**HMCDDO REQUEST FOR HCBS I/DD ACCESS**

***New access to HCBS I/DD program services is limited to eligible individuals who have been allocated funding from the waiting list, unless KDADS determines that they meet the criteria for one of the following categories: Crisis, Transitioning from other KDADS programs, or other KDADS - identified Priority Situations. Submit this form and supplementing documentation to the Funding Coordinator for a person requesting to by-pass the waiting list process and obtain immediate access to the HCBS I/DD Program.***

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| --- | --- | --- | --- | --- | --- |
| Name: |  | Date of request: |  | KanCare MCO: |  |
| Age: |  | Medicaid #: |  | Care Coordinator: |  |
| DOB: |  | Tier: |  | Care Coordinator Phone: |  |
| SS#: |  | TCM: |  | Care Coordinator Email: |  |

***Type of Request: (Please mark all that apply)***

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| --- | --- |
|  | ***Crisis:*** |
|  | Confirmed Abuse/Neglect/Exploitation |  | Significant, imminent risk of serious harm to self or others |

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| --- | --- |
|  | ***Transition from:*** |
|  | Institutional Setting |  | PRTF/YRC2 |  | TA Waiver |  | Autism Waiver |  | TBI Waiver |

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| --- | --- |
|  | ***Priority Situations:*** |
|  | Child in DCF Custody |  | Child at risk of DCF custody |  | Personleaving DCF custody |  | Military Inclusion Policy |
|  | VR case successfully closed & needs HCBS I/DD Supported Employment |

***List HCBS/IDD Program services and units requested:***

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| Service: |  | Units: |  |
| Service: |  | Units: |  |
| Service: |  | Units: |  |
| Service: |  | Units: |  |

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1. **Describe the current situation in detail & how requested HCBS I/DD Program services will address the situation:**

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1. ***Describe all community resources, MCO resources, and natural supports offered to the person and used by the person and why they did not address the situation (community resources include, but are not limited to, behavioral health, mental health, church supports, civic clubs, community recreation centers, vocational rehabilitation, etc.):***

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1. ***\*\* Attach Supporting Documentation for the request (Functional Assessment, Person Centered Support Plan that demonstrates need, Behavior Support Plan, Medical documentation, Needs Assessment, Individualized Education Plan, communication from community resources, and KanCare MCO recommendation)***

***PLEASE SIGN & DATE***

|  |  |  |
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| ***Signature of Person completing form:*** |  | Date: |
| ***Person/Legally Responsible Party Signature:*** |  | Date: |

***FOR CDDO USE ONLY***

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| **Date Complete Request Received:** |  |
| **Date Reviewed by CDDO Funding Committee:** |  |

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| **CDDO Funding Committee Determination:**  |
|  | **Recommend approval to KDADS**  |  | **I/DD Notification Form sent to KDADS**  |
|  | **Denied** | ***Reason:***  |  |
|  | **Notification sent to person, guardian, & TCM** |

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| ***Signature of HMCDDO Executive Director:*** |  | Date: |