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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**](mailto: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*: | | | | | | | | | | | | | | | | | | | | | | | | |
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| **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: | | | | | | | | | | | | | | | | | | | | | | | | |
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| **16.** Describe the plan to eliminate a need for a variance in the future *(what efforts or alternatives will be explored or implemented)*: | | | | | | | | | | | | | | | | | | | | | | | | |
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| 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: | | | | | | | | | | | | | | | | |
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| 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: |  |
|  | | | | | | | | | | | | | | | | |
| **Submit this form to ODDS via email:** [**ODDS.Variances@dhsoha.state.or.us**](mailto: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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