2	$25
BREMERTON-KITSAP	$60,000	189,731	13,770	37,028	19.52%	$488	$488
CHELAN-DOUGLAS	$38,550	78,455	20	54	0.07%	$1	$25
CLALLAM	$32,321	56,464	670	1,802	3.19%	$43	$43
COLUMBIA	$3,855	4,024	0	0	0.00%	$0	$25
COWLITZ-WAHKIAKUM	$32,407	85,446	20	54	0.06%	$1	$25
GARFIELD	$3,878	2,248	0	0	0.00%	$0	$25
GRANT	$32,324	54,758	10	27	0.05%	$1	$25
GRAYS HARBOR	$60,151	64,175	95	255	0.40%	$10	$25
ISLAND	$13,168	60,195	7,200	19,361	32.16%	$176	$176
JEFFERSON	$7,767	20,146	30	81	0.40%	$1	$25
KITTITAS	$12,842	26,725	20	54	0.20%	$1	$25
LEWIS	$23,741	59,358	10	27	0.05%	$0	$25
LINCOLN	$6,451	8,864	10	27	0.30%	$1	$25
MASON	$18,132	38,341	80	215	0.56%	$4	$25
N.E. TRI-COUNTIES	$71,218	46,158	40	108	0.23%	$7	$25
OKANOGAN	$17,278	33,350	15	40	0.12%	$1	$25
PACIFIC	$9,942	18,882	120	323	1.71%	$7	$25
SAN JUAN	$9,930	10,035	0	0	0.00%	$0	$25
SEATTLE-KING	$227,706	1,507,319	5,590	15,032	1.00%	$95	$95
SKAGIT	$27,752	79,555	110	296	0.37%	$4	$25
SNOHOMISH	$112,827	465,642	705	1,896	0.41%	$19	$25
S.W. WASHINGTON	$113,197	262,958	360	968	0.37%	$17	$25
SPOKANE	$115,212	361,364	4,355	11,711	3.24%	$156	$156
TACOMA-PIERCE	$173,647	586,203	27,315	73,450	12.53%	$907	$907
THURSTON	$41,453	161,238	1,000	2,689	1.67%	$29	$29
WALLA WALLA	$25,893	48,439	20	54	0.11%	$1	$25
WHATCOM	$46,328	127,780	25	67	0.05%	$1	$25
WHITMAN	$11,153	38,775	15	40	0.10%	$0	$25
YAKIMA VALLEY MEM HOSP	$124,310	188,823	200	538	0.28%	$15	$25
	$1,545,255	4,866,692	61,845	166,301	3.42%	$1,988	$2,518

SOURCES:

A. Initial 1991-1993 Treatment Allocation
B. 1990 Census
C. Population Trends for Washington State, 1990
D. Defense Medical Information System, 1989 annual report of population counts for the Military Health Services System (A multiplier of 2.689 was derived from this information and used to determine active duty military population, including dependents)

FORMULA: D = C x 2.689
E = D ÷ B
F = (E x A) ÷ 24
G = Adjusted to minimum $25/month

CHAMPUS MONTHLY "SETASIDE"
1991-1993 BIENNIUM

NEURODEVELOPMENTAL CENTER	COUNTY	CONTRACT $ Initial	TOTAL POPULATION 91 - 93	MILITARY POPULATION (FY 1989) RESIDENT	TOTAL INCL. DEPENDENTS	PERCENT OF TOTAL POP.	RAW MONTHLY SETASIDE	ADJUSTED MONTHLY SETASIDE
		A	B	C	D	E	F	G
BOYER CHILD CLINIC	KING	$217,188	1,507,319	5,590	15,032	0.37%	$34	$34
CHILD THERAPY-KENT	KING	$273,892	1,507,319	5,590	15,032	0.37%	$42	$42
GOOD SAMARITAN	PIERCE	$191,736	586,203	27,315	73,450	4.66%	$372	$372
HOLLY RIDGE	KITSAP	$87,936	189,731	13,770	37,028	7.26%	$266	$266
MARY BRIDGE	PIERCE	$248,748	586,203	27,315	73,450	4.66%	$483	$483
MERRYWOOD	KING	$62,044	1,507,319	5,590	15,032	0.37%	$10	$25
PROGRESS CENTER	COWLTZ-WAHK	$63,608	85,446	20	54	0.02%	$1	$25
PROVIDENCE	SNOHOMISH	$230,924	465,642	705	1,896	0.15%	$15	$25
SKAGIT (SPARC)	SKAGIT	$9,732	79,555	110	296	0.14%	$1	$25
SPOKANE GUILD	SPOKANE	$308,876	361,364	4,355	11,711	1.21%	$155	$155
UNITED CEREBRAL PALSY	CHELAN-DOUG	$64,000	78,455	20	54	0.03%	$1	$25
VALLEY MEDICAL CENTER	KING	$48,852	1,507,319	5,590	15,032	0.37%	$8	$25
WHATCOM/SKAGIT	WHATCOM	$31,732	127,780	25	67	0.02%	$0	$25
YAKIMA VALLEY MEM HOSP	YAKIMA	$40,924	188,823	200	538	0.11%	$2	$25
		$1,880,192	1,757,032	52,110	140,124	2.97%	$1,388	$1,552

SOURCES:
A. Initial 1991-1993 Contracted Amount
B. 1990 Census
C. Population Trends for Washington State, 1990
D. Defense Medical Information System, 1989 annual report of population counts for the Military Health Services System
(A multiplier of 2.689 was derived from this information and used to determine active duty military population, including dependents)

FORMULA: D = C x 2.689
E = D ÷ B
F = (E x A) + 24
G = Adjusted to minimum $25/month

RLLformat-SETASD4

CHAMPUS Set-Aside Tracking

CHAMPUS Set-Aside Tracking
Agency: ____________________
Month: ___________ Year: ____ Monthly Set-Aside Amount: ______

Child's Name	CSHCN #	Service		Amount Authorized	Set-aside Balance	Comments
		Type	Date			

Appendix E

Memorandum of Understanding

Economic Services and Medical Assistance Administration

MEMORANDUM OF UNDERSTANDING
BETWEEN
ECONOMIC SERVICES (ES) & MEDICAL ASSISTANCE ADMINISTRATION (MAA),
WASHINGTON STATE
DEPARTMENT OF SOCIAL AND HEALTH SERVICES (DSHS)
AND
MADIGAN ARMY MEDICAL CENTER (MAMC),
UNITED STATES ARMY

I. PURPOSE

The purpose of this memorandum of understanding is to facilitate the provision of services for which birth to 5 children with disabilities and special health care needs who are dependents of the armed forces may be eligible. The goal is to facilitate communication about available services, and to expedite authorization of appropriate services in Pierce, Kitsap, Thurston, Mason, Lewis, and King Counties.

II. ES/MAA RESPONSIBILITIES

A. ES/MAA will provide to MAMC the pre-printed DSHS application related forms.

B. ES will accept the MAMC computer generated DSHS 14-001(X) Part 1 in place of the DSHS printed Application for Benefits Part 1.

C. ES/MAA will provide MAMC with appropriate Community Services Office (CSO) envelopes for the MAMC clients use when additional verification is required.

D. ES/MAA will help in dealing with MAMC clients' transportation difficulties by waiving an in-office interview for medical when appropriate and in accordance with existing regulations.

E. ES, Region 5 Economic and Medical Field Services (EMFS) Office will provide training to personnel designated by MAMC in completion of the forms and the application process and any follow-up training that is needed.

F. EMFS will establish a CHAMPUS liaison in Pierce North, Pierce South, Pierce West, Puyallup Valley, Bremerton, Olympia, Shelton, Chehalis, and King County Alternate Care CSOs.

G. CSO staff will contact MAMC designated staff to request needed information if the person appears eligible and the CSO has been provided a signed consent for release of information for MAMC to represent them in the application process.

H. ES will provide MAMC with revised copies of the DSHS 14-001(X) part 1 so revisions can be made to the forms software.

III. MAMC RESPONSIBILITIES

A. Provide the client Part 1 and Part 2 of the DSHS Application for Benefits.

B. Aid the military family in completing the application forms and securing needed verification.

C. Coordinate the application and interview process with designated staff in the appropriate CSO.

D. Provide the CSO verification of the applicants' medical history, including diagnosis, prognosis and expected duration of the disability. If MAMC does not provide medical history records, a signed consent for release of information to the institution holding such records must be included.

E. Be available to the military family to complete a telephone interview when, due to hardship in accordance with existing regulations, the family is unable to be interviewed at the CSO.

F. MAMC will not make decisions about an applicant's eligibility. Individuals have a right to apply for all services through EMFS.

G. MAMC will update the forms software for any revisions made to the DSHS 14-001(X) Part 1.

IV. OTHER CONSIDERATIONS

A. This memorandum of understanding can be amended by mutual agreement, at the initiation of either party.

B. In the case of dispute with CSO staff, the immediate supervisor will be contacted. If unresolved, the CSO Administrator in the appropriate CSO will be contacted. If the dispute remains unresolved, the Regional Administrator in the same regional office will be contacted. If unresolved, the matter can be referred to the EMFS Director.

C. In the case of dispute with MAMC staff, the Chief, Coordinated Care Division will be contacted who will facilitate resolution at the lowest appropriate level. Unresolved disputes may require action by the MAMC Commander or Deputy Commander.

D. This memorandum of understanding will be jointly reviewed annually by EMFS and MAMC.

APPROVED BY:

Robert Lolcama 12/6/91
Assistant Secretary, Economic Services Date
Washington Department of Social and Health Services

James A. Peterson 12/20/91
Assistant Secretary, Medical Assistance Administration Date
Washington Department of Social and Health Services

JOHN E. HUTTON, JR., BG, MD, Commanding 1/7/92
Commander, Madigan Army Medical Center Date
United States Army

Appendix F

Memorandum of Understanding

Division of Developmental Disabilities

MEMORANDUM OF UNDERSTANDING
BETWEEN
THE DIVISION OF DEVELOPMENTAL DISABILITIES (DDD),
WASHINGTON STATE
DEPARTMENT OF SOCIAL AND HEALTH SERVICES (DSHS)
AND
MADIGAN ARMY MEDICAL CENTER (MAMC),
DEPARTMENT OF THE ARMY
TACOMA, WASHINGTON

I. PURPOSE

The purpose of this memorandum of understanding is to facilitate provision of services for which individuals and families who are dependents of the armed forces personnel may be eligible. The purpose is to facilitate communication about available services, and to expedite authorization of appropriate services.

II. DDD RESPONSIBILITIES

A. DDD will provide to MAMC the form "Application For Services, Division of Developmental Disabilities" DSHS 14-151, Exhibit A herein attached.

B. DDD Region 5 Field Services Office and DDD Region 6 Field Services Office will, upon receipt of the completed "Application For Services" form, and accompanying documentation of the individual's developmental and medical history and current status, open an intake file, and proceed with necessary actions to determine eligibility.

C. DDD staff will administer the Inventory for Client and Agency Planning (ICAP), if required to determine eligibility under 275-27-026(6)(b).

D. If additional information is needed, DDD intake staff will contact staff designated by MAMC to request such information.

E. If the person appears to be eligible, DDD staff will contact the individual or his/her family to set up an interview to discuss services.

F. DDD intake staff will notify the MAMC designated staff of the results of the eligibility determination.

G. If the person is determined to be ineligible, DDD staff will contact the MAMC designated staff and the family to communicate the eligibility decision, and to provide information about other possible community resources to meet the person's needs. This contact will be made prior to or at the time of written notification of ineligibility and right of appeal to the person and his/her family.

H. If a family applies directly to DDD for services on behalf of a family member, independent of the referral process described herein, DDD intake staff will proceed with the application process. DDD intake staff will ask the applicant's family for written consent to release information about the referral to MAMC.

I. DDD Region 5 Field Services Office will provide training to personnel designated by MAMC in completion of the form.

J. Services to DDD eligible individuals are based upon the availability of resources.

III. MAMC RESPONSIBILITIES

A. MAMC will complete the "Application for Services" form and send with documentation of medical history and current developmental status.

B. Documentation of disability shall include medical or developmental history, current developmental status, using an approved tool according to WAC 275-27-026, Exhibit B herein attached. If MAMC does not provide medical history records, a signed consent for release of information to the institution holding such records must be included.

C. If the individual is school age or older, school records should be included with the completed application materials, or a signed release of information must be provided which DDD can use to obtain school records.

D. MAMC will not make decisions about an applicant's eligibility for DDD services. Individuals have a right to apply for services from DDD. Even though MAMC may suspect that a person is ineligible for DDD services, MAMC must facilitate the application, if the individual wishes to apply.

IV. OTHER CONSIDERATIONS

A. This memorandum of understanding can be amended by mutual agreement, at the initiation of either party.

B. In the case of MAMC dispute with DDD staff, either the DDD case/resource manager or the involved MAMC staff may refer the matter to the DDD Field Services Administrator in the appropriate DDD Regional Office for resolution. If the dispute remains unresolved, at the request of MAMC staff, the DDD Field Services Administrator will refer it to the DDD Regional Manager in the same region. In the case of disputes which remain unresolved, MAMC staff may request that the DDD Regional Manager refer the matter to the DDD division director, whose decision will be final.

C. In the case of DDD dispute with MAMC staff, either the involved MAMC staff or the DDD case/resource manager may contact the Chief, Coordinated Care Division who will facilitate resolution at the lowest appropriate level. Unresolved disputes shall be referred to the MAMC Deputy Commander or Commander, whose decision shall be final.

D. This memorandum of understanding will be jointly reviewed by DDD and MAMC six months following its implementation and annually thereafter. Either party may initiate a request for review of the document, or of specific terms of the agreement, at any time when there appears to be a problem. It is recommended that such request be made in writing and specify the reason for review. Such requests should be directed to the agency representatives who have signature authority on this document.

APPROVED BY:

2-28-92

Director, Division of Developmental Disabilities
Washington State Department of Social and Health Services
Date

3-10-92

Commander, Madigan Army Medical Center
United State Army
Date