



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.)

- YES     LTSR                       Domiciliary Care \_\_\_\_\_  
 CRR                       Private ICF/MR  
 Residential Treatment Facility     Personal Care Home  
 Other \_\_\_\_\_  
 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