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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](mailto: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** |
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| **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** | |
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| **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** | |
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| **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** | |
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| **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** | |
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| **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** |
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| **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** |
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| **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 | | | |