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; and a copy of the home care provider contract 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: _____

☐ ___ Incarcera☐ history: _____ ___Sexual Offender History_____