DEPARTMENT OF AGING & DISABILITIES

DEVELOPMENTAL DISABILITY ORGANIZATION

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STEPHEN SHAUGHNESSY, EXECUTIVE DIRECTOR • SEDGWICKCOUNTY.ORG

Waiting List Exception Request

Date:

Name:

Age: SSN:

Date of Last Functional Assessment:

Tier, if applicable: Child Assessment Score:

Medicaid? Yes No If no, date of application:

Insurance Provider/MCO, if applicable:

Current Funding:

Day:

Residential:

Personal Care Services:

Specialized Medical:

Unserved:

If the individual has been determined not eligible for Medicaid, and/or does not have health insurance please specify the reason(s):

TCM & Agency Name: TCM Phone #:

Type of Request:

Section 1: Crisis - Which crisis or exception definition applies to this situation?

Section 2: Kid in Custody

Date of Custody: Child Placing Agency: Date of Placement:

Social Worker and Phone Number: Current Resource Home:

Section 3: Kid in Custody - Transitioning to Adult Services

Current Placement: Anticipated Release from Custody Date:

Has Guardianship been Established? Is Adult SSI Being Received?

If Guardianship has not been established or Adult SSI is not being received, please explain why:

Section 4: PRTF Discharge

Current Placement: Expected Date of Release:

Services Being Requested:

Current Arrangements		
Living Arrangements	Support System	Community Supports
☐ Lives alone, own home ☐ Lives with others, own home ☐ Lives with parents/family/friend ☐ Lives in group home setting ☐ Lives in residential provider home ☐ Homeless ☐ Foster Care Placement ☐ Other Please explain:	☐ Has Informal Supports ☐ Parents (under 18) ☐ Guardian ☐ Adult Siblings/Family ☐ Friends/Church ☐ Has Private Pay Supports ☐ Have no informal/paid supports ☐ Other Please explain:	☐ Enrolled in school (up to 22) ☐ Vocational Rehabilitiation ☐ Employment ☐ Other Please explain:

Please explain natural resources available that could be utilized in creating a solution. Include why natural supports will not be sufficient or explain why current level of natural supports cannot be maintained.

Support Need Indicators
☐ Terminally ill ☐ Physically disabled and/or significant health issues ☐ Recent confirmation for abuse, neglect or exploitation (please provide documentation) ☐ Placed in nursing facility, assisted living facility or other institution ☐ No longer willing/able to provide the supports ☐ Inability to private pay ☐ Other Please explain:

History of Behavioral/Health Challenges

Does the individual have a history of significant behavioral challenges? ☐ Yes ☐ No

Are the needs currently being met? ☐ Yes ☐ No ☐ N/A

Is there a Behavior Support Plan? ☐ Yes ☐ No *If yes, please provide documentation*

Does the individual have significant medical challenges? ☐ Yes ☐ No

Is there a Psychotropic Medication Plan? ☐ Yes ☐ No *If yes, please provide documentation*

Day Activities Level of Need

No longer in school, aged out of education programs (at least 18 or over) ☐ Yes ☐ No ☐ N/A

Unable to qualify for or maintain vocational rehabilitation without support ☐ Yes ☐ No ☐ N/A

Individual needs support to maintain or obtain employment or achieve employment outcome ☐ Yes ☐ No ☐ N/A

Residential Level of Need

Support is required to provide constant care and/or supervision in order to maintain health and safety needs (person should not be left alone for extended periods of time) Yes ◯ No ◯ N/A ◯

Individual prefers to remain living at home or does not have immediate need for residential ◯ Yes ◯ No ◯ N/A

Individual needs supports for significant medical challenges, medically fragile or terminally ill conditions ◯ Yes ◯ No ◯ N/A

Individual needs supports for significant behavioral challenges ◯ Yes ◯ No ◯ N/A

Family/caregiver needs additional support for minor child (under 18) or still in school (under 22) ◯ Yes ◯ No ◯ N/A

Family/caregiver needs short-term support so that consumer can remain in their own home ◯ Yes ◯ No ◯ N/A

Family/caregiver needs long-term support so that consumer can remain in their own home ◯ Yes ◯ No ◯ N/A

Individual needs short-term support to stay in their own/family home ◯ Yes ◯ No ◯ N/A

Individual needs long-term support to stay in their own/family home ◯ Yes ◯ No ◯ N/A

