



For questions, contact Care Management at 1-877-642-9283

Fax completed access form to:
 Care Management at (785) 232-2610

HCBS PRTF WAIVER ACCESS FORM

Member Name _____ Date of Birth _____

Address _____ City _____

Phone # _____ SS # _____

Medicaid Number _____ Custody Status JJA SRS CWCBS NONE

County of Residence _____ CMHC of Responsibility _____

Referral Source Name _____ Referral Source Phone# _____

DSM Axis I Diagnosis _____

Name, address of Primary Care Giver/Guardian _____

Current living situation/location _____

Is youth currently in a PRTF? Yes No If yes, name of PRTF _____

Justification supporting PRTF Waiver referral (i.e. history of past PRTF use, identify safe/stable living options)

Are there current qualifying CAFAS scores? Completed CBCL? Yes No

If no, is the CAFAS and CBCL scheduled to be administered? Yes No Date _____

 Signature of Parent/Guardian _____ Date _____

 Signature of CMHC Contact Person _____ Date _____

CMHC Contact Person Phone # _____ Fax # _____

For KHS Use Only: Yes No

 CM Staff _____ Date Received _____ Slot Bookmarked _____

If no, why: _____

