State of Alaska • Department of Health and Social Services • Senior and Disabilities Services

Home and Community-Based Waiver Services

Request for Monthly In-person Visit Exception

Participant Name: ____ Medicaid #: ____________________
Address: ____
Support Plan Start date: __________________ Support Plan End date: __________________
Care Coordinator Name: ____________________________________ CM #: _________________
Telephone Number: ___________________________
Care Coordination Agency: ___________________________________ CMG#:._________________
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 every three months, and to develop the annual Support Plan 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, appointment, 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% or reimbursement. Multiply amount on line 4 by line 5 $ ____________
7. Is the cost of travel to visit the participant equal to or does it exceed 50% of reimbursement for Care Coordination 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

UNI-10 Revised 1/9/2020
ADA 1/9/2020)