CRISIS EXCEPTION REQUEST: PHYSICIAN STATEMENT

PATIENT – FIRST/LAST NAME: _____ DOB: _____

The above patient has been placed on the waiting list for Home and Community Based Services and is requesting a Crisis Exception to bypass the Wait List. The following physician statement is required to assist the Kansas Department for Aging and Disability Services in determining eligibility for a Crisis exception.

Physician Statement Options (*PLEASE SELECT ONLY ONE*)

I confirm that I have seen the above-named patient for medical treatment, and it is my professional medical recommendation:

☐ **YES** ☐ **NO** *The patient is at **IMMINENT RISK** for nursing facility or hospital placement in the next thirty (30) calendar days without services and supports that meet the patient's needs.*

☐ **YES** ☐ **NO** *The patient has been determined to be in the end stages of a Terminal Illness with a life expectancy of six (6) months or less.*

Provide a detailed description below of the current medical diagnosis/conditions which place this individual at IMMINENT RISK for admission to a hospital or a nursing facility without services and supports that meet this individual's needs.

_____ _____

Signature/Title **Date**

_____ _____

Name/Title (Printed) **Physician Address/Practice Address**

NOTE: The **signature/name (Title)** can be the individual's primary healthcare provider with the qualification of any of the following: Medical Doctor (MD), Registered Nurse (RN), Advanced Practicing Registered Nurse (APRN), or Physician's Assistant (PA).

Please check your qualification from this list:

☐ Medical Doctor (MD) ☐ Advanced Practicing Registered Nurse (APRN)

☐ Registered Nurse (RN) ☐ Physician's Assistant (PA)

NOTE*: ALL fields on this form MUST be completed, and ALL fields MUST be legible, or this form may not be accepted.*