WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES

Traumatic Brain Injury Waiver Geographical and Cultural/Linguistic Conflict of Interest Exception Application for Home and Community-Based Waiver Services

Member Name: _____

Medicaid ID#: _____

Current Case Management Agency: _____

Current Personal Attendant Agency: _____

Date of Exception Application Request: _____

Dual Services (Personal Care and Waiver): ___ Yes ___ No

Current Personal Care Provider:

The above named TBIW member is requesting a Conflict of Interest (COI) Exception on the basis that there are no other "willing and qualified entities" in the area to provide case management services independent of personal attendant services as required by 42 CFR 431.301 (c) (1) (vi), 441.730 (b) and 441.555 (c) Conflict of Interest Federal Requirements (*enrollment in the HCBS authorities, 1915 (c), (i), and (k) triggers COI requirements and note that the COI requirements apply no matter what type of funding stream is used for case management activities).*

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.

This application must be submitted to the UMC and receive BMS' approval, before receiving conflicted services. **Send the completed form to: barbara.recknagel@acentra.com**

Complete the section below corresponding to the needed exception type:

	Geographic Exception Request	**YES**	**NO**
1	Is there a case management agency within a 25-mile radius of the member's physical address? **If no, skip remaining questions.**	☐	☐
2	List the agency/agencies within 25-miles:		
3	If yes to #1, does the case management agency have the ability to accept a service referral for the member?	☐	☐
4	If yes to #3, have referrals been made and rejected to the agency/agencies?	☐	☐
5	For provider(s) listed in #2, has the member previously received services from one or more of those agencies?	☐	☐
6	If yes to #5, list the agencies where services were received and why services were transferred from that agency:		

	Cultural/Linguistic Exception Request	**YES**	**NO**
1	Describe the cultural/linguistic need necessitating the member maintain services at their current agency:		
2	Are there case management agencies within a 25-mile radius of the member's home? **If no, skip remaining questions.**	☐	☐
3	List the agency/agencies(s) within 25-miles:		
4	If yes to #2, do any of those agencies have the capability of meeting the cultural/linguistic need(s)?		
5	If no to #4, explain how the agencies are unable to meet the cultural/linguistic need:		
6	For agency/agencies listed in #3, has the member previously received services from one or more of those agencies?		
7	If yes to #6, list the agencies where services were received and why services were transferred from that agency:		

Authorization for this Exception, if granted, is only valid for one year dur Service Plan/Individualized Program Plan development. The exception will be reviewed by the UMC and approved by BMS annually thereafter.

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I certify that I have read and understood all the questions in this Conflict-of-Interest Exception Application and that all the foregoing information and statements submitted are true and correct to the best of my knowledge, and all responses to the questions are full and complete, omitting no material information.

I acknowledge and agree that any misrepresentations in the submitted application will be grounds for removal from agency selection forms, of all types; members being transferred to other approved agency; and for initiating action under federal and/or state law concerning false statement, fraud, or other applicable offenses.

Under penalty of perjury, I certify that the information I have provided is true, accurate, and complete to the best of my knowledge.

Submitted by Signature	Printed Name-Title	Date

Administrative Use Only:

UMC reviewed and verified content of Application and submitted to BMS:

UMC Signature:_____ Date: ____

BMS: Approved _____ Denied _____ Reason for denial: _____

BMS Signature: _____ Date:

Exception Expiration date:

Agency Notification and copy of form provided Date:

This exception applies for the Dual Service case when the HCBS Case Management Provider is also the Personal Care Services Provider to the member.

(This form must be kept in the waiver member's file)