**WV I/DD Waiver**

**Direct Support Services – Living Arrangement Assessment Short Form**

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| Guidance for completion. |
| This assessment would be appropriate to complete for individuals who recently received a funded slot, those currently in Crisis/State Hospital/Psychiatric Care, or those that wish to change their current living arrangement to a more costly environment including and limited to:* *Natural Family to LGH 4+/ISSx2/ISSx3*
* *ICF and/or LGH4+ to ISSx2/ISSx3*
* *ISSx3 to ISSx2*

Those pursuing a change to their current living arrangement to an ISSx1 or ISSx1 Personal Options MUST utilize the Direct Support Services – Living Arrangement Assessment Long Form in order to be considered. The Bureau for Medical Services (BMS) does not advise teams regarding an individual’s chosen living arrangement; however, prior authorization is required if the chosen living arrangement results in a more expensive array of services for the individual. Forms completed in full MUST be emailed to WVIDDWaiver@acentra.com with supporting documentation as necessary in order to be processed. |

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| Section 1. General Information (complete this section for all requests) |
| Date Submitted: | **Click here to enter a date.** |
| Name of Person Who Receives Services: | **Click here to enter text.** | Record ID: | **Click here to enter text.** |
| Anchor Date: | **Click here to enter a date.** |
| Anticipated Start Date of Service Request: | **Click here to enter a date.** |
| Case Management Provider Agency: | **Click here to enter text.** |
| Residential Services Provider Agency: | **Click here to enter text.** |
| Name of person submitting request:  | **Click here to enter text.** |
| Phone #/Extension: | **Click here to enter text.** |
| Email Address: | **Click here to enter text.** |

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| Section 2. Summary of Request: (complete this section for all requests) |
| Please include a brief description of the circumstances related to the requested change in services. If the member has behavioral or medical needs – describe in as much detail available to you the circumstances and how/why those needs necessitate a more restrictive environment. Supporting documentation may be requested related to behaviors/medical concerns. **Click here to enter text.** |
| Living Arrangement Requested:  |
| [ ]  ISS x2 |
| [ ]  ISS x3 |
| [ ]  Group Home 4+  |

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| Section 3. Roommate Review (complete this section for all requests—indicate the individual’s current and planned roommates, as applicable) |
| Record ID for Current Roommate(s) | Record ID for Planned Roommate(s) |
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| Section 4. Anticipated Member Need (complete this section for all requests—indicate, based on information available, how many hours of 1:1 the team feels will meet the members needs and how many hours/days the member requires. Some members receive natural support, so you may estimate on average how many hours/days the member requires. Indicate how many CM units are required for the full year, because it is a required authorization to seek an Exception.) |
| **Anticipated hours/day of 1:1**  |
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| **How many hours/days of direct-care services will the member require?** |
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| **How many CM units are required for the remainder of the service year?** |
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Recommendations will be for Living Setting only, except for those cases where the budget will not support required direct-care hours under-budget. In those cases, a recommendation will be made for approximately 60 days of 1:1 in the hours anticipated to meet the member’s needs, and all remaining direct-care services will be allocated to lower ratios. This will allow the team to obtain authorizations and seek an Exception.

\*ISS setting = Unlicensed or Licensed 24-hour site\*\*

BMS/UMC use only below this line.

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| Anticipated Date of Move or Change: | Anchor Date: | # of Days Between Date of Move/Change and Anchor Date: |
|  |  |  |
| Living Setting at Time of Annual Functional Assessment: | Living Setting Requested: |
| [ ]  Natural Family/SFCP | [ ]  ISS x2 |
| [ ]  ISS x1 | [ ]  ISS x3 |
| [ ]  ISS x2 | [ ]  Group Home 4+  |
| [ ]  ISS x3 |  |
| [ ]  Group Home 4+  |  |
| Describe the Circumstances of the Change: |
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**Approval of Request is:**

[ ]  RECOMMENDED:

[ ]  RECOMMENDED CONDITIONALLY:

[ ]  NOT RECOMMENDED

Name of Acentra Health staff reviewing request:

Date of Acentra Health review:

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| **BMS Decision:**  |
| [ ]  Approved as Requested: |
| [ ]  Approved Conditionally:  |
| [ ]  Not Approved: |

Name of BMS staff reviewing request:

Date of BMS review: