State of Illinois- Department of Human Services
Division of Developmental Disabilities

Application for 60D CILA Support Services

This application is to be completed by a licensed CILA provider in cooperation with an Independent Service Coordination (ISC) agency and should represent the conditions applicable to a specific eligible individual for whom CILA support funding is being requested. The information provided must be accurate and complete to the best of the CILA provider's and ISC agency's knowledge. Please refer to the "Application for 60D CILA Support Services Instructions".

PLEASE COMPLETE ONLINE AND PRINT FORM. HANDWRITTEN FORMS WILL NOT BE ACCEPTED OR PROCESSED.

INDIVIDUAL INFORMATION

1. Name of Individual: _____
(Last Name) (First Name)

2. Social Security Number *(Nine Digits):* _____

3. Recipient Identification Number (RIN) *(Nine Digits):* _____

4. Date of Birth: _____ (MM/DD/YYYY)

5 Gender: ___Male ___Female

6. Is the person ambulatory (walks independently or with assistive devices)? ☐ Yes ☐ No

7. Inventory for Client & Agency Planning (ICAP) or Scales of Independent Behavior Revised (SIBR) Summary Score (2 digits): _____

8. ICAP or SIBR Maladaptive Behavioral Index Score (2 digits): _____

9. Date of Evaluation - ICAP or SIBR Summary: _____ (MM/DD/YYYY)

NOTE: ICAP Summary must be less than one year old and copy attached.

CILA PROVIDER & SITE INFORMATION

10. Provider Agency Name: _____

11. Provider Agency DHS four-digit number (e.g., 0104, 1912, etc.): _____

12. Address of the CILA site where the person will be living: _____
(Address) (Apt. #)

_____
(City) (Zip Code)

13. County where the CILA home is located: _____

14. Total residential capacity of the CILA site in which the person will be living: _____

NOTE: Residential capacity is the number of people intended to be served at this site. Use Licensed Capacity only if that is the number of people who will be served at this site.

15. What level of CILA support services is provided at this CILA site?

☐ 24 Hour with Shift Staff ☐ 24 Hour with Foster Care/Host Family

☐ Family or Relative (Answer #17) ☐ Intermittent **Not with** Family or Relative (Answer #17)

NOTE: If "Family or Relative" or "Intermittent Not with Family or Relative" is checked, then #17 MUST be answered. If "Foster **Care/Host Family" is checked then a Prior Approval Request for Host Family Services form (IL462-4426) is also required.**

16. Is Night Shift Staff allowed to sleep at any time? ☐ Yes (Asleep) ☐ No (Awake)

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17. These questions MUST be answered if requesting "Intermittent" CILA or "Family or Relative" CILA Support Services in #15 above:

Type of Intermittent or Family/Relative Support	Weekly Quantity
Direct Support Person (DSP):	_____ Hours / Week
Supervisor:	_____ Hours / Week
Qualified Intellectual Disability Professional (QIDP):	_____ Hours / Week
Mileage for staff-related miles:	_____ Hours / Week

If more than 15 DSP hours per week are needed an Additional Staff Support and 1 or 2 Person CILA Request form with appropriate supporting documentation is required.

18. List names of all other individuals living at or moving to this site (if the capacity is vacant, please list as such):

	Name of Person	Is the person living at this site now?			Is the person currently funded by DHS? If "yes", then by what program code?		
1.	_____	☐ Yes	☐ No	☐ Proposed	☐ Yes	☐ No	_____
2.	_____	☐ Yes	☐ No	☐ Proposed	☐ Yes	☐ No	_____
3.	_____	☐ Yes	☐ No	☐ Proposed	☐ Yes	☐ No	_____
4.	_____	☐ Yes	☐ No	☐ Proposed	☐ Yes	☐ No	_____
5.	_____	☐ Yes	☐ No	☐ Proposed	☐ Yes	☐ No	_____
6.	_____	☐ Yes	☐ No	☐ Proposed	☐ Yes	☐ No	_____
7.	_____	☐ Yes	☐ No	☐ Proposed	☐ Yes	☐ No	_____

Independent Service Coordination (ISC)

The destination (receiving) ISC agency will be specified on the individual's CILA Rate Sheet based on the county and zip code of the CILA site where the person will be served as identified in questions #12 and #13 above.

RATE TYPE / RESIDENT LOCATION INFORMATION

19. Rate Type: Please mark the appropriate "Rate Type" indicator for the applicant (person in Question #1 above).

☐ Aging Out DCFS (Department of Children & Family Services (DCFS) youths 17.5 yrs. or older)
☐ Aging Out DHS (Person funded by Department of Human Services (DHS) aging-out of residential supports for children)
☐ Aging Out ICG (Person funded by Division of Mental Health (DMH) aging-out of an Individual Care Grant)
☐ Aging-Out ISBE (Person funded by the Illinois State Board of Education (ISBE) aging-out of children's supports)
☐ Community Emergency (Person meets the DDD emergency crisis criteria)
☐ Conversion (Any person with DDD funding to convert to 60D CILA funding)
☐ ICF/DD Closure or Downsizing (Part of a planned downsizing or closure of the ICF/DD)
☐ Ligas - ICF/DD Choice (Chose to move from the ICF/DD)
☐ Ligas, PUNS Selection (Person selected from the Prioritization of Urgency of Need for Services database)
☐ Rate Redetermination (Current CILA resident; Rate being determined by the CILA Rate Model)
☐ State-Operated Developmental Center Census Reduction
☐ State-Operated Mental Health Center Discharge
☐ Other, please describe: _____

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20. **Residence Location Prior to CILA Placement:** Please mark the appropriate "Residence Location" prior to the CILA placement. If "Rate Redetermination" is marked in #19, then mark "CILA."

