*This form is to be used by CDDOs to notify KDADS when a person leaves HCBS-IDD Program services or when a person has been defined as in crisis and needs new HCBS-IDD services. For persons leaving services, this form is to be submitted within 14 days of the date the person is closed in KAMIS with a copy of the 3160/3161 sent to DCF and the MCO. For persons is defined as crisis for new services, this form is to be submitted within 5 days for review and response from KDADS within 5 days.*

|  |  |
| --- | --- |
| **Request/Effective Date** |   |

**Section 1: Demographics**

|  |  |  |  |
| --- | --- | --- | --- |
| **Person’s Name** |   | **KAMIS ID Number** |   |
|  |  |  |  |  |  |
| **CDDO Area** |   | **Contact Person** |   | **Contact Phone** |   |
| **Date of Birth** |   | **Date of Death** |   | **Age** |  | **Tier** |   |
| **Social Security** |   | **Medicaid ID** |   | **KanCare MCO** |   |

**Section 2: Crisis Exception Request** (*To be completed* ***ONLY*** *for persons determined in crisis* ***and*** *requesting access to HCBS-IDD services.)*

**[ ]** Person is at significant, imminent risk of serious harm to him/herself or others in current situation.

**[ ]** Person requires protection from **confirmed** abuse, neglect or exploitation or written documentation of pending action for the same ([ ]  documentation attached)

|  |  |  |  |
| --- | --- | --- | --- |
| Supports are expected to be: | **[ ]** Temporary | **[ ]** Permanent | [ ]  Needed by: Select Date |
| MCO Recommendation: | **[ ]** Included | **[ ]** Pending | [ ]  Expected by: Select Date |

**Section 3: Access Exception Request:** Expected date of transfer: **Select Date**

|  |  |  |
| --- | --- | --- |
| **[ ]** Request for: | **[ ]** Children’s Residential  | **[ ]** Children’s Residential (to ***exceed*** 2 non-related children) |
| **[ ]** Transition from: | **[ ]** PRTF/YRC II |  **[ ]** Intermediate Care Facility-Individuals with Intellectual Disabilities |
| **[ ]** State Custody: | [ ]  Child/Person in Custody | [ ]  At Risk of Custody |  [ ]  Exiting Custody |
| **[ ]** Transfer from: | [ ]  HCBS-Technology Assisted | [ ]  HCBS-Autism |  [ ]  HCBS-Traumatic Brain Injury  |
| **[ ]** Supported Employment | **Date of successful VR Closure/Stabilization** |   |

**Section 4: Requested Services**

|  |  |
| --- | --- |
| **[ ]** Adult Residential Supports  | **[ ]** Specialized Medical Care (RN/LPN) |
| **[ ]** Day Supports – Under 22 | **[ ]** Sleep Cycle Support/Overnight Respite |
| **[ ]** Day Supports – No longer in school  | **[ ]** Wellness Monitoring/PERS Unit |
| **[ ]** Employment Supports | **[ ]** Assistive Technology/Home Modification |
| **[ ]** Personal Assistive Services | **[ ]** Supportive Home Care |
|  |  |
| Supports are expected to be: | **[ ]** Temporary | **[ ]** Permanent | [ ]  Needed by: Select Date |
| MCO Services Available: | **[ ]** Included | **[ ]** Pending | [ ]  Expected by: Select Date |

**Section 5: Intermediate Care Facility for Intellectual Disabilities (ICF-ID) – [ ]** required documentation attached

|  |  |
| --- | --- |
| **[ ]** Guardian Approves ICF-IID | **[ ]** Court Order granting Guardian authority |
| Requesting admission to : | **[ ]** Public ICF-IID  | **or** | **[ ]** Private ICF-IID | Provider:  |   |

**Section 6: Reason for Leaving Services/Removal from Waiting List**

**[ ]** Deceased (**[ ]** Death Report attached) **Critical Incident? [ ]** No **[ ]** Yes, reported in AIR Date:

**[ ]** Moved (left State or CDDO area, with no plans to seek services in another CDDO area)

**[ ]** Voluntary Removal: person or his/her family or guardian removed the person from services

**[ ]** Terminated: CDDO terminated services to the person (failure to apply for benefits)

**[ ]** Terminated: Confirmed Medicaid fraud, waste or abuse (from Attorney General’s Medicaid unit)

**[ ]** Determined no longer eligible for waiver services (NOA/MR-5 sent: \_\_\_\_\_\_\_\_\_\_\_\_\_)

**[ ]** Admitted to Nursing Facility (permanent placement) – Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

**[ ]** Other (please describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 7: Extraordinary Funding:**

|  |  |  |
| --- | --- | --- |
| Date Completed: Select date. |  Review Conducted by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Fiscal Year: \_\_\_\_\_\_\_\_\_\_\_ |
| Tier: \_\_\_\_\_ | Level: \_\_\_\_\_\_ | [ ]  **Initial Request:** | [ ]  Day  | Proposed Start Date for Day EF: Select Date |
|  |  |  | [ ]  Residential | Proposed Start Date for Res EF: Select Date |
|  |  | [ ]  **Renewal Request:** | [ ]  Day  |  [ ] Residential |

**EF Funding Review:**

Complete the following section if a person is currently receiving extraordinary funding and the CDDO has completed the review and approved CONTINUATION of extraordinary funding.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Service** | Units Approved For Current FY  | Difference Between EF and Regular Daily Rate | Total Additional Cost for Current FY | Total Additional Cost for Next FY (Annualized) |
|   |   |   |   |   |
|   |   |   |   |   |
|   |   |   |   |   |

**Elimination of EF Costs**

|  |
| --- |
| Reason EF costs have been eliminated: |
|  | [ ]  Deceased: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | [ ]  Moved: The person left the state or CDDO area with no plans to seek services in another CDDO area |
|  | [ ]  Terminated: CDDO reviewed this individual and found him/her to no longer be eligible for EF funds per EF tool |
|  | [ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Service** | Units Approved For Current FY Which will not be used | Difference Between EF Daily Rate and Regular Daily Rate | Total Funds Approved which will not be used in Current FY | Total Funds Approved which will not be used Next FY (Annualized) |
|   |   |   |   |   |
|   |   |   |   |   |
|   |   |   |   |   |

**Section 8: MCO Recommendation:** (**[ ]** Documentation attached)

**Person Completing \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |
| --- | --- |
| **[ ]** Recommend to Approve | **[ ]** Recommend to Approve a HCBS Service other than what was requested |
| **[ ]** Recommend to Deny |

**Section 9: Additional Information:**

Please include information regarding other services offered, status of those services, and additional information regarding the reason for the recommendation; including information about number of units recommended, if applicable

**Person Completing \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |
| --- |
|   |

**Date Sent:** Select date. **Sent To:** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** at **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*For submission to the KDADS, please submit completed form to* *HCBS-KS@kdads.ks.gov*