

**STANDARDIZED ICF-IID TRANSITION REQUEST**

All sections of this request must be completed.

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| **Individual Information** |
| Individual Name: | Enter Name Here | Birth Date: | Enter MM/DD/YYYY |
| Street: | Enter Street Address | City: | Enter City  |
| County: | Enter Home County | Zip: | Enter Zip Code |
| Medicaid Number: | Enter Medicaid Number | MCO: | Choose an item. |
| Who is requesting a referral for transition to an ICF-IID facility? Click or tap here to enter text. |
| Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID):Click or tap here to enter text.ICF-IID Contact Person: Click or tap here to enter text. |
| Has an IQ Evaluation been completed? Choose an item. | Date IQ Evaluation Completed:Click or tap to enter a date. |
| IQ Score: Number Is IQ 70 or below? Choose an item. | Diagnosis:Click or tap here to enter text. |
| [ ]  ***Check here if this is an Expedited Transition request due to health, safety, and welfare of the person.*** |
| [ ]  ***Check here if this is a transition from another ICF/IID facility.*** |

1. Is the individual a Kansas resident? Choose an item.
2. Has a Functional Eligibility Assessment been completed within the last 365 days? Choose an item.
3. Date Functional Assessment was completed Click or tap to enter a date.
4. If the person has a legal guardian, does the guardian approve of this request? Choose an item.
5. If there is a court-appointed legal guardian, does the court-appointed guardian

have authority to place individual in an ICF? (K.S.A. 59-3077) Choose an item.

***NOTE: If “NO” to any of the applicable questions (1-5) above, this request may not proceed.***

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| Does the individual have a legal guardian? Choose an item. **Parent (*if individual is under the age of 18*) or Guardian Information (*if individual has a court appointed guardian regardless of age*)** |
| Name: | Click or tap here to enter text. |
| Street: | Click or tap here to enter text. | City: | Click or tap here to enter text. |
| County: | Click or tap here to enter text. | Zip: | Click or tap here to enter text. |
| Phone Number: | Click or tap here to enter text. | Fax Number: | Click or tap here to enter text. |
| E-Mail: | Click or tap here to enter text. |

Is this a request for placement in a public or private ICF-IID? [ ] Public [ ] Private

Where is the individual transitioning from? [ ] Private ICF-IID [ ] State ID Hospital [ ] Other: (explain) Click or tap here to enter text.

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| **Transition Information** |
| Does the individual have a current Individual Program Plan (IPP)? Choose an item.If yes, submit copy of IPP with transition application.Submit documentation that individual is being transitioned for “good cause.”   |

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| **ICF-IID Transition Meeting** |
| Was the individual present at the transition meeting? Choose an item. |
| Was the guardian present at the transition meeting? Choose an item. |
| If no, indicate why the individual/guardian was not present.Click or tap here to enter text.  |
| Discharging ICF-IID Representative: | Present at Meeting: Choose an item. | Click or tap here to enter text. | Email: | Click or tap here to enter text. |
| Phone: | Click or tap here to enter text. |
| Admitting ICF-IID Representative: | Present at Meeting: Choose an item. | Click or tap here to enter text. | Email: | Click or tap here to enter text. |
| Phone: | Click or tap here to enter text. |
| MCO Representative: | Present at Meeting: Choose an item. | Click or tap here to enter text. | Contact: | Click or tap here to enter text. |
| CDDO Representative: | Present at Meeting: Choose an item. | Click or tap here to enter text. | Contact: | Click or tap here to enter text. |
| Other: | Present at Meeting: Choose an item. | Click or tap here to enter text. | Relationship: | Click or tap here to enter text. |
| Date of Transition meeting: Click or tap to enter a date. |
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**Individual/Guardian Consent**

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

 The information provided above for the transition request is accurate to the best of my knowledge.

 I have reviewed the transition request and agree with the contents provided in the document.

 I permit the submission of the transition request to the Kansas Department for Aging and Disability Services (KDADS) to review for final transition determination.

Individual/Guardian Name (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Individual/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **MCO Comments** |
| Click or tap here to enter text. |
| MCO LTSS Signature |  | Date: |  |

\*If the individual contacts the discharging ICF-IID to provide additional information for the transition request. It is the responsibility of the discharging ICF-IID representative to update the transition request with the additional information and obtain individual/guardian signature next to the update information. Failure to obtain the necessary signature will result in invalid information for the transition request and will be disregarded for KDADS ICF-IID transition review.

***This document will not be considered unless all signatures are present.***

***This document will not be considered without the completion of the MCO comments.***

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| KDADS Review |
| Date Received | Click or tap to enter a date. | Determination Date | Click or tap to enter a date. |
| Determination:  | [ ] Approved | [ ] Denied | [ ] Other |
| Comments:Click or tap here to enter text. |
| Reviewed by: |  |