Kansas
Department for Aging and Disability Services

Home and Community Based Services (HCBS)
Physical Disability (PD) Waiver

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 qualified assessing entity. The individual or their legal representative shall request a crisis exception via the assessing entity. This form replaces the previous CONSUMER EVALUATION OF NEEDS form.*

Section 1: Applicant Information

Last Name:	First 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. I have been determined 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.
2. I am currently on the Home and Community Based Services (HCBS) Physical Disability Waiting List.	**Yes:** ☐ **No:** ☐
3. I am totally dependent upon others to assist with performing daily living activities, for example: bathing, cooking, toileting, dressing?	**Yes:** ☐ **No:** ☐
4. If you do not receive PD waiver services immediately, will you be moved to an institution, such as a nursing facility or hospital, in the next 60 days?	**Yes:** ☐ **No:** ☐

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Section 3: Applicant Statement of Need

Below, please provide an explanation of the crisis due to your physical disability (if space is not enough, please continue your narrative on a blank paper and attach to request)

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 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 the information stated above (Sections 1 – 3) is true to the best of my knowledge.

Applicant Name (printed):	
Applicant Signature:	Date:

If you completed this form:

Legal Guardian: ☐ **DPOA:** ☐

Name (printed):

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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:	
Intermediate care facility/nursing facility/hospital: ☐ Name:	Aging and Disability Resource Center (ADRC): ☐ 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 Name/address/phone: Name/address/phone: Name/address/phone:	**Other(s):** Name/address/phone Name/address/phone: Name/address/phone: Name/address/phone:

Description of Information to be Used or Disclosed:

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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 **<u>must</u>** be completed before signing).

Signature:	Date:

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

Section 6: For Eligibility Assessor Use Only

1.	Applicant 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 applicant 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.	Applicant has been determined to be in the end stages of a terminal illness (life expectancy of six months or less)?	**Yes:** ☐ **No:** ☐
4.	Applicant has been the victim of domestic violence within the last thirty (30) days?	**Yes:** ☐ **No:** ☐
5.	Physician has determined that applicant is at imminent risk of NF placement due to recent hospitalizations.	**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: