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 Te			elephone No.
Name – COP-W / CIP II / CIP Participant			
Name - Description Descrite			
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?			
for institutional respite cannot be approved. You must choose a Medicaid-certified facility.			
Respite Cost per Day:			
<ol> <li>Anticipated length of respite placement—check one</li> <li>One-time only request—specify dates/duration of respite stay:</li> </ol>			
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]			
<ol> <li>Respite Request Narrative—address the following:</li> <li>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</li> </ol>			
<ul> <li>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?</li> </ul>			
b. Describe this facility—why was this specific facility chosen?			
c. 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
December desired "	P. LLA		

Reason for denial (if applicable)