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| **DEPARTMENT OF HEALTH SERVICES**  Division of Medicaid Services  F-02749 (02/2023) | | |  | | | | **STATE OF WISCONSIN** | |
| **CHILDREN’S lONG-tERM sUPPORT (CLTS) exceptional expense Notification** | | | | | | | | |
| Name – Participant | | | | | Age | Date of Birth | | Date of Submission |
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| Living Arrangement | | | | | | | | |
| Natural or Adoptive Home | Children’s Foster Home | | | Other, specify: | | | | |
| **EXCEPTIONAL EXPENSE NOTIFICATION DETAILS (F-02749i)** | | | | | | | | |
| **Tier 1 Notification**  CLTS Per Diem ≥$162.45/day (excluding start-up or one-time costs) | | **Tier 2 Notification (DHS Approval Required)**  CLTS Per Diem ≥ $287.67/day (excluding start-up or one-time costs).  Individual Service Plan Attached:  Yes  No  Is participant residing in a Level 4 or Level 5 home:  Yes  No | | | | | | |
| **For Both Tier 1 and Tier 2 Report Anticipated Costs:**  CLTS cost/day:  Estimated Service Start Date: | | | | | | | | |
| **NARRATIVE SUMMARY – TIER 2 NOTIFICATIONS ONLY** | | | | | | | | |
| 1. Describe the child and family’s goals, current needs and concerns based on the Deciding Together conversation. | | | | | | | | |

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| 1. Describe anticipated on-going needs of participant and a description of how the identified services on the ISP meet the identified outcomes and needs of the child. Include any recommendations provided by a qualified professional, as appropriate. |

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| 1. Describe the participant’s daily schedule. How do all the services on the ISP work together to support the child/family? |

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| 1. Describe efforts to find the most cost-effective services, including efforts made to obtain coverage from other funding sources as appropriate. |

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| **APPROVALS** | | |
| Name – Care Manager / Service Coordinator | Name – Agency / County | Email Address |
| **ATTESTATION** | | |
| As the authorizing county waiver agency representative, I support this request and attest it meets identified outcomes, all Medicaid Home and Community-Based Services Waiver Manual polices, and appropriate state and federal procedure code requirements: | | |
| Name – Authorizing Representative | Name – Agency/County | Email Address |
| \*\*Please email completed form and necessary documentation to [dhscltshighcost@dhs.wisconsin.gov](mailto:dhscltshighcost@dhs.wisconsin.gov) using an **encrypted email** program or by entering [**Send Secure**] on the subject line. | | |