**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](mailto: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: