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

Guidance for completion.
This assessment must be completed and submitted for all individuals who wish to change their current living arrangement to an ISSx1 or ISSx1 Personal Options setting. *Examples include:* • *Natural Family to ISSx1 or ISSx1 Personal Options* • *ICF and/or LGH4+ to ISSx1 or ISSx1 Personal Options* • *ISSx3/ISSx2 to ISSx1 or ISSx1 Personal Options* • *ISSx1 Personal Options 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. Forms completed in full MUST be emailed to WVIDDWaiver@acentra.com with supporting documentation as necessary in order to be processed.

Section 1. General Information (complete this section for all requests)			
Date Submitted:			
Name of Person Who Receives Services:		Record ID:	
Anchor Date:			
Date of IPP/Addendum where Team Agreed to Services Requested (must be uploaded to UMC's web portal):			
Anticipated Start Date of Service Request:			
Case Management Provider Agency:			
Residential Services Provider Agency:			
Name of person submitting request:			
Phone #/Extension:			
Email Address:			

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.

☐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: _____
Complete section 11: Other

Record ID for Current 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 UMC's web portal 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 UMC's web portal before the assessment can be processed.

By approximately how much will the requested services, if approved, cause the budget to be exceeded?

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

A. Does the individual currently live with others?

B. How many others receiving I/DD Waiver live with the individual?

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?

D. Any additional information relevant to the individual living with others?

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.

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:) _____

☐ No

B. How many bedrooms are in the residence?

_____

C. How long has the individual owned the home?

_____

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?

_____

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?

_____

Provide the required supporting documentation:

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

☐ Additional documentation that supports the request (list):

_____

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

A. When does the rental/lease agreement expire?

_____

B. How many bedrooms are in the residence?

_____

Provide the required supporting documentation:

☐ Current rental/lease agreement

☐ Additional documentation that supports the request (list):

_____

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.)

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

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.)

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)

- How long has the Positive Behavior Support Plan been implemented?

- What do formal interventions look like at home or in the community?

☐ 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):

☐ Additional documentation that supports the request (list):

How many incidents have taken place WITH roommates in the home within the past 6 months?

- What do those incidents look like? When do they take place? Who is typically involved? Common triggers?

How many incidents have taken place WITHOUT roommates in the home within the past 6 months?

- What do those incidents look like? When do they take place? Who is typically involved? Common triggers?

Does the member have a history of state/psychiatric hospital and/or crisis placement?

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

What medical condition(s) limits exposure to others?

How does the medical condition(s) prevent the member from living with a roommate?

Is the medical condition(s) temporary or pervasive?

What does treatment look like for the medical condition(s)?

Describe what the current treatment for the medical condition(s) looks like for the individual including if any special considerations such as more than one staff, a type of equipment, incredibly frequent administration, constant monitoring, etc. are required for daily living.

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):

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

*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 x2	☐ ISS x1 PO	
☐ Maladaptive Behaviors	☐ ISS x3		
☐ Medical Conditions	☐ Group Home 4+		

☐ Other:	☐ ISSx1 PO		
Describe the Circumstances of the Change:			
Describe the Daily Breakdown of Requested Services:			
Acentra Health RN Recommendations:			
Additional Information:			

Approval of Request is:

☐ RECOMMENDED:
☐ RECOMMENDED CONDITIONALLY:
☐ NOT RECOMMENDED

Name of Acentra Health staff reviewing request:
Date of Acentra Health review:

BMS Decision:
☐ Approved as Requested:
☐ Approved Conditionally:
☐ Not Approved:

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