☐ State-Operated Developmental Center, (Name of SODC) _____

☐ State-Operated Mental Health Center, (Name of SOMHC) _____

Community-Based Residential Settings: (Name of setting) _____

☐ Child Care Institution (CCI - 19D)

☐ Child Group Home (CGH - 17D)

☐ Community-Integrated Living Arrangement (CILA)

☐ Community Living Facility (CLF - 67D)

☐ Family Home

☐ Foster Care (DCFS-funded)

☐ Home/Individual Placement (HIP - 68D)

☐ Intermediate Care Facility for DD (ICF/DD)

☐ Intermediate Care Facility for MI Intermediate Care Facility/Mental Illness (ICF/MI)

☐ Nursing Facility (NF)

☐ Skilled Nursing Facility for Pediatrics (SNF/Ped)

☐ Special Home Placement (SHP - 41D)

☐ Specialized Living Center (SLC)

☐ Supported Living Arrangement (SLA - 42D)

☐ Other, Please Describe, (e.g., Hospital, Homeless): _____

Developmental Training Program Supports: The applicant named in question #1 will be automatically authorized for Developmental Training (Bill code 31U).

ALTERNATIVE DAY PROGRAM SUPPORTS

All other alternative day program authorizations listed below require prior approval from the Division of Developmental Disabilities. These programs include:

* Regular Work / Sheltered Employment - (Program 38U),
* Supported Employment - SEP (Program 39U, 36U, 39G, 36G),
* Adult Day Care - (Program 35U - Not Including Senior DT),
* At Home Day Program - (Program 37U),
* Other Day Program - (Program 30U).

Please see the Home and Community-Based Services Waiver Manual, Section VIII, Revised January 2007, for more information on developmental training and alternative day program supports. Complete and attach the Alternative Day Program Request (IL462-0285) with appropriate supporting documentation to officially request prior authorization for any of the alternative day programs reflected above.

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SIGNATURES

The CILA provider's and ISC signatures represents the information included in this application is true and thorough to the best of each agency's ability.

CILA Provider Agency	ISC Agency (Originating)
Print Name of Authorized Agency Representative	Print name of ISC Agency Representative
Telephone No. Extension	Telephone No. Extension
Provider Agency's E-Mail Address	ISC Agency's E-Mail Address
Signature of Authorized Agency Representative Date	Signature of Authorized ISC Agency Date

This Application must be signed and dated by both the CILA provider and the ISC agency.
Incomplete Applications and Applications missing Required Attachments will be returned to the ISC agency.

REQUIRED ATTACHMENTS

A complete individual DD CILA individualized rate model support application packet includes several pieces of information, in addition to the application. CILA providers should include the following attachments in the DD CILA support application packet. Submit the complete packet with the attachments in order of number below to the originating (sending) ISC Agency for signature who will forward it to the DDD.

1. Individual/Guardian Information form (IL462-2026);
2. Application for 60D CILA Support Services (IL462-4425);
3. Prior Approval Request for Host Family Services form (IL462-4426 if applicable);
4. Copy of the individual's Social Security card or SSA print screen OR;
5. Copy of the individual's most recent (current) Medicaid card or HFS print screen.
6. Copy of DDPAS-5
7. Copy of the three-page ICAP summary (less than 1 year old);
8. Complete Nursing Service Packet (NSP) including, but not limited to:
   - ** Physical Status Review (PSR) - Health Risk Screening Tool (HRST) page 1 only,
   - ** Self-Administration of Medication Assessment (SAMA) Report, page 3 of 3 only,
   - ** Medication Administration Record (MAR), and
   - ** Treatment Administration Record (TAR);
9. Copy of the individual's psychological evaluation (less than 5 years old); If over 5 years old, attach the psychological with an updated addendum which is less than 5 years old;
10. Prioritization of Urgency of Need for Services (PUNS) print screen;
11. Copy of the proposed/preliminary Individual Service/Habilitation Plan (ISP/IHP);
12. Copy of the preliminary Behavior Program (if maladaptive behaviors exist);
13. Copy of the individual's Psychiatric Evaluation (if applicable for autism, dual diagnosis, or mental illness); and Psycho-Social Assessment (if applicable for autism, dual diagnosis or mental illness);
14. Alternative Day Program Request form (IL462-0285) (if applicable);
15. Medicaid Waiver Therapy Prior Approval Request form (IL462-1302) (if applicable);
16. Additional Staff Support and 1 or 2 Person CILA Request form (IL462-4424 if applicable);
17. STAR - Service Termination Authorization Request form (IL462-2028 as appropriate)
18. Crisis form, PUNS selection letter, or PAL.