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HCBS – PHYSICAL DISABILITY

CONSUMER EVALUATION OF NEEDS

Section 1: ***Consumer Information***

Consumer Name: _____

Date of Birth: _____ Social Security Number: _____ Age: _____

Address: _____ City: _____ Zip:_____

Phone Number: _____ Medicaid ID Number (*if applicable*): _____

Parent(s)/Guardian(s) Name: _____ Email Address: _____

I have a sensory deficit: Legally Deaf ☐ Legally Blind ☐ N/A ☐

Section 2: ***Factors for Consideration***

1. I have been determined physically disabled by Social Security Administration (SSA) Standards (*see* Disability Determination by Social Security Standards *definition below*)
   Yes: ☐ No: ☐

   Disability Determination by Social Security Standards *– Individuals must be determined disabled under the definition as defined in section 1614(a)(3)(A) of the Social Security Act. Physical disability is defined as a medically determinable impairment or combination of impairments that significantly limit physical functions* similar to those required in a basic work setting such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling. Your physical disability must result primarily from an anatomical or physiological abnormality that is consistent with acceptable medical evidence in the form of clinical/laboratory findings and physical examinations including documentation of symptoms. A diagnosis alone is not sufficient. 20 CFR 404.1508; 404.1520(c); 404.1521(b)(1); 404.1525(d); 404.1528.*

2. I am currently on the Home and Community Based Services (HCBS) Physical Disability Waitlist:
   Yes: ☐ No: ☐

3. I have a primary diagnosis of Severe and Persistent Mental Illness (SPMI):
   Yes: ☐ No: ☐

4. I live with a spouse, guardian or others capable of performing activities for daily living such as lawn care, snow removal, shopping, ordinary housekeeping, and meal prep that can be completed within the routine of others in the household. ***The person should rely on those informal natural supports and paid personal attendant services should not be used for this request.***
   Yes: ☐ No: ☐

5. What is the nature of your living arrangement/relationship with the individual providing informal supports? _____

6. I am totally dependent upon others to assist with performing daily living activities, for example: *bathing, cooking, toileting, dressing*?
   Yes: ☐ No: ☐

7. Please rate your level of need for physical assistance with mobility:
   Independent ☐;
   Independent w/ Assistive Technology ☐;
   Two Person Assistance for Transfer ☐;
   Total Dependence ☐

Section 3: ***Consumer Statement of Need***

Below, please provide an explanation of your crisis due to your physical disability

_____

_____

_____

_____

Section 4: ***Consumer Crisis Exception Request Authorization***

I,_____, am requesting to be considered for a Crisis Exception to access Home and Community Based Services (HCBS) for the Physical Disability program. I have read the above definition of physical disability (Section 1) and understand that the Physical Disability program is designed to serve individuals with a physical disability determination by Social Security Administration Standards. I am receiving Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) for a determination of a physical disability. A mental health diagnosis (i.e. depression, bipolar disorder, schizophrenia, etc…) is not a physical disability diagnosis. I attest that all of the information stated above (Sections 1 – 3) is true to the best of my knowledge.

Consumer Name (printed): _____

Consumer Signature:_____ ***Date***: _____

If you completed this form: **Legal Guardian: ☐ DPOA: ☐**

Name (printed): _____

Signature:_____ ***Date:*** _____

Relationship to Consumer: _____

<u>Section 5</u>: ***Authorization for Release of Protected Health Information***

I,_____, Social Security Number: - - __ __ __ __ DOB___/___/___
Name of client **[optional]**

hereby authorize the use and/or disclosure of my individually identifiable health information as described below. I understand that signing this form is voluntary. I understand by not signing this form I may experience a delay in accessing crisis services.

<u>Providing the information</u>:

P**erson(s)/Organization(s)** (check all that apply)
____ Community mental health center(s)
Name _____
____ Intermediate care facility/nursing facility/hospital
Name _____
____ State Agency/Department
Name _____
____ Community developmental disability organization(s)
Name _____
____ Aging and Disability Resource Center

Other(s): Name/address/phone:

_____
_____
_____

<u>Receiving the information</u>:

Person(s)/Organization(s) (check all that apply)

____ Aging and Disability Resource Center
Name _____

____ Kansas Department on Aging and Disability Services

Other(s): Name/address/phone

_____
_____
_____

Description of Information to be Used or Disclosed:

The purpose of the Use or Disclosure:

The Individual or the Individual's Representative must read or have the following read to them and initial by each item below:

_____ *(Initials)*	I understand that I may inspect or copy the protected health information to be used or disclosed under this authorization. I understand I may refuse to sign the authorization. I understand that the refusal to sign this authorization may mean that the use and/or disclosure described in this form will not be allowed.
_____ *(Initials)*	I understand this Release is valid for one year from today's date.
_____ *(Initials)*	I understand that I may revoke this Release at any time by notifying the **providing organization** in writing. It will not have an effect on actions that were taken prior to the revocation.
_____ *(Initials)*	I understand that once the uses and disclosures have been made pursuant to this authorization, the information released may be subject to re-disclosure by any recipient and will no longer be protected by federal privacy laws.
_____ *(Initials)*	This will not condition treatment or payment on my providing authorization for this use or disclosure except to the extent the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.

I certify that I agree to the uses and disclosures listed above and that I have received a copy of this Authorization. (Form must be completed before signing).

_____ _____
Signature Date

_____ _____ _____
Signature of Personal Representative (if applicable) Date Description of Authority

Section 6: For Eligibility Assessor Use Only

1. Consumer has been confirmed/substantiated by the Department for Children and Families (DCF) within the last three (3) months for abuse, neglect or exploitation?
   Yes: ☐ **No:** ☐

2. Adult Protective Services (APS) or Child Protective Services (CPS) has determined that the consumer is at risk of family unit dissolution (break-up) involving potential state custody of minor child(ren) or dependent spouse within the last 3 months?
   Yes: ☐ **No:** ☐

3. Consumer has been determined to be in the end stages of a terminal illness (life expectancy of six months or less)?
   Yes: ☐ **No:** ☐

4. Consumer has been the victim of domestic violence within the last thirty (30) days?
   Yes: ☐ **No:** ☐

5. Physician has determined that consumer is at imminent risk of NF placement due to recent hospitalizations.
   Yes: ☐ **No:** ☐

6. Reasonable indicator screening determined that this individual has a physical disability.
   Yes: ☐ **No:** ☐

7. What is the consumer's physical disability?

   Detail: _____

I attest that all information submitted meets the criteria for consideration in accordance with the HCBS-PD Crisis Exception Request Policy.

Eligibility Assessor Name (printed): _____ *Phone:* _____

Eligibility Assessor Signature: _____ *Date:* _____