

Choices for Care - Case Management, Respite & Companion Services CFC 813A 8/12

Variance Request Form

- **Instructions:** Case Management, Respite, and Companion services all have a maximum allowed number of hours per calendar year. Complete this form for **individuals** who require additional hours 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 Unit (ASU) at the Division of Disabilities and Aging Services (DDAS). A new Service Plan is not required. *One request per form please.*
- **Variance Criteria:** A variance will only be approved in situations in which the additional services are necessary to protect or maintain the health, safety or welfare of the individual. (*See CFC Regulations, Section XI.*)
- **Retroactive Requests:** Approved variances are effective no earlier than the date the request was received at DDAS. Retroactive requests will be considered only when a precipitating event necessitated an immediate increase of services exceeding the currently approved volume of services. The immediate increase must be necessary to prevent harm to the individual, a hospitalization or nursing facility placement.

NOTE: Prior to approval, DAIL may request additional information including case notes as needed.

Completed by Case Manager:

Program (check one): Moderate Needs High/Highest

Service (check one) Case Management Respite (High/Highest Only) Companion (High/Highest only)

- | | |
|---|--|
| 1. Individual's Name: | |
| 2. Date of Birth: | |
| 3. Social Security Number: | |
| 4. Hours currently authorized: | |
| 5. Hours used as of the date of this request: | |
| 6. Additional hours being requested: | |
| 7. Requested Start Date: | |

8. Describe the consumer's unmet needs that require additional hours.

9. Describe the services that will be provided if the request is granted. For case management include actual tasks to be delivered to the individual.

10. Describe what other options have been explored (such as informal supports, Adult Day, consultation with Division for Blind and Visually Impaired, etc.).

11. If a **retroactive start date** is being requested, explain the precipitating event that necessitated an immediate increase of services exceeding the currently approved volume of services. Include the date of the event and explain why the delay of request.

Case Manager's name: _____

Agency: _____ Phone number: _____

Signature: _____ Date: _____

Mail request to:

Choices for Care Program, DAIL
 103 South Main Street, Weeks Building
 Waterbury, VT 05671-1601 or
Fax: (802) 871-3052

ASU Team Decision: <input type="checkbox"/> Approve <input type="checkbox"/> Deny <input type="checkbox"/> Partial Approval		Hours approved in this request: _____
Total Hours for Calendar Year: _____	Effective Date: _____	Retroactive? <input type="checkbox"/> Yes or <input type="checkbox"/> No
LTCCC: _____	Prior Authorization needed? <input type="checkbox"/> Yes or <input type="checkbox"/> No	
Copy to ARIS: <input type="checkbox"/> Yes or <input type="checkbox"/> No		
Comments: 		
DAIL Authorized Signature: _____		Date: _____