PD Applicant Crisis Evaluation (PD-ACE) Form

Instructions: *This form shall be used in accordance with the current approved HCBS PD waiver, and the PD Waiver Crisis Exception Policy, PD Waiver Eligibility Policy. The individual applying for crisis exception shall first meet reasonable indicators and be determined functionally eligible for the PD waiver by the contracted assessing entity. The individual or their legal representative shall request a crisis exception through the contracted assessing entity. This form replaces the previous CONSUMER EVALUATION OF NEEDS form.*

Section 1: Applicant Information

First Name:	Last Name:	MI:	
Date of Birth:	Social Security Number:		Age:
Address:	City:		Zip:
Phone Number:	Medicaid ID Number *(if applicable):*		
Parent(s) / Guardian(s) Name:			
Email Address:	Phone Number:		
I have a sensory deficit	Legally Deaf ☐	Legally Blind ☐	N/A ☐

Section 2: Factors for Consideration

1. Have you been determined to be disabled by Social Security Administration (SSA) Standards? (Note: Individuals must be determined disabled under the definition in section 1614(a)(3)(A) of the Social Security Act.)	**Yes:** ☐ **No:** ☐
	If no, date of application:
2. Are you currently on the Home and Community Based Services (HCBS) Physical Disability Waiting List?	**Yes:** ☐ **No:** ☐
3. Are you totally dependent upon others to assist you with performing Activities of Daily Living (ADLs)—including bathing, dressing, toileting, transferring, ambulating, and eating—and/or Instrumental Activities of Daily Living (IADLs)—including meal preparation, shopping, medication and treatment monitoring, laundry and housekeeping, money management, telephone use, and transportation?	**Yes:** ☐ **No:** ☐
4. Have you been diagnosed with a Mental Health Condition?	**Yes:** ☐ **No:** ☐
a. What is your overall *primary* diagnosis?	

b. What is your overall *secondary* diagnosis?	
5. Are you currently residing with another person?	**Yes:** ☐ **No:** ☐
a. What is your relationship to that other person? (Note: If space is not enough, then please provide this information in Section 3: Applicant Statement of Need.)	
b. What services and supports do they currently provide? (Note: If space is not enough, then please provide this information in Section 3: Applicant Statement of Need.)	
6. If you do not receive PD waiver services, then will you require placement in a nursing facility or hospital in the next thirty (30) calendar days?	**Yes:** ☐ **No:** ☐
7. If you will not require placement in a nursing facility or hospital in the next thirty (30) calendar days, then will you provide documentation for another qualifying crisis reason as defined by the PD Crisis Exception Policy?	**Yes:** ☐ **No:** ☐

Section 3: Applicant Statement of Need

Below, please provide an explanation of the crisis due to your physical disability.
(Note: If space is not enough, then please continue your narrative on a blank paper and attach it to this form.)

Section 4: Applicant 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

disability (Section 2) and understand that the Physical Disability Program is designed to serve individuals with a physical disability consistent with 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 the information stated above (Sections 1 – 3) is true to the best of my knowledge.

Applicant Name (printed):	
Applicant Signature:	Date:

If a Legal Guardian or DPOA completed this form:

Legal Guardian: ☐ **DPOA:** ☐

Legal Guardian or DPOA Name (printed):	
Signature:	Date:
Relationship to Applicant:	

Section 5: Authorization for Release of Protected Health Information

I, _____ , Date of Birth: ; with the Social Security Number: - - *(Last 4 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.

Providing the Information	**Receiving the Information**
Person(s)/Organization(s) *(check all that apply)*	**Person(s)/Organization(s)** *(check all that apply)*
Community Mental Health Center(s) (CMHC) ☐ Name:	Aging and Disability Resource Center (ADRC): ☐ Name:
Intermediate care facility/nursing facility/hospital: ☐ Name:	
State Agency/Department: ☐ Name:	
Community Developmental Disability Organization(s) (CDDO): ☐ Name:	Kansas Department for Aging and Disability Services (KDADS): ☐
Aging and Disability Resource Center (ADRC): ☐ Name:	

Other(s): Name/address/phone	**Other(s):** Name/address/phone
Name/address/phone:	Name/address/phone:
Name/address/phone:	Name/address/phone:
Name/address/phone:	Name/address/phone:

Description of Information to be Used or Disclosed:

The purpose of the Use or Disclosure:

<u>IMPORTANT:</u> 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 **<u>providing organization</u>** 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:
Date: Signature of Personal Representative (if applicable)	Description of Authority:

Section 6: For Eligibility Assessor Use Only

1.	Applicant was the victim of abuse, neglect, or exploitation, and that finding was substantiated by the Department for Children and Families Adult Protective Services (APS) or Child Protective Services (CPS) within the last thirty (30) calendar days?	**Yes:** ☐ **No:** ☐
2.	Applicant is at imminent risk of a family dissolution (break-up) involving a minor, dependent child, or dependent spouse, and that finding was reached by the Department of Children and Families (DCF) within the last thirty (30) calendar days?	**Yes:** ☐ **No:** ☐
3.	Applicant has been determined to be in the end stages of a terminal illness with a life expectancy of six (6) months or less, and that determination is documented by a physician statement?	**Yes:** ☐ **No:** ☐
4.	Applicant has been the victim of domestic violence within the last thirty (30) calendar days, and that determination is documented by a police report or court order?	**Yes:** ☐ **No:** ☐
5.	Applicant is at imminent risk of nursing facility or hospital placement without services and supports that meet the applicant's needs within thirty (30) calendar days, and that determination is documented by a physician statement?	**Yes:** ☐ **No:** ☐

6.	What is the applicant's physical disability?	**Describe Here**

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: