LTS PLANNING COMMITTEE
COP VARIANCE REQUEST

Case Manager: __Yer Yang_____Date**:** 1/22/16

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: Agrace Hospice Care

2. EXPECTED DURATION: Will return to the community before the 90 days if symptoms improve.

3. PARTICIPANT INFORMATION

- Male _Female X Age 57 Time on COP/Waiver programs May 2011 Protective Placement N/A
- Current living arrangement: _X_ home
  ___ AFH
  ___CBRF (name, size)
  ___(name) _____

- **Health & medical problems (please use non-medical terms):** This client was admitted to Meriter Hospital on December 19, 2015 and transferred to Agrace Hospice Care on January 14, 2016 for comfort care due to end stage liver disease as recommended by the doctors.

- **Situation requiring rehabilitation and desired outcomes:** Due to the above medical condition, the health care providers recommended that this client receives appropriate comfort care services for up to 30 days at Agrace Hospice before returning home. This client does not have a worker or family member to coordinate and provide appropriate health cares services for her at home. This client will be discharged back to her own apartment in the community if her health condition and symptoms stabilized. CLA CIP II Program will continue to provide case management and service coordination services with appropriate health care providers, Agrace Hospice Staff, and the client for up to 90 days from the above hospital admission date.

Services to be funded during rehabilitation: Case Management services **X** for up to 90 days from the above hospital admission date.

LTS Committee action: Chair approval date _____; Full committee approval date _____;
Non approval date _____; Reason _____
_____
Consumer Name: _____