



Request for Monthly In-person Visit Exception

Participant Name: _____ CCAN: _____
 Address: _____
 Plan of Care Start Date: _____ End Date: _____
 Care Coordinator Name: _____ CM Number: _____
 Telephone Number: _____
 Care Coordination Agency: _____ CMG Number: _____

I request a waiver of monthly in-person visits to the participant for the period of _____ to _____
 I understand that, if approved, the visit waiver is valid only for the period specified and must be renewed before the end of that period. I agree to provide and document a minimum of one in-person visit per calendar year quarter, and to develop the annual Plan of Care during an in-person visit.

Describe how the location of the community in which the participant resides meets the criteria for remoteness.

Compare the cost of travel to reimbursement for care coordination (CC) services.

1. Cost of travel for one visit to the participant. \$ _____
2. Estimated number of visits per year (excluding visits while the participant is in the care coordinator's local area for shopping, appointments, travel, etc.). _____
3. Projected cost of travel. Multiply line 1 by line 2. \$ _____
4. 50% of reimbursement: Multiply monthly care coordination services reimbursement by 6. \$ _____

If the named participant is the only person served by the CC agency in the destination community, determine whether line 3 is equal to or greater than line 4 and skip to item 7; if not the only participant served, continue with items 5 and 6.

5. Number of participants served by the CC agency in the destination community. _____
6. 50% of reimbursement. Multiply amount on line 4 by line 5 \$ _____

Determine whether line 3 is equal to or greater than line 6, and note in answering item 7.

7. Is the cost of travel to visit the participant equal to or does it exceed 50% of reimbursement for CC services?
 Yes: Eligible for visit waiver consideration.
 No: Not eligible for visit waiver consideration; do not submit a request.

I certify that the cost of travel to make monthly in-person visits to the named participant amounts to or exceeds 50% of the reimbursement for CC services provided to all participants who receive services from the CC agency and who reside in the destination community for the 12-month period of the request.

 Signature of Care Coordinator Date

For SDS Use only

Request: Approved; effective date: _____ expiration date: _____
 Denied; date notice sent _____

Reason for denial: _____

 SDS Waiver Unit reviewer Date