Choices for Care ERC Home Tier Variance Request Form | CFC 813E

Variance Criteria

A variance will only be approved in situations in which the additional funding is necessary to protect or maintain the health, safety or welfare of the individual. (See CFC Regulations, Section XI.)

Variance Requests shall be submitted by the ERC Provider and shall include the following:

The tier being requested

1. An explanation of why the individual's specific care needs cannot be met with the current tier
2. A description of the actual/immediate risk posed to the individual's health, safety or welfare
3. The intended goals and outcomes for the individual
4. Other options that have been explored to meet the unmet need
5. Other important info

Client Name: _____ Date of Birth: _____
Mailing address: _____
Current location (if different than mailing): _____

ERC Provider submitting the request: _____

Name of the person completing this form: _____Phone: _____

1. *Current Tier* from ERC Tier Score Sheet: _____ *Requested Tier/Monthly Budget:* _____

2. Please give an explanation of the individual's specific unmet care needs and describe how the requested tier rate will provide services to meet the individual's needs.

3. Please give a description of how the individual's unmet needs pose an actual and/or immediate risk to the individual's health, safety or welfare.

4. Describe the intended goals and outcomes for this individual.

5. Please describe other options that have been explored to meet the individual's unmet need.

6. Other important information (or see attached "Client Care Needs" sheet for additional info):

7. Please attach any other information you feel is important and useful.

Send request to:
EMAIL: Paula.Brown@vermont.gov (Northern, VT) or Mary.Woods@vermont.gov (Southern, VT)
MAIL: Division of Disabilities, Aging and Independent Living, HC 2 South, 280 State Drive, Waterbury, VT 05671-2070. Attention: Paula Brown, RN (North) or Mary Woods, RN (South)
FAX: (802) 241-0385.

DAIL Decision:
☐Approved Tier/Monthly Budget: _____ ☐Request Denied

☐Copy to LTCCC_____

DAIL Authorized Signature: _____ Date: _____

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Client Care Needs and Social History

Two Person Assist in 1 or more ADLs: ☐Toileting ☐Transferring ☐Bathing ☐Dressing ☐ Mobility

Medical Treatments: ☐Oxygen Therapy ☐Chemotherapy ☐Radiation Therapy ☐Gastric Tube Feeding ☐Parenteral Feedings ☐Dialysis ☐Transfusions ☐Wound Care ☐Medication Injections ☐Suctioning ☐Other: Click here to enter text.

Traumatic Brain Injury: ☐Yes ☐No

Dementia/Alzheimer's Diagnosis: ☐Yes ☐No

Memory and Use of Information: ☐No Difficulty ☐ Minimal Difficulty (cueing 1-3x/day) ☐Difficulty Remembering (cuing 4+ x/day) ☐Cannot Remember

Decision making regarding tasks of daily life:

☐Independent (decisions consistent/reasonable)

☐Modified Independence (some difficulty in new situations)

☐ Moderately Impaired (decisions poor; cues/supervision)

☐Severely Impaired (never/rarely makes decisions)

**** Behaviors:** ☐Wandering ☐Verbal Aggression ☐Resistant to Care

** Behaviors- ***Not easily altered*** ☐Physical Aggression ☐Socially Inappropriate ☐Other: Click here to enter text.

Violent Behavior: ☐Yes ☐No If yes, please explain: Click here to enter text

Behavior Plan: ☐Yes ☐No

**** Rehabilitative and Restorative Care:** ☐Yes ☐No

Mental Health Diagnosis/treatment plan: Click here to enter text.

☐Psychologist ☐Psychiatrist ☐CRT ☐Other: Click here to enter text.

High Risk Factors: ☐Alcohol dependency ☐Drug dependency ☐Smoking

Self-Neglect: ☐Yes ☐No

Adult Protective Services: ☐Past ☐Current: Click here to enter text.

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History of Incarceration: ☐Yes ☐No If yes, please explain: Click here to enter text.

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