



When additional waiver capacity may be needed by an administrative entity, or AE, to address an unanticipated emergency, the following information will be discussed between the regional Waiver Capacity Manager and the AE point person for capacity management.

1. Information identifying the individual receiving services experiencing an unanticipated emergency:
 - a. Name
 - b. MCI #
 - c. Age
 - d. Current residential status/living situation
 - e. Name and relationship of individual's family, guardian, or advocate
 - f. Name of supports coordinator (if applicable)

2. Information identifying the Regional Waver Capacity Manager
 - a. Name
 - b. Region

3. Information identifying the AE point person:
 - a. Name
 - b. AE
 - c. Role within the AE
 - d. Contact information

4. What is the nature of the unanticipated emergency? (brief summary)

5. Does the individual meet the unanticipated emergency criteria?

An unanticipated emergency is:

 1. *an individual or participant is at immediate risk to his/her health and welfare due to illness or death of a caretaker;*
 2. *an individual living independently experiences a sudden loss of their home (for example, due to fire or natural disaster); or*
 3. *an individual loses the care of a relative or caregiver, without advance warning or planning.*

YES NO

6. Is this individual registered in HCSIS for the county for Mental Retardation services?

YES (If yes, indicate active or inactive.) NO

7. Does this individual appear to be eligible for Mental Retardation services?

YES NO

8. Can this individual be determined eligible for an ICF/MR level of care?

YES NO

9. Is this individual currently enrolled in a waiver? (If yes, which waiver?)

YES Consolidated Waiver PFDS/Waiver
 NO



10. Is this individual involved with any other county or state agencies? (If unknown, AE is expected to verify this with the county assistance office and other county agencies before additional waiver capacity can be approved.)

- Aging Mental Health
 CYF Other (If applicable, please name agency.)

11. Would another agency's services be appropriate to support the individual? (If yes, please check the appropriate agency.)

- YES Aging Mental Health
 CYF Other (If applicable, please name agency.)
 NO

12. What supports does the individual need?

- | | |
|---|---|
| Type: | Special Accomodations: |
| <input type="checkbox"/> In-home supports | <input type="checkbox"/> Sign language |
| <input type="checkbox"/> Residential supports | <input type="checkbox"/> Wheelchair accessibility |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Others _____ |

13. Are alternative residential settings available or more appropriate? (If yes, please check the appropriate setting.)

- | | | |
|------------------------------|---|---|
| <input type="checkbox"/> YES | <input type="checkbox"/> LTSR | <input type="checkbox"/> Domiciliary Care _____ |
| | <input type="checkbox"/> CRR | <input type="checkbox"/> Private ICF/MR |
| | <input type="checkbox"/> Residential Treatment Facility | <input type="checkbox"/> Personal Care Home |
| | | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> NO | | |

14. What non-waiver funded natural supports are available? (Brief summary)

15. Does the AE have resources available to support the individual? (If yes, please name.)

- YES _____
 NO

16. Is the AE able to support the individual within its current waiver capacity?

- YES NO

17. Is the need for support expected to be short-term (90 days or fewer) or long-term?

- Short-term Long-term

Explanation:

18. Has a potential provder been identified to address the individual's needs?

- YES Provider Name: _____
 NO