



**Waiting List Exception Request**

Date: \_\_\_\_\_

Client Name: \_\_\_\_\_

SS#: \_\_\_\_\_ DOB: \_\_\_\_\_

Tier: \_\_\_\_\_

TCM: \_\_\_\_\_ TCM Phone: \_\_\_\_\_

Medicaid:  Yes  No

Date of application: \_\_\_\_\_

If not eligible for Medicaid, please explain why:

\_\_\_\_\_

**1. Which crisis definition applies to this situation? (Please mark one)**

Requires protection from confirmed abuse, neglect, or exploitation or written documentation of pending action for same (Please provide supporting documentation)

DCF currently involved?  Yes  No

Police/Court currently involved?  Yes  No

Medical Specialist currently involved?  Yes  No

At significant, imminent risk of causing harm to self or others in their current situation  
Explain:

\_\_\_\_\_  
\_\_\_\_\_

**2. Are there current significant Behavioral/Mental Health Needs?**  Yes  No

Explain: \_\_\_\_\_  
\_\_\_\_\_

Are Behavioral/Mental Health Services in place?  Yes  No

Provider: \_\_\_\_\_

Services: \_\_\_\_\_

Is there a current Behavioral Support Plan?  Yes  No

Are these needs being met? If not, why:  Yes  No

\_\_\_\_\_  
\_\_\_\_\_

**3. Are there current significant Medical Needs?**  Yes  No

Diagnosis: \_\_\_\_\_

Are these needs being met? If not, why:  Yes  No

\_\_\_\_\_  
\_\_\_\_\_

Can these needs be met through EPSDT? If not, why:  Yes  No

\_\_\_\_\_  
\_\_\_\_\_



**5. What other community resources have been explored prior to making this request (Check all that apply)?**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Other HCBS Waivers                 | <input type="checkbox"/> Mental Health Services      | <input type="checkbox"/> Parsons Outreach Team |
| <input type="checkbox"/> MCO Value Added Benefits           | <input type="checkbox"/> Local Family Support Grants | <input type="checkbox"/> EPSDT                 |
| <input type="checkbox"/> Private Insurance                  | <input type="checkbox"/> Vocational Rehab            | <input type="checkbox"/> DCF Programs          |
| <input type="checkbox"/> Educational Programs               | <input type="checkbox"/> After School Care           | <input type="checkbox"/> CDDO State Aid        |
| <input type="checkbox"/> Independent Living Skills Services | <input type="checkbox"/> Other: _____                |  |

**6. Persons living in the home:**

Name	Relationship	Age	Employed
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**7. Gross Monthly Income:**

SSI/SSDI	\$	Employment	\$
Family Support/Subsidy	\$	Alimony/Child Support	\$
Cash Assistance	\$	Trust Fund Payments	\$
Adoption Subsidy	\$	Food Stamps	\$
Other	\$	Explain Other	
		<b>Monthly Income</b>	\$
		<b>Annual Income</b>	\$

**8. Gross Monthly Expenses:**

Mortgage/Rent	\$	Electric/Gas	\$
Phone	\$	Cable	\$
Water/Trash	\$	Alimony/Child Support	\$
Food	\$	Laundry	\$
Transportation (payment, gas, insurance)	\$	Childcare	\$
Insurance	\$	Savings	\$
Retirement/Investments	\$		
Other	\$	Explain Other:	
		<b>Total Monthly Expenses</b>	\$
		<b>Annual Expenses</b>	\$

9. What is the immediate negative outcome if the service is not approved?

10. Please summarize the request for exception with any additional detail the funding committee should be aware of related to this request? This includes any barriers to placement (family, financial, behavioral)

I \_\_\_\_\_ authorize my case manager to submit this request for funding  
(person/guardian)

to the CDDO & Kansas Department for Aging and Disability Services. The CDDO of Butler County will review the request and supporting documentation within 3 business days and determine if all other community supports have been exhausted prior to making a possible recommendation to KDADS.

If/When the request is forwarded to KDADS, they have 10 business days to follow up with additional questions and make a determination on the exception to services. If KDADS has determined an approval to bypass the waiting list and access I/DD Waiver Services, they will inform the parent/guardian via mail.

The Managed Care Organization (MCO) managing the Medicaid Card will contact the parent/guardian to complete a Needs Assessment to determine the HCBS services which will be approved. Once services have been approved, the parent/guardian will need to contact the CDDO of Butler County to complete Options Counseling/Provider Choice choosing the providers in our area for the services.