STANDARDIZED ICF-IID GATEKEEPING SUMMARY

Kansas Department for Aging and Disability Services

Consumer Information			
Consumer Name:		Birth Date:	
Street:		City:	
County:		Zip:	
Medicaid Number:		MCO:	
Community Developmental Disabilities Organization (CDDO):			

Guardian Information			
Guardian Name:			
Street:		City:	
County:		Zip:	
Phone Number:		Fax Number:	
E-Mail:			

1. Is the consumer a Kansas Resident at the time of the gatekeeping request? ☐ Yes ☐ No
2. If a guardian, does the guardian approve of this request? ☐ Yes ☐ No ☐ N/A
3. Has court approval of this request been obtained? ☐ Yes ☐ No (K.S.A. 59-3077)

***NOTE**: If no to any of the above questions, this application should not proceed.*

ICF-IID Gatekeeping Meeting			
Was the consumer present at the gatekeeping meeting? ☐ Yes ☐ No			
Was the guardian present at the gatekeeping meeting? ☐ Yes ☐ No ☐ N/A			
If no, indicate why the consumer/guardian was not present.			
CDDO Representative:		Email:	
		Phone:	
MCO Care Coordinator:		Email:	
		Phone:	
Targeted Case Manager:		Contact:	
Other:		Relationship:	
Other:		Relationship:	
Date of Gatekeeping meeting:			

Gatekeeping Efforts
1. List the person's preferences in the five life areas of the preferred lifestyle plan: (Include information source) a. In what type setting does the person want to live? b. With whom does the person want to live? c. What work or other valued activity does the person want to do? d. With whom does the person want to socialize? e. In what social, leisure, religious or other activities does the person want to participate?
2. Does the consumer have a current Person-Centered Service Plan (PCSP)? ☐ Yes ☐ No - If yes, submit copy with gatekeeping summary. - If no, indicate why a PSCP has not been completed for the consumer.
3. List consumer's strengths that could contribute to success in the community.
4. Does the consumer have health or medical related needs? If yes, please list the needs and the reason the needs are not able to be meet in the community.
5. What are the consumer's active treatment needs?

Consumer/Guardian Consent

As the consumer or guardian, I attest that *(initial by each statement):*

_____The information provided above for the gatekeeping summary is accurate to the best of my knowledge.

_____I have reviewed the gatekeeping summary and agree with the contents provided in the document.

_____I permit the submission of the gatekeeping summary to the Kansas Department for Aging and Disability Services (KDADS) to review for final admission determination.

Consumer/Guardian Name (print): _____

Consumer/Guardian Signature: _____

Date: _____

CDDO Recommendation			
CDDO Director Signature		Date	

MCO Recommendation			
MCO Care Coordinator Signature		Date:	

*If the consumer contacts the CDDO to provide additional information for the gatekeeping summary. It is the responsibility of the CDDO representative to update the gatekeeping summary with the additional information and obtain consumer/guardian signature next to the update information. Failure to obtain the necessary signature will result in invalid information for the gatekeeping summary and will be disregarded for KDADS admission review.