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| **Department of Health Services**Division of Medicaid ServicesF-21353 (03/2025) |  | **State of Wisconsin** |
| **Children’s Long-Term Support (CLTS) One Time High-Cost Notification** |
| **Participant details** |
| Participant name | Age | Date of birth | Date of submission |
| Participant name | Age | DOB | Date |
| Living arrangement |
| [ ]  Natural or adoptive home [ ]  Children’s foster home [ ]  Other, specify: Enter text. |
| **Service submission ≥ $2000** |
| Home modification/adaptation: Choose an item.Specialized supplies: Choose an item.[ ]  Service animal Click or tap here to enter text.Vehicle modifications: Choose an item.[ ]  Adaptive driving |
| Specific item or service to be provided: Enter text. |
| Total amount of request: Enter text. | Amended total amount of request: Enter text. |
| **Tier 1 or Tier 2 determination** |  | Calendar Year of High-Cost Completion: Enter text. |
| Use the Service Price Ranges from [F-21353i](https://www.dhs.wisconsin.gov/clts/waiver/county/forms.htm?combine=21353i&field_language_target_id=All) to determine Tier level:[ ]  Tier 1 Notification[ ]  Tier 2 Notification:  Bids/Diagrams attached: [ ]  Yes [ ]  No  | Provide for **both** Tier 1 & Tier 2:* Permanent Ramps: total cost of ramp and cost by running slope per linear foot
* Fences: total linear feet, material type, and cost per linear foot
* Specialized Supplies, including Medical Equipment: professional recommendation and when applicable, MA adjudication denial
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| **Narrative summary – Tier 2 notifications only** |
| 1. Describe the child’s functional needs, issues, and goals this request will address.
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| 1. Describe the other pertinent services and supports in place to support the child and family. How does the requested item or service connect to the child’s functional outcomes in relation to other services currently in place that support the child/family?
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| 1. How was it determined that the requested item or service will be effective at meeting the outcome when compared to other options identified in the Deciding Together conversation? Provide rationale why this item or service exceeds the typical Tier 1 range.
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| 1. Describe efforts to obtain coverage from Medicaid or another funding source, if applicable.
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| **Support and service coordinator approval** |
| Name – Care manager/service coordinator | Name – Agency/County | Email address |
| **Approving county waiver agency representative 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 submit completed information and necessary documentation into the ForwardHealth interChange Portal for Waiver Agencies, by using the Quick Links option “High-Cost and Outlier Requests”. |