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| **DEPARTMENT OF HEALTH SERVICES** **STATE OF WISCONSIN**  Division of Medicaid Services  F-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? | | | | | | |
| Approved  Denied | **SIGNATURE** – QAC or CIS | | | | Date Approved/Denied | |
| Reason for denial (if applicable) | | | | | | |