Choices for Care - Case Management, Respite & Companion Services Variance Request Form

- **Instructions**: Case Management services have a maximum allowed number of hours per calendar year. Companion and Respite Care has a maximum service budget per calendar year.
  - Complete this form for **individuals** who require additional Case Management hours or an increase in service budget for Companion and Respite Care and meet the variance criteria.
  - A new Service Plan is not required. *See additional instructions on back.*

- **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 DAIL/Adult Services Division. 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. Individual's Mailing or Email Address: ______________________
3. Date of Birth: ______________________
4. Social Security Number (last 4 digit): xxx-xx-______________
5. Hours currently authorized: ______________________
6. Hours used as of the date of this request: ______________________
7. Additional budget being requested: *See Grid on Back Page*
8. Requested Start Date: *See Grid on Back Page*

9. Describe why the participant requires a budget increase. What is the current unmet care need?

10. Describe the services that will be provided if the request is granted and include the actual tasks or care to be delivered to the individual and how it will meet their goals.

11. Describe what other options have been explored (such as informal supports, Adult Day, consultation with Division for Blind and Visually Impaired, etc.) to meet the participants care needs/goals.

12. For Companionship and Respite Variances, please complete this grid:

UNPAID ASSISTANCE		**PAID ASSISTANCE**	
Name	Schedule	Name-indicate if companion or caregiver	Schedule

13. 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: ________________________________ Email: ________________________________

Agency: ____ Phone number: ______________________

Signature: ____ Date: ______________________

***How to submit request*:**
Attach completed document in DAIL Database
Send Alert to CFC Program Supervisors at: "LTCCC alert Supervisors" or MNG alert

ASD Team Decision: ☐ Approve ☐ Deny ☐ Partial Approval

Budget approved in this request: $ ______________________ ***Effective Date:*** __________________________

Total Budget for Calendar Year: $ ______________________ ***Retroactive?*** ☐ Yes or ☐ No

LTCCC*:** ____ ***Prior Authorization needed? ☐ Yes or ☐ No
***Copy to ARIS*:** ☐ Yes or ☐ No

DAIL Authorized Signature: ____ **Date:** ____________

Instructions for Respite/Companion Variance Requests CFC (High/Highest only):

When requesting an increase in the budget for additional Respite/Companion services **please use the table below** to indicate the desired budget by each service.

Link to rates on file: ASD Medicaid Rate Table

Respite/Companion Budget Request Table: **Requested Start Date: ______________________________**

Service	Revenue Code	Requested Hours	Budget = # Hours X (rate on file)
Respite by **Home Health**	073		$
Companion by **Home Health**	073		$
Respite by **Consumer** Directed Personnel	075		$
Companion by **Consumer** Directed Personnel	075		$
Respite by **Surrogate** Directed Personnel	080		$
Companion by **Surrogate** Directed Personnel	080		$

Case Management Request **Requested Start Date: ______________________________**

Service	Requested Hours	Budget = # Hours X (rate on file)
Case Management **Home Health**		
Case Management **Area Agency on Aging**		

ASD Team Use Only

Prior Authorization (PA) # ______________________________