I/DD Waiver Exception Request Form
Request for Services above the Budget

Member Name: ***Record ID:***

Case Manager (CM):		*Case Management Agency:*	
CM Email Address:		*Legal Representative (if applicable)*	
Service Agency/Agencies:		*Service Year (e.g., 1/1/24 – 12/31/24):*	

This is a request for services above the I/DD Waiver member's budget. Please fill out this form completely. BMS will review the request to determine if desired services are medically necessary to ensure your health and safety in efforts to avoid a heightened risk of institutionalization.

In deciding, BMS will consider the current: structured interview, ICAP, and ABAS III results along with IPPs from the current service year. **BMS may, but is not required to, review any additional documents not attached to this request. Please ensure to attach concise documentation you feel supports your request.**

Submit completed form securely to Acentra Health via email at IDDWExceptions@acentra.com or by mail to:

Acentra Health
1007 Bullitt St. Suite 200
Charleston, WV 25301

Please list **all** services you are requesting for this IPP year. This should match the total services requested in the "Over-Budget Services" section of the most current IPP. Please ensure you are using the most current Purchase Worksheet for service requests; your assigned PE can provide this if needed.

Name of Agency Providing Service:	Service Name as Identified in the UMC Web Portal:	Service Code:	Total Units Needed for the Service Year:

Medicaid services are available via non-IDD Medicaid options – such as the State Plan – and must be accessed prior to accessing Waiver funds. Services may also be available through private insurance. By law, BMS can only pay for services not covered by private insurance. BMS may contact your insurance provider, which may delay the decision. To expedite, please include any evidence that requested services are not covered by private insurance.

Some services are available in multiple ratios such as Person-Centered Support and LPN services. Nursing services are provided by Approved Medication Administration Personnel (AMAP), LPNs, and RNs based upon the scope of practice for each licensure. The member's IDT is responsible to evaluate all services and determine if less-expensive service/support options will meet the member's needs when choosing a service array.

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General Questions

1. Are any of the requested services available through Medicaid outside of I/DD Waiver (a list of Medicaid services is available through your Case Manager)?

****If yes, please complete the following sub-questions. If the answer is no, please skip to Question Two.***

☐ NO – Requested services are not available via non-Waiver Medicaid
☐ YES – Please check any/all reasons why these non-IDD Medicaid services are not sufficient to meet your needs. You may also include additional information/attachments, if needed:

- ☐ Max benefit does not cover total amount of service required
- ☐ A non-IDD Medicaid provider is not available in my catchment area
- ☐ Benefits do not capture all needs (e.g., NEMT covers transportation to and from day facilities, but not community outings)

☐ Other:

Please expand upon any of the above and/or provide additional information you feel supports your request:

2. Are any services requested available via private insurance?

****If yes, please complete the following sub-questions. If the answer is no, please skip to Question Three.***

☐ NO – The member/parent/guardian does not carry private insurance
☐ NO – The requested services are not available via private insurance
☐ YES – Services are available but are not sufficient to meet my needs.
Insurance Provider:

Please check any/all reasons why services available via private insurance are not sufficient to meet your needs. You may also include additional information/attachments, if needed:

- ☐ Max benefit does not cover total amount of service required
- ☐ A qualified provider is not available in my catchment area
- ☐ Unable to meet all prior authorization requirements necessary to receive the max benefit

☐ Other:

Please expand upon any of the above and/or provide additional information regarding reduction and/or substitution of services:

3. Are any services able to be reduced or substituted for a less intensive service?

☐ YES – Reduced and/or substituted services are reflected in the list of services being requested
☐ NO – Please check any/all reasons why services cannot be reduced or substituted for less intensive services. You may also include additional information/attachments, if needed:

- ☐ The member is currently receiving the least intensive services available
- ☐ Needs have progressed beyond the scope of less intensive services
- ☐ Needed services are being provided as scheduled and no changes in need are anticipated

☐ Other:

Please expand upon any of the above and/or provide additional information regarding reduction and/or substitution of services:

Service Questions

1. Do you live in an ISS or Group Home? ☐ YES ☐ NO

**If yes, please complete the following sub-questions. If the answer is no, please skip to Question Two.*

1A. How many people currently reside in the home?

1B. Is the current living situation temporary or permanent?

1C. If the current situation is permanent, include the approved/conditionally approved DSSLA decision as applicable.

1D. If the current situation is temporary, please describe the situation and approximately how long is it anticipated to last.

1E. If the team is searching for a roommate, complete the table below adding lines as needed:

Date of Referral	Provider Agency	Outcome

1F. If you are requesting 1:1 units in excess of 8 hours per day, please select all that apply:

☐ The member is experiencing new or worsening medical and/or behavioral issues necessitating more 1:1 to address

☐ The member has obtained a job, which requires additional 1:1 time outside the home

☐ The member is currently without a/any roommate(s)

☐ Other:

Please expand upon any of the above and/or provide additional information you feel supports your request for additional 1:1 services:

1G. If you reside in a three- or four-person home and are requesting 1:2 units in excess of 8 hours per day, please select all that apply.

☐ Another member in the home is experiencing increased needs, necessitating different ratios in the home

☐ The member is experiencing new or worsening medical/behavioral issues necessitating more intensive ratios

☐ The member is currently without one or more roommates

☐ Other:

Please expand upon any of the above and/or provide additional information you feel supports you r request for additional 1:2 services:

2. Do you live in a Natural Family or Specialized Family Care Setting? ☐ YES ☐ NO

**If yes, please complete the following sub-questions. If the answer is no, please skip to Question Three.*

Members living in Natural Family or Specialized Family Care settings are expected to receive natural supports. IDD Waiver services may not be substituted for routine care and supervision expected to be provided to biological, adoptive, or foster children/adults by a parent or Specialized Family Care Provider. Be advised family members who are unable to provide natural supports due to disability or age will be unable to receive compensation for the provision of Waiver Services.

2A. Please complete the following chart regarding adults who live in the home.

Name and Relationship of Adult	**Please Check All that Apply**	
	☐ Age 65 or older	☐ Works outside the home 35 or more hours per week
	☐ Disabled	☐ Is primary caregiver for more than one person
	☐ Provides paid services	☐ Provides natural supports
	☐ Age 65 or older	☐ Works outside the home 35 or more hours per week
	☐ Disabled	☐ Is primary caregiver for more than one person
	☐ Provides paid services	☐ Provides natural supports
	☐ Age 65 or older	☐ Works outside the home 35 or more hours per week
	☐ Disabled	☐ Is primary caregiver for more than one person
	☐ Provides paid services	☐ Provides natural supports

Please expand upon any of the above and/or provide additional information regarding limitations of adults living in the home providing natural supports. You may wish to include supporting documentation such as age verification, proof of eligibility to receive disability/workers comp payments, etc.:

2B. If you are requesting additional units of Person-Centered Supports and/or Respite services, please select all that apply:

☐ The member is experiencing new or worsening medical and/or behavioral issues necessitating more 1:1 to address

☐ Primary caregiver is out of the home 35 or more hours per week

☐ Primary caregiver does not have natural supports to provide amount of respite needed

☐ Other:

Please expand upon any of the above and/or provide additional information you feel supports you r request for additional PCS and/or Respite services:

3. Are you requesting any/additional Day services (FBDH, PV, JD, SE)? ☐ YES ☐ NO

**If yes, please complete the following sub-questions. If the answer is no, please skip to Question Four.*

3A. Does the member wish to work/volunteer more for more hours and/or spend more time during the week at a Facility-Based Day program than they did in the previous service year? ☐ YES ☐ NO

3A-1. If yes to 3A, why was the IDT unable to reduce direct-care services to account for the additional day services being requested?

3B. Were services underutilized in the previous service year and/or since the previous exceptions request due to lack of staff, frequent/prolonged illness, behavioral concerns, and/or other medical concerns? ☐ YES ☐ NO

3C. Are any of the situations listed in 3B continuing/anticipated to continue in the current service year? ☐ YES ☐ NO

Please expand upon any of the above and/or provide additional information you feel supports your request for additional Day services:

4. Are you requesting any/additional Nursing services (LPN, RN, RN IPP)? ☐ YES ☐ NO

**If yes, please complete the following sub-questions. If the answer is no, please skip to Question Five.*

****An updated DD9 will be required if the request includes increases for LPN services.***

4A. Has the member transitioned from a NF setting to a 24-hour setting and/or started day services since the previous service year and/or exceptions request? ☐ YES ☐ NO

4B. Has the member had any new and/or worsening medical concerns since the previous service year and/or exceptions request? ☐ YES ☐ NO

4C. Has the member been discharged from a hospital, rehabilitation center, and/or other long-term care facility within the past 30 days? ☐ YES ☐ NO

4D. Were services underutilized in the previous service year and/or since the previous exceptions request due to lack of staff, frequent/prolonged hospitalization(s), behavioral concerns, and/or improved medical status? ☐ YES ☐ NO

4E. Are any of the situations listed in 4D continuing/anticipated to continue in the current service year? ☐ YES ☐ NO

4F. Has an updated DD9 been uploaded to the UMC Web Portal to support additional nursing services? ☐ YES ☐ NO

Please expand upon any of the above and/or provide additional information you feel supports your request for additional Nursing services:

5. Are you requesting any/additional Behavior services (BSP I, BSP II, BSP IPP)? ☐ YES ☐ NO
**If yes, please complete the following sub-questions. If the answer is no, please skip to Question Six.*

5A. Has the member transitioned from a NF setting to a 24-hour setting and/or started day services since the previous service year and/or exceptions request? ☐ YES ☐ NO

5B. Has the member had any new and/or worsening behavioral concerns since the previous service year and/or exceptions request? ☐ YES ☐ NO

5C. Has the member experienced any significant life changes within the past 90 days? ☐ YES ☐ NO

Examples include: loss of primary caregiver or a loved one, change in residence, loss/change in roommate(s), graduated/transitioned from high school, witnessed/experienced a traumatic event, etc.

5D. Has the member been discharged from a hospital, psychiatric hospital, crisis center, and/or other long-term care facility where the member was placed due to behavioral concerns within the past 30 days? ☐ YES ☐ NO

5E. Were services underutilized in the previous service year and/or since the previous exceptions request due to lack of staff, frequent/prolonged hospitalization(s), medical concerns, and/or improved behavior status? ☐ YES ☐ NO

5F. Are any of the situations listed in 5E continuing/anticipated to continue in the current service year? ☐ YES ☐ NO

Please expand upon any of the above and/or provide additional information you feel supports your request for additional Behavior services:

6. **Did the most recently processed Exceptions Request or DSS-LA result in a directive from BMS or Acentra Health, to develop or update a Positive Behavior Support Plan (PBSP)?** ☐ YES ☐ NO
**If yes, please complete the following sub-questions. If the answer is no, please skip to Question Seven.*

6A. If yes, was the PBSP developed/updated as directed? ☐ YES ☐ NO

6B. If the PBSP was <u>not</u> developed/updated as directed, why not?

7. Are you requesting any/additional Therapy services (DT, OT, PT, ST)? ☐ YES ☐ NO
**If yes, please complete the following sub-questions. If the answer is no, please skip to Question Eight.*

7A. Is the member aged 21 or older? ☐ YES ☐ NO

7B. Has the member experienced a medical and/or traumatic event impacting their appetite/ability to eat, hands, extremities, and/or ability to speak within the last 90 days? ☐ YES ☐ NO

7C. Has the member shown improvement and/or lessened symptoms due to receiving therapy since the previous service year and/or exceptions request? ☐ YES ☐ NO

7D. Were services underutilized in the previous service year and/or since the previous exceptions request due to lack of staff, frequent/prolonged hospitalization(s), medical concerns, and/or behavioral concerns? ☐ YES ☐ NO

7E. Are any of the situations listed in 7D continuing/anticipated to continue in the current service year? ☐ YES ☐ NO

Please expand upon any of the above and/or provide additional information you feel supports your request for additional Therapy services:

8. Are you requesting any/additional Transportation services (Miles and/or Trips)? ☐ YES ☐ NO

**If yes, please complete the following sub-questions. If the answer is no, please skip to Question Nine.*

8A. If you are requesting additional units of Transportation, please select all types of activities for which services are utilized:

☐ Formal goal completion ☐ Informal goal completion ☐ Medical needs
☐ Behavioral needs ☐ Quality of life improvement

☐ Other:

8B. Has the member graduated/transitioned from high school in the past 60 days? ☐ YES ☐ NO

8C. Does the member reside in a rural area where a round-trip to the local community exceeds 30 miles? ☐ YES ☐ NO

8D. Has the member started day services and/or new community goals since the previous service year and/or exceptions request? ☐ YES ☐ NO

Please expand upon any of the above and/or provide additional information you feel supports your request for additional Transportation services:

9. Are you requesting any/additional Environmental Accessibility Adaptations (EAA-H, EAA-V) and/or Goods and Services? ☐ YES ☐ NO

**If yes, please complete the following sub-questions. If the answer is no, please skip to Question Ten.*

****Please note that a DD8 and estimate(s) will be required.***

9A. If you are requesting EAA and/or PDGS not previously authorized in the current service year, please select all types of adaptation(s)/purpose(s) for which services are needed:

☐ Accessibility into/out of the home ☐ Accessibility within the home ☐ Improve functioning within the home
☐ Accessibility into/out of the vehicle ☐ Accessibility within the vehicle ☐ Improve functioning within the vehicle
☐ Improve overall functioning/independence ☐ Promote community inclusion/access ☐ Increase safety

☐ Other:

9B. Describe the adaptation, service, equipment, and/or supplies requested:

9C. Have the DD8 and estimate(s) been uploaded to the UMC Web Portal to support this request?
☐ YES ☐ NO

Please expand upon any of the above and/or provide additional information you feel supports your request for additional EAA/PDGS services:

Additional Questions and Information

1. Do you believe an error was made in your budget calculation*?* ☐ YES ☐ NO
**If yes, please complete Questions two and three. If the answer is no, please skip to Question Four.*
****Please note that a DD13 will be required.***

2. What type of error do you believe was made in your budget calculation?

3. Have you submitted a DD-13 (Annual Functional Assessment Data Modification Request)?

☐ YES
☐ NO – Explain why not:

4. Is there anything else you would like BMS to know about your request for services above the budget?
Additional sheets may be attached, with necessary information highlighted, if necessary.

Please note: If dollars above the budget are not found to be clinically necessary (at all - or - not the full amount requested) to prevent institutionalization, BMS will **not** reduce currently authorized services. Rather, the team must evaluate the total dollar amount approved and prioritize which services to rearrange to best meet the members' needs.

After evaluation and planning (to include analyzing current utilization to determine if modifications can be made to underutilized services) if the team disagrees that the approved dollar amount will meet the members needs to prevent institutionalization, the team may submit a request for a Medicaid Fair Hearing.

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PLEASE NOTE THAT SIGNATURES ARE REQUIRED FOR ALL AGENCIES PROVIDING IDDW SERVICES.

ROLE:	SIGNATURE:	PRINTED NAME:	DATE:
Case Manager			
Member (Required only if a Legal Adult)			
Legal Representative			
Service Provider (24 hour Residential only)			
Service Provider (other, as applicable)			
Click or tap here to enter text.			
Click or tap here to enter text.			

Prior to submitting this request, please ensure the following have been completed as applicable:

☐ Services requested on this form match the most recent Over Budget Service Evaluation (IPP) uploaded to the UMC Web Portal and includes the total number of units requested for the service year.

☐ All documents related to this request are uploaded to the UMC Web Portal i.e., DD8, DD9, etc.

☐ All necessary signatures are included on the related IPP to indicate team agreement to the Exceptions process.

☐ Signatures from representatives of all agencies providing IDD services are included on this form to indicate team agreement to this request.