Emergency Reserve Slot Request

This form is intended to be completed by a provider or member guardian requesting an emergency reserve slot.

Emergency reserve slots are allocated by the state to support individuals with emergent needs and prioritize those individuals over their Registry of Unmet Needs date. Individuals requesting emergency reserve slots must be determined eligible for the respective waiver prior to award of a reserve capacity slot.

Potential eligibility for either the NC Innovations Waiver or the NC TBI Waiver must be established before requesting an emergency reserve capacity slot for the respective waiver.

If an emergency reserve slot is awarded, accessing services through an emergency reserve slot may take up to 90 days or more for those already covered by long-term Medicaid and an additional 90 days or more for those who do not already have long-term Medicaid in place.

Emergency slot requests will be processed in the order the completed form and supporting documentation are received at EmergencyReserveWaiverRequest@AllianceHealthPlan.org.

Member information

This section must be completed by a provider or member guardian on behalf of a member.

1

Date of request (mm/dd/yyyy): _____

Alliance Claims System (ACS) ID: ☐☐☐☐☐☐

Date of birth (mm/dd/yyyy): _____

Gender: ◯ Male ◯ Female ◯ Other: _____ County: _____

Medicaid coverage: ◯ No ◯ Yes (if yes, enter MID): _____

Other insurance: _____

Current diagnosis: _____

Please indicate the member's current location. This may be a different location than the associated home address. Examples may include: home with family, a specific hospital, or some other location.

Current location: _____

Eligibility Information

2

Innovations Waiver eligible: ◯ No ◯ Yes (if yes, date of eligibility mm/dd/yyyy): _____

TBI Waiver eligible: ◯ No ◯ Yes

Identified as a child with complex needs: ◯ No ◯ Yes

Assigned care manager (if applicable): _____

Provider agency: _____

Individual/Guardian information

3

First name: _____ Last name: _____

Phone number: _____ Email: _____

Address line 1: _____ (Street, P.O. Box, etc.) Address line 2 _____ (Suite, Building, etc.)

City _____ State _____ Postal code _____

Are you seeking residential services (group home, AFL, etc.)? ◯ No ◯ Yes

Current living situation

Describe where the individual lives, who lives with them (parent, siblings, caretakers) and how individuals can assist in the care of the individual.

4

Current behavioral needs of the individual

Describe behavioral/ emotional needs that keep the caregiver from being able to take care of the individual. Please include the frequency of such behaviors including aggression, destruction of property, self-injury, running away and sexual harm. Be descriptive of the issues and be sure to include how often the issues happen, where the behaviors occur, how long do they last, how intense or severe they are and how they are disruptive or unmanageable to the current supports.

5

Current medical needs of the individual

Describe the individual's medical needs, including medical support provided in the home and equipment or supplies needed. Please note physicians or other specialists routinely involved in the individual's care, such as psychiatry, neurology, endocrinology, nutritionist, occupational, speech, physical therapy, etc.

6

Current medications

7

Medication name	Dosage/Frequency	Purpose

Department of Social Services involvement

Describe DSS reports of confirmed or suspected abuse, neglect or exploitation. Describe any issue determined by DSS that may or have resulted in the individual coming into the custody of the DSS. Include names of DSS staff involved.

8

DSS staff name and contact if applicable: _____

Criminal justice involvement

Describe arrests or charges or other involvement with the criminal justice system. Include any outstanding charges or scheduled hearing.

9

Educational supports

Describe supports received in school plus any behavioral issues in school, the individual's class setting, current IEP goals inclusive of modifications and any suspensions or expulsions.

10

Barriers that interfere with caregiver taking care of the individual

Describe issues such as physical or mental health and other people the caregiver is responsible for. Describe other natural supports for the individual.

11

Requested services and/or supports

If approved for a waiver slot, what services or supports would you like to see in place for the individual? Describe the type of help needed and what you desire to be as the outcome.

12

Treatment history

13 Select all that apply

	Provider information (If known)	Dates of treatment (mm/dd/yyyy)
☐ I/DD or TBI in-home supports such as **developmental therapy, personal assistance, respite, community living and support**		
☐ I/DD or TBI community supports such as **day activity, ADVP, day program, developmental day, supported employment**		
☐ I/DD or TBI residential supports such as **state-funded residential supports/supported living, long term community supports or ICF-IID**		
☐ Autism spectrum supports such as **applied behavioral analysis (ABA) or RB-BHT** (research based-behavioral health treatment)		
☐ Mental health supports such as **community support team, assertive community treatment team or psychosocial rehabilitation**		
☐ Substance use supports such as **peer support, SAIOP, SACOT, substance use residential treatment, detox, medication assisted treatment**		
☐ Mental health residential supports such as **PRTF or therapeutic foster care**		
☐ Residential rehabilitative supports such as **rehabilitation center or skilled nursing**		
☐ **Hospitalizations**		
☐ **NC-START**		
☐ **Other** _____		

Please enter the names and contact information for any professionals or providers involved in the care of the individual who are not listed elsewhere.

Name: _____ Phone number: _____

Name: _____ Phone number: _____

Name: _____ Phone number: _____

Please add any additional clinical information to highlight the complexity of this case:

_____

Supporting documentation

Please attach supporting documents as applicable/available

Note: Older evaluations may be needed to verify eligibility before age 22.

14 Please select the relevant supporting documentation you are including with your request.

- ☐ Most recent psychological/neuropsychological evaluation with cognitive testing and adaptive functioning assessment scores.
- ☐ Documentation that includes formal diagnosis if not included in the most recent psychological/neuropsychological evaluation. (May include older psychological/ neuropsychological evaluation, medical records, letter from PCP, etc.)
- ☐ Genetic testing, if relevant
- ☐ Behavior summary or data (type and frequency of behavior)
- ☐ Hospital or institutional records
- ☐ DSS reports
- ☐ Guardianship papers
- ☐ IEP, if available

Requester information

This section is to be completed by the individual member or guardian.

16

Provider agency: _____

First name: _____ Last name: _____

Address line 1: _____ (Street, P.O. Box, etc.) Address line 2 _____ (Suite, Building, etc.)

City _____ State _____ Postal code _____

Phone number: _____ Email: _____

Consent authorization

Please list the name and provide a signature for the individual, guardian, or LRP providing consent for the emergency slot request.

15

Full name* _____ Title* _____

Signature (name or typed)*		Date (mm/dd/yyyy)*
x		

Submission instructions

Please email completed request forms to: EmergencyReserveWaiverRequest@AllianceHealthPlan.org.
Emergency slot requests will be processed in the order the completed form and supporting documentation are received.