SCL Emergency Form

In order to be considered for emergency services, please complete this form in its entirety. Verification may be requested concerning any information that is incomplete or unclear. Attach any additional relevant information if necessary.

Individual's Name ______________________
SSN: _____ – ____ – _____
DOB: _____ – ____– _____

On the SCL Waiting List ☐ yes ☐ no
Status on the SCL Waiting List ___________

Person completing form __________________
Relationship to individual _________________
Telephone # ________________________
Fax#________________________________
Email ___________________________________

Has Case Manager for SCL Supports been identified, if so who:________________________________

Has Residential Provider for SCL Supports been identified, if so who:_________________________________

Current Situation:

1. Where does the individual live? *Address*

2. How is this arrangement working?

3. Is there a guardian? ☐ yes ☐ no
   If yes, what is the type of guardianship? ☐ Parent of a minor child
   ☐ Conservator ☐ Limited Guardianship ☐ Full Guardianship ☐ Other
   Guardian name:
   Guardian address:
   Guardian phone number:
   What is the guardian's involvement in providing care?

4. What is the involvement of family? What prevents the family from being able to provide care? *List contacts and reasons they are unable to provide care.*

5. Does the health status of any caregiver or potential caregiver affect their ability to support the individual? If so, how? *Provide documentation from whenever possible.*

Past Efforts and Services: *To qualify for Emergency SCL Services, any and all other possible appropriate services must have been tried.*

6. Is the individual receiving services or funding from the local mental health center or any other source? ☐ yes ☐ no *If yes, list services received and the name and number of the contact person(s).*

7. What services have been explored prior to the emergency request and why they were not appropriate? If any services were received in the past, how long were they provided and why were they unsuccessful?
   - ☐ Personal Care Home: ______
   - ☐ Family Care Home: ______
   - ☐ Group Home: ______
   - ☐ Michelle P Waiver: ______
   - ☐ HCBS Waiver: ______
   - ☐ Hart-Supported Living: ______
   - ☐ Acquired Brain Injury Waivers: ______
   - ☐ Medicaid Home Health: ______
   - ☐ Education System: ______
   - ☐ Impact Services: ______
   - ☐ Impact Plus Services: ______
   - ☐ ICF/ID: ______
   - ☐ DDID State General Fund Specialized Services and Equipment: ______
   - ☐ Department for Aging and Independent Living: ______

☐ Center for Accessible Living: ____________________

☐ HUD Housing: ____________________

☐ Medicaid EPSDT Program: ____________________

☐ Other: ____________________

Abuse, Neglect, Exploitation (A/N/E): *(If applicable)*

8. If there have been complaints of abuse/neglect/exploitation, what were the findings? *List name of protective services worker.*

Psychiatric Hospitalization:

9. Is the individual currently in a psychiatric hospital? ☐ yes ☐ no *If yes, send treatment team notes signed by the members of the treatment team of the hospital indicating that the individual has met treatment goals and is ready for discharge to a community placement.*

Statement from Guardian: *The following should be filled out and signed by the guardian.*
What services does the individual need?

Guardian's Signature: ____________________

Statement from Individual:
What help do you need to live in the community?

Individual's Signature: ____________________

Please mail or fax to:
The Division of Developmental & Intellectual Disabilities
275 East Main Street, 4CF
Frankfort, KY 40621
Phone: 502-564-7700
Fax: 502-564-8917

Internal Use Only
Date Reviewed:
Action Taken: