State of Illinois
Department of Human Services
Division of Developmental Disabilities

CRISIS TRANSITION PLAN and FUNDING REQUEST

(Please Submit Typed Form to Network Staff via secure E-mail Scan or confidential Fax)

Complete Funding Request Packet ☐ **or** **Pre-Award Letter (PAL) Request** ☐

Individual's Name _____ **Date of Birth** _____ **Age** _____

Height: _____ **Weight:** _____ **SSN:** _____ **RIN/E-RIN:** _____

Address: _____ **Region/Network:** _____

Currently Resides With: _____ **How long:** _____ **Relationship to Person:** _____

Guardian: _____ **Relationship:** _____

Sending PAS/ISC Agency: _____ **PAS/ISC Worker:** _____

Sending PAS/ISC Email address: _____ **Phone:** _____ **Fax:** _____

Receiving PAS/ISC Agency: _____ **Receiving Network:** _____

Crisis Service Requested :

☐ CILA, 24 HOUR ☐ CILA HOST FAMILY ☐ CILA, INTERMITTENT ☐ CILA FAMILY ☐ ADULT HBS
☐ CHILD GROUP HOME ☐ CHILD HBS ☐ CHILD RESIDENTIAL SCHOOL ☐ OTHER _____

Please verify by your signature that ICF/DD (adult) or SNF/PED (child) was given as a service choice option: _____ .

(If ICF/DD or SNF/PED is choice of service, submission of this form is not required)

Axis Diagnoses by Name: (Psychological Evaluation must be completed by a licensed clinical psychologist per PAS Manual)

Axis I: _____ Axis II: _____ Axis III: _____

Axis IV: _____ Other Conditions: _____

Psychological Date: _____ Functioning Level: _____

FSIQ _____ Age of Onset _____ (as documented in Psychological Evaluation)

ICAP or SIB-R Date _____ Service Score _____ Maladaptive Score _____

Psychiatric Evaluation Date: _____ (see PAS Manual) **Psychosocial Assessment Date:** _____

1) **Temporary Safety Plan:** What short-term measure(s) are in place now to ensure health, safety, and welfare of this individual:

Also, date Temporary Safety Plan was implemented: _____

(Temporary Safety Plan must be in place until long-term arrangement are implemented)

Individual's Name: _____

2) **Receiving other Waiver or community services?** If yes, explain:

3) **Supports Attempted/Explored [i.e., Division of Rehabilitation Services (DRS), Division of Specialized Care for Children (DSCC), respite and reason(s) why the support(s) did not/will not work or meet the need]:**

4) **Describe Behaviors: i.e. Frequency, Intensity, Duration and Severity of Behaviors:**

5) **Detailed Summary of crisis needs and issues (must include - evidence of imminent risk):**

Check all that apply: ☐ Abuse ☐ Neglect ☐ Homelessness

6) **Presenting Medical Issue(s) of the individual and/or caregiver(s) and how it impacts the individual's care. Also, summarize any/all pertinent professional medical (MD, RN, etc...) evaluations of service needs relevant to the service being requested:**

Individual's Name: _____

7) **Detailed summary of other contributing factors (e.g., family dynamics, police/court involvement, OIG/DPH/DCFS/OSG involvement):**

8) **Is this request for service the long-term plan of choice? If yes, proceed to question #9. If no, ensure the Prioritization of Urgency of Need for Services (PUNS) record reflects up-to-date and accurate information:** _____

9) **What supports in addition to the Crisis Service being requested should be explored? [e.g., TA, CART, SST, Etc.]:**

**** Proposed Provider of Crisis (Requested) Services:*** _____

**** Provider Contact Person and Email:*** _____

**** Provider Phone #:*** _____ **** Provider Fax Number #:*** _____

**** Full Address of Proposed Residential Site:*** _____

_____ ***(If A/CHBS, attach Service Plan)***

**** Earliest Date that Proposed Provider Will Initiate The Requested Services:*** _____

**** Provider Contact Person's Signature:*** _____ ***Date:*** _____

PAS/ISC Signature: _____ ***Date Sent to Networks:*** _____

DHS-DDD USE ONLY
DETERMINATION OF THE CRISIS AND ELIGIBILITY STATUS

Date that complete funding request packet or Pre-Award Letter (PAL) request was received by Network: _____

Date returned to PAS/ISC due to incomplete request: _____

* Reason (be specific):

☐ Ineligible for DD Waiver Services: Network will immediately inform the PAS/ISC agency in writing of the DDD's decision regarding ineligibility.

Recommend the Service Requested (reference 4/16/2008 memo and state reason for Approval of this request or Denial of this request):

☐ Approval OR ☐ Denial

* Reason (be specific):

DDD Review Committee Approval or Denial Date: _____

Track-it Database Record Number: _____

Date complete funding request forwarded to BCR: _____

Network Staff Signature: _____ Date: _____

CRISIS TRANSITION PLAN AND FUNDING REQUEST INSTRUCTIONS

Introduction:

The procedures outlined below provide instructions for the Crisis Transition Plan and Funding Request for adults and children document [formerly titled "Crisis Funding Information Request" - IL462-0140 (R-5-09)]. For individuals in "Crisis", a Pre-Award (PAL) or emergency funding packet may be requested. In these situations, the Crisis Transition Plan and Funding Request form will be completed and submitted. The crisis plan will end when the choice of services start and the individualized service plan (ISP) begins.

Please note that with Crisis situations, time is of the essence. In an effort to ensure all approvable requests for services and/or placement for individuals who are in a situation of Crisis receive such services and/or placement expeditiously (generally within 72 hours, once the Division determines the individual to be in crisis), we ask that you submit the complete funding request packet or pre-award letter (PAL) request to Network Staff via secure e-mail scan or confidential fax only.

Process:

The information provided by the Division of Developmental Disabilities (DDD) within the Illinois Department of Human Services is intended for the use and convenience of interested persons. The information contained herein should not be considered a substitute for the appropriate official statutes, rules, regulations, or the advice of legal counsel.

While the following procedural information/guidance has been long standing and still current Department practice, it is effective immediately with this release.

The Pre-Admission Screening/Independent Service Coordination/Individual Service & Support Advocacy (PAS/ISC/ISSA) agencies shall complete the Crisis Transition Plan and Funding Request form for adults and children with a developmental disability who meet the crisis criteria as described in the "Children Crisis Criteria for Funding" and "Adult Crisis Criteria for Funding" documents - See Attachments. The questions listed on the Crisis Transition Plan and Funding Request form are designed to provide core information about the individual as it relates to the conditions of: Abuse, Neglect, and Homelessness.

Crisis Transition Plan and Funding Request Completion:

In order for the DDD to consider authorizing funding for crisis requests the PAS/ISC/ISSA must submit a complete Crisis Transition Plan and Funding Request form in typed text to network staff for review of crisis status and final determination. Again, submission must be done via secure e-mail scan or confidential fax only. Once the Division determines that an individual is in Crisis, authorized services must begin within 72 hours. Please complete all appropriate section(s) as they pertain to the crisis situation. Please expound in great detail on all questions that apply, as well as any information you feel pertinent to the respective request. Also, it may be necessary for the network staff to request additional information to assist them in fully understanding the crisis, support needs and/or clinical eligibility of the individual being presented for funding. Please note, per Attachment-A of the Community Service Agreement, "The Division of Developmental Disabilities reserves the right to review and reverse any PAS determination."

Submission of the Crisis Transition Plan and Funding Request form is not necessary for individuals that are part of the SODC or DCFS Transition Initiatives. We ask, however, that your agency still include a cover memorandum on agency letterhead with **all** funding requests sent to the DDD. Please begin using this document immediately and, as applicable; attach additional typed pages with the respective request. Please **do not** re-format the Crisis Transition Plan and Funding Request form, as the form will automatically expand to accommodate additional information.

CRISIS TRANSITION PLAN AND FUNDING REQUEST INSTRUCTIONS

INDIVIDUAL AND PAS/ISC INFORMATION

- **Individual's Name -** Enter the FIRST NAME, LAST NAME & MIDDLE INITIAL of the individual for whom the Crisis and Eligibility Information Request form is being submitted. *It is important that the name appear exactly as it will be entered in the Community Reimbursement Sub-System (CRS) and Medicaid system*. Differences in spelling or using a nickname cause errors and may result in program authorization, rate change, and other payment-related problems.

- **Individual's Date of Birth and Age** - Enter the month, day, and year of the individual's date of birth as well as the individual's age. Use the format of MM/DD/ YYYY for date of birth. Dates of birth are useful factors for determining age appropriate services and can be used to differentiate individuals with similar or identical names.

- **Individual's Height and Weight** - Enter the individual's current height and weight.

- **Social Security Number** - Enter the nine-digit Social Security Number (SSN) of the individual named above. *It is important that the SSN be reported exactly as it will be entered into the Community Reimbursement Sub-System and Medicaid system*. This is one of the most frequent error-causing data entry points that cause program authorization, rate change, and payment problems. Do not enter "999-99-9999" if the Social Security Number is not known.

- **Medicaid Recipient Identification Number (active RIN/E-RIN)** - Enter the nine-digit Recipient Identification Number (RIN/E-RIN) of the individual named above. *It is important that the RIN/E-RIN be reported exactly as it will be entered into the Community Reimbursement Sub-System and Medicaid system.* Do not enter "999-99-999" if the Recipient Identification Number is unknown.

- **Address -** Provide the address of the individual's current living arrangement.

- **Network -** Provide the DDD Network based on the individual's/legal guardian's home address.

- **Currently Resides With -** Explain with whom the individual is currently residing and for how long. Also provide the relationship to the individual.

- **Guardian's Name and Relationship -** Enter the FIRST NAME and LAST NAME of the individual's legal guardian(s). *It is important that the name(s) appear as entered on the Individual/Guardian Information Form. It is also important to know the relationship of the guardian to the individual.*

- **Sending PAS/ISC Agency** - The "Sending/Originating" PAS/ISC agency's name is required for processing.

- **PAS/ISC Worker** - The "Sending/Originating" PAS/ISC worker's name is required for processing.

- **Sending PAS/ISC Email Address, Phone# and Fax#** - The "Sending/Originating" PAS/ISC worker's e-mail address, phone and fax numbers (including extensions) are required for processing.

- **Receiving PAS/ISC Agency** - The "Receiving" PAS/ISC agency's name is required for processing.

- **Receiving Network -** Provide the DDD Network based on where the individual will be moving/ residing.

CRISIS TRANSITION PLAN AND FUNDING REQUEST INSTRUCTIONS

TYPE OF ADULT/CHILD SERVICE

- **Crisis Service Requested -** Answer by placing an "X" in the box next to the adult or children DD service the individual is applying for due to crisis status

Adult DD Services:
*** 60D - CILA, 24-Hour**
*** 60D - CILA, Host Family**
*** 60D - CILA, Intermittent**
*** 60D - CILA, Family**
*** Adult Home-Based Supports**
*** ICF/DD**
*** Other**

Children's DD Services:
*** 17D - Children's Group Home**
*** Children's Home-Based Supports**
*** 19D - Child Care Institution (Residential School)**
*** SNF/PED**

NOTE: If ICF/DD or SNF/PED is choice of service, submission of this Crisis Transition Plan and Funding Request form is not required. However, please verify by your signature that ICF/DD (adult) or SNF/PED (child) was given as a service choice option. The ICF/DD and SNF/PED options are only included to ensure an individual's right to choose ICF/DD or SNF/PED service.

DIAGNOSTIC/CLINICAL INFORMATION

- **Multi-Axial Assessments -** Provide the Axis I thru IV domains of information from the individual's valid clinical/medical evaluations and assessments. Must put the full name of the diagnosis and not just the classification number.

- **Psychological Evaluation Info -** A Licensed Clinical Psychologist must complete and sign the psychological evaluation. The psychological evaluation must be current within five years for adults (at least 18 years old). For children, the psychological evaluation must be current within two years for children 13 up to 18 years old and within one year for children 3 through 12 years old. Provide the date, functioning level, full scale IQ, and age of onset noted in the psychological evaluation. (Per DDD PAS Manual; Chapter 500.20 G - In order for the individual's disability to be substantiated, the PAS agency must ensure that the age of onset of the individual's mental retardation or related condition is documented in the psychological assessment (for mental retardation) or the physician's assessment (for related conditions) - See DDD PAS Manual for details/guidance.

- **ICAP or SIB-R Report Info -** The Inventory for Client and Agency Planning (ICAP) or Scales of Independent Behavior-Revised (SIB-R) must be administered by a Qualified Intellectual Disabilities Professional (QIDP) and it must be current within one year. Provide the date, service score, and maladaptive score from the ICAP or SIB-R.

- **Psychiatric Evaluation Info -** The psychiatric evaluation is completed and signed by a licensed psychiatrist. The psychiatric evaluation may be completed by a licensed psychologist, a master's degree psychiatric nurse, or a licensed clinical social worker, if a licensed psychiatrist co-signs the assessment. Please **Note:** For children under the age of 16 whose primary disability appears to be a developmental disability, this assessment may be performed by a pediatrician with expertise in developmental or behavioral problems - See DDD PAS Manual for details/guidance. The psychiatric evaluation must be current within one year for an individual with a dual diagnosis. Provide the date of the psychiatric evaluation.

CRISIS TRANSITION PLAN AND FUNDING REQUEST INSTRUCTIONS

- **Psychosocial Evaluation Info -** The psycho-social assessment must be signed by a MSW, a Qualified Mental Health Professional (QMHP), or an MA or MS in Psychology. The assessment may be completed by a Qualified Intellectual Disabilities Professional (QIDP), if co-signed by one of the aforesaid disciplines. The psycho-social assessment must be current within one year for an individual with a dual diagnosis. Provide the date of the psychosocial evaluation.

TEMPORARY SAFETY PLAN

- **Temporary Safety Plan -** Please describe in great detail the short-term measures that are currently in place to ensure the immediate health, safety, and welfare needs of the individual (e.g., respite, temporary increased in-home supports, psychiatric/medical hospitalization, etc.) and the date(s) implemented. NOTE: Safety Plan must be in place until long-term arrangements are implemented.

RESOURCES RECEIVED AND ATTEMPTED

- **Other Services Currently Received -** Please document in detail any/all waivered or community services [i.e., Developmental Training DT-31U, Local Mental Health Counseling, etc…] that the individual is currently authorized for/ receiving by responding to the applicable question.

- **Supports Attempted/Explored For The Individual -** Please document in detail all direct/indirect supports and/or resources [i.e., Division of Rehabilitation Services (DRS), Division of Specialized Care for Children (DSCC), respite, etc…] that the individual has attempted/explored and reasons why it did not/will not work or meet the need by responding to the applicable question.

CRISIS CIRCUMSTANCES AND TRANSITION PLAN

NOTE: As a "Mandated Reporter", any/all suspected abuse, neglect and/or exploitation must be reported to the proper investigative authority (ie, OIG, IDPH, IDCFS, law enforcement, etc.).

- **Behaviors -** Please describe in great detail all of the individual's behaviors (e.g., verbal and/or physical aggression, bodily harm to self and/or others, property damage, etc.) that put the individual and/or family member(s) at risk of serious harm.

- **Individual's Crisis Status -** Check any/all boxes that apply to the individual's conditions of "Abuse, Neglect, and/or Homelessness".

  Please document all direct/indirect crisis circumstances that are impacting the individual by providing a detailed summary pertaining to the conditions of "Abuse, Neglect and/or Homelessness". Please describe in great detail all that apply, as well as any information you feel pertinent to the request.

- **Presenting Medical Issues -** Please describe in great detail any health/medical condition(s) of the individual and/or primary caregiver(s) that impacts the individual's care. Include the date(s) of onset. Also, summarize any/all pertinent professional medical (MD, RN, etc…) evaluations of service needs relevant to the service being requested.

- **Other Contributing Factors -** Please describe in great detail all factors that impact the needs of the individual (dynamics of the household, legal matters, conditions of the home inside and/or outside, etc.) and any current or prior involvement by an investigative authority (ie, OIG, IDPH, IDCFS, law enforcement, etc.).

- **Choice/Selection of Service (Adults Only) -** If the requested DD service matches the adult individual's long-term service choice, complete the rest of Crisis Transition Plan and Funding Request form.

If the requested DD service does NOT match the adult individual's long-term service choice, explain the situation in detail. Then upon completion of the Crisis Transition Plan and Funding Request form, ensure the Prioritization of Urgency of Need for Services (PUNS) record reflects up-to-date and accurate information.

- **Additional Supports -** Please describe in great detail any support(s) in addition to the Crisis Service being requested that may be explored or needed and requested as part of the individual's transition (e.g., technical assistance, Clinical and Administrative Review Team (CART), Support Services Team (SST), etc.).

PROPOSED PROVIDER INFORMATION

- **Required Information -** The proposed (residential or home-based support) crisis service provider's name as well as the agency contact person's name, e-mail address, phone and fax numbers (including extensions) are required for processing requests for residential services, as applicable for processing requests for A/CHBS. For residential services, enter the full address of the proposed residential site (include zip code). For home-based services, attach a copy of the A/CHBS service plan. In addition, enter the date that the requested service will be initiated.

SIGNATURE AND DATE

- **Provider Contact Person's Signature and Date** - The provider contact person's signature and date is required for processing. This entry verifies that the provider has seen the information that is being presented to the Division and also signifies that the provider is in agreement with the information.
- **PAS/ISC Signature and Date** - The "Originating/Sending" PAS/ISC worker's signature and date is required for processing. This entry reflects the date of submission (sent) to Network staff.

DHS-DDD USE ONLY SECTION

- **Determination of Crisis and Eligibility Status -** The Network Staff will use this section to document the date that the complete funding request packet or Pre-Award Letter (PAL) request was received. As applicable, the Network Staff will also use this section to document date of return, if the submitted information is incomplete.

  Please Note: Network Staff will immediately inform the PAS/ISC agency of incomplete/missing information and the reason. Furthermore, Network Staff will return the request to the PAS/ISC agency as an Incomplete/Missing Information Request.

- The Network Staff will inform the PAS/ISC agency in writing of the DDD's decision regarding ineligibility and the reason.

- In addition, the Network Staff will use this section to document recommended Approval or Denial of an individual's request for services/placement and the reason.

Summary:

Please Note: The information listed on the Crisis Transition Plan and Funding Request form will be used by Division Staff to review/verify an individual's crisis status and is just one part of an entire funding request packet. A complete funding request packet includes several other required pieces of information as referenced in the "60D CILA Support Application" and the "Application for Service Authorization" documents. If you have any questions on completing the Crisis Transition Plan and Funding Request form, please contact your Network Facilitator.