WV I/DD Waiver
Direct Support Services – Living Arrangement Assessment

This assessment must be completed and submitted for all individuals who wish to change their current living arrangement to a costlier environment. *Examples include:*

- *Natural Family to any ISS setting*
- *ICF and/or LGH4+ to any ISS setting*
- *ISSx3 to ISSx2/ISSx1*
- *ISSx2 to ISSx1*

The Bureau for Medical Services (BMS) does not advise teams regarding an individual's chosen living arrangement; however, prior authorization is required if the chosen living arrangement results in a more expensive array of services for the individual.

Section 1. General Information (complete this section for all requests)			
Date Submitted:	**Click here to enter a date.**		
Name of Person Who Receives Services:	**Click here to enter text.**	Record ID:	**Click here to enter text.**
Anchor Date:	**Click here to enter a date.**		
Date of IPP/Addendum where Team Agreed to Services Requested (must be uploaded to CareConnection©):			**Click here to enter a date.**
Anticipated Start Date of Service Request:	**Click here to enter a date.**		
Case Management Provider Agency:	**Click here to enter text.**		
Residential Services Provider Agency:	**Click here to enter text.**		
Name of person submitting request:	**Click here to enter text.**		
Phone #/Extension:	**Click here to enter text.**	Email Address:	**Click here to enter text.**

Section 2. Reason(s) for Request: (complete this section for all requests and select all that apply)
Please include a brief description of the circumstances related to the requested change in services. **Click here to enter text.**
☐A. Residence Ownership: Individual owns his/her own residence

Complete section 7: Residence Ownership

☐B. Residence Rental/Lease: Individual is currently in a lease/rental agreement

Complete section 8: Residence Rental/Lease

☐C. Maladaptive Behaviors: Individual has a history of extremely serious maladaptive behaviors documented as placing the member or others in imminent danger

Complete section 9: Maladaptive Behaviors

☐D. Medical Conditions: Individual has a medical condition requiring limited exposure to others

Complete section 10: Medical Conditions

☐E. Other **Click here to enter text.**

Complete section 11: Other

Section 3. Roommate Review (complete this section for all requests—indicate the individual's current and planned roommates, as applicable)	
Record ID for Current Roommate(s)	Record ID for Planned Roommate(s)

Section 4. Requested Services, Ratios, and Units (complete this section for all requests—indicate ALL services requested for the entire service year so a total cost can be determined)			
Service Description and Code	Ratio	**Authorized Units** (how many units are currently authorized in CareConnection© for each service? For services not authorized put N/A)	**Requested Units** (how many units of each service does the team project the individual will need during the service year?)
Example: Unlicensed PCS (S5125HI)	1:1	5,000	11,680

Any request for new or increased LPN services requires a DD9 uploaded to CareConnection© before the assessment can be processed.			

By approximately how much will the requested services, if approved, cause the budget to be exceeded? **Click here to enter text.**

Section 5. History of Living with Others: (complete this section for all requests)

A. Does the individual currently live with others?
Click here to enter text.
B. How many others receiving I/DD Waiver live with the individual?
Click here to enter text.
C. Explain why the individual cannot access 1:3 or 1:2 services. Why are those less restrictive ratios a concern for the individuals health and/or safety?
Click here to enter text.
D. Any additional information relevant to the individual living with others?
Click here to enter text.

Section 6. Explanation of Professional Services: (complete this section for any request to increase professional services)

Indicate why an increase is being requested for each professional service, as applicable.
Click here to enter text.

Example: Behavior Support Professional – Sally requires more BSP services because she has never lived with anyone other than her family. Services will address the change in environment and allow for revisions to her current goals and training of staff to meet her needs in her new home.

Section 7. Residence Ownership (complete ONLY if this item is selected in section 2 above)

A. Is the residence attached to a family dwelling or on property shared by family, such as an attached apartment or mobile home that has been placed on the property?

☐ Yes (Describe:) **Click here to enter text.**

☐ No

B. How many bedrooms are in the residence?
Click here to enter text.

C. How long has the individual owned the home?
Click here to enter text.

D. Is the name on the title/deed that of the person who receives I/DD Waiver services?

☐ Yes ☐ No

If "no" is selected, whose name is on the title/deed? What is that person's relationship to the individual?
Click here to enter text.

E. Is the residence in trust for the individual who receives services? ☐ Yes ☐ No

F. Any additional information relevant to the individual owning the residence?
Click here to enter text.

Provide the required supporting documentation:

☐ Proof of ownership, such as deed/title, current real estate property ticket

☐ Additional documentation that supports the request (list):
Click here to enter text.

Section 8. Residence Rental/Lease (complete ONLY if this item is selected in section 2 above)

A. When does the rental/lease agreement expire?
Click here to enter text.

B. How many bedrooms are in the residence?
Click here to enter text.

Provide the required supporting documentation:

☐ Current rental/lease agreement

☐ Additional documentation that supports the request (list):
Click here to enter text.