Individual needs supports in order to transition to community from ICF/ID, PRTF, YRC or other services ◯ Yes ◯ No ◯ N/A

Support is required to provide on site 24/7 care and/or supervision to maintain health and safety needs (individual can never be left alone in a room, must be in constant line of sight) ◯ Yes ◯ No ◯ N/A

Individual is recently homeless or living in a shelter ◯ Yes ◯ No ◯ N/A

Individual is living in an intolerable living situation and is at risk of abuse, neglect or exploitation ◯ Yes ◯ No ◯ N/A

Please describe the individual's current situation. Regarding a crisis situation, please include specific examples with date and time frames (including police involvement, DCF contact, etc.). Narrative should describe how gaining access to supports will mitigate the current crisis; if applicable. If additional space is needed to provide information, please use a separate piece of paper.

What harm will come to the individual if the requested services are not available?

List and describe the other service systems involved in creating a solution to this situation. What training or environmental changes have been tried to reduce any risks?

If requesting residential services and the person is still in school, what school/district do they attend? Describe if and how the school is engaged to assist with the current situation.

What other services are currently in place (TA, Mental Health, etc.)? Please describe each service and number of hours per week engaged in this service (for example: attendant care with MHA, 2 hours per week). Are the current services fully utilized? Please explain.

List and describe community resources which have been explored and exhausted prior to making this request (examples include Parson's Outreach Team, MCO Value Added Benefits, Family Support Allocation, consultation regarding behavior management, Vocational Rehabilitation, etc.). Please explain why these resources are not sufficient to meet the current needs.

Managed Care Organization (MCO) Information:

Care Coordinator's Name: Date Contact was Made:

Response from MCO; to include Value Added Benefits that were offered and any other information about the interaction (please provide written documentation):

Have any of the recommendations been accessed?

If yes, please describe the outcomes of the recommendations. If no, describe why the recommendation is not sufficient.

If requesting Day services, are they aware of transportation costs?

If requesting Residential services, please include information about what resources the person has available to pay room and board:

Please include income/expense information to determine ability to "self-fund" the requested service. Household income/expense information is required for those living with family/guardian, regardless of age.

Persons living in the home and relationship to applicant (include additional members on another sheet, if needed):

Name	Relationship	Age	Employed	Receives IDD Service

Average Monthly Income (Gross)			
SSI/SSDI		Employment	
Family Support/Subsidy		Alimony/Child Support	
General Assistance		Trust Fund/Adoption Subsidy	
Temporary Aid for Needy Families (TANF)		Food Stamps (Vision Card)	
Other (please explain below)		**Average Monthly Income**	$ 0.00
		Average Annual Income	$ 0.00

Average Monthly Expenses			
Mortgage/Rent		Electric/Gas	
Phone/Cable		Water/Trash	
Food/Laundry		Alimony Paid/Child Support	
Transportation (payment, gas, insurance, etc.)		Childcare	
Insurance		Savings	
Retirement		Investments	
Other Payroll Deductions		**Average Monthly Expenses**	$ 0.00
Other (please explain below)		**Average Annual Expenses**	$ 0.00

Is there any additional information the committee should be aware of? This includes any barriers to placement (familial, financial, behavioral, etc).

****Applicable If Approved For Day/Residential Only****

Please ensure the individual and their support network is aware if HCBS-IDD Program access is approved, SCDDO will offer the individual/guardian a risk assignment to a Community Service Provider (CSP) contracted to provide crisis access within 7 days.

- **The individual/guardian should contact SCDDO within 3 business days to accept the crisis CSP or choose a non-crisis CSP. Please note, if the crisis CSP is not chosen, the non-crisis provider chosen will have an average of 60 days to provide services from the date they are notified of choice.**
- **Once choice is made, the individual should contact the chosen CSP within 3 business days to initiate the admissions process.**
- **Funding Committee will be monitoring the time lines noted above and failure to comply could place the individual's HCBS-IDD Program access in jeopardy.**

By signing below, I confirm the information provided is accurate, I understand the time lines listed above, and consent to the submission of this request and supporting documentation to the Sedgwick County Developmental Disability Organization (SCDDO) Funding Committee for review and possible recommendation to Kansas Department for Aging and Disability Services (KDADS) for access to HCBS-IDD Program Funds or State Aid.

Date

Signature of Individual/Individual's Representative

Printed name of Individual/Individual's Representative and if a representative, the relationship to the Individual