Participant: _____ Plan Developer: _____ Date of Request: _____

MID #:

Plan of Service Date:

Extenuating Circumstances

This is a request for services beyond the identified negotiated participant budget. The Person Centered Planning Team has evaluated all the requested services and has determined there are no natural supports or less costly services available to meet the participant's current assessed needs. The need for additional services is based on one or more of the medical necessity criteria as follows.

Medical Necessity Criteria
A service is medically necessary if:

a. It is reasonably calculated to prevent, diagnose or treat conditions in the participant that endanger life, cause pain, or cause functionally significant deformity or malfunctions.

b. There is no other equally effective course of treatment available or suitable for the participant requesting the service which is more conservative or substantially less costly.

c. Medical services shall be of a quality that meets professionally recognized standards of health care and shall be substantiated by records including evidence of such medical necessity and quality.

Plan Developers complete this form.

1. Identify each of the applicable primary categories and use the prompts to help specify the type of information to include in the request.

2. Documentation shall include enough information to justify the need for additional services. Additional information may be attached to this form if necessary.

3. Completed form and documentation is submitted to the IAP for review.

Participant: _____ Plan Developer: _____ Date of Request: _____

Primary Categories	*Narrative*
1. Behavioral Health or Psychiatric: Prompts: ☐ The behavior is of such intensity it poses danger ☐ There is risk of victimization to others ☐ There is a risk of inappropriate sexual behavior ☐ There is a risk of violent or self injurious behavior ☐ Symptom management difficulties(ability to manage psychiatric symptoms in their environment) ☐ Other behavioral management problem in the community ☐ Recent hospitalization/risk of hospitalization.	
2. Safety: Prompts: ☐ Lack of ability to respond to emergencies ☐ Structural, physical, or environmental barriers present concerns for well being of consumer ☐ Requires life support ☐ Requires a personal emergency response system ☐ Victimization	
This box is used for Supported Living requests: Only check the box that is relevant to the current request. ☐ Safety plan for persons meeting intense criteria that do not require 1-1 for 24 hours	The Safety Plan must be detailed, specific to the participant and include the following elements: 1. What are the risks? 2. Describe how the safety plan will reduce the risk to self and/or others allowing the participant to less than 1-1 staff during a 24 hour day? 3. What are the scheduled staffing ratios specific to the participant for a typical calendar week? Include an activity schedule to support the staffing ratios for this participant.

Participant: _____ Plan Developer: Date of Request:

Primary Categories	***Narrative*** _____ _____
☐ Transition Plan to provide less than 1-1 Intense Supported living and move participant from Intense to High Support (can be authorized for up to one (1) year. ☐ Safety Plan to maintain participant with High Support (can be authorized following the completion of the Transition Plan). .	The Transition Plan must be detailed, specific to the participant, and include the following elements: 1. What are the risks? 2. Describe how the risk issues affect safety to self and/or others. 3. What is the plan to fade 24 hr/day 1:1staff? 4. What is the back up plan to assure safety when 1:1 is not being provided? 5. What is the scheduled staffing ratio specific to the participant for a typical calendar week? Include an activity schedule to support the staffing ratios for this participant. The Safety Plan must be detailed, specific to the participant, and include the following elements: 1. What are the risks? 2. Describe how the safety plan has reduced the risk to self and/or others allowing the participant to move from Intense to High Support. Include progress notes and data. 3. What is the scheduled staffing ratio specific to the participant for a typical calendar week?
3. Residential Services for Adults with Developmental Disabilities: Prompts: ☐ The participant requires 24 hour support in their home ☐ Lower cost alternatives to the frequency and type are not available ☐ Alternatives that would allow the participant to function with reduced or no supports for part of the day have been exhausted ☐ Other	
4. Risk for Deterioration or Loss of Skills:	

Participant: _____ Plan Developer: Date of Request:

Primary Categories	***Narrative*** _____ _____
Prompts: ☐ Reduction of services would result in reduced independence or loss of skills ☐ Reduction of services would result in symptoms or conditions worsening ☐ Reduction of services may lead to a more restrictive environment ☐ Validate how this deterioration or loss of skills has been shown. ☐ Other	
5. Functional Limitations: Prompts: ☐ Self Care – Basic living skills ☐ Ability to understand ☐ Ability to communicate ☐ Learning ☐ Mobility ☐ Self-Direction ☐ Economic Self – Sufficiency ☐ Housing ☐ Employment ☐ Other	

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6. Medical or Physical Conditions: Prompts: ☐ Confirm that the medical or physical condition requires continued treatment or follow-up and has significant impact on the individuals functioning. ☐ Confirm that the ability to function at a normal level is decreased because of frequent exacerbations of medical or physical conditions. ☐ Confirm that the functioning level of the individual is lower than the cognitive level would indicate because of the physical or medical condition. ☐ Other	
7. Significant Co-Occurring Disorders: DD - Mental Retardation/Psychiatric; Mental Retardation/Substance Abuse MH - Psychiatric/Medical; Psychiatric/Substance Abuse; Psychiatric/Mental Retardation Prompts: ☐ Confirm that the co-occurring disorder would indicate a higher level of care than either one alone. ☐ Other	
8. Court-Ordered Treatment: Prompts: ☐ Court-ordered treatment. ☐ Outpatient commitment ☐ Treatment necessary to meet other conditions stipulated by the court.	
9. Homelessness: Prompts: ☐ History of evictions ☐ Unable to maintain housing ☐ Other	

Additional information has been submitted with this form.

☐ Yes ☐ No