pennsylvania
DEPARTMENT OF HUMAN SERVICES
OFFICE OF DEVELOPMENTAL PROGRAMS

Consolidated, Person/Family Directed Support and Community Living Waiver Variance Form

General Information

NAME OF INDIVIDUAL:	DOB:	MCI NUMBER OF INDIVIDUAL:
WAIVER THE INDIVIDUAL IS ENROLLED OR ENROLLING IN (CHOOSE ONE): ☐ Person/Family Directed Support ☐ Community Living ☐ Consolidated		
SUPPORTS COORDINATION ORGANIZATION:		
SUPPORTS COORDINATOR NAME:	SUPPORTS COORDINATOR EMAIL ADDRESS:	

	Type of variance being requested (check all that apply):	Corresponding section of the form to be completed:	Entity responsible for approval:
☐	Community Participation Support standard (Request for individual to spend less than 25% of service time in community settings.)	Section 1: Community Participation Support Standard	ISP Team
☐	Community Participation Support with 1:1 enhanced staffing, 2:1 staffing and/or 2:1 enhanced staffing (6-month review required)	Section 2: Enhanced Levels of Service	Administrative Entity
☐	In-Home and Community Support with 2:1 staffing and/or 2:1 enhanced staffing (6-month review required)	Section 2: Enhanced Levels of Service	Administrative Entity
☐	Supplemental Habilitation (Request to exceed 90 calendar days.)	Section 2: Enhanced Levels of Service	Administrative Entity
☐	More than 14 hours daily of In-Home and Community Support, Companion, and/or Community Participation Support	Section 3: Intensive Staff Support	ODP
☐	Respite (Request to exceed limits on 15 minute and/or day units.)	Section 4: Respite	ODP
☐	Respite (A residential setting that will exceed approved program capacity or in a home with approved program capacity for five to eight for emergency circumstances or to meet medical or behavioral needs, a nursing facility, a private ICF/ID, a residential location that is not funded through the waiver.)	Section 4: Respite	ODP
☐	Respite (Request for a child under age 21 with medical needs that require Respite by a licensed nurse.)	Section 4: Respite	ODP
☐	Assistive Technology	Section 5: Assistive Technology	ODP
☐	Home Accessibility Adaptations	Section 6: Home Accessibility Adaptations	ODP

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Section 1 – Community Participation Support

Provider 1 Information	Provider 2 Information
MPI:	MPI:
SERVICE LOCATION CODE:	SERVICE LOCATION CODE:
SERVICE LOCATION ADDRESS:	SERVICE LOCATION ADDRESS:
PROVIDER CONTACT NAME:	PROVIDER CONTACT NAME:
PROVIDER CONTACT EMAIL:	PROVIDER CONTACT EMAIL:

Reason for Variance Request (check all that apply):

The individual:

- ☐ Receives fewer than 12 hours (48 units) per week of Community Participation Support from the provider(s).
- ☐ Has current medical needs that limit the amount of time he or she can safely spend in the community.
- ☐ Has an injury, illness, behaviors, or change in mental health status that results in a risk to themselves or others.
- ☐ Declines the option to spend time in the community having been provided with opportunities to do so consistent with his or her preferences, choices, and interests.

Describe the circumstances or condition requiring a variance. Include a summary of the approaches taken to address the individual's circumstances or condition and/or explore the individual's interests and preferences. As appropriate, describe future efforts to offer opportunities for community experience for the individual. Describe whether the variance will only apply to a specific time period.

ISP Team to Complete:	
DATE OF ISP TEAM DETERMINATION/APPROVAL DATE:	DATE VARIANCE EXPIRES (NEXT ANNUAL REVIEW UPDATE DATE):
DATE THE SUPPORTS COORDINATOR FORWARDED THE APPROVED VARIANCE FORM TO THE ADMINISTRATIVE ENTITY FOR INFORMATIONAL PURPOSES:	
DATE THE SUPPORTS COORDINATOR FORWARDED THE APPROVED VARIANCE FORM TO THE PROVIDER:	

Section 2 – Enhanced Levels of Service

REQUESTED EFFECTIVE DATE OF VARIANCE:

Provider 1 Information	Provider 2 Information
MPI:	MPI:
SERVICE LOCATION CODE:	SERVICE LOCATION CODE:
SERVICE LOCATION ADDRESS:	SERVICE LOCATION ADDRESS:
PROVIDER CONTACT NAME:	PROVIDER CONTACT NAME:
PROVIDER CONTACT EMAIL:	PROVIDER CONTACT EMAIL:

Reason for Variance Request (check all that apply):

- ☐ An Annual Review ISP that includes 1:1 enhanced staffing (Level 3 Enhanced), 2:1 staffing (Level 4) and/or 2:1 Enhanced staffing (Level 4 Enhanced) for Community Participation Support.
- ☐ An Annual Review ISP that includes 2:1 staffing (Level 3) and/or 2:1 enhanced staffing (Level 3 Enhanced) for In-Home and Community Support.
- ☐ A Critical Revision ISP that includes an initial request for 1:1 enhanced staffing (Level 3 Enhanced), 2:1 staffing (Level 4) and/or 2:1 enhanced staffing (Level 4 Enhanced) for Community Participation Support.
- ☐ A Critical Revision ISP that includes an initial request for 2:1 staffing (Level 3) and/or 2:1 enhanced staffing (Level 3 Enhanced) for In-Home and Community Support.
- ☐ A six-month review that includes an ongoing request for 2:1 staffing (Level 3) and/or 2:1 enhanced staffing (Level 3 Enhanced) for In-Home and Community Support.
- ☐ A six-month review that includes an ongoing request for 1:1 enhanced staffing (Level 3 Enhanced), 2:1 staffing (Level 4) and/or 2:1 enhanced staffing (Level 4 Enhanced) for Community Participation Support.
- ☐ A Critical Revision ISP that includes a request that Supplemental Habilitation previously approved for 90 days be extended. The Administrative Entity should advise the Regional Office if the second request for Supplemental Habilitation is approved.

NUMBER OF UNITS CURRENTLY AUTHORIZED:	NUMBER OF UNITS REQUESTED:
SERVICE CODES CURRENTLY AUTHORIZED:	SERVICE CODES REQUESTED:
For Supplemental Habilitation only, describe the staffing schedule in the home prior to the individual's need for supplemental habilitation.	

Section 2 – Enhanced Levels of Service (continued)

Provide a detailed explanation of the mental health, behavioral, and/or medical reason(s) the individual needs the enhanced support requested:
Provide the health and safety reasons for this level of supervision. Describe the risk the individual presents to himself/herself or others if this support is not provided:
Identify alternatives or less intensive supports that have been explored. Examples include but are not limited to medical evaluation, assistive technology, natural supports, and/or HCQU consultation:
Describe the strategies that **have** shown positive results in the last 12 months (not applicable for Supplemental Habilitation):
Describe the strategies that **have not** shown positive results in the last 12 months (not applicable for Supplemental Habilitation):

Section 2 – Enhanced Levels of Service (continued)

Describe the plans for the reduction or discontinuance of this level of staff support:
Describe what data will be collected or information that will be maintained to determine the effectiveness of intensive staffing and the progress being made to reducing the level of support:
If the individual's circumstance or condition is not expected to change and a reduction in support is not considered feasible, please explain:
For Supplemental Habilitation requests extending beyond 90 days, provide date of SIS reassessment or needs exception request. (Please verify that this information is reflected in the ISP.) Describe the reason that Residential Habilitation without day is not sufficient to meet the individual's needs:

Section 2 – Enhanced Levels of Service (continued)

Administrative Entity to Complete:	
DATE ADMINISTRATIVE ENTITY RECEIVED VARIANCE FORM:	ADMINISTRATIVE ENTITY REVIEWER:
DATE RETURNED TO SUPPORTS COORDINATION ORGANIZATION WHEN MORE INFORMATION IS NEEDED:	
REASON VARIANCE FORM RETURNED TO SUPPORTS COORDINATION ORGANIZATION/INFORMATION REQUESTED:	
DATE ADMINISTRATIVE ENTITY RECEIVED INFORMATION FROM SUPPORTS COORDINATION ORGANIZATION:	
ADMINISTRATIVE ENTITY DECISION: ☐ Approved as requested ☐ Approved with the following modifications: _____ ☐ Denied. Reason for denial: _____	
WHEN APPROVED, DATE VARIANCE BEGINS:	WHEN APPROVED, DATE VARIANCE EXPIRES:
IF THIS IS A SECOND 90-DAY EXTENSION OF SUPPLEMENTAL HABILITATION, LIST THE DATE A COPY OF THIS VARIANCE FORM WAS SENT TO THE APPROPRIATE ODP REGIONAL OFFICE:	

Section 3 – Intensive Staff Support

REQUESTED EFFECTIVE DATE OF VARIANCE:

