APPLICATION FOR SCL WAIVER AND ICF/MR SERVICES

Read attached instruction sheet before completing this application

Section 1

Sex: M ☐ or F ☐

Name: _____
First Middle Last

Social Security Number _____ Medical Assistance Number _____

Date of Birth _____ Phone #: ( ) -
month day year

Present Address: _____
street

_____ KY _____
city County State Zip Code

Section 2

Legal Representative/Guardian _____

Address _____

_____ KY _____
city County State Zip Code

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

Legal Rep./Guardian Signature _____ Date _____

Section 3

Case Management Provider Name
And Address

Name: _____

Address: _____

_____
City County State Zip Code Phone Number

Section 4

DSM Diagnosis:
Axis I (Mental Health): _____
Axis II (Mental Retardation/Developmental Disability): _____
Axis III: (Physical Health): _____
Age Disability Identified: _____

_____ _____
Physician/QMRP Signature Date

_____ _____
CMHC MR/DD Director Signature Date

☐ SCL Waiver

☐ ICF/MR

Section 5

Applicant's Signature _____ **Date** _____

PLEASE TELL US BOUT THE APPLICANT BY CHECKING ONE BOX UNDER EACH HEADING.

6. MOBILITY

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

Comments _____

7. COMMUNICATION

- ☐ 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: _____

8. HOW MUCH TIME IS REQUIRED FOR ASSURING SAFETY?

- ☐ 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: _____

9. HOW MUCH ASSISTANCE IS NEEDED FOR DAILY LIVING TASKS (Choose only ONE box)

☐ **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 areas and
Minimal to complex assistance needed to complete complex skills such as financial planning and 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, & complete skills

☐ **Extreme need:** All tasks must be done for the individual, with no participation from the individual

10. HOW OFTEN ARE DOCTOR VISITS NEEDED?

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

COMMENTS: _____

_____

11. HOW OFTEN ARE NURSING SERVICES NEEDED?

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

COMMENTS: _____

_____

12. ARE THERE BEHAVIORAL PROBLEMS? Yes ☐ No ☐

IF YES-PLEASE CHECDK ALL THAT APPLY.

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

PLEASE CHECK ONE ANSWER UNDER EACH QUESTION, UNLESS OTHERWISE INDICATED

13 WHERE IS THE INDIVDUAL CURRENTLY LIVING?

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

14 DOES THE INDIVIDUAL CURRENTLY RECEIVE ANY OF THE FOLLOWING SERVICES? (CHECK ALL THAT APPLY)

- ☐ Supported Living
- ☐ Medicaid Acquired Brain Injury
- ☐ Supported Employment
- ☐ Home Health
- ☐ Other Medicaid Services
- ☐ Day Program
- ☐ School
- ☐ Behavior Support
- ☐ Transportation
- ☐ Speech Therapy
- ☐ Physical Therapy
- ☐ Medicaid EPSDT (if under 21)
- ☐ Medicaid Home & Community Based Waiver
- ☐ Mental Health Counseling or Medication for a mental health condition
- ☐ In home support
- ☐ Residential
- ☐ Respite
- ☐ Occupational Therapy
- ☐ Case Management
- ☐ Other _____

15 WHAT SERVICES ARE NEEDED NOW OR IN THE FUTURE?

- ☐ Day Program
- ☐ School
- ☐ Respite
- ☐ Transportation
- ☐ Speech Therapy
- ☐ Physical Therapy
- ☐ In home support
- ☐ Residential
- ☐ Behavior Support
- ☐ Occupational Therapy
- ☐ Case Management
- ☐ Supported Employment

16 THE FOLLOWING ARE 5 CHOICES FOR FUTURE LIVING ARRANGEMENTS. WHERE WOULD THE APPLICANT PREFER TO LIVE IN THE FUTURE? CHOOSE ONLY ONE (1):

- ☐ At home with a family member with someone to come in and help
- ☐ In the person's own home with minimal support
- ☐ In a 24 hour staffed residence in the community
- ☐ In a 24 hour supervised family home in the community
- ☐ In a 24 hour staffed group home in the community
- ☐ In an ICF/MR

17 WHO IS THE PRIMARY CAREGIVER? (If staff, do not answer questions 18 & 19)

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

18 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

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

☐ Poor ☐ Stable ☐ Good ☐ Very Good

COMMENTS: _____

_____

_____

Person Completing this Application _____

Print Name _____

_____

Relationship to Individual (if not individual)

_____

Phone Number _____

_____ _____

Signature Date

Additional Comments: _____

_____

Mail to: The Division of Mental Retardation, 100 Fair Oaks Lane, 4W-C, Frankfort KY. 40621