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| Customized Rate Request for Pre-Review |
| **Intent:** This form is intended for the purpose of requesting committee review of customized rate funding prior to submitting a formal application in the Waiver Management System (WaMS). **When to use this form:** Providers should only use this form if one of the following prevents the use of WaMS when submitting an application: * The individual does not have a Supports Intensity Scale
* The individual is not actively enrolled in a Waiver Program
* The individual does not have an assigned Support Coordinator

**Submission:** Providers should send this form via email to: dbhdscustomizedrate@dbhds.virginia.gov. Providers should make every attempt to collect and submit relevant supplemental documentation to support the request. **Process:** Once submitted, the customized rate review committee will schedule a review meeting and make a determination. The provider will be notified of the committee decision in writing. Approval of a pre-reviewed customized rate does not guarantee a customized rate. Providers are required to submit an application in WaMS for final approval.  |

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| V1: 11-6-2020 |

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| **SECTION 1: INDIVIDUAL INFORMATION** |
| **Individual Name** | **First Name:**      **Last Name:**      |
| **Date Submitted**  | Click here to enter a date. |
| **Individual DOB**  |       |
| **Individual Medicaid #** |       |
| **Height/Weight** | **Height:**      **Weight:**       |
| **Current Medical Diagnosis** |       |
| **Current DSM-V Diagnosis** |       |
| **CSB/BHA** | Choose an item. |
| **Where Is the Individual currently residing?** | Choose an item.Other:       |
| **Has the individual been accepted into services?** | [ ]  **Yes** [ ]  **No****Expected start date of services:**       |
| **SECTION 2: PROVIDER INFORMATION**  |
| **Provider Name & Contact** | **Provider Name:**      **Point of Contact:**       **Phone:**      **Email:**       |
| **Provider Business Address** | **Street Address:**      **City, State, Zip:**       |
| **Address where supports will be provided**  | **Street Address:**      **City, State, Zip:**       |
| **How many individuals is the home licensed to support?** | Choose an item. |
| **How many individuals are currently supported in the home?** | Choose an item. |
| **Under what service is pre-review of a customized rate requested?** | Choose an item. |
| **SECTION 3: PROGRAM OVERSIGHT**  |
| **Is Program Oversight Requested?**Program Oversight: Oversight that is associated with the need for higher qualified supervision of direct support to ensure key programmatic elements related to the individual’s exceptional support needs are carried out in a safe and effective manner. This supervision must be provided by staff with a higher level of expertise than routinely required by Qualified Developmental Disabilities and whose expertise is not available through contracting for professionals which are Medicaid waiver vendors. (Credentials Required)  | [ ]  **Yes:** List the staff information below[ ]  **No:** Skip the remainder of this section |
| **Name of Staff**  | **Description of Supports Provided** |
|       |       |
|       |       |
|       |       |
|       |       |
|       |       |
| **SECTION 4:ONE TO ONE SUPPORT**  |
| **Are One to One Supports Requested?** | [ ]  **Yes:** Summary:     [ ]  **No:** Skip the remainder of this section |
| **Indicate the total hours requested for staffing direct support at a 1:1 ratio with STANDARD staffing.** |  | **Total Hours Requested** | **Timeframe that supports will occur** |
| **Monday** |       |       |
| **Tuesday**  |       |       |
| **Wednesday** |       |       |
| **Thursday** |       |       |
| **Friday** |       |       |
| **Saturday** |       |       |
| **Sunday** |       |       |
| **Is SPECIALIZED 1:1 staffing requested?**Specialized Staffing: Direct support provided by professionals who have a higher level of expertise which is required to ensure proper supports is given based on the individual’s exceptional support need.(Credentials Required)  | [ ]  **Yes:** Indicate the hours requested below[ ]  **No:** Skip this question |
|  | **Total Hours Requested** | **Timeframe that supports will occur** |
| **Monday** |       |       |
| **Tuesday**  |       |       |
| **Wednesday** |       |       |
| **Thursday** |       |       |
| **Friday** |       |       |
| **Saturday** |       |       |
| **Sunday** |       |       |
| **Are One to One supports requested overnight?**  | [ ]  **Yes:** Summary:     [ ]  **No:** Skip this question |
| **How many hours does the individual typically sleep at night?** |       |
| **Does the individual have a consistent pattern of day time sleeping?** | [ ]  **Yes:** Please Explain**:**      [ ]  **No:** Skip this question |
| **List 1:1 Overnight Supports** | **Support** | **Description** |
|       |       |
|       |       |
|       |       |
|       |       |
|       |       |
|       |       |
| **SECTION 5: TWO TO ONE SUPPORT**  |
| **Are Two to One Supports Requested?** | [ ]  **Yes:** Summary:     [ ]  **No:** Skip the remainder of this section |
| **Indicate the total hours requested for staffing direct support at a 2:1 ratio with STANDARD staffing.** |  | **Total Hours Requested** | **Timeframe that supports will occur** |
| **Monday** |       |       |
| **Tuesday**  |       |       |
| **Wednesday** |       |       |
| **Thursday** |       |       |
| **Friday** |       |       |
| **Saturday** |       |       |
| **Sunday** |       |       |
