Choices for Care AFC Home Tier Variance Request Form | CFC708

Variance Criteria

A variance will only be approved in situations in which the additional funding is necessary to protect or maintain the health, safety, or welfare of the individual. (See CFC Regulations, Section XI.)

Variance Requests shall be submitted by the AFC Authorized Agency and shall include the following (please feel free to submit in a separate word document in the below format if more space is needed):

1. The tier rate being requested.
2. An explanation of why the individual's specific care needs cannot be met with the current tier rate.
3. A description of the actual/immediate risk posed to the individual's health, safety or welfare.
4. The intended goals and outcomes for the individual.
5. Other options that have been explored to meet the unmet need.
6. Other important information
7. Budget Request

Client Name: ____ **Date of Birth:** ___________________
Mailing address: ____
Current location (if different than mailing): ____

Authorized Agency submitting the request: ____
Name of the person completing this form: _____________________________Phone: ____________________

1. Current Tier rate from AFC ILA: __________ Requested daily rate variance: __________

2. Please explain the individual's specific **unmet** care needs and describe why they cannot be met with the current tier.

3. Please give a description of the actual and/or immediate risk posed to the individual's health, safety, or welfare.

4. Describe the intended goals and outcomes for this individual.

5. Please describe other options that have been explored to meet the individual's unmet need.

6. Please provide information about current respite budget and what funding has been used:

7. Please attach the proposed budget sheet to include respite budget, home care provider stipend and service coordination as well as any other information you feel is important and useful.

To submit the request:
Upload the completed document to the DAIL database.
Send an alert to CFC Program Supervisors at: "LTCCC alert Supervisors"
Or fax to (802) 241-0385 Attention: ASD

DAIL Decision:
☐Approved Tier Rate: __________ ☐Partial Approval ☐Request Denied
LTCCC: ________________________________
Comments: ____

DAIL Authorized Signature: ____________________________________ Date: ____________

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Client Care Needs

___ Two Person Assist in 1 or more ADLs: ____

___ Medical Treatments: ____

___ Neurological Diagnosis: ____

___ Dementia/Alzheimer's Diagnosis

___ Memory and Use of Information:

- ___No Difficulty
- ___ Minimal Difficulty (cueing 1-3x/day)
- ___ Difficulty Remembering (cuing 4+ x/day)
- ___ Cannot Remember

___Decision making regarding tasks of daily life:

- ___ Independent (decisions consistent/reasonable)
- ___ Modified Independence (some difficulty in new situations)
- ___ Moderately Impaired (decisions poor; cues/supervision)
- ___ Severely Impaired (never/rarely makes decisions)

___ Behaviors: ___ Wandering ___ Verbal Aggression ___ Physical Aggression
___ Socially Inappropriate ___ Resistant to Care

___ Psychiatric Diagnosis: ____

___Treatment plan: ____

___ High Risk Factors: ___ Alcohol dependency ___ Drug dependency ___Smoking

Client Social History

___ Self-Neglect: ____

___ Dangerous Behaviors: ____

___ Adult Protective Services: ____

___ Incarceration history: ______________________ ___Sexual Offender History___________________________