Slot Assignment Review Form

WSAC: (Required) **WSAC Date:** (Required)
CSB: (Required)
Support Coordinator: (Required)

Non-PHI Identifier: (Required)

I. Age: (Required)

II. Month/Year of Birth: (Required)

III. Current Diagnoses: (Required)

IV. (Required) Indicate which of the Priority 1 criteria were met and describe how the individual's situation meets the criteria:

☐ An immediate jeopardy exists to the health and safety of the individual due to the unpaid primary caregiver having a chronic or long-term physical or psychiatric condition or conditions that significantly limit the ability of the primary caregiver or caregivers to care for the individual; there are no other unpaid caregivers available to provide supports.

☐ There is immediate risk to the health or safety of the individual, primary caregiver, or other person living in the home due to either of the following conditions:

☐ The individual's behavior or behaviors, presenting a risk to himself/herself or others, cannot be effectively managed by the primary caregiver or unpaid provider even with support coordinator/case manager-arranged generic or specialized supports.

Or

☐ There are physical care needs or medical needs that cannot be managed by the primary caregiver even with support coordinator/case manager-arranged generic or specialized supports.

☐ The individual lives in an institutional setting and has a viable discharge plan; or

☐ The individual is a young adult who is no longer eligible for IDEA services and is transitioning to independent living. After individuals attain 27 years of age, this criterion shall no longer apply.

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V. Risks to the individual's safety in his/her present environment:

Challenge (Choose all those that apply. If checked, all fields to the right are required.)	**Intensity** (Required if checked)	**Frequency** (Required if checked)
☐ Physical aggression (If checked, ALL fields to the right MUST be completed.)		
	(Required if checked) Please provide examples utilizing descriptive language:	
☐ Self-injurious (If checked, ALL fields to the right MUST be completed.)		
	(Required if checked) Please provide examples utilizing descriptive language:	
☐ Sexually inappropriate (If checked, ALL fields to the right MUST be completed.)		
	(Required if checked) Please provide examples utilizing descriptive language:	
☐ Property damage (If checked, ALL fields to the right MUST be completed.)		
	(Required if checked) Please provide examples utilizing descriptive language:	
☐ Verbal aggression (If checked, ALL fields to the right MUST be completed.)		
	(Required if checked) Please provide examples utilizing descriptive language:	
☐ Leaves a safe setting putting self in jeopardy (If checked, ALL fields to the right MUST be completed.)		
	(Required if checked) Please provide examples utilizing descriptive language:	
☐ Other: (If checked, ALL fields to the right MUST be completed.)		
	(Required if checked) Please provide examples utilizing descriptive language:	

VI. Community integration needs/social isolation issues

(Required) List all current challenges, such as residence in an institution, homebound due to lack of services, impact of elderly caregiver, etc.: (If none, enter None)

VII. (Required) What resources have been sought and/or are received to address the needs of the individual?

A: For individuals age 22 and under:

Resource **You must ANSWER the questions to the right for EVERY resource listed below.*	*YOU MUST CHOOSE APPLIED or NO APPLICATION MADE and WHY*		*IF APPLIED, YOU MUST CHOOSE RECEIVED or NOT RECEIVED and WHY*	
	Applied	**If no application made, why not?**	**Received**	**If applied but not received, why not?**
Early and Periodic Screening, Testing and Diagnostic Treatment (EPSDT) (Through age 21)	☐		☐	
	If receiving, service(s) type and frequency? (If receiving, this is required)			

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CCC+	☐		☐	
	If receiving, service(s) type and frequency? (If receiving, this is required)			
Individual and Family Support (IFSP)	☐		☐	
	If receiving, how is the service being utilized? (If receiving, this is required)			
Summer camp	☐		☐	
	If receiving, how is the service being utilized? (If receiving, this is required)			
Comprehensive Services Act (CSA/FAPT)	☐		☐	
	If receiving, service(s) type and frequency? (If receiving, this is required)			
School Based/IEP Services	☐		☐	
	If receiving, service(s) type and frequency? (If receiving, this is required)			
Housing (Housing Voucher, State Rental Assistance Program, Section 8, etc.)	☐		☐	
	If receiving, how is the service being utilized? (If receiving, this is required)			
Department of Aging and Rehabilitative Services (DARS)	☐		☐	
	If receiving, how is the service being utilized? (If receiving, this is required)			
Other-Name any locally funded services received	☐		☐	
	If receiving, service(s)/support type and frequency? What is the funding source? (If receiving, this is required)			

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B: For individuals age 23 and older:

Resource **You must ANSWER the questions to the right for EVERY resource listed below.*	*YOU MUST CHOOSE APPLIED or NO APPLICATION MADE and WHY*		*IF APPLIED, YOU MUST CHOOSE RECEIVED or NOT RECEIVED and WHY*	
	Applied	**If no application made, why not?**	**Received**	**If applied for but not received, why not?**
CCC+ Waiver	☐		☐	
	If receiving, service(s) type and frequency? (If receiving, required)			
Individual and Family Support (IFSP)	☐		☐	
	If receiving, how is the service being utilized? (If receiving, required)			
Summer camp	☐		☐	
	If receiving, how is the service being utilized? (If receiving, required)			
Housing (Housing Voucher, State Rental Assistance Program, Section 8, etc.)	☐		☐	
	If receiving, how is the service being utilized? (If receiving, required)			
Department of Aging and Rehabilitative Services (DARS)	☐		☐	
	If receiving, how is the service being utilized? (If receiving, required)			
Other-Name any locally funded services received	☐		☐	
	What is the funding source? Service(s) type and frequency? (If receiving, required)			

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VIII. (Required) Describe the primary caregiver(s)' ability and challenges to providing natural supports such as transportation, supervision, promotion of community integration, etc.):

IX. (Required) Are there other natural supports in the person's life such as family members, neighbors, friends, other community members? If so, please describe their availability.

X. (Required) A. In the person's own words where would he/she like to live and with whom?

(Required) B. In the person's own words, what would he/she like to do during the day?

(Required) C. Does the person have a legal guardian and if so, does the legal guardian agree with the person's wishes?

XI. (Required) A. What will happen (and when) if this individual is not awarded one of the available waiver slot?

(Required) B. Describe indicators that support this statement:

XII. (Required) Identify only those waiver services that best meet immediate needs. If a service is identified, explain how this service would be used to address immediate needs?

- ☐ Assistive Technology
- ☐ Benefits Planning
- ☐ Center-Based Crisis Supports
- ☐ Community Coaching
- ☐ Community Engagement
- ☐ Community Guide
- ☐ Community-Based Crisis Supports
- ☐ Companion
- ☐ Crisis Support Services
- ☐ Electronic Home-Based Supports
- ☐ Employment and Community Transportation
- ☐ Environmental Modification
- ☐ Group Day
- ☐ Group Home Residential
- ☐ Group Supported Employment
- ☐ In-Home Support
- ☐ Independent Living Supports
- ☐ Individual & Family/Caregiver Training
- ☐ Individual Supported Employment
- ☐ PERS
- ☐ Peer Mentor Supports

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- ☐ Personal Assistance
- ☐ Private Duty Nursing
- ☐ Respite
- ☐ Services Facilitation
- ☐ Shared Living
- ☐ Skilled Nursing
- ☐ Sponsored Residential
- ☐ Supported Living Residential
- ☐ Therapeutic Consultation
- ☐ Transition Services
- ☐ Workplace Assistance

XII. A. (Required) Any other information about the individual that would help the Waiver Slot Assignment Committee determine if this individual is most in need of a slot:

Support Coordinator completing this form: **Date:**