**HCBS Crisis/Exception Request**

**Date of Request:** Click or tap to enter a date.

|  |  |  |
| --- | --- | --- |
| **Name:** Click or tap here to enter text. | **Age:**  Click or tap here to enter text. | |
| **D.O.B.:** Click or tap to enter a date. | **SSN:** | |
| **MCO:** Choose an item. | **Medicaid #:** Click or tap here to enter text. | |
| **Guardian Name:** Click or tap here to enter text. | | |
| **TCM Agency:** Click or tap here to enter text. | **TCM:**  Click or tap here to enter text. | |
| **Date of Last Functional Assessment:**  Click or tap to enter a date. | | **Tier:**  Choose an item. |
| **I/DD Diagnosis:**  Click or tap here to enter text. | | |

**Services Requested:**

|  |  |  |
| --- | --- | --- |
| Day Services | Residential Services | PCS |

**Type of Request:**

**Crisis:**   Person is at significant, imminent risk of serious harm to self or others

Person requires protections from confirmed abuse, neglect or exploitation

**Exception:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Child in DCF Custody | Exiting DCF Custody | At risk of DCF Custody | Military Inclusion | WORK/Working Healthy |

**Transition from:** State Hospital  Nursing Home  PRTF  Jail/Prison

Expected Date of Discharge/Release of Custody:Click or tap to enter a date.

**Describe in detail the reason for the request and what has changed to warrant a request.**

Click or tap here to enter text.

**How will I/DD services resolve the reason for the request?**

Click or tap here to enter text.

**What will happen pending the results of the request and if services are not approved?**

Click or tap here to enter text.

**COMMUNITY SUPPORTS:**

**Identify current supports and supports that have been exhausted.** *Include documentation in the request (as applicable).*

**Mental Health (Check all that apply):**

SED Waiver Services: Click or tap here to enter text.

Counseling/Therapy: Click or tap here to enter text.

Medication Management: Click or tap here to enter text.

Behavioral Consultation: Click or tap here to enter text.

Inpatient Services: Click or tap here to enter text.

Other: Click or tap here to enter text.

**Education (Check all that apply):**

In School: Click or tap here to enter text.

Anticipated Date of Graduation: Click or tap to enter a date.

18-21 Program: Click or tap here to enter text.

Not in School: Click or tap here to enter text.

Other: Click or tap here to enter text.

**Employment/Vocational Services/Working Healthy (Check all that apply):**

Community Employment: Click or tap here to enter text.

Vocational Rehabilitation: Click or tap here to enter text.

WORK/Working Healthy: Click or tap here to enter text.

Other: Click or tap here to enter text.

**Transportation (Check all that apply & please explain):**

Access to public transportation: Click or tap here to enter text.

Has own transportation/able to drive: Click or tap here to enter text.

Other: Click or tap here to enter text.

**Other Community Supports:**

Click or tap here to enter text.

**NATURAL SUPPORTS:**

**What natural supports are available? If no natural supports are available, why not?**

Click or tap here to enter text.

**SUPPORT NEEDS:**

**Describe the individual’s abilities as well support needs. Provide the level of support needed for ADL’s & IADL’s.**

Click or tap here to enter text.

**MCO RECOMMENDATION/RESOURCES:**

**List MCO and recommendations/response received including other services offered by MCO. Documentation of correspondence must be submitted. If not currently Medicaid eligible, provide date of application.**

Click or tap here to enter text.

**MALADAPTIVE BEHAVIORS:**

**Describe in detail any maladaptive behaviors or patterns of such, frequency, and interventions used, etc. Provide a copy of signed Behavior Support Plan where applicable.**

Click or tap here to enter text.

**Have the behaviors identified resulted in intervention by any of the following? (Check all that apply, explain & attach supporting documentation):**

Law Enforcement: Click or tap here to enter text.

Adult Protective Services/Child Protective Services: Click or tap here to enter text.

Hospitalizations/ER: Click or tap here to enter text.

Other: Click or tap here to enter text.

**MEDICAL/HEALTH CONDITIONS:**

**Describe current medical concerns and health risks if applicable.**

Click or tap here to enter text.

**Check the supporting documentation you have submitted with this request:**

Documentation to establish imminent risk

Police Reports  ER Visits  Corrections/Probation Reports

Documentation to establish abuse, neglect and/or exploitation

ANE Reports  APS/CPS Reports

Documentation of current community resources and those that have been exhausted

Documentation of MCO recommendation & resources suggested or provided by MCO

Current signed/dated PCSP

Current signed/dated BSP (if applicable)

IEP (if applicable)

Permanency Plan (for individuals exiting DCF Custody)

Documentation verifying Expected Discharge/Release of Custody Date

**Signature of TCM: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Individual/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**