Print Form

Senior and Disabilities Services (SDS)
Request for Exception to Monthly Care Coordination Face-to-Face Visits

Legal Name (Last, First):

CCAN#: **POC Start Date:** **POC End Date:**

Recipient Street Address:

City, State and Zip Code:

Telephone Number:

Care Coordinator: **C.C. Number:** **C.C. Agency Number:**

C.C. Telephone Number:

I am requesting an exception to the monthly face-to-face visit requirements outlined in 7 AAC 43.1041. I understand that two contacts are required each month with this recipient, one of which must be face-to-face; however, I am requesting SDS to waive the monthly face-to-face requirement because this recipient lives in a rural community as defined in 7 AAC 43.1054(c)(5)(B). I further acknowledge that this exception, if approved, is only valid for the remainder of the current waiver plan-year for the recipient specified herein and must be renewed with each new waiver plan-year thereafter.

If approved, I certify that I will document a minimum of one face-to-face visit per calendar quarter with this recipient, and monitor service delivery twice monthly. I also acknowledge that I will develop the annual plan of care for this recipient during a planned face-to-face contact.

_____

Care Coordinator Signature **Date**

State Use Only:

☐ **Approved Effective Date:** _____ **Expiration Date:** _____

☐ **Denied**

☐ **Previous Approval Rescinded (See comments)**

Comments:

_____

_____

_____

SDS Signature of Authorization for Exception