

Community Developmental Disability Organization

Serving Lyon, Chase, Morris and Wabaunsee Counties

HCBS I/DD WAIVER ACCESS REQUEST

**Access to funding for HCBS I/DD Waiver services is limited to Waiver eligible individuals who have been allocated funding from the waiting list unless they meet criteria as a crisis or one of the exceptions categories. Those categories include transitioning from other KDADS programs, or other KDADS identified priority situations. Submit this form to the CDDO for a person requesting to by-pass the waiting list process and obtain immediate access to the HCBS I/DD Waiver.**

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| Member Name: | |
| Date of Request: | KanCare MCO: |
| Medicaid Number: | Care Coordinator: |
| Date of Birth: | Care Coordinator Phone: |
| TCM Name: | Care Coordinator Email: |

Type of Request:

**CRISIS:**

|  |  |
| --- | --- |
|  | Confirmed Abuse/Neglect/Exploitation |
|  | Significant, imminent risk of serious harm to self or others |

**TRANSITION FROM:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Institution |  | PRTF/YRC2 |  | Autism Waiver |
|  | TA Waiver |  | TBI Waiver |  | WORK program |

**PRIORITY SITUATION:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Child in DCF Custody |  | Child at RISK of DCF custody |  | Person leaving DCF custody |
|  | VR Case closed and needs supported employment | | |  | Military Inclusion |

Explain how individual meets the above request.

***(Be very specific.)***

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Please describe what supports both paid and unpaid that the person currently has and explain why these supports are not enough to alleviate the need for waiver access. (for example, are they still in school, do they access any other waiver, do they have attendant care through some other program.) **Be specific.**

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Describe all community resources, MCO resources, and natural supports offered to the person and used by the person and why they did not address the situation. **Attach supporting documentation for the request.**

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Does the person currently have Medicaid? YES NO

If not, are they in the process of applying? YES NO Date application submitted:

What specific services are being requested?

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Financial considerations: Please note individual and/or family ability to private pay for the requested services?

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**I give consent for this funding request and supporting documentation to be shared with the Kansas Department of Aging and Disability Services (KDADS) on behalf of , for the purpose of determining immediate access to the I/DD waiver.**

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| --- | --- |
| Member/Guardian Signature: | Date: |

HCBS I/DD WAIVER FUNDING REQUEST CHECKLIST

* Functional Assessment current within 365 days (schedule if needed after submitting request packet)

**Crisis & Priority Situation Requests:**

* Statement from MCO of exhausted resources/recommendations (contacts below)

Healthy Blue: [institutionaltransitions@healthybluekansas.com](mailto:institutionaltransitions@healthybluekansas.com)

Sunflower: [KSLifeshare@sunflowerhealthplan.com](mailto:KSLifeshare@sunflowerhealthplan.com)

United Healthcare: [uhcksltss@uhc.com](mailto:uhcksltss@uhc.com)

* Documentation that community resources have been exhausted prior to applying for HCBS
* Person Centered Support Plan with signature page (updated to reflect need for request)
* Individualized Education Plan (any requests for school age children)
* Behavior Support Plan with signature page (if applicable)
* Documentation of Law Enforcement Involvement (if applicable)
* Documentation of medical treatment (if applicable)
* Documentation of confirmed abuse/neglect/exploitation from DCF (if applicable)
* VR Case Closure letter and documented need for on-going support (SE Exceptions)
* Documentation of planned release from DCF custody (DCF release exception)
* Documentation of non-supervision needs not duplicated by foster parent (DCF Exception)
* Documentation of KS Residency, Tricare ECHO, and DD 214 Form (Military Inclusion Exception)

**Transition Requests:**

* Documentation of impending transfer (PRTF discharge plan required for PRTF transitions back to HCBS)

CDDO USE ONLY:

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| Date Received: | Date emailed to funding committee: |
| Funding Committee Determination | |
| Recommend approval to KDADS | Funding Committee Denied request |
| Reason for denial: | |
| Notification sent to person, guardian & TCM: |  |
| Request uploaded to KDADS for review: |  |

Revised: 08-20-2025