I/DD WAIVER EXCEPTIONS REQUEST FORM
REQUEST FOR SERVICES ABOVE THE BUDGET

Member Name		Record ID#	

This is a request for services above the I/DD Waiver member's budget. Please fill out this form completely, and attach all documentation that you feel supports your request for services. BMS will review the request to determine if the services for which you are requesting funding are medically necessary to ensure your health and safety in order to avoid a heightened risk of institutionalization. In making its decision, BMS will consider: the Member's ICAP; the Member's Structured Interview; and all IPPs from the Member's current IPP year. **BMS may, but is not required to, review any additional documents not attached to this request. If there are any other documents that you would like considered, please attach those documents to this request.**

Submit completed form securely to KEPRO via email at IDDWExceptions@kepro.com or by mail to:

KEPRO
1007 Bullitt St.
Suite 200
Charleston, WV 25301

Service Coordinator Name	
Service Coordinator Agency	
Service Coordinator Phone Number	
Service Coordinator Email	
Legal Representative Name (if applicable)	
IPP year (e.g., 2/12/2015 to 2/11/2016)	

Please list all services you are requesting for this IPP year:

Service Code	Service Name	Per Unit Cost	Total Units Requested Within Your Budget	Total Units Requested for Service Year

MEMBER'S BUDGET: $_____

TOTAL COST OF SERVICES REQUESTED IN EXCESS OF THE BUDGET: $_____

1. General Questions

A. Medicaid pays for many services outside of the I/DD Waiver. For example, Medicaid pays for personal care services, physical therapy, and speech therapy, outside of the I/DD Waiver. A list of Medicaid services is available through your service coordinator.

Are any of the services you are requesting available through Medicaid outside of the Waiver? YES ☐ NO ☐

If yes, please describe why these Medicaid services provided outside of the I/DD Waiver are not sufficient to meet your needs (attach separate sheet if more space is needed):

_____
_____
_____

B. Do you have private insurance? YES ☐ NO ☐ If yes, what is the name of your private insurance company and what policy do you have?

_____

If you have private insurance, are any of the services you are requesting through the I/DD Waiver covered by private insurance? YES ☐ NO ☐

Please list the services requested that are covered by your private insurance:

_____

By law, BMS can only pay for services not covered by private insurance. In order to approve a request for professional services (e.g. physical therapy, RN services)

above your budget, BMS will need confirmation that none of your Waiver services (both those paid within your budget and the request for additional services) are not available through your private insurance. Please submit any evidence that the requested professional services are not covered by your private insurance. Otherwise, BMS will contact your insurance company, which may delay a decision on your request.

C. Can you decrease or substitute other services to try to purchase the requested units within your budget? (e.g. substitute Approved Medication Administration Personnel services for LPN services; substitute LPN services for RN services; substitute 1:2 or 1:3 person-centered support for 1:1 person-centered support) YES ☐NO ☐

If decrease or substitution is not possible, please explain why:

_____
_____
_____

2. Are you requesting additional units of <u>Person-Centered Support (PCS) or Respite</u>? This includes Home-Based PCS, Family PCS, PCS-Personal Options, and In-Home or Out-of-Home Respite.

YES ☐ NO ☐ (If no, please skip to Question 3)

A. Please provide a detailed explanation supporting the request. Please attach an additional sheet if more space is needed.

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_____
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Please attach any documentation that supports your request.

B. If you live with your family or in a certified Specialized Family Care Home, please answer the following questions: (If not, please skip to Section C).

i. Why are the adult family members with whom you live not able to provide these additional services (Check all boxes that apply)
   a. ☐ All the adults with whom I live are elderly (age 65 or older) or disabled**

b. ☐ Other _____

Please attach any documentation that supports your answer. For example:

- An official government document, such as a driver's license that establishes the age of an elderly adult.
- Documentation establishing that an adult receives, or is eligible to receive, disability payments or workers compensation.

ii. Please fill out the following chart about the adults that live in your family home:

Name of Adult	At least age 65? (Circle one)	Disabled? (Circle one)	Other reason why the adult cannot provide support for the Waiver member
	Y / N	Y / N	
	Y / N	Y / N	
	Y / N	Y / N	

**Please Note: Family members who are unable to provide natural support due to disability or age will not be eligible to be paid for other services provided to the Waiver Member.

C. Do you live in an ISS or a Group Home?

YES ☐ NO ☐ (If no, please skip to Question 3)

i. Are you requesting additional 1:1 services? YES ☐ NO ☐

If yes, why do you require additional 1:1 services, instead of 1:2 or 1:3 services? (check all that apply).

a. ☐ I have obtained employment that requires additional 1:1 services

b. ☐ Other (please describe)

_____

_____

_____

ii. Are you requesting more than 4 hours per day (28 hours per week) in 1:1 services? YES ☐ NO ☐

If yes, please explain why you cannot substitute 1:2 or 1:3 services for some or all of the 1:1 that you are requesting. Please attach an additional sheet if more space is needed.

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iii. Are you requesting additional 1:2 services? YES ☐ NO ☐

If yes, why do you require additional 1:2 services, instead of 1:3 services? (Check all that apply)

a. ☐ I have obtained employment that requires additional 1:2 services.

b. ☐ Other (please describe)

_____
_____

If you are requesting additional 1:1 or 1:2 services, please provide documentation to support your request that 1:1 or 1:2 services are necessary. For example, you may attach medical records that show the need for additional 1:1 or 1:2 services.

3. **If you are requesting additional units of Day Habilitation, Supported Employment, Pre-Vocational Training, Job Development, LPN, RN, Service Coordination, Behavior Support Professional, Dietary Therapy, Physical Therapy, Occupational Therapy, Speech Therapy or Transportation, <u>please provide a detailed explanation supporting the request</u>, including the reason that your Interdisciplinary Team requested additional professional services.** Please attach an additional sheet if more space is needed.

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Please attach any documentation that supports your request. For example:

- Documentation of diagnoses and/or prescriptions that make frequent, professional medical monitoring and assessment necessary.
- Documentation of the frequency of maladaptive behaviors.
- Documentation as to how the therapy plan for which units are requested in excess of the budget would improve functionality and/or prevent deterioration.

4. **Are you requesting additional units of Environmental Home or Vehicle Adaptations or Goods and Services?** YES ☐ NO ☐ (If no, please skip to Question 5).

   A. What type of environmental adaptation, goods, or services are you requesting? (check all that apply)
      i. Ramps for the home
      ii. Hoyer Lift
      iii. Therapy table
      iv. ☐ Other adaptations for the home (please specify)_____
      v. ☐ Other adaptations for transportation (please specify)_____

   B. Why is this adaptation needed? What need listed on the IPP does this address?

   _____
   _____
   _____
   _____

   Please provide any documentation that supports your request for an environmental adaptation.

5. **Is there anything else you would like BMS to know about your request for services above the budget?** Please attach an additional sheet if more space is needed.

_____
_____
_____
_____
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_____

6. **Do you believe an error was made in your budget calculation?** YES ☐ NO ☐

   A. Please describe what error you believe was made in your budget calculation.

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Please provide any documentation that supports your belief that an error was made in your budget calculation.

Service Coordinator Signature: _____

Printed Name: _____

Date: _____

Member and/or Legal Representative Signature:

_____

Printed Name(s): _____

Date: _____