Branch:	Prime number:
Individual's name:	
Case manager name:	
Case manager phone:	Case manager email:

Request for State Plan Personal Care (SPPC) Exception

Services

Effective date: ____________________ Most recent assessment date: __________

Request: ☐ New ☐ Renewal ☐ Reviewed for SPL Eligibility?

Reviewer name:

Reviewer email:

Reasons for exceptions

1. Which activities does the individual require paid assistance from another person?

☐ Personal hygiene	☐ Cognition	☐ Transportation
☐ Eating	☐ Housework	☐ Grocery shopping
☐ Mobility	☐ Laundry	☐ Using the telephone
☐ Toileting	☐ Meal preparation	☐ Medication management

2. Is exceptional housecleaning needed to ensure the health and safety of the individual?

   ☐ Yes ☐ No

Other considerations

Have you discussed other resource or service options?	☐ Yes	☐ No
Have natural supports been discussed?	☐ Yes	☐ No
Have assistive devices been explored?	☐ Yes	☐ No

Summary of service needs

Please use the space below to summarize client service needs or to add additional information. You may include a separate sheet if necessary. Include the following:

- How you arrived at the exceptional hours being requested?
- What is the reason for any increase or decrease in the service hours?
- Additional information about service needs that may not be documented in the assessment or service plan (*e.g. reasons for needing more than 10 hours per pay period or 270 hours yearly, other resources/strategies considered*).

(*Complete summary of service needs below*)

(Complete calculator for the activities with which paid assistance is required)

Activity (ADL/IADL)	Minutes Per Task	Need Per Day	Days Per Week	Number of Providers	Assessed Hours
Hygiene					
Eating					
Mobility					
Toileting					
Cognition					
Housework					
Laundry					
Meal Preparation					
Transport					
Shopping					
Telephone					
Medication Management					

Allowed hours:

Exception hours requested per pay period: