**HMCDDO Discretionary Funding Request for Medicaid-Ineligible TCM**

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| Individual Name/Address: |  |
| Guardian/Conservator/Payee: |  |

***Reason for Request:***

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|  | Individual is awaiting Title-XIX KanCare eligibility |
|  | Individual is not eligible for KanCare |

***Required Attachments:***

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|  | Current Person-Centered Support Plan (completed within the first quarter) |
|  | Targeted Case Management (TCM) Provider Service Agreement |
|  | Required Ongoing Provider Documentation: TCM Monthly Monitoring QA Checklist & Case Logs |

***Provider Billing Notes:***

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| * Full cost of TCM services will be covered by the HMCDDO pursuant to the current fiscal year HMCDDO Local Finance Plan, or until the HMCDDO Local Finance Plan funds have been fully expended. * Quarterly TCM provider payments will not be issued until all “Required Attachments” have been received by the HMCDDO. |

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| ***TCM Provider Signature*** |  | Date: |
| ***Person/Legally Responsible Party Signature*** |  | Date: |

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| **Harvey-Marion County CDDO Use Only:** | ***Date Request Received:*** |  |

* Person Centered Support Plan Provided (unless Medicaid-Ineligible TCM with no prior PCSP)
* Supporting Information Provided
* Request Complete/Forward to Resource Allocation Committee
* Request Incomplete/Return for completion

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| ***Signature of HMCDDO Funding Coordinator*** |  | Date: |

**Resource Allocation Committee Use Only:**

* Approved, Funds Available, Options Counseling to be provided
* Approved, Added to Discretionary Funding Waiting List
* Holding for more information

*Comments:*

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| ***Signature, Resource Allocation Committee Chair*** |  | Date: |