

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	Phone
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: _____

SCL Waiver

Physician/SCL DDP Signature

Date

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.

<div style="display: flex; justify-content: space-between; width: 80%; margin: 0 auto;"> Applicant's Signature Date </div>

INFORMATION ABOUT THE APPLICANT

1. MOBILITY (Check ONE)

- | | | |
|---|--|---|
| <input type="checkbox"/> Walks independently | <input type="checkbox"/> Walks with supportive devices | <input type="checkbox"/> Uses wheelchair operated by self |
| <input type="checkbox"/> Uses wheelchair & needs help | <input type="checkbox"/> Walks unaided with difficulty | <input type="checkbox"/> No mobility |

Comments:

2. COMMUNICATION (Check ONE)

- | | | |
|---|--|---|
| <input type="checkbox"/> Speaks and can be understood | <input type="checkbox"/> Speaks and is difficult to understand | <input type="checkbox"/> Uses sign language |
| <input type="checkbox"/> Uses communication board or device | <input type="checkbox"/> Uses gestures | <input type="checkbox"/> 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
- Daily
- For routine health care only
- Extreme Need:** Several times daily or continuous availability
- 1-3 times per month
- Weekly

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
- Takes prescribed medications for behavior control
- Life threatening (threat of death or severe injury to self or others)

Comments:

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

- Living with family/relative
- Group home or personal care home
- ICF/MR (Intermediate Care Facility)
- Other: _____
- Living in own home or apartment
- Nursing home
- Living with a friend
- Foster Care
- Psychiatric Facility

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

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

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

- Behavior Support
- Case Management
- Community Access
- Day Training
- Other: _____
- Occupational Therapy
- Personal Assistance
- Physical Therapy
- Residential
- Respite
- School
- Speech Therapy
- Supported Employment

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		Phone
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Email: _____

Comments:

Person Completing Application: _____
Print Name

	Relationship to Individual		Phone Number		Email address
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	Signature
	Date

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