

## **Instructions for Level of Care Variance Request Form**

The variance request form must be used whenever a facility determines that it desires to admit or retain a resident who meets nursing home level of care (LOC) eligibility OR if a facility has been pre-approved for a specific number of nursing home LOC eligible residents and the facility desires to exceed the pre-approved number.

### **Section A Facility Statement**

Complete this section first. This section must be completed by the facility RN or Manager.

1. Name of facility requesting variance and Resident name
2. Will the resident be a new admit to the facility or is the variance request to retain a current resident whose needs now exceed what the home is licensed to provide.
3. Circle whether the resident is private paying or an ERC applicant.
4. Provide a brief Description of the resident's current level of cognition, medical /nursing conditions and assistance needed related to ADL function. This description and the current assessment will be used to determine if the resident meets Nursing Home Level of Care.
5. Provide a brief description of how your facility will meet the identified needs listed above.
6. Identify current total facility census.
7. Total number of residents in facility that meet nursing home LOC.

The Facility RN and Manager must sign the Facility Statement to affirm that the care needs of the resident and the needs of all other residents in the facility can and shall be met.

### **Section B Resident Statement**

The individual or responsible party must document by signing the resident statement that it is her/his desire to reside in the facility, and the individual is aware that a variance is necessary to reside in the home because the home is not licensed to provide nursing home LOC.

### **Section C Physician Statement**

Complete this section only after A and B have been completed

The resident's physician must sign the physician statement that indicates that she/he recommends admission or continued stay at the named residence.

### **\*EMERGENCY PLACEMENT\***

If an Emergency Placement Variance approval is needed contact the Division of Licensing and Protection at **802-241-0480** to request an emergency placement variance. Provide information regarding the resident's functional, cognitive, and medical/nursing needs and how the facility will meet these needs. A verbal approval may be granted in an emergency situation. All information required in Step I shall be submitted within 7 days of admission.

## LEVEL OF CARE (LOC) VARIANCE REQUEST

This variance request is to admit or retain a resident whose care needs exceed what the facility is licensed to provide.

### **Facility Statement**

#### *Section A*

1. Name of Facility: \_\_\_\_\_ Resident Name: \_\_\_\_\_
2. Admit or Retain (*circle one*)                      3. ERC or Private Pay (*circle one*)
4. Describe how the resident's functional, cognitive, or medical/nursing needs meet criteria for nursing home placement.
5. Describe how the facility will meet the resident's needs: (*i.e. additional staffing, assistive devices*)
6. Current resident census \_\_\_\_\_
7. Total number of residents with LOC variance **NOT** including this request \_\_\_\_\_

**I affirm that the care needs of this resident and all other residents of the facility shall be met.**

\_\_\_\_\_  
Facility RN

\_\_\_\_\_  
Date

\_\_\_\_\_  
Manager

\_\_\_\_\_  
Date

### **Resident Statement**

#### *Section B*

I understand that the manager believes that my care needs may exceed what the facility is licensed to provide. I wish to continue to live here and the manager has assured me that they can meet my care needs. I further understand that I will have to leave this facility if this request is not approved or terminated in the future.

\_\_\_\_\_  
Resident/Legal Guardian Signature

\_\_\_\_\_  
Date

### **Physician Statement**

#### *Section C*

As the attending physician I recommend continued stay or admission at this facility.

\_\_\_\_\_  
Physician

\_\_\_\_\_  
Date

**Mail or fax (802-241-0343) this request with a current assessment/Clinical Eligibility Worksheet and staffing pattern to include any changes if this request is approved to:**

Dept. of Disabilities, Aging and Independent Living  
Division of Licensing and Protection  
HC2 280 State Drive  
Waterbury VT 05671-2060