State of Illinois- Department of Human Services
Division of Developmental Disabilities

Application for 60D CILA Support Services

This application is to be completed by a licensed CILA agency in cooperation with a Pre-Admission Screening/Independent Service Coordination/Individual Service & Support Advocacy (PAS/ISC/ISSA) agency and should represent the conditions applicable to a specific individual for whom CILA support funding is being requested. The information provided must be accurate and complete to the best of the CILA provider's and PAS/ISC/ISSA agency's knowledge. Please refer to the "Application for 60D CILA Support Services Instructions".

INDIVIDUAL INFORMATION

1. Name of Individual: ______________________________
   (Last Name) (First Name)
2. Social Security Number *(Nine Digits):* ______________
3. Recipient Identification Number (RIN) *(Nine Digits):* ______________
4. Date of Birth: ______________ (MM/DD/YYYY)
5. Gender: ___Male ___Female
6. Is the person ambulatory (walks independently or with assistive devices)? ☐ Yes ☐ No
7. Inventory for Client & Agency Planning (ICAP) or Scales of Independent Behavior Revised (SIBR) Summary Score (2 digits): ________
8. ICAP or SIBR Maladaptive Behavioral Index Score (2 digits): ________
9. Date of Evaluation - ICAP or SIBR Summary: ______________ (MM/DD/YYYY)

NOTE: ICAP Summary must be less than one year old, and copy attached.

CILA PROVIDER & SITE INFORMATION

10. Provider Agency Name: ______________________________
11. Provider Agency DHS four-digit number (e.g., 0104, 1912, etc.): ______________
12. Address of the CILA site where the person will be living: ______________________________
    (Address) (Apt. #)
    ____
    (City) (Zip Code)
13. County where the CILA home is located: ______________________________
14. Total residential capacity of the CILA site in which the person will be living: ______________

NOTE: Residential capacity is the number of people intended to be served at this site. Use Licensed Capacity only if that is the number of people who will be served at this site.

15. What level of CILA support services is provided at this CILA site?
    ☐ 24 Hour with Shift Staff ☐ 24 Hour with Foster Care/Host Family
    ☐ Family or Relative Intermittent (Answer #17) ☐ Intermittent **Not with** Family or Relative (Answer #17)

NOTE: If "Family or Relative Intermittent" or "Intermittent Not with Family or Relative" is checked, then #17 MUST be answered. If "Foster **Care/Host Family" is checked then a Prior Approval Request for Host Family Services form is also required.**

16. Is Night Shift Staff allowed to sleep at any time? ☐ Yes (Asleep) ☐ No (Awake)

17. This question MUST be answered if requesting "Intermittent" CILA or "Family" CILA Support Services in #16 above:

Type of Intermittent / Family Support	Weekly Quantity	
Direct Support Person (DSP):	______	Hours / Week
Supervisor:	______	Hours / Week
Qualified Intellectual Disability Professional (QIDP):	______	Hours / Week
Mileage for staff-related miles:	______	Hours / Week

18. List names of all other individuals living at, or moving to this site (if the capacity is vacant, please list as such):

	Name of Person	Is the person living at this site now?			Is the person currently funded by DHS? If "yes", then by what program code?		
1.	______	☐ Yes	☐ No	☐ Proposed	☐ Yes	☐ No	______
2.	______	☐ Yes	☐ No	☐ Proposed	☐ Yes	☐ No	______
3.	______	☐ Yes	☐ No	☐ Proposed	☐ Yes	☐ No	______
4.	______	☐ Yes	☐ No	☐ Proposed	☐ Yes	☐ No	______
5.	______	☐ Yes	☐ No	☐ Proposed	☐ Yes	☐ No	______
6.	______	☐ Yes	☐ No	☐ Proposed	☐ Yes	☐ No	______
7.	______	☐ Yes	☐ No	☐ Proposed	☐ Yes	☐ No	______

Pre-Admission Screening (PAS) / Independent Service Coordination (ISC) / Individual Service & Support Advocacy (ISSA)

The destination (receiving) PAS/ISC/ISSA agency will be specified on the individual's CILA Rate Sheet based on the county and zip code of the CILA site where the person will be served as identified in questions #12 and #13 above.

"FLOW THROUGH" INFORMATION

Flow through information is no longer collected.

RATE TYPE / RESIDENT LOCATION INFORMATION

19. Rate Type: Please mark the appropriate "Rate Type" indicator for the applicant (person in Question #1 above).

- ☐ Aging Out-DCFS (Department of Children & Family Services (DCSF) ward now nearing his/her 18th birthday)
- ☐ Aging Out-DHS (Person funded by Department of Human Services (DHS) aging-out of residential supports for children)
- ☐ Bogard (Member of the Bogard Class, new placements only)
- ☐ Community Emergency (Person meets the DHS "emergency crisis criteria")
- ☐ Conversion (Any person with DDD-funding to convert to 60D CILA funding)
- ☐ PUNS Selection (Person selected from the Prioritization of Urgency of Need for Services database)
- ☐ Rate Redetermination (Current CILA resident; Rate being determined by the CILA Rate Model)
- ☐ State-Operated Developmental Center Downsize (Part of a planned downsize or closure initiative)
- ☐ State-Operated Mental Health Center Discharge (Formerly Nathan v. Levitt, new placement only)
- ☐ Other, please describe: ______________________________

20. **Residence Location Prior to CILA Placement:** Please mark the appropriate "Residence Location" prior to the CILA placement. If "Rate Redetermination" is marked in #19 then mark "CILA."

