IOWA | Health and Human Services

Iowa Medicaid Variance Request Form

Please note: Variance requests are applicable only to members accessing the Brain Injury (BI) and Intellectual Disability (ID) Waiver. Habilitation members are required to complete a Waiver of Administrative Rule request.

A variance request form must be completed for a member if they meet any of the following criteria:

- Member is under the age of 16 and is requesting access to more than 52 Hours per month of Intermittent Supported Community Living (SCL).
- Member is under the age of 16 and is requesting to reside in a licensed or certified Residential-Based Supported Community Living (RBSCL) setting.
- Member is under the age of 16 and is requesting access to Daily SCL services **outside** a licensed or certified RBSCL setting.
- Member is under the age of 18 and is requesting access to Daily SCL services with others in the setting over the age of 21.

Instructions:

Please provide written documentation addressing each of the following items. Ensure your responses are concise, thorough, and fully address each item.

Reminder: All supporting documents must be emailed to exceptions@hhs.iowa.gov. If separate from the Variance Request Form, reference the member's name and State ID in the body of the email.

Requestor Information

1. Date form submitted: Click or tap to enter a date.
2. Name of Individual Completing Form:
3. Title of Individual Completing Form:
4. Email address of Individual Completing Form:

Member Information

1. Member Name:
2. Member State ID:
3. Member Date of Birth:
4. Has an application been completed for a Home and Community Based Services (HCBS) ID Waiver or BI Waiver slot for the member? ☐Yes ☐No ☐N/A
5. Was a Waiver Priority Needs Assessment (WPNA) completed for an ID Waiver or BI Waiver slot? ☐ Yes ☐ No ☐ N/A
6. Which of the following applies to this member?
   ☐ The member is under the age of 16 requesting access to more than 52 Hours per month of Intermittent SCL. If selected, complete the section titled **Variance Request to Access More**

than 52 hours per month of Intermittent SCL along with submission of noted supporting documentation.

☐ The member is currently living outside their home and discharge is recommended. Returning to the parent or guardian's home is not an option due to the health and safety needs of the member and/or other family members. All available community options have been exhausted as determined through the prior authorization process. If selected, complete the section titled **Variance Request to Access Daily SCL.**

☐ The member is currently living in the parent, or guardian's home and all available community options have been exhausted as determined through the prior authorization process. Remaining in the parent or guardian's home is not an option due to the health and safety needs of the member and/or other family members. If selected, complete the section titled **Variance Request to Access Daily SCL.**

☐ The member is currently living outside their home under a previously approved variance and would like to remain in current residence. If selected, complete the section titled **Variance Request to Access Daily SCL.**

Variance Request to Access More than 52 hours per month of Intermittent SCL:

Member is under the age of 16 requesting access to more than 52 Hours per month of Intermittent SCL.

1. How many hours of Intermittent SCL are being requested for access each month?
2. Will the member be accessing more than 52 hours of Intermittent SCL long term?
   ☐ Yes ☐ No ☐ N/A

   If yes, please explain:
3. Based on the number of hours requested, outline a weekly schedule for the member including the number of Intermittent SCL hours used per day.

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Example:	2 hrs. SCL	4 hrs. SCL	2 hrs. SCL			

4. In addition to Intermittent SCL, does the member access additional services?
   ☐ Yes ☐ No ☐ N/A

   If yes, please indicate what other services are accessed and the number of hours authorized for each service listed. Outline the weekly schedule of these services on the chart above.

Supporting Documents: Email the following to exceptions@hhs.iowa.gov on behalf of the member.

☐ Current Person-Centered Service Plan (PCSP)

☐ CCO budget (if applicable)

Reminder: Include the member's name and State ID in the body of the email that contains the supporting documents sent on behalf of the member.

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Variance Request to Access Daily SCL:

- Member is under the age of 16 requesting to reside in a licensed or certified RBSCL setting.
- Member is under the age of 16 requesting access to Daily SCL services **outside** a licensed or certified RBSCL setting.
- Member is under the age of 18 requesting access to Daily SCL services with others in the setting over the age of 18.

1. Has the member's parent or guardian provided written consent for utilization of Daily SCL services?

   ☐ Yes ☐ No ☐ N/A

2. List member's current diagnoses:
3. Outline the member's current overall status and justification to support utilization of Daily SCL.

4. Explain why in-home supports are no longer able to meet the needs of the member.

5. Is there a plan for the member to return to the family or foster home if improvement is demonstrated? ☐ Yes ☐ No ☐ N/A

   If yes, please explain:

6. Does the member have any current or historical behavior concerns?
   ☐ Yes ☐ No ☐ N/A

   If yes, please explain:

7. Does the member have a Behavior Support Plan?
   ☐ Yes ☐ No ☐ N/A
8. Are there current court orders in effect for the member?
   ☐ Yes ☐ No ☐ N/A

   If yes, please explain the purpose of the court order:

9. Does the member have current or historical legal matters?
   ☐ Yes ☐ No ☐ N/A

   If yes, please explain and include current status of legal matter.

10. Is Health and Human Services or a Juvenile Court Officer involved?
    ☐ Yes ☐ No ☐ N/A

    If yes, please explain and include contact information:

11. List member's medical history (including major illnesses):
12. Outline the member's current or historical behavior concerns.

13. Outline how a provider should address the member's current or historical behavior concerns to ensure the safety of staff and other members.
14. Will the member be attending school?
    ☐Yes ☐No ☐N/A
15. If the member will be attending school, outline the plan for the provider to ensure school is attended as required. Include details of transportation and the communication plan for the provider with the school.
16. List all individuals of the member's planning team who agree with the proposed plan for the member to access Daily SCL services (such as, but not limited to, the youth, parent, guardian, GAL, HHS, Court, Case Manager).
17. List of denials from alternative residential options (including in-state, Therapeutic Foster Care/Foster Home, family home, out-of-state):

Proposed Living Environment

1. What is the proposed living environment?
2. What is the address of the proposed living environment?
3. Will the member have roommates?
   ☐ Yes ☐ No ☐ N/A
4. If the member will have roommates in the proposed location, what are their genders and ages?
5. If the member will have roommates in the proposed location, have they had an opportunity to meet?
   ☐ Yes ☐ No ☐ N/A

   If yes, please explain results of meet and greet and member compatibility:
6. Is the member able to pay room and board costs in their proposed location?
   ☐ Yes ☐ No ☐ N/A
7. What is the member's source to pay for their room and board? (Examples: Supplemental Security Income (SSI), child support, adoption subsidy, private funds)

Proposed Provider Information

All providers of the service setting requested must agree to meet the following additional safety and service requirements for serving members under the age of 18:

- Members under the age of 18 shall receive 24-hour site supervision and support.
- Members under the age of 18 may not reside in settings with other members over the age of 21.
- The service plan shall specifically identify educational services and support for members who have not obtained a high school diploma or equivalent.
- For members who have obtained a high school diploma or equivalent, supported employment/additional training/educational supports shall be included in the service plan.

1. What is the name of the proposed service provider?
2. What is the NPI of the proposed service provider?

Supporting Documents

Identify the supporting documents below that will be emailed to exceptions@hhs.iowa.gov on behalf of the member (if applicable).

☐ CASH/CALOCUS or interRAI-ID assessment

☐ Current Person-Centered Service Plan (PCSP)

☐ Updated Social History

☐ Current HHS Case Permanency Plan

☐ Court order

☐ Behavior Support Plan

☐ Current psychiatric information (within the last 6 months)

☐ Current psychological assessment/evaluation report (include any psychological testing results)

☐ Proposed service plan from the Daily SCL or Residential Based Supported Community Living (RBSCL) provider, including preliminary discharge plan

☐ Individual Education Program (IEP) (if applicable)

☐ Permission from parent/guardian for transition

☐ Approval/Acceptance letter from provider

☐ Proposed provider's policies and procedures that outline their ability to serve members under the age of 18

Reminder: Include the member's name and State ID in the body of the email that contains the supporting documents sent on behalf of the member.