

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: _____

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.

History of Incarceration: Yes No If yes, please explain: [Click here to enter text.](#)