State of Illinois
Department of Human Services
Division of Developmental Disabilities

CRISIS FUNDING INFORMATION REQUEST

(Please Submit Typed Form to Network Staff) _____

Date of Request:

Individual's Name _____ Date of Birth _____

Network _____ Packet or PAL _____ Age _____

Social Security # _____ Active RIN/E-RIN# _____

Sending PAS/ISC Agency _____ Sending PAS/ISC Worker _____

Receiving PAS/ISC Agency _____ Sending PAS/ISC Fax # _____

Sending PAS/ISC Phone # _____

Crisis Service Requested (X):

☐ CILA, 24 HOUR/HOST ☐ CHILD GROUP HOME ☐ CHILD HBS ☐ OTHER

☐ ADULT HBS ☐ CILA, INT/FAM ☐ RESIDENTIAL SCHOOL

Axis Diagnoses: (Psychological Evaluation must be completed by a licensed clinical psychologist)

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

Axis V: _____ Axis IV: _____ Other Conditions: _____

Psychological Date _____ Full Scale - IQ _____ Functioning Level _____

ICAP or SIB Date _____ Service Score _____ Maladaptive Score _____

Guardian _____ Relationship _____

Receiving other government or community services? If yes, explain: _____

Supports Attempted/Explored [i.e., DRS, DSCC, Respite and Reason(s) Why the Support(s) Did Not/Will Not Work or Meet the Need]:

_____

_____

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Describe Behaviors: i.e. Frequency, Intensity, Duration and Severity of Behaviors: _____

_____

Detailed summary of Crisis Needs and Issues (must include - imminent risk of abuse, neglect, and/or homelessness). Check any/all that apply: ☐ **Abuse** ☐ **Neglect** ☐ **Homelessness**

_____

_____

_____

Presenting Medical Issues of the individual and/or caregiver(s):

_____

_____

_____

Detailed Summary of Other Contributing Factors (e.g., family dynamics, police/court involvement, OIG/DPH/DCFS involvement):

_____

_____

_____

*** Proposed Community Provider:** _____

*** Provider Contact Person:** _____

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

*** Address of Residential site (city and zip code):**

_____

*** Date that services will be initiated:** _____

*** Proposed Service Facilitator:** _____ **[If AHBS or CHBS, attach Service Plan.]**

PAS/ISC Signature: _____ Date: _____

DHS-DD Use Only

☐ Support the Service Requested ☐ Yes ☐ No Date _____

☐ Track it Number: _____

☐ Internal Checks: Medicaid and Waiver Eligibility Screens

Network Staff Signature: _____ Date: _____

Network Coordinator Signature: _____ Date: _____