____State-Operated Developmental Center, (Name of SODC ____________________)

____State-Operated Mental Health Center, (Name of SOMHC ____________________)

Community-Based Residential Settings: (Name of setting ____________________)

____Child Care Institution (CCI - 19D)

____Child Group Home (CGH - 17D)

____Community-Integrated Living Arrangement (CILA)

____Community Living Facility (CLF - 67D)

____Family Home

____Foster Care (DCFS-funded)

____Home/Individual Placement (HIP - 68D)

____Intermediate Care Facility for DD (ICF/DD)

____Intermediate Care Facility for MI Intermediate Care Facility/Mental Illness (ICF/MI)

____Nursing Facility (NF)

____Skilled Nursing Facility for Pediatrics (SNF/Ped)

____Special Home Placement (SHP - 41D)

____Specialized Living Center (SLC)

____Supported Living Arrangement (SLA - 42D)

____Other, Please Describe, (e.g., Hospital, Homeless): ____________________

Developmental Training Program Supports: The applicant named in question #1 will be automatically authorized for Developmental Training (Bill code 31U).

ALTERNATIVE DAY PROGRAM SUPPORTS

All other alternative day program authorizations listed below require prior approval from the Network Facilitator or the BTS Representative. These programs include:

* Regular Work / Sheltered Employment - (Program 38U),
* Supported Employment - SEP (Program 39U, 36U, 39G, 36G),
* Adult Day Care - (Program - Not Including Senior DT),
* At Home Day Program - (Program 37U),
* Other Day Program - (Program 30U).

Please see the Home and Community-Based Services Waiver Provider Manual, Section VIII, Revised January 2007, for more information on developmental training and alternative day program supports. Complete and attach the *Alternative Day Program Request Form* [Revised 11/2010 (IL462-0285)] with appropriate supporting documentation to officially request prior authorization from the Network Facilitator or BTS Representative for any of the alternative day programs reflected above.

SIGNATURES

The CILA provider's and PAS/ISC/ISSA signatures represents the information included in this application is true and thorough to the best of each agency's ability.

CILA Provider Agency		PAS/ISC/ISSA Agency (Originating)	
Print Name of Authorized Agency Representative		Print name of PAS/ISC/ISSA Agency Representative	
Telephone No.	Extension	Telephone No.	Extension
Provider Agency's E-Mail Address		PAS/ISC/ISSA Agency's E-Mail Address	
Signature of Authorized Agency Representative	Date	Signature of Authorized PAS/ISC/ISSA Agency	Date

This Application must be signed and dated by both the CILA provider and the PAS/ISC/ISSA agency. Incomplete Applications and Applications missing Required Attachments will be returned to the PAS/ISC/ISSA agency.

REQUIRED ATTACHMENTS

A complete individual DD CILA Individualized Rate Model Support Application Packet includes several pieces of information, in addition to the application. CILA agencies should include the following in the DD CILA Support Application Packet. Submit the complete packet to the originating (sending) PAS/ISC Agency for signature who will forward it to the Network Facilitator.

1. PAS/ISC/ISSA) Agency Cover Letter explaining need for, and level of, CILA Services;
2. Individual/Guardian Information Form (IL462-2026);
3. Application for 60D CILA Support Services (IL462-4425);
4. Prior Approval Request for Host Family Services form (if applicable);
5. Complete Nursing Service Packet (NSP) including, but not limited to:
   ** Physical Status Review (PSR) - Health Risk Screening Tool (HRST) Report Page,
   ** Self-Administration of Medication Assessment (SAMA) Report Page,
   ** Medication Administration Record (MAR), and
   ** Treatment Administration Record (TAR);
6. Copy of the three-page ICAP Summary (less than 1 year old);
7. Copy of the individual's psychological evaluation (less than 5 years old); If over 5 years old, attach the psychological with an updated addendum which is less than 5 years old;
8. Prioritization of Urgency for Need of Services (PUNS) Print Screen;
9. DDD (client) PAS/Redetermination Print Screen;
10. Copy of the proposed/preliminary Individual Service/Habilitation Plan (ISP/IHP);
11. Copy of the preliminary Behavior Program (if Maladaptive Behaviors exist);
12. Copy of the individual's psychiatric evaluation (if applicable for Autism, dual diagnosis, or mental illness);
13. Psycho-Social Assessment (if applicable for Autism, dual diagnosis or mental illness);
14. Alternative Day Program Request form (IL462-0285) (if applicable);
15. Medicaid Waiver Therapy Prior Approval Request Form (IL462-1302) (if applicable);
16. Non-Base Support Documentation Form and HFS letter of denial for requested Non-Base Supports (if applicable);
17. Copy of the individual's Social Security Card or SSA Print Screen;
18. Copy of the individual's most recent (current) Medicaid Card of HFS Print Screen.
19. Crisis Funding Information Request (IL462-0140).