Provider 1 Information	Provider 2 Information
MPI:	MPI:
SERVICE LOCATION CODE:	SERVICE LOCATION CODE:
SERVICE LOCATION ADDRESS:	SERVICE LOCATION ADDRESS:
PROVIDER CONTACT NAME:	PROVIDER CONTACT NAME:
PROVIDER CONTACT EMAIL:	PROVIDER CONTACT EMAIL:
Provider 3 Information	**Provider 4 Information**
MPI:	MPI:
SERVICE LOCATION CODE:	SERVICE LOCATION CODE:
SERVICE LOCATION ADDRESS:	SERVICE LOCATION ADDRESS:
PROVIDER CONTACT NAME:	PROVIDER CONTACT NAME:
PROVIDER CONTACT EMAIL:	PROVIDER CONTACT EMAIL:

Reason for Variance Request (check one):

☐ An Annual Review ISP that includes more than 14 hours daily of In-Home and Community Support, Companion and/or Community Participation Support (whether authorized alone or in combination with one another).

☐ A Critical Revision ISP that includes an initial request for more than 14 hours daily of In-Home and Community Support, Companion and/or Community Participation Support (whether authorized alone or in combination with one another).

a. Does this request vary from current authorized services? ☐ Yes ☐ No If yes, provide an explanation for the change.
b. Describe why this requested amount of support is needed and what the health and safety reasons are for this level of services:
c. Have other community or non-waiver resources been contacted or utilized (i.e. HCQU)? If yes, list the resources and outcome. If no, why have other resources not been contacted or used?

Section 3 – Intensive Staff Support (continued)

d. Describe the risk the individual presents to himself/herself or others if this requested support is not provided:

e. Have other alternatives or less intensive supports been explored (such as a medical evaluation, use of technology, etc.)? If yes, please describe.

f. What are the plans for the reduction or discontinuance of this level of staff support? What data will be collected/information maintained to determine the effectiveness of intensive staffing and the progress being made to reducing the level of support? If the individual's circumstance or condition is not expected to change and a reduction in support is not considered feasible, please explain. (Please verify that this information is reflected in the ISP.)

List the requested daily schedule of In-Home and Community Support, Companion, and/or Community Participation Support for a one-week period.

KEY: CPS – Community Participation Support
IHCS – In-Home and Community Support
Comp – Companion

	SUN	MON	TUE	WED	THUR	FRI	SAT
START TIME							
END TIME							
SERVICE	☐ CPS ☐ IHCS ☐ Comp	☐ CPS ☐ IHCS ☐ Comp	☐ CPS ☐ IHCS ☐ Comp	☐ CPS ☐ IHCS ☐ Comp	☐ CPS ☐ IHCS ☐ Comp	☐ CPS ☐ IHCS ☐ Comp	☐ CPS ☐ IHCS ☐ Comp
START TIME							
END TIME							
SERVICE	☐ CPS ☐ IHCS ☐ Comp	☐ CPS ☐ IHCS ☐ Comp	☐ CPS ☐ IHCS ☐ Comp	☐ CPS ☐ IHCS ☐ Comp	☐ CPS ☐ IHCS ☐ Comp	☐ CPS ☐ IHCS ☐ Comp	☐ CPS ☐ IHCS ☐ Comp
START TIME							
END TIME							
SERVICE	☐ CPS ☐ IHCS ☐ Comp	☐ CPS ☐ IHCS ☐ Comp	☐ CPS ☐ IHCS ☐ Comp	☐ CPS ☐ IHCS ☐ Comp	☐ CPS ☐ IHCS ☐ Comp	☐ CPS ☐ IHCS ☐ Comp	☐ CPS ☐ IHCS ☐ Comp

Section 3 – Intensive Staff Support (continued)

Administrative Entity to Complete:	
DATE ADMINISTRATIVE ENTITY RECEIVED VARIANCE FORM:	ADMINISTRATIVE ENTITY REVIEWER:
DATE RETURNED TO SUPPORTS COORDINATION ORGANIZATION WHEN MORE INFORMATION IS NEEDED:	
REASON VARIANCE FORM RETURNED TO SUPPORTS COORDINATION ORGANIZATION/INFORMATION REQUESTED:	
DATE ADMINISTRATIVE ENTITY RECEIVED INFORMATION FROM SUPPORTS COORDINATION ORGANIZATION:	
ADMINISTRATIVE ENTITY RECOMMENDATION: ☐ Approved as requested ☐ Approved with the following modifications: _____ ☐ Denied. Reason for denial: _____	
DATE ADMINISTRATIVE ENTITY FORWARDED VARIANCE FORM TO THE APPROPRIATE ODP REGIONAL OFFICE:	

