

**VARIANCE REQUEST FOR ADULT DAY CARE LOCATED WITHIN OR ON THE GROUNDS OF A NURSING HOME / INSTITUTION**

A variance request is required under the Human Service Reporting System SPC 102. 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 – Adult Day Care (ADC)		
Address of ADC		
Nursing Home/Institution where ADC is Located		

Is the ADC a state certified facility:  Yes  No

• **If Yes, continue. If No, STOP.** This variance for ADC cannot be approved. Please choose another ADC that is state certified.

Cost per Day: \_\_\_\_\_ Proposed Frequency of Attendance at ADC: \_\_\_\_\_

Explain why an ADC provider outside of the nursing home/institution listed above is not available to this participant. (Example, no other ADC in the area, transportation to other ADCs in the area is not available, etc.)

Explain why an ADC provider outside of the nursing home listed above is not able to be used by this participant. (Example, the other ADCs in the area have too low of a staff/participant ratio for this participant’s overall cognitive/care needs, the other ADCs do not have staff knowledgeable about the participant’s medical and/or cognitive needs, the other ADCs are not wheelchair accessible, etc.)

**NOTE:** As required, please send (fax, mail, or email) to TMG or CIS a copy of an updated ISP containing this service addition.

<input type="checkbox"/> Approved <input type="checkbox"/> Denied	SIGNATURE – QAC or CIS	Date Approved/Denied
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Reason for denial (if applicable)