1915(i) RISE Referral Submission Form

Eligibility for 1915(i) RISE Services

- Be 18 or older.
- Be enrolled in Kentucky Medicaid.
- Have a primary diagnosis of SMI, such as schizophrenia, bipolar disorder, or major depressive disorder with functional impairment.
- May also have a co-occurring substance use disorder (SUD).
- Experience one or more of the following:
  - History of behavioral health hospitalizations in the past two years.
  - History of clinically significant symptoms of mental illness for at least two years.
  - History of episodic debilitating behavioral health symptoms expecting to continue for a two-year period.
- Demonstrate functional need in two or more functional domains such as social interaction, personal care, or physical or intellectual functioning.

Submit referrals by

Email: 1915(i)RISEInitiative@ky.gov (Email must be encrypted)
Fax: 502-573-1584
Mail: 1915(i) RISE Initiative, 275 E. Main Street, Frankfort, KY 40621

All required documentation must be submitted with the referral. If you are submitting records that are multiple pages, please label the relevant information or files (statement of SMI diagnosis, SUD diagnosis (if present), discharge records, psychosocial history, etc.)

Please verify all required documentation is attached by checking each box.

- ☐ KY Determination Criteria Checklist for Serious Mental Illness – completed and signed by a Licensed Behavioral Health Professional. Checklist can be found here: Kentucky Determination Criteria Checklist for Serious Mental Illness (SMI)
- ☐ Statement of Serious Mental Illness diagnosis from a Licensed Behavioral Health Professional
- ☐ Psychiatric hospital discharge records from the past two years (if applicable)
- ☐ No psychiatric hospitalizations within the past two years
- ☐ Psychosocial assessment and history completed within the past two years

Referral Source - Complete all information

Who is completing referral? ☐ Self ☐ Other – specify

Referral Name

Referral Organization

Referral Phone Number(s)

Referral Email

Select one of the following options:

☐ Person being referred is their own legal decision-maker.

☐ Person has Power of Attorney. (Attach court-order documentation.)

☐ Person has a legal guardian or conservator. (Attach court-order documents and letter of guardianship dated within the past 12 months). Complete information below:

Guardian/Conservator Name

Relationship to Person

Phone Number(s)

Email Address

Person's Information

First Name | Middle Initial | Last Name

Goes By | Date of Birth

Social Security # | Medicaid #

Email | Phone #

Emergency Contact

Name

Address

Phone Number

☐ **Homeless Risk Factors are present. (**Check if the person meets any of the criteria below.)

Currently Homeless

At risk of homelessness (per 24 CFR § 578.3)

History of frequent (i.e., more than one per year) stays in inpatient settings

Experienced homelessness in the past 24 months or formerly homeless; now residing in U.S. Department of Housing and Urban Development assisted housing

Identify the risk factors: ☐

☐ **Temporary Housing** (Check if the person currently resides in temporary housing.)

☐ **Homeless Shelter** (Check if the person currently resides in a homeless shelter.)

☐ **Personal Care Home** (Check if the person lives in a Personal Care Home.)

☐ **Psychiatric Hospital** (Check if the person is currently in a psychiatric hospital.)

☐ **Sober Living Facility** (Check if the person is currently in a sober living facility.)

☐ **Domestic Violence Shelter** (Check if the person is currently in a domestic violence shelter.)

☐ **Currently Incarcerated.** (Check if the person is currently incarcerated.)

☐ **Intellectual/Developmental Disability** (Check if the person has a diagnosis of an intellectual or developmental disability.)

IQ Score ☐

What is the person's preferred county or counties to receive services? (Enter county or counties below.)

☐

Accommodation Requests

Please list any accommodation requests. We will do our best to accommodate requests.

Language

☐ American Sign Language (ASL) Interpreter

☐ Other Language (please specify) ☐

Additional Requests ☐

Support Personnel ☐ No ☐ Yes

If yes, who will attend?	
Relationship to person	

Medication List

Please fill out or attach a list of all current medications? including information in the chart below; if additional room is needed, include as a separate document.

Name	Dose (#)	Unit (mg, etc.)	Route (oral, injection, etc.)	Frequency (2x daily, etc.)	As Needed? Yes or No

Consent to Participate in 1915(i) RISE

By signing below, I give consent for the person listed on this application to be referred to the 1915(i) RISE Initiative. I also acknowledge that the 1915(i) RISE Initiative has been explained to the person listed on this referral application. Additionally, the person understands that participation is voluntary and of their own choice.

By signing below, I acknowledge that I understand if a person is currently enrolled in a Medicaid Managed Care Organization (MCO) and they become a participant in the 1915(i) RISE Initiative they will be changed to traditional Medicaid (fee-for-service). This transition should not affect eligibility for services, but participants may notice changes in how providers bill for services and how certain services are accessed.

By signing below, I understand 1915(i) RISE services cannot be duplicated with other Medicaid or waiver services. This means the same care and support services cannot be billed or paid for by two different programs at the same time. For example, someone receiving 1915(i) RISE Services cannot have duplicative services in 1915(c) waiver services or be enrolled in Targeted Case Management and/or Comprehensive Community Support Services.

Before signing, please ensure that all required documents from page 1 are included.

Signature of person or guardian

Printed Name

Date

Relationship of person signing ☐ Self ☐ Guardian ☐ Conservator ☐ Other (please specify relationship to person)

Contact Us

Phone: 502-564-9189
Email: 1915(i)RISEInitiative@ky.gov
Fax: 502-564-8917
Mail: 1915(i) RISE Initiative, 275 E. Main Street, Frankfort, KY 40621

1915(i) RISE Initiative Website

TEAM KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES