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| **DEPARTMENT OF HEALTH SERVICES** **STATE OF WISCONSIN**Division of Medicaid ServicesF-21059 (03/2017) |
| **VARIANCE REQUEST FOR institutional respite** |
| A variance request is required under the Human Service Reporting System SPC 103.24. Use of this form is optional. |
| Name – CM/SSC or Social Worker      | County/Agency      | Date of Request      |
| Email Address      | Telephone No.      |
| Name – COP-W / CIP II / CIP Participant      |
| Name – Person Requiring Respite      | Relationship to Participant      |
| Reason/Circumstance for Respite      |
| Name and Location of Hospital/Nursing Home/ICF-MR      |
| Is this facility certified for Medicaid? [ ]  Yes [ ]  No**If Yes**, continue below. **If No, STOP**. Only facilities certified as Medicaid providers may be used for institutional respite. This variance for institutional respite cannot be approved. You must choose a Medicaid-certified facility. |
| Respite Cost per Day: |       |
| 1. Anticipated length of respite placement—check one [ ]  One-time only request—specify dates/duration of respite stay: |
|  [ ]  Request for recurring stay at this facility. If yes, what is the frequency of the respite requested? [example, one weekend/month, or up to X days/year (specify planned days), etc] |
| 2. Respite Request Narrative—address the following: a. Why can’t an AFH, CBRF or RCAC be utilized or, the hours of in-home respite or SHC increased, or other waiver services be provided to meet this need?      |
|  b. Describe this facility—why was this specific facility chosen?      |
| 1. What is being done or put in place to make the participant’s stay at the facility as pleasant and non-disruptive as possible?

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| [ ]  Approved[ ]  Denied | **SIGNATURE** – QAC or CIS | Date Approved/Denied |
| Reason for denial (if applicable)      |