*Prior to submitting a request for emergency access to waiver services the CSB should thoroughly explore the availability of slots at the CSB and if there are other resources that could be sought to support this individual. Emergency Slots are typically loaned and must be repaid.*



|  |  |
| --- | --- |
| **Date:** Click here to enter Date | **Referring CSB:** Click here to enter CSB or DD Agency**Support Coordinator/Case Manager:** Click here to enter Support Coordinator/Case Manager**Address:** Click here to enter Address**Phone:** Click here to enter Phone**Email:** Click here to enter Email |
| **Who at Central Office has been assisting you with this referral?** Click here to enter Name |
| **Individual:** Click here to enter Individual Name **Date of Birth:** Click here to enter Date of Birth.**Medicaid Number:** Click here to enter Medicaid Number **Current Address:** Click here to enter Address | **AR/Guardian:** Click here to enter Name**Address:** Click here to enter Address**Phone:** Click here to enter Phone**Email:** Click here to enter Email |
| **If Applicable Discharge Date from Training Center:** Click here to enter Date | **Current Funding Support:** Choose an itemDescribe Other | **Current Residential Status:** Choose an itemDescribe Other |
| **Services Utilized** |
| **Crisis services/REACH provided and result** | Click here to enter text |
| **Community Options that have been explored and Result *(include dates of contacts)*** | Click here to enter Options |

| **Consultations** | **Date** | **Recommendations** | **Result** |
| --- | --- | --- | --- |
| **Consultation has been completed with CRC.** | Click here to enter Date | Click here to enter Recommendations | Click here to enter Result |
| **RST Referral**  | Click here to enter Date | Click here to enter Recommendations | Click here to enter Result |
| **Consultation has been completed with REACH; *if referral is due to behavioral issues*** | Click here to enter Date | Click here to enter Recommendations | Click here to enter Result |
| **Presenting Concern and Reason for Referral*****(What is being requested and why is this an emergency?)*** | Click here to enter text |

| **DD Diagnosis** | **Medical Diagnoses**  | **Most Recent Evaluation/s** | **Psychiatric Diagnoses** | **Physician/s** | **Medication/s** |
| --- | --- | --- | --- | --- | --- |
| Click here to enter Diagnosis | Click here to enter Medical Diagnosis | Click here to enter evaluation/s | Click here to enter Psychiatric Diagnosis | Click here to enter Physician/s | Click here to enter Medication/s |
| **Recent History:** | Click here to enter Recent History |
| **Summary of Current Plan:** | Click here to enter Summary of Current Plan |

|  |  |
| --- | --- |
| Type of waiver slot being requested: | Choose an item. |
| Please explain why the above selected waiver is the most appropriate for the individual and why another waiver was not considered. | Click here to enter text |
| Next Scheduled WSAC: | Click here to enter Date | Has a provider been identified? | Choose an item. |
| Is the individual on Waiting List? | Choose an item. | Name of provider | Click here to enter text |
| Priority Level | Click here to enter text | Date provider can begin providing supports. | Click here to enter Date |
| Emergency access to waiver services is subject to available funding and a finding of eligibility for waiver services. Eligible individuals may currently be on the Priority 1, 2, or 3 waiting lists or may be newly known as needing supports resulting from an emergent situation. Please indicate below which emergency access criteria the individual meets. |

[ ]  Child Protective Services has substantiated abuse/neglect against the primary caregiver and has removed the individual from the home.

[ ]  Adult Protective Services has found that the individual needs and accepts protective services.

[ ]  Adult Protective Services has not found abuse/neglect, but corroborating information from other sources (agencies) indicate that there is an inherent risk present and there are no other caregivers available to provide support services to the individual.

[ ]  Death of primary caregiver or lack of alternative caregiver, coupled with the individual's inability to care for him/herself and danger to self or others without supports.

[ ]  An individual who transitioned from one of the DD Waivers to the Medicaid Works program who chooses to resume DD Waiver services.

Comments: Click here to enter text

**Please forward this form to** **emergency\_slot\_request@dbhds.virginia.gov** **via secure email.**

**NOTE**: Individuals and family/caregivers shall have the right to appeal the application of the emergency criteria to their circumstances pursuant to 12 VAC 30-110.  All notifications of appeal shall be submitted to DMAS.

Additional information about emergency slots may be found in the DD waivers’ emergency regulations at 12VAC30-120-580.