

**Brain Injury Program (BIP) -  
Regulation/Policy  
Variance Request Form**

BIP 10.2023

- **Instructions:** The Brain Injury program has regulations and policies governing the program. Complete this form for individuals who require an exception to a current regulation or policy and meet the variance criteria. Send the request to the contact noted at the bottom of the form. Requests will be reviewed by the Adult Services Division (ASD) at the Department of Disabilities Aging and Independent Living (DAIL). *One request per form please.*
- **Variance Criteria:** A variance to a Brain Injury program regulation or policy will only be approved in situations in which the variance is necessary to protect or maintain the health, safety or welfare of the individual.

**Completed by Brain Injury Program Provider**

1. Individual's Name: \_\_\_\_\_ 2. Date of Birth: \_\_\_\_\_
2. Site BIP Regulation/Policy: \_\_\_\_\_
3. Describe the request, including the individual's unmet need for which a variance is necessary: (Use the back if needed.)

4. Describe the risk posed to the individual's health, safety or welfare without the variance:

5. What other options have been explored to the meet the unmet need?

Case manager: \_\_\_\_\_  
Agency: \_\_\_\_\_ Phone number: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Send request via Alert in Wellsky to:** TBI Alert BIP Program Staff : Heather Blair, RN, Brain Injury Program Coordinator :Heather.Blair@vermont.gov **or** FAX: (802) 241-0385 Attention: ASD- BIP.

<b>ASD Team Decision:</b>	<input type="checkbox"/> Approve	<input type="checkbox"/> Deny	<input type="checkbox"/> Partial Approval: _____
Comments			
DAIL Authorized Signature: _____			Date: _____
<b>NOTE: A notice must be sent to the individual and case manager/consultant.</b>			