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Kansas Health Solutions

Exception Request for 1915(b) Attendant Care

Member Name: _____ Date of Birth: _____
Last First Middle mm/dd/yy

Medicaid Number: _____ Social Security Number: _____

Provider Agency: _____

Units Requested: _____

Timeframe of Request: Start Date: _____ (mm/dd/yy) End Date: _____ (mm/dd/yy)
Maximum end date – June 30th of benefit year

Medical necessity for continued Attendant Care:

- ☐ Member requires assistance to complete Activities of Daily Living and Instrumental Activities of Daily Living
- ☐ Member requires assistance to maintain daily routines
- ☐ Member requires assistance to engage in activities critical to residing in their home and community
- ☐ Member at risk to be placed in a more restrictive setting due to significant functional impairments

Rationale for the medical necessity of Attendant Care must be substantiated within progress note documentation.

Describe the specific symptoms the member is experiencing which are contributing to the continued medical necessity for Attendant Care:_____
_____
_____
_____
_____

Treatment plan goal being addressed by the provision of Attendant Care:_____
_____
_____
_____

Completed By: _____ Date: _____ (mm/dd/yy)
First Name Last Name

Contact Number: _____

Phone: 1-877-642-9283
Fax: 1-785-232-2610