SHARED AIDE PROGRAM
EXEMPTION REQUEST

Social Services District: _____

Name and Title of Person Completing Exemption Request: _____

Telephone: (_ _ _) _ _ _ - _ _ _ _ , extension _ _ _ _
Fax: (_ _ _) _ _ _ - _ _ _ _

Date of Exemption Request Completion: _ _ / _ _ / _ _

I. A. Describe/explain how your current method for delivering personal care services is adequately meeting the assessed needs of clients and can continue to meet those needs.

B. Show that you currently have a sufficient supply of home care workers to meet the assessed needs of clients and that a sufficient supply is reasonably expected to continue to be available.

II. Indicate the reason(s) for your exemption request by checking <u>at least one</u> of the following exemption criteria. For each criterion checked, explain <u>why</u> you should be granted an exemption under that criterion from implementation of a shared aide program.

A.___The number of personal care services clients is either too few to support a shared aide program or so geographically dispersed that we cannot identify a group of clients for which a shared aide program would be appropriate.

(OVER)

B.___The annual costs of delivering personal care services under a shared aide model would be equal to, or greater than, the annual costs of delivering personal care services under our existing method.

C.___We have another cost-effective method to improve the efficiency of the delivery of personal care services.

III.(OPTIONAL): Provide any other data which you feel should be considered during the review of your exemption request.

IMPORTANT NOTE
You MUST attach or support your explanation of items I.-II with documentation consistent with the exemption criteria specified in APPENDIX D. All documentation must be identified as to source and date. Any documentation attached to this exemption request must be clearly labeled to correspond to explanations of items I.-II.

END OF SHARED AIDE EXEMPTION REQUEST

NEW YORK STATE DEPARTMENT OF SOCIAL SERVICES
SHARED AIDE EXEMPTION REQUEST

NOTICE OF APPROVAL/DISAPPROVAL

To:_____

Initial Exemption Request:____
Amended Exemption Request:____

Date Received by Department: _ _ /_ _ / _ _
Date of this Notice: _ _ /_ _ /_ _

DISPOSITION:

____Exemption request approved; no recommendations

____Exemption request approved; recommendations below:

Recommendations:

EXEMPTION EXPIRATION DATE: _ _ / _ _ / _ _

____Exemption request disapproved; deficiencies as follows:

___Incomplete or inconsistent information;

___Inadequate documentation;

___Non-compliance with exemption conditions;

___Other;

(OVER)

NECESSARY ACTION:

_____Submit an amended exemption request or a shared aide plan within thirty business days of receipt of this notice. If you submit an amended exemption request, the request must include the following:

_____Submit a shared aide plan within thirty business days of receipt of this notice.

_____Not applicable.

Name:_____
Title:_____
Signature:_____
Telephone Number:_____
Fax Number: (518) 473-4232

Submit amended exemption request or shared aide plan to:

New York State Department of Social Services
DMA-LTC
Home Care Unit
P.O. Box 1935
Albany, New York 12201-1935