Section 4 – Respite

REQUESTED START DATE(S):	REQUESTED END DATE(S)

Provider 1 Information	Provider 2 Information
MPI:	MPI:
SERVICE LOCATION CODE:	SERVICE LOCATION CODE:
SERVICE LOCATION ADDRESS:	SERVICE LOCATION ADDRESS:
PROVIDER CONTACT NAME:	PROVIDER CONTACT NAME:
PROVIDER CONTACT EMAIL:	PROVIDER CONTACT EMAIL:

Is this a request for Emergency Respite? ☐ Yes ☐ No

Will the requested Respite be provided as a participant-directed service? ☐ Yes ☐ No

Is this a continuation of a previously-approved Respite request? ☐ Yes ☐ No

If yes, last approval range: _____

Reason for variance request (check one):

- ☐ Initial request for Respite for a child (under age 21) with a licensed nurse.
- ☐ 15-minute units beyond 480 units per fiscal year for an individual enrolled in the Consolidated Waiver.
- ☐ 15-minute units beyond 1440 units per fiscal year for an individual enrolled in the P/FDS or Community Living Waivers.
- ☐ Day units beyond 30 days in a fiscal year for an individual enrolled in the Consolidated, P/FDS, or Community Living Waivers.
- ☐ Respite in a home licensed under 55 Pa. Code Chapter 6400, 3800, or 5310 that meets one or more of the following:
  - Providing Respite will exceed the home's approved program capacity.
  - The home is in a contiguous location and/or campus setting.
  - The home has approved program capacity of 5 to 8 individuals, with Respite provided for emergency circumstances or to meet medical or behavioral needs.
- ☐ Respite provided in a hotel.
- ☐ Respite provided in a private licensed intermediate care facility for individuals with an intellectual disability (55 Pa. Code 6600) or a licensed nursing home.

If this request is for a unit increase above the waiver limit, provide the following information:	
THE NUMBER OF UNITS CURRENTLY AUTHORIZED:	THE NUMBER OF UNITS BEING PROPOSED:
CURRENT PROCEDURE CODE(S):	PROPOSED PROCEDURE CODE(S):

Complete for all Respite variance requests. Provide a brief description of the location where Respite will be provided:

Section 4 – Respite (continued)

Complete for all Respite variance requests except Respite by a nurse for a child. Describe the circumstances requiring a variance. (Include information about the time period for desired exception, efforts taken to address the situation, plans to avoid a recurrence when possible.) If the request is to provide respite in a setting that requires a variance (hotels, non-waiver funded residential settings, nursing homes, etc.), describe:

1. The individual's medical or behavioral needs or the emergency circumstance; and
2. Attempts to locate a Respite provider to render the service in a community setting.

When the variance is to request Emergency Respite beyond the home's approved capacity, or in a hotel, or Respite in a private ICF/ID or Licensed Nursing Home, provide the following:

1. The individual's current living situation.
2. A summary describing the nature of the emergency including any other funding options that are available or what natural supports are available.
3. Current program/funding type associated with the individual.
4. The supports that the individual will need while in Respite.
5. The expected duration of the Respite.

When the variance is to request Respite for a child (under age 21) who has medical needs that require Respite by a nurse, document the following:

- The number of hours per day that child is authorized to receive nursing through private insurance or Medical Assistance;
- The activities that require care by a licensed nurse (administration of intravenous fluid or medication, use of monitoring, defibrillating or resuscitating equipment, or a combination of the three; or other skilled activities that must be provided by a nurse);
- Whether the Respite is to be provided by a RN or LPN.

Section 4 – Respite (continued)

Administrative Entity to Complete:	
DATE ADMINISTRATIVE ENTITY RECEIVED VARIANCE FORM:	ADMINISTRATIVE ENTITY REVIEWER:
DATE RETURNED TO SUPPORTS COORDINATION ORGANIZATION WHEN MORE INFORMATION IS NEEDED:	
REASON VARIANCE FORM RETURNED TO SUPPORTS COORDINATION ORGANIZATION/INFORMATION REQUESTED:	
DATE ADMINISTRATIVE ENTITY RECEIVED INFORMATION FROM SUPPORTS COORDINATION ORGANIZATION:	
ADMINISTRATIVE ENTITY RECOMMENDATION: ☐ Approved as requested ☐ Approved with the following modifications: _____ ☐ Denied. Reason for denial: _____	
DATE ADMINISTRATIVE ENTITY FORWARDED VARIANCE FORM TO THE APPROPRIATE ODP REGIONAL OFFICE:	

Section 5 – Assistive Technology

REQUESTED EFFECTIVE DATE OF VARIANCE:

Provider 1 Information	Provider 2 Information
MPI:	MPI:
SERVICE LOCATION CODE:	SERVICE LOCATION CODE:
SERVICE LOCATION ADDRESS:	SERVICE LOCATION ADDRESS:
PROVIDER CONTACT NAME:	PROVIDER CONTACT NAME:
PROVIDER CONTACT EMAIL:	PROVIDER CONTACT EMAIL:

Assistive Technology Lifetime Limit	
ITEM, EQUIPMENT, OR PRODUCT REQUESTED:	TOTAL AMOUNT OF ITEM, EQUIPMENT, OR PRODUCT REQUESTED:
LIFETIME AMOUNT USED:	ADDITIONAL AMOUNT REQUESTED (BEYOND $10,000):

Summarize results of independent evaluation, including name of organization or professional conducting the review. (Evaluation may be submitted as an attachment.)
Provide or explain documentation obtained to determine that the item, equipment, or product requested is not covered through the Medical Assistance State Plan, Medicare, and/or private insurance.
Describe circumstances requiring a variance to the established limit. (Specify what other less costly alternatives have been considered or used and why each was determined not to be an effective option.)

Section 5 – Assistive Technology (continued)

Administrative Entity to Complete:	
DATE ADMINISTRATIVE ENTITY RECEIVED VARIANCE FORM:	ADMINISTRATIVE ENTITY REVIEWER:
DATE RETURNED TO SUPPORTS COORDINATION ORGANIZATION WHEN MORE INFORMATION IS NEEDED:	
REASON VARIANCE FORM RETURNED TO SUPPORTS COORDINATION ORGANIZATION/INFORMATION REQUESTED:	
DATE ADMINISTRATIVE ENTITY RECEIVED INFORMATION FROM SUPPORTS COORDINATION ORGANIZATION:	
ADMINISTRATIVE ENTITY RECOMMENDATION: ☐ Approved as requested ☐ Approved with the following modifications: _____ ☐ Denied. Reason for denial: _____	
DATE ADMINISTRATIVE ENTITY FORWARDED VARIANCE FORM TO THE APPROPRIATE ODP REGIONAL OFFICE:	

Section 6 – Home Accessibility Adaptations

REQUESTED EFFECTIVE DATE OF VARIANCE:

Provider 1 Information	Provider 2 Information
MPI:	MPI:
SERVICE LOCATION CODE:	SERVICE LOCATION CODE:
SERVICE LOCATION ADDRESS:	SERVICE LOCATION ADDRESS:
PROVIDER CONTACT NAME:	PROVIDER CONTACT NAME:
PROVIDER CONTACT EMAIL:	PROVIDER CONTACT EMAIL:

Type of Home Accessibility Adaptation Request (check one):

- ☐ Maintenance or repair to existing Home Accessibility Adaptation
- ☐ Track lift system
- ☐ Additional doorway to ensure safe egress

TOTAL AMOUNT REQUESTED:	LIFETIME AMOUNT USED:	ADDITIONAL AMOUNT (BEYOND $20,000) REQUESTED:

Explain the planned adaptation or lift system. (For maintenance and repair, include:

1. Verification that it is not covered by a warranty or homeowner's insurance; and,
2. How it was determined to be a cost-effective option, including more cost-effective than replacement. For lift systems, describe how the system will reduce the need for other services. For an additional doorway, describe circumstances requiring an exception, including current means of egress.)

Describe or provide documentation used to determine that this proposed Home Accessibility Adaptation meets the needs of the individual:

Section 6 – Home Accessibility Adaptations (continued)

Administrative Entity to Complete:	
DATE ADMINISTRATIVE ENTITY RECEIVED VARIANCE FORM:	ADMINISTRATIVE ENTITY REVIEWER:
DATE RETURNED TO SUPPORTS COORDINATION ORGANIZATION WHEN MORE INFORMATION IS NEEDED:	
REASON VARIANCE FORM RETURNED TO SUPPORTS COORDINATION ORGANIZATION/INFORMATION REQUESTED:	
DATE ADMINISTRATIVE ENTITY RECEIVED INFORMATION FROM SUPPORTS COORDINATION ORGANIZATION:	
ADMINISTRATIVE ENTITY DECISION: ☐ Approved as requested ☐ Approved with the following modifications: _____ ☐ Denied. Reason for denial: _____	
DATE ADMINISTRATIVE ENTITY FORWARDED VARIANCE FORM TO THE APPROPRIATE ODP REGIONAL OFFICE:	