

DEVELOPMENTAL DISABILITIES PROGRAM

REQUEST FOR EMERGENCY SELECTION OF 0208 WAIVER SERVICES

This form is to be used when a person on the DD waiting list is experiencing a critical situation that can only be addressed by the person immediately receiving the long-term supports and services available via the DDP 0208 waiver.

The completed form and required attachments for individuals currently residing in an institutional setting must be submitted to the DDP Client Services Program Officer. For individuals currently residing in the community these will be submitted to the appropriate Regional Manager.

The form will be reviewed based on criteria identified in ARM 37.34.907 (11). If accepted, the information will be submitted to the DDP Bureau Chief for final review and determination. The referral source will be notified in writing of the final decision.

Name of Individual: _____ DOB: _____ AWACS #: _____

Address: _____

Guardian, if applicable and type of guardianship: _____

Case Manager: _____ CM Agency: _____ Date: _____

DD Eligibility Date: _____ WL Referral Date: _____

What resources are available to the individual? (Identify all paid and unpaid services/supports the individual receives (include provider contact information). Also list services/supports the individual qualifies for, even if the person is using only a portion of, or none of these services/supports. Examples include natural supports, personal assistance services, counseling, etc. If the individual is currently receiving institutional care please list all resources the individual will qualify for upon return to the community.)

Service/Support	Provided By	Frequency (how often)	# hours authorized/wk	# hours used/week

Is the individual using 100% of all resources available? (For individuals currently receiving institutional care, respond based on what the person will access once residing in the community.) **Yes** **No**

If the person is not using all available resources please describe the barriers (including if the individual/guardian has chosen to not fully access supports).

Where is the person currently residing, and what led up to him/her being there?

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Has the individual been a victim of maltreatment, abuse, neglect or exploitation supported by findings of protective services? **Yes** **No**

If yes, please provide the date(s) of occurrence along with a copy of investigative report with findings and recommendations from protective services, or name and contact information of the Protection Specialist from whom a copy of the investigative report can be obtained.

What concerns does the team have about the person's health and/or safety if he/she does not receive DD 0208 waiver services?

If the person is selected to participate in the DD 0208 waiver, which waiver services has the individual and his/her team determined would best meet the individual's health and safety needs, and which environment(s) would be most appropriate to meet those needs?

Does the person understand the requirements of the DD 0208 waiver and indicate willingness to participate in habilitation as described in the response to the previous question? **Yes** **No**

Required Attachments: MONA/Estimated Individual Cost Plan
Current Plan of Care or Treatment Plan

Upon completion of the information above, the Case Manager or referral entity submits this form along with required attachments to Sam Morgenroth, DDP Program Officer for individuals currently residing in an institutional setting; or to the Regional Manager for individuals currently residing in the community. Information must be transmitted in a HIPAA-compliant method such as Therap SComm or the State's File Transfer Service.

DDP Program Officer/Regional Manager Recommendation:

Accept and submit to Bureau Chief Return for additional information Decline

Comments:

Signature: _____ Date: _____

DDP Bureau Chief Decision:

Approved for 0208 Waiver Services NOT Approved for 0208 Waiver Services

Signature: _____ Date: _____