| **Is SPECIALIZED 2:1 staffing requested?**Specialized Staffing: Direct support provided by professionals who have a higher level of expertise which is required to ensure proper supports is given based on the individual’s exceptional support need.(Credentials Required) | [ ]  **Yes:** Indicate the hours requested below[ ]  **No:** Skip this question |
|  | **Total Hours Requested** | **Timeframe that supports will occur** |
| **Monday**  |       |       |
| **Tuesday**  |       |       |
| **Wednesday** |       |       |
| **Thursday** |       |       |
| **Friday** |       |       |
| **Saturday** |       |       |
| **Sunday** |       |       |
| **Are Two to One supports requested overnight?**  | [ ]  **Yes:** Summary:      [ ]  **No:** Skip this question |
| **How many hours does the individual typically sleep at night?** **(Skip if answered previously)** |       |
| **Does the individual have a consistent pattern of day time sleeping?****(Skip if answered previously)** | [ ]  **Yes:** Please Explain:     [ ]  **No:** Skip this question |
| **List 2:1 Overnight Supports** | **Support** | **Description** |
|       |       |
|       |       |
|       |       |
|       |       |
|       |       |
|       |       |
| **SECTION 6: BEHAVIORAL SUPPORT**  |
| **Does the individual engage in challenging behaviors that require 1:1 or 2:1 staffing?**  | [ ]  **Yes:** Summary:      [ ]  **No:** Skip the remainder of this section |
| **List the primary challenging behaviors that require 1:1 or 2:1 supports and provide a short description of the behavior.**  | **Behavior** | **Description**  |
|       |       |
|       |       |
|       |       |
|       |       |
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|       |       |
|       |       |
|       |       |
| **Is the individual currently receiving supports from a behaviorist?**  | [ ]  **Yes: Organization:**       **Name:**       **Email:**       **Phone:**     [ ]  **No: Describe any plans:**      **Is the individual currently on any waitlists for behavioral services?** [ ]  **Yes**: Details**:**      [ ]  **No:** Skip this question |
| **Over the past year have challenging behavior resulted in injury to the individual or others?**  | [ ]  **Yes:** List the referenced events below[ ]  **No:** Skip this question |
| **Event Date**  | **Description of Event** |
|       |       |
|       |       |
|       |       |
|       |       |
|       |       |
|       |       |
| **Over the past year have challenging behaviors resulted in legal system involvement?**  | [ ]  **Yes:** List the referenced event below[ ]  **No:** Skip this question |
| **Event Date** | **Description of Event** |
|       |       |
|       |       |
|       |       |
|       |       |
|       |       |
| **Over the past year have challenging behaviors resulted in hospitalization?** | [ ]  **Yes:** List the referenced event below[ ]  **No:** Skip this question  |
| **Event Date** | **Length of Stay** | **Description of Event** |
|       |       |       |
|       |       |       |
|       |       |       |
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|       |       |       |
| **SECTION 7: MEDICAL SUPPORT** |
| **Does the individual have chronic medical conditions that require 1:1 or 2:1 staffing?** | [ ]  **Yes**[ ]  **No:** Skip this section |
| **List the primary medical conditions that require 1:1 or 2:1 supports and provide a short description of the supports required to address these conditions.** | **Medical Condition** | **Description of Support** |
|       |       |
|       |       |
|       |       |
|       |       |
|       |       |
|       |       |
|       |       |
| **Over the past year have chronic medical conditions resulted in hospitalization?** | [ ]  **Yes:** List the referenced events below[ ]  **No:** Skip this question |
| **Event Date** | **Length of Stay** | **Description of Event** |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
| **Does the provider plan to request skilled or private duty nursing?** | [ ]  **Yes** Explain:     [ ]  **No:** Explain:      |
| **Does the individual receive any other medical services or supports such as supports provided by Hospice or a Wound Care Specialist?** | [ ]  **Yes:** Explain:     [ ]  **No:** Skip this question |
| **SECTION 8: DAY ACTIVITIES**  |
| **Is the individual currently involved in any formal day activities?** | **Check all that apply:**[ ] Group Day[ ] Community Coaching[ ] Community Engagement [ ] Volunteering[ ] Employment[ ] School[ ] Other:      [ ] N/A, Individual is not currently participating in day activities **How many hours per week does the individual typically engage in these activities?**       |
| **Does the individual have future plans to participate in formal day activities?** | **Check all that apply:**[ ] Group Day[ ] Community Coaching[ ] Community Engagement [ ] Volunteering[ ] Employment[ ] School[ ] Other:      [ ] N/A, Individual does not have any future plans to participate in day activities Expected Start Date:       |
| **Describe any barriers to participation in day services.** |      [ ]  **N/A:** Individual does not have any barriers to participation in day services |
| **SECTION 9: BARRIERS AND FUNDING NEEDS**  |
| **Describe any barriers to bringing needed supports to the individual.**  |      [ ]  **N/A**: Individual does not have any barriers to accessing needed supports |
| **How much funding per day, above the standard rate is required to provide necessary safety supports?** |       |
| **Is there additional information that the reviewing committee should know?** | [ ]  **Yes:** Description:      [ ]  **No:** Skip this question |