LTS PLANNING COMMITTEE
COP VARIANCE REQUEST

Case Manager: David Moskoff _______Date**:** 4/8/2015 ______________

FUND COP SERVICES FOR PARTICIPANT RECEIVING RECUPERATIVE SERVICES IN AN INSTITUTION (UP TO 90 DAYS).

The purpose of this variance is to maintain a participant's support network during relatively brief institutional stays. No variance is needed for recuperative stays of 30 days or less. When a recuperative stay exceeds 30 days a variance is necessary to allow the use of COP funds to continue to pay for noninstitutional community service expenses for up to 90 days for current COP recipients.

1. INSTITUTION NAME: _Capitol Lakes___

2. EXPECTED DURATION: Fewer than 90 days

3. PARTICIPANT INFORMATION

- Male ___ Female _X_ Age 80 years old_ Time on COP/Waiver programs 10/1/2013 Protective Placement _No_
- Current living arrangement: _X_ home
  ___ AFH
  ___ CBRF (name, size) _____________
  ___ NH (name) ____
- Health & medical problems (please use non-medical terms): Client was admitted to the VA Hospital on 2/25/2015 for leg weakness and leg cramps. Client was also seen for medication review for urinary issues. Client transferred to Capitol Lakes skilled nursing facility for rehabilitation and medication monitoring.
- Situation requiring rehabilitation and desired outcomes: _
  _ Client is expected to discharge from Capitol Lakes and return to the community by the middle of May. He was receiving occupational, physical and speech therapies. Client was working on building strength and addressing medication management. As of 3/27/2015, client has since discontinued therapy services as he showed no more improvement. Client uses a wheelchair for mobility, and was deemed unsafe to transfer or ambulate independently. Upon discharge from Capitol Lakes, client will return to the community to an assisted living facility as living at his home is no longer safe. This will be an interdisciplinary recommendation, decided by client, writer and Capitol Lakes staff.
- Services to be funded during rehabilitation:
  Case Management ______X_________________
  Lifeline __________________________________
  Other (identify other) ______________________

LTS Committee action: Chair approval date __________; Full committee approval date _______________;

Non approval date _____________; Reason ____
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Consumer Name: ____