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| The following form is ONLY to be used for individuals who are currently on the SCL waiting list on future planning or urgent status.  For individuals not currently on the SCL waiting list, a new waiver application must be submitted in MWMA for review. The waiver application should include all of the relevant information regarding the need for emergency allocation using the text boxes available or by attaching additional documentation to support the need for emergency allocation.  Please read the instructions thoroughly and provide detailed responses. If sufficient information is not provided to support the need for emergency status, the individual will remain in their current category of need on the waiting list. | | | |
| **Name of Individual on SCL waiting list:** |  | **DOB:** |  |
| **Name of Individual completing form:** |  | **Relationship to Individual:** |  |
| **Date Form Completed:** |  | | |

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| **Change necessitating emergency SCL placement**: An emergency request form should be completed ONLY when there has been a significant change in the individual’s situation that you believe may meet criteria for emergency category of need. Please describe that change here. |

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| Please confirm with a **yes** response that **all of the needed documentation to verify that the individual meets criteria for SCL are in the individual’s documents in MWMA**.  -Required documents include: psychological evaluation with current I/DD diagnosis, supported by IQ testing with FSIQ score, an adaptive behavior assessment less than 2 years old, and records of previous evaluations or detailed developmental history to support onset of disability prior to adulthood.  **If these items are not uploaded to the individual’s documents within MWMA, DO NOT submit the emergency request form, as it cannot be reviewed without these documents**  Are all required documents uploaded in MWMA? |

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| Please list **diagnoses for intellectual or developmental disability, psychiatric disorders, and medical conditions**. Diagnoses should be supported by records uploaded in MWMA that indicate the individual was evaluated and diagnosed in accordance with best practices by appropriate professional healthcare providers. |

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| Please provide the name and all available contact info for the individual’s **guardian** and whether they are appointed through CHFS or a private guardian. For private guardians please provide what their relationship is to the individual (parent, sibling, friend, attorney, etc.) and what role they play currently and will be providing in the future regarding both direct provision of care and indirect monitoring and coordination of supports. Also **describe the support** the guardian is providing, and why they are unable to continue providing support. |

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| Please indicate any other individuals who are **authorized representatives** for the individual’s medical or financial decisions. Please provide the name and all available contact info for the individual(s), their relationship to the individual and the specific nature and scope of their role in monitoring or provision of care for the individual. |

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| Please provide any information regarding direct or indirect support the individual receives from **non-paid supports**. What is the relationship to the individual, what type of supports have they or could they provide (frequency, etc.) |
| Please indicate the type of **residence** where the individual currently lives  Where is the individual currently residing?  own home/apartment family home friends home homeless shelter  paid provider residence family care home/personal care home nursing facility  Other (provide details below):    If the individual is temporarily located somewhere other than their usual residence please explain the reason and when the individual is expected to return to their residence or why they cannot return. |

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| Please list any **paid supports** (private/self-pay, private insurance, Medicare, Medicaid State Plan, waivers, state general funds, and other public programs) that provide for individuals financial, medical, or other support needs. Please provide specifics about the type and amount of support being provided, whether it is ongoing or time-limited, etc. |

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| Please list any **additional supports** that are needed to maintain the individual safely in the community. Be specific regarding the type and amount of assistance needed and what activities of daily living the assistance is for. Please explain why the individual cannot receive these services through any other source (paid or non-paid supports) other than SCL. Do NOT list names of waiver services. Why are these supports needed to maintain health and safety related to their intellectual or developmental disability? BE SPECIFIC |

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| Please indicate whether the individual has requested and/or received any services through their **Community mental health Center-Crisis Services** orfrom **ICF specialty clinic** to address their current needs. Please detail the date(s), what types of assistance was provided and the outcome. |

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| Please provide specific information regarding the **plan for transition to SCL services** if approved. Please indicate the type of services, whether providers have been identified, and goals for the services. This plan should be clearly linked to the needs identified above and address the health and safety issues that qualify the individual for emergency allocation. |

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| **Instructions to submit this form**:   * Instructions for submitting an Emergency Request are located here: <https://tris.eku.edu/MWMA/20220204Docs/Emergency%20Requests%20for%20SCL%20Waitlist%20Individuals%20QRG.pdf> * Do **not** submit form via email to [SCLER@ky.gov](mailto:SCLER@ky.gov). All SCL emergency requests must be submitted through MWMA. This mailbox should only be used for follow up questions. |