Section 9. Maladaptive Behaviors (complete ONLY if this item is selected in section 2 above)

Current ICAP General Maladaptive Behavior Index score:

☐ 10 to -10 *Normal*

☐ -11 to -20 *Marginally Serious*

☐ -21 to -30 *Moderately Serious*

☐ -31 to -40 *Serious*

☐ -41 and below *Very Serious*

Describe the problem behaviors preventing the individual from using the least restrictive services (i.e. 1:2 and/or 1:3): (Provide detailed information **including specific incidents with dates**. Include how long the individual has experienced the issue that prevents him/her from sharing a residence.)

Click here to enter text.

Describe the measures the team has implemented to address the issue preventing him/her from accessing 1:2 and/or 1:3 services:

Click here to enter text.

Has the individual ever shared a residence with others, excluding parents/family? (If yes, describe, including when and for how long, and events preventing the individual from continuing in the current setting.)

Click here to enter text.

Behavior Documentation is required. Indicate which type of data is included. If no behavioral documentation is available, please indicate why the team has not taken steps to formally address problem behaviors:

☐ Current Positive Behavior Support Plan, Functional Behavioral Assessment, and 6-months of behavioral tracking (if PBSP is less than 6-months old, provide all tracking data from date of implementation)

☐ Behavior Protocol and 6-months of behavioral tracking (if Protocol is less than 6-months old, provide all tracking data from date of implementation)

☐ Behavior Guideline

☐ No formal implementation of behavioral interventions (explain below):
Click here to enter text.

☐ Additional documentation that supports the request (list):
Click here to enter text.

Section 10. Medical Conditions (complete ONLY if this item is selected in section 2 above)

Does the individual have a life-threatening condition characterized by frequent periods of acute exacerbation which requires frequent medical supervision and/or physician consultation? (If yes, describe, including name and description of diagnosed condition, date of diagnosis, and duration of condition.)

Click here to enter text.

Does the individual require frequent and time-consuming administration of specialized treatments that are medically necessary? (If yes, describe, including name and description of required treatments, and reason treatment is required.)

Click here to enter text.

If the individual does require such treatments, is there an available natural support who can assist with administration?

Click here to enter text.

Does the individual have a condition that requires limited exposure to others? (If yes, describe, including name and description of diagnosed condition, date of diagnosis, duration of condition, and reason limited exposure is required. Also, indicate the number of staff/visitors currently enter/exit the home on a regular basis.)

Click here to enter text.

Are there other medical reasons preventing the individual from sharing a residence with others? (If yes, describe, including name and description of diagnosed condition, date of diagnosis, duration of condition, and reason limited exposure is required.)

Click here to enter text.

Medical Documentation is required. Indicate which type of data is included:

☐ DD9, if applicable (for individuals with LPN services and/or LPN services requested)

☐ Physician's orders, if applicable

☐ Additional documentation that supports the request (list):

Click here to enter text.

Section 11. Other (complete ONLY if this item is selected in section 2 above)

Describe the situation including why the individual is seeking a change in living and why they are unable to access the least restrictive services (1:2 and/or 1:3).

Click here to enter text.

For consideration, provide supporting documentation, if applicable (list):

Click here to enter text.

*Provider should include this form with the clinical record for verification of any approvals.

For consideration, all supporting documentation described in applicable sections above must be included.

BMS/UMC use only below this line.

Anticipated Date of Move or Change:	Anchor Date:	# of Days Between Date of Move/Change and Anchor Date:	
Total Cost of Requested Services (Entire Service Year):	Assigned Budget:	Requested Over-Budget Amount:	
Reason for Request: (from section 3 above, choose all that apply)	Living Setting at Time of Annual Functional Assessment:	Living Setting Requested:	Direct Care Services and Units Requested, including LPN:
☐ Residence Ownership	☐ Natural Family/SFCP	☐ ISS x1	
☐ Residence Rental/Lease	☐ ISS x1	☐ ISS x2	
☐ Maladaptive Behaviors	☐ ISS x2	☐ ISS x3	
☐ Medical Conditions	☐ ISS x3	☐ Group Home 4+	
☐ Other:	☐ Group Home 4+		
Describe the Circumstances of the Change:			
Describe the Daily Breakdown of Requested Services:			
KEPRO RN Recommendations:			
Additional Information:			

Approval of Request is:
☐RECOMMENDED:
☐RECOMMENDED CONDITIONALLY:
☐NOT RECOMMENDED

Name of KEPRO staff reviewing request:
Date of KEPRO review:

BMS Decision:
☐Approved as Requested:

☐Approved Conditionally:
☐Not Approved:

Name of BMS staff reviewing request:
Date of BMS review: