Kansas
Department for Aging and Disability Services

Physical Disability Crisis Exception Request Form

Section 1: ***Participant's Information***

Name: _____

Date of Birth: _____ Social Security Number: _____ Age: _____

Address: _____ City: _____ Zip: _____

Phone Number: _____ Medicaid ID Number (*if applicable*): _____

Parent(s)/Guardian(s) Name: _____ Email Address: _____

I have a sensory deficit: Legally Deaf ☐ Legally Blind ☐ N/A ☐

Section 2: ***Eligibility Requirements (completed by the assessing entity)***

1. I have been determined physically disabled by Social Security Administration (SSA) Standards (*see* Disability Determination by Social Security Standards *definition below*)
   Yes: ☐ **No:** ☐

   Disability Determination by Social Security Standards *– Individuals must be determined disabled under the definition as defined in section 1614(a)(3)(A) of the Social Security Act. Physical disability is defined as a medically determinable impairment or combination of impairments that significantly limit physical functions* similar to those required in a basic work setting such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling. Your physical disability must result primarily from an anatomical or physiological abnormality that is consistent with acceptable medical evidence in the form of clinical/laboratory findings and physical examinations including documentation of symptoms. A diagnosis alone is not sufficient. 20 CFR 404.1508; 404.1520(c); 404.1521(b)(1); 404.1525(d); 404.1528.*

2. Are you receiving SSI or SSDI? **Yes** ☐ **No** ☐

3. What is your physical disability?

   _____

4. I am currently on the Home and Community Based Services (HCBS) Physical Disability Waitlist:
   Yes: ☐ **No:** ☐

Section 3: Please provide an explanation of your crisis due to your physical disability.

Section 4: Crisis Exception Request: Individual's Attestation

☐ I am requesting to be considered for a Crisis Exception to access Home and Community Based Services (HCBS) for the Physical Disability program.

☐ I have read the above definition of physical disability (Section 2) and understand that the Physical Disability program is designed to serve individuals with a physical disability determination by Social Security Administration Standards.

☐ I am receiving Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) for a determination of a physical disability.

☐ I understand that a mental health diagnosis (i.e. depression, bipolar disorder, schizophrenia, dementia, etc.) is not a physical disability diagnosis.

I attest that all the information listed above is true and accurate to the best of my knowledge.

Name (printed): _____

Signature: _____ ***Date***: _____

Legal Guardian: ☐ DPOA: ☐ completed this form.

Name (printed): _____

Signature: _____ ***Date:*** _____

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Section 5: This section is to be completed by the assessing entity.

Indicate which crisis exception the individual is applying for. **NOTE**: A crisis exception request is not complete until the required documentation is attached to this form and uploaded to KDADS.

	Crisis Reason	**Required Documentation**
	Adult Protective Service (APS) or Child Protective Service (CPS) report of abuse, neglect or exploitation	Copy of the substantiated report from APS or CPS within 30 days prior to the date of the crisis request
	Imminent risk of family dissolution (break-up) involving a minor, dependent child or dependent spouse	Written notification from Department of Children and Families within 30 days prior to the date of the crisis request
	Individual is in the end stages of terminal illness and life expectancy, documented by a physician, is less than six (6) months from the date of the crisis request	Certification of Terminal Illness (CTI) or a letter issued by a physician indicating the individual is in the end stages of terminal illness and life expectancy is less than six (6) months from the date of the crisis request
	Victim of domestic violence	Documentation from a police report or the court indicating the individual is the victim of domestic violence within 30 days prior to the date of the crisis request
	Imminent risk of nursing facility placement	Physician statement of imminent risk of nursing facility placement within 30 days prior to the date of the crisis request

I, the eligibility assessor, attest that this form is filled out in its entirety and that the appropriate required documentation has been attached prior to submission to KDADS for review.

Eligibility Assessor Name (printed): _____ Phone: _____

Eligibility Assessor Signature: _____ Date: _____