WV I/DD Waiver
Direct Support Services – Living Arrangement Assessment Short Form

Guidance for completion.
This assessment would be appropriate to complete for individuals who recently received a funded slot, those currently in Crisis/State Hospital/Psychiatric Care, or those that wish to change their current living arrangement to a more costly environment including and limited to: • *Natural Family to LGH 4+/ISSx2/ISSx3* • *ICF and/or LGH4+ to ISSx2/ISSx3* • *ISSx3 to ISSx2* Those pursuing a change to their current living arrangement to an ISSx1 or ISSx1 Personal Options MUST utilize the Direct Support Services – Living Arrangement Assessment Long Form in order to be considered. The Bureau for Medical Services (BMS) does not advise teams regarding an individual's chosen living arrangement; however, prior authorization is required if the chosen living arrangement results in a more expensive array of services for the individual. Forms completed in full MUST be emailed to WVIDDWaiver@acentra.com with supporting documentation as necessary in order to be processed.

Section 1. General Information (complete this section for all requests)			
Date Submitted:	**Click here to enter a date.**		
Name of Person Who Receives Services:	**Click here to enter text.**	Record ID:	**Click here to enter text.**
Anchor Date:	**Click here to enter a date.**		
Anticipated Start Date of Service Request:	**Click here to enter a date.**		
Case Management Provider Agency:	**Click here to enter text.**		
Residential Services Provider Agency:	**Click here to enter text.**		
Name of person submitting request:	**Click here to enter text.**		
Phone #/Extension:	**Click here to enter text.**		

Email Address:	**Click here to enter text.**

Section 2. Summary of Request: (complete this section for all requests)
Please include a brief description of the circumstances related to the requested change in services. If the member has behavioral or medical needs – describe in as much detail available to you the circumstances and how/why those needs necessitate a more restrictive environment. Supporting documentation may be requested related to behaviors/medical concerns. **Click here to enter text.**
Living Arrangement Requested:
☐ ISS x2
☐ ISS x3
☐ Group Home 4+

Section 3. Roommate Review (complete this section for all requests—indicate the individual's current and planned roommates, as applicable)	
Record ID for Current Roommate(s)	Record ID for Planned Roommate(s)

Section 4. Anticipated Member Need (complete this section for all requests—indicate, based on information available, how many hours of 1:1 the team feels will meet the members needs and how many hours/days the member requires. Some members receive natural support, so you may estimate on average how many hours/days the member requires. Indicate how many CM units are required for the full year, because it is a required authorization to seek an Exception.)
Anticipated hours/day of 1:1
How many hours/days of direct-care services will the member require?
How many CM units are required for the remainder of the service year?

Recommendations will be for Living Setting only, except for those cases where the budget will not support required direct-care hours under-budget. In those cases, a recommendation will be made for approximately 60 days of 1:1 in the hours anticipated to meet the member's needs, and all remaining direct-care services will be allocated to lower ratios. This will allow the team to obtain authorizations and seek an Exception.

*ISS setting = Unlicensed or Licensed 24-hour site**

BMS/UMC use only below this line.

Anticipated Date of Move or Change:	Anchor Date:	# of Days Between Date of Move/Change and Anchor Date:

Living Setting at Time of Annual Functional Assessment:	Living Setting Requested:
☐ Natural Family/SFCP	☐ ISS x2
☐ ISS x1	☐ ISS x3
☐ ISS x2	☐ Group Home 4+
☐ ISS x3	
☐ Group Home 4+	

Describe the Circumstances of the Change:

Approval of Request is:
☐ RECOMMENDED:
☐ RECOMMENDED CONDITIONALLY:
☐ NOT RECOMMENDED

Name of Acentra Health staff reviewing request:
Date of Acentra Health review:

BMS Decision:
☐ Approved as Requested:
☐ Approved Conditionally:
☐ Not Approved:

Name of BMS staff reviewing request:
Date of BMS review: