

INITIAL SECTION 21 WAIVER ELIGIBILITY and/or FUNDING REQUEST

Applicant's name: _____

Date: _____

ISC/CCM: _____

Region: _____

CURRENT STATUS: NOT currently on the waiver _____

ON the waiver _____

* **Adult Protective request:** _____

(This is a request for

* **Eligibility Determination:** _____

additional services or funding)

CURRENT FUNDING LEVEL

Service	# Units	Rate	Total \$
Home Support			
Community Support			
Work Support			
Other			
TOTAL CURRENT			

PROPOSED FUNDING LEVEL

Service	# Units	Rate	Total \$
Home Support			
Community Support			
Work Support			
Other			
TOTAL PROPOSED			

(Please make sure to reflect any concurrent reductions. For example, if a person is going to start attending day hab, will she have a concurrent reduction in residential hours?)

REQUIRED ACTIONS/ATTACHMENTS (Place a check mark or "NA")

_____ This request originates with a PCP or Service Plan (Date of Plan: _____)

_____ Current budget is attached

_____ Proposed budget is attached

_____ Supporting material from agency is attached, if needed

_____ Proposed staffing pattern is attached, if needed

Please use responses to the questions below to introduce the person, describe the situation (particularly potential harm or unsafe circumstances) and give an overview of the proposed solution.

Who Is (Consumer's Name-Please type consumer's name here)?

Age:

MR Diagnosis and other Dx:

Current Location:

Describe briefly the consumer's greatest support needs:

Applicant's name: _____

What Happened? (Include description of medical/behavioral/other condition that is contributing to the emergency)

What Was Done To Help?

List current medical/behavioral/other providers:

List medical/behavioral/other providers' opinion of medical condition:

Describe medical/behavioral/other providers' recommendations and treatment choices:

Describe the medical/behavioral/other providers' determination of risk:

What's The Plan and What Will the Waiver Do?

Ability and/or willingness of current care providers to continue supports:

Effectiveness of current plan/living situation:

Describe living situation if it will change:

Name of waiver provider (if different from current provider):

Provider location:

Describe Provider's qualifications (skills, training):

Describe Provider's experience with the unique needs of the consumer:

Does provider's location permit continued contact with current medical services and family? If not, what's the plan?

Are provider's other residents compatible with the consumer and have the caseworkers and guardians of the other residents been informed of the plan?

Describe all staff support to be provided (i.e., 24/7 supervision, transportation, medication monitoring, etc.):

Applicant's name: _____

What Will Happen Without the Waiver? (Include timeline of what is most likely to happen; i.e., risk, possibility of consumer getting worse, current caregiver burn out, accidents, assaults, etc.)

The Request:

Name of waiver provider:

Type of support (personal supports, residential training, day hab, supported employment, Shared Living, etc.):

Units and yearly rate:

REVIEW TEAM RESPONSE: Approved _____ Denied _____ Tabled _____
Date:
Comments:
Central Committee
Authorizing Signature: _____ Date: _____