

Additional or Substitute Home and Community Based Service Exception Request

* If your request is to exceed the EW Budget Capitation, please use the "Request to Exceed Case Mix Cap" Form*

FAX 612-884-2499 or 1-877-447-4384

Date of Request: _____

Member Information

Name: _____

UCare ID #: _____

D.O.B _____

Requesting Care Coordinator/Case Mgr Name:

Care System/County or UCare: _____

Phone Number: _____ **Fax Number:** _____

Service/Item Requested: _____

Primary Diagnosis: _____ **HCPCS/CPT Code:** _____

Dates needed or how long will this service be required: _____

Why is it an exception?

Not allowable item for HCBS funding Member not on a Waiver item or service not covered by Medical Benefits items/services exceeds Medical Assistance limits (not for supply limits).

Include the following information

Who will provide service or item: _____

Where does the member live (e.g. apartment/house/assisted living/nursing home/group home etc)?

Please answer ALL of the following question regarding the item/service requested (incomplete requests will be returned)

Does the item or service serve the same purpose as an item or service currently in use by member?

Yes/No _____

Does the item/service meet an assessed need documented in the individual community support plan? Yes/ No. If yes, describe:

Is the item or service the most cost effective way to meet the member's needs? Yes/No. If yes, explain costs/rationale:

Is the item or service a substitute health service that would be used as a replacement for or in lieu of a covered service? Yes/No. If yes, what is the covered service that is being replaced.

Is the substitute service expected to improve the health status and quality of life for the member? Yes/No. If yes, explain.

Does the item/service help member function with greater independence in the community? Yes/No. If yes, please explain.

Attach additional documentation if necessary.