

APPLICATION FOR SCL WAIVER AND ICF/MR SERVICES

Section 1

DO NOT leave any information blank in section 1. Applications will be returned if left blank.

Name - Legibly print first, middle and last name of applicant

Sex - Check whether the applicant is male or female

SS# - Be sure the social security number has 9 numbers

Medical Assistance Number - This is the # on the MEDICAID card (10 numbers)

DOB - example: 08/18/1966

Phone Number - Always include area code. If no phone, please write "no phone"

Current Address - Please print legibly.

Name _____
First Middle Last Sex: M F

Social Security Number _____ Medical Assistance Number _____

Date of Birth _____ Phone # (_____) _____
(Month, Day, Year)

Current Address _____

City County State Zip Code

Section 2

Complete this section only if there is a LEGAL representative or guardian

If the applicant is a minor, there **must** be a legal guardian

If there is a legal guardian, the **signature is REQUIRED.**

Legal Representative/Guardian _____

Address _____

City County State Zip Code

Phone _____ Relationship to Applicant _____
(Ex: mother, father, friend)

Email _____

Legal Rep/Guardian's Signature _____ **Date** _____

2nd Legal Representative/Guardian _____

Address _____

City County State Zip Code

Phone _____ Relationship to Applicant _____
(Ex: mother, father, friend)

Email _____

Co-Guardian's Signature _____ **Date** _____

Section 3

Complete this section IF there is a Case Manager

A Case Manager coordinates services. This could be a person or an agency such as the local community mental health center. Leave this section blank if there is no case manager for the applicant.

Case Management Agency _____

Case Manager Name _____

Address _____

City	County	State	Zip Code	Phone Number
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Email _____

Section 4

This section MUST be completely filled out and SIGNED by a physician or SCL Developmental Disability Professional
If you need assistance with this section, contact the community mental health center in your area: <http://www.mhmr.ky.gov/CMHC/>
If applying for placement on the SCL waiting list, you must attach the results of a psychological examination completed by a licensed psychologist or psychologist with autonomous functioning. The examination must support the ID/DD diagnosis (including IQ score and adaptive behavior assessment).

CMHC DD Director Signature is **NOT** required unless you are applying for ICF/MR (facility) placement.
If applying for ICF/MR placement you must attach a copy of applicant's current Plan of Care, current psychological, social history, crisis plan, behavior support plan, a current needs assessment, and minutes from the team meeting recommending ICF/MR admission. The DD director's signature indicates that all community options have been exhausted and an ICF/MR is the least restrictive placement available.

DSM Diagnosis

Axis I – DO NOT LEAVE BLANK - write "none" on the line if there is no diagnosis

Axis II - DO NOT LEAVE BLANK - write "none" on the line if there is no diagnosis

Axis III - DO NOT LEAVE BLANK - write "none" on the line if there is no diagnosis

Age disability identified is the age the applicant was diagnosed with an intellectual or developmental disability (Ex: birth, 1 yr old, etc.). Intellectual disability must be present prior to age 18. Developmental disability must be present prior to age 22.

DSM Diagnosis:

Axis I (Mental Health) _____

Axis II (Mental Retardation/Developmental Disability) _____

Axis III (Physical Health) _____

Age Disability Identified _____

Physician/SCL DDP Signature

Date

SCL Waiver

CMHC DD Director Signature

Date

ICF/MR

Section 5

The APPLICANT MUST sign this section IF s/he does NOT have a legal guardian.

If unable to sign, a mark (such as "X") is acceptable.

Most of the headings to describe the applicant require checking only the one that best describes the person. Numbers 7, 9, and 10 allow more than one item to be checked.

The person completing the application MUST sign, date, and provide contact information.

Applicant's Signature _____ Date _____

INFORMATION ABOUT THE APPLICANT

1. MOBILITY (Check ONE)

- Walks independently
- Walks with supportive devices
- Walks unaided with difficulty
- Uses wheelchair operated by self
- Uses wheelchair & needs help
- No mobility

Comments: _____

2. COMMUNICATION (Check ONE)

- Speaks and can be understood
- Speaks and is difficult to understand
- Uses gestures
- Uses sign language
- Uses communication board or device
- Does not communicate

Comments: _____

3. HOW MUCH TIME IS REQUIRED FOR ASSURING SAFETY? (Check ONE)

- Requires less than 8 hours per day on average
- Requires 9-16 hours daily on average
- Requires 24 hours (does not require awake person overnight)
- Requires 24 hours with awake person overnight
- Extreme Need:** Requires 24 hours, awake person trained to meet individual's particular needs; continuous monitoring

COMMENTS _____

4. HOW MUCH ASSISTANCE IS NEEDED FOR DAILY LIVING TASKS? (Check ONE)

- No assistance** needed in **most** self-help and daily living areas, **and minimal assistance (use of verbal prompts or gestures as reminders)** needed in **some** self-help and daily living **and Minimal to complex assistance** needed to complete complex skills such as financial planning & health planning.
- No assistance** in **some** self-help, daily living areas, **and minimal assistance** for many skills, **and complete assistance (caregiver completes all parts of task)** needed in **some** basic skills and all **complex** skills.
- Partial (use of hands on guidance for part of task) to complete assistance** needed in **most** areas of self-help, daily living, and decision making, **and cannot complete complex** skills.
- Partial to complete assistance** is needed in **all areas** of self-help, daily living, decision making, and complex skills.
- Extreme Need:** All tasks must be done for the individual, with no participation from the individual.

5. HOW OFTEN ARE DOCTOR VISITS NEEDED? (Check ONE)

- For routine health care only / once per year
- 2-4 times per year for consultation or treatment for chronic health care need
- More than 4 times per year for consultation or treatment
- Extreme Need:** Chronic medical condition requires immediate availability and frequent monitoring

6. HOW OFTEN ARE NURSING SERVICES NEEDED? (Check ONE)

- Not at all
- For routine health care only
- 1-3 times per month
- Weekly
- Daily
- Extreme Need:** Several times daily or continuous availability

COMMENTS: _____

7. ARE THERE BEHAVIORAL PROBLEMS? Yes No

IF THERE ARE BEHAVIORAL PROBLEMS CHECK ALL THAT APPLY.

- Self Injury
- Aggressive towards others
- Inappropriate sexual behavior
- Property destruction
- Life threatening (threat of death or severe injury to self or others)
- Takes prescribed medications for behavior control

COMMENTS: _____

8. WHERE IS THE INDIVIDUAL CURRENTLY LIVING? (Check ONE)

- | | | |
|--|--|---|
| <input type="checkbox"/> Living with family/relative | <input type="checkbox"/> Living in own home or apartment | <input type="checkbox"/> Foster Care |
| <input type="checkbox"/> Group home or personal care home | <input type="checkbox"/> Nursing home | <input type="checkbox"/> Psychiatric Facility |
| <input type="checkbox"/> ICF/MR (Intermediate Care Facility) | <input type="checkbox"/> Living with a friend | <input type="checkbox"/> Other _____ |

9. SERVICES THE INDIVIDUAL CURRENTLY RECEIVES (Check ALL THAT APPLY)

- | | |
|--|--|
| <input type="checkbox"/> Acquired Brain Injury | <input type="checkbox"/> Occupational Therapy |
| <input type="checkbox"/> Behavior Support | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> Case Management | <input type="checkbox"/> Residential |
| <input type="checkbox"/> Day Program | <input type="checkbox"/> Respite |
| <input type="checkbox"/> EPSDT (if under 21) | <input type="checkbox"/> School |
| <input type="checkbox"/> Hart Supported Living | <input type="checkbox"/> Speech Therapy |
| <input type="checkbox"/> Home & Community Based Waiver | <input type="checkbox"/> Supported Employment |
| <input type="checkbox"/> Home Health | <input type="checkbox"/> Other Medicaid Services _____ |
| <input type="checkbox"/> Mental Health Counseling/Medication | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Michelle P Waiver | |

10. SERVICES NEEDED NOW OR IN THE FUTURE? (Check ALL THAT APPLY)

- | | |
|---|---|
| <input type="checkbox"/> Behavior Support | <input type="checkbox"/> Residential |
| <input type="checkbox"/> Case Management | <input type="checkbox"/> Respite |
| <input type="checkbox"/> Community Access | <input type="checkbox"/> School |
| <input type="checkbox"/> Day Training | <input type="checkbox"/> Speech Therapy |
| <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Supported Employment |
| <input type="checkbox"/> Personal Assistance | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Physical Therapy | |

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11. WHERE WOULD THE APPLICANT PREFER TO LIVE IN THE FUTURE? (Check ONE)

- At home with a family member with someone to come in and help
- In the person's own home with supports
- In residential services in the community living with a family
- In residential services in a community home with staff

12. WHO IS THE PRIMARY CAREGIVER? (If staff is primary caregiver, leave 13 & 14 blank)

- Mother Father Grandmother Grandfather Aunt Uncle Staff
- Sister Brother Friend Neighbor Other: Who? _____

13. WHAT IS THE AGE OF THE PRIMARY CAREGIVER?

- Less than 30 years old 31-50 years old 51-60 years old 61-70 years old
- 71-80 years old Over 80 years old

14. THE PRIMARY CAREGIVER'S HEALTH STATUS COULD BE CLASSIFIED AS:

- Poor Stable Good Very Good

Primary Caregiver Name _____

Primary Caregiver contact information (complete this information if different from guardian)

Address _____

City	County	State	Zip Code	Phone Number
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Email _____

Comments: _____

Person Completing Application: _____
Print Name

Relationship to Individual	Phone Number	Email address
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Signature	Date
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Additional Comments: _____

Mail or fax to:
The Division of Developmental & Intellectual Disabilities
100 Fair Oaks Lane, 4W-C
Frankfort, Kentucky 40621
Fax: 502-564-8917

