AGED AND DISABLED WAIVER FORMS INSTRUCTIONS

Form Name: Aged and Disabled Waiver Geographical and Cultural/Linguistic Conflict of Interest Exception Application for Home and Community-Based Waiver Services
Purpose: To request an exception to the Provider Conflict of Interest Federal Requirement.

Form Definitions:

Conflict of Interest: A "real or seeming incompatibility between one's private interests and one's public or fiduciary duties." This means providers of Medicaid home and community-based services (HCBS) for the individual, or those who have an interest in, or are employed by a provider of HCBS for the individual, must not be the same entity to provide case management or develop the person- centered service plan.

Geographic Exception: There are no qualified or willing entities to provide case management services independent of personal attendant services within a 25-mile radius of the member's physical address.

Cultural/Linguistic Exception: There are no qualified or willing entities, able to meet the member's cultural and/or linguistic needs, to provide case management services independent of services within a 25-mile radius of the member's physical address.

Section I. Complete:

- Member Name
- CareConnection Record ID#
- Current Case Management Agency
- Current Personal Attendant Agency
- Date you submit Exception Request to the OA
- Check either Yes or No that the member receives dual services
- Current Personal Care Provider

Section II Geographic Exception Request

1. Answer Yes or No, is there a case management agency within a 25-mile radius of the member's physical address? (This should be calculated using Google Maps, MapQuest or other mileage estimating software.) If the answer is No, you may skip the remaining questions, sign, date and submit the Conflict of Interest form to the OA.
2. If the answer to Question 1 is Yes, list all agencies within a 25-mile radius of the member's physical address.

NOTE: In order to answer Questions 3 and 4, you must contact the agencies within a 25-mile radius of the member's physical address and ask if they have the ability to accept a service referral for case management services. You must also document the date you contacted each agency and who you spoke with as well. This information must be included when submitting the form.

3. If Yes to Question 1, does the case management agency have the ability to accept a service referral for case management? Answer Yes or No.
4. If yes to Question 3, have referrals been made and rejected to the agency/agencies? Answer Yes or No.
5. For provider(s) listed in #2 (within a 25-mile radius of the member), has the member previously received services from one or more of those agencies? Answer Yes or No.
6. If yes to #5, list the agencies where services were received and why services were transferred from that agency.

Section III. Cultural/Linguistic Exception Request

1. Describe the cultural/linguistic need necessitating the member maintain services at their current agency. Be as detailed as possible.
2. Answer Yes or No, is there a case management agency within a 25-mile radius of the member's physical address? (This should be calculated using Google Maps, MapQuest or other mileage estimating software.) If the answer is No, you may skip the remaining questions, sign, date and submit the Conflict of Interest form to the OA.
3. If the answer to Question 1 is Yes, list all agencies within a 25-mile radius of the member's physical address.

NOTE: In order to answer Question 4, you must contact the agencies within a 25-mile radius of the member's physical address and ask if they have the ability to accept a service referral for case management services. You must also document the date you contacted each agency and who you spoke with as well. This information must be included when submitting the form.

4. If the answer to Question 2 is Yes, do any of those agencies have the capability of meeting the cultural/linguistic need(s)? Answer Yes or No.
5. If No to Question 4, fully explain how the agencies are unable to meet the cultural/linguistic need(s).
6. For provider(s) listed in #3 (within a 25-mile radius of the member), has the member previously received services from one or more of those agencies? Answer Yes or No.
7. If yes to #6, list the agencies where services were received and why services were transferred from that agency.

After completing the appropriate section(s), the person submitting the Conflict of Interest form must sign, print their name and title, date and submit the form to the OA.

Authorization for this Exception, if granted, is only valid for one year during the annual Service Plan/Individualized Program Plan development therefore, a new Conflict of Interest Exception Application must be submitted each year. The exception will be reviewed by the OA and approved by BMS, as appropriate.