DEPARTMENT OF HEALTH SERVICES **STATE OF WISCONSIN**
Division of Medicaid Services
F-21059 (03/2017)

VARIANCE REQUEST FOR INSTITUTIONAL RESPITE

A variance request is required under the Human Service Reporting System SPC 103.24. Use of this form is optional.

Name – CM/SSC or Social Worker	County/Agency	Date of Request
Email Address		Telephone No.

Name – COP-W / CIP II / CIP Participant

Name – Person Requiring Respite	Relationship to Participant

Reason/Circumstance for Respite

Name and Location of Hospital/Nursing Home/ICF-MR

Is this facility certified for Medicaid? ☐ Yes ☐ No
If Yes, continue below. **If No, STOP**. Only facilities certified as Medicaid providers may be used for institutional respite. This variance for institutional respite cannot be approved. You must choose a Medicaid-certified facility.

Respite Cost per Day:

1. Anticipated length of respite placement—check one
   ☐ One-time only request—specify dates/duration of respite stay:

   ☐ Request for recurring stay at this facility. If yes, what is the frequency of the respite requested? [example, one weekend/month, or up to X days/year (specify planned days), etc]

2. Respite Request Narrative—address the following:
   a. Why can't an AFH, CBRF or RCAC be utilized or, the hours of in-home respite or SHC increased, or other waiver services be provided to meet this need?

   b. Describe this facility—why was this specific facility chosen?

   c. What is being done or put in place to make the participant's stay at the facility as pleasant and non-disruptive as possible?

☐ Approved ☐ Denied	**SIGNATURE** – QAC or CIS	Date Approved/Denied

Reason for denial (if applicable)