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| **ODDS Variance Request** |  |

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| **[ ]  New Request** | **[ ]  Previously Approved/Continuing Request** | **[ ]  Urgent Request\*** |

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| **This form must be completed by the provider requesting the variance and submitted to the appropriate case management entity. Instructions to complete this form are here (**[**DHS 6001i**](https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/de6001i.docx)**) or on the forms server. The CDDP or Brokerage will submit the request to ODDS. CDDPs and Brokerages requesting a variance may send the request directly to ODDS. Only electronic variance requests will be accepted. Submit requests to:** **ODDS.Variances@dhsoha.state.or.us****.** |

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| Variance is being requested by:  | [ ]  Provider:  |       | [ ]  CDDP/Brokerage:  |       |
| **1.** County:  |       |  | **2.** Case Management Entity:  |       |
| **3.** Case Management Entity Contact and Email: |       |
| **4.** Agency/Provider:  |       |  | **5.** Provider email: |       |
| **6.** Provider Site Address: (*if applicable*) |       |  | **7.** Service/Setting Type: |       |
| **8.** Is the variance being requested specific to an individual or expected to personally impact an individual? [ ]  No [ ]  Yes |
| If yes, list individual(s) and prime number(s):  |       |
| **9.** OAR for which the variance is being sought *(cite the specific Oregon Administrative Rule number and language of the rule)*: |
| Rule Number: OAR  |       |
| Rule Text:  |       |
| **10.** Requested dates *(individual-specific request- the end date may not exceed the individual’s ISP plan year; site or agency request- the end date should not exceed the license/certificate expiration date)*: |
| Start date:  |       |  | End date:  |       |
| [ ]  N/A- explain:  |       |
| **11.** Provider’s proposal for variance *(describe the specific action, alternative practice, or exception being*  |
| *Requested)*: |  |
| **12.** Reason for variance- *explain why a variance is being requested, including how the variance will  provide equal or greater effectiveness*:  |
|  |       |
| **13.** Describe any alternatives tried, explored, and ruled out- *what was tried or considered and why are these not appropriate options*:       |
| **14.** Does the proposed variance pose a risk to an individual’s ability to receive Medicaid service funding? |
| [ ]  No [ ]  Yes  | Explain: |       |
| **15.** Does the proposed variance present a potential to risk the health and safety of an individual? |
| [ ]  No [ ]  Yes  |
| If yes, explain the risk and what is the proposal to mitigate the risk:  |
|  |       |
| **16.** Describe the plan to eliminate a need for a variance in the future *(what efforts or alternatives will be explored or implemented)*: |
|  |       |
| Agency Provider Signature:  |  |  | Date:  |       |

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| **To be completed by the case management entity *(Unless variance is being submitted by CME)*** |
| Case Management Entity Recommendation- provide an explanation or summary of the case management entity’s recommendation for approval or denial: |
|  |       |
| Recommend: | [ ]  Approval | [ ]  Denial |
| Case Management Entity Representative Making Recommendation:  |
|  |       |
| Date:  |       |  | Email: |       |
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| **To be completed by ODDS** |
| ODDS Determination: |
| [ ]  Approved | From: |       |  | To: |       |
| [ ]  Denied |
| [ ]  No Variance Needed |
| ODDS Comments: |       |
| Signature of ODDS Director/designee: |  |  | Date: |       |
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| **Submit this form to ODDS via email:** **ODDS.Variances@dhsoha.state.or.us** |
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| \*An “urgent” request is a variance request where due to a situation beyond the control of the provider requesting a variance, a determination is needed immediately (less than 14 days from the date of the submission of the request), for situations such as to facilitate an immediate placement of an individual. |
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