Health Home for Beneficiaries with Fetal Alcohol Spectrum Disorder

HEALTH HOME FOR BENEFICIARIES WITH FETAL ALCOHOL SPECTRUM DISORDER ELIGIBILITY CHECKLIST

Use this checklist to determine a recipient's eligibility for enrollment in the Health Home program for individuals with Fetal Alcohol Spectrum Disorder (HH FASD). The Health Home Provider must complete this form and attach it to the initial claim submission via the Nevada Medicaid Provider Web Portal (PWP). For guidance on submitting claims and attaching documentation, refer to Chapter 3 of the PWP Claims Manual.

Recipient's Name (Last, First): _____

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

The recipient must meet all the following criteria		
☐ Medicaid eligible	☐ Resides in Nevada	☐ Consent documentation complete
☐ P04.3 or Q86.0 ICD-10 code diagnosis		

In addition, the recipient must have—or be at risk for—at least one other chronic condition, which may include but is not limited to the following (*check all that apply*):	
☐ Abnormal facial features	☐ Pervasive and developmental disorders
☐ Abnormal findings on functional studies of the peripheral nervous system and special senses	☐ Intellectual disabilities
☐ Adult attention-deficit/hyperactivity disorder (ADHD)	☐ Neurobehavioral disorders associated with prenatal exposure to alcohol
☐ Autism Spectrum Disorder (ASD)	☐ Mood disorders (e.g., depression, anxiety, post-traumatic stress disorder (PTSD))
☐ Cognitive delay	☐ Oppositional Defiant Disorder (ODD)
☐ Conduct disorder	☐ Psychotic disorders
☐ Chronic serous otitis media	☐ Receptive language disorder
☐ Expressive language disorder	☐ Speech and language delays
☐ Externalizing disorders	☐ Poor coordination
☐ Low body weight	☐ Vision or hearing problems
☐ Special learning disorders	☐Other: _____

The Health Home Provider who completes this form must enter their name and sign below.

Provider Name (print or type): _____

Provider Signature: _____