*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*](mailto:HCBS-KS@kdads.ks.gov)