**Children’s Long-Term Support Waiver Program — Outlier Rate Request**

Many supports and services through the Children’s Long-Term Support (CLTS) program are subject to a uniform, statewide rate schedule. County waiver agencies (CWAs) use this form to document and request an outlier rate due to a participant’s exceptional care needs or provider access issues. A participant may require an outlier rate for one or more services on their individual service plan (ISP). CWAs may use one form for multiple outlier requests. All outlier rates are subject to DHS review and approval.

**Instructions**

1. Service Categories: Click on “Click here to select service description” and choose category from the drop-down menu. Under each service category where an outlier rate is being requested, indicate whether the outlier rate is required due to an individual’s care needs or provider access issues.

**NOTE**: When respite and personal supports outlier rates are needed due to an individual’s care needs, a care level determination must first find that the participant’s needs exceed the high care level classification. This is not the case if the outlier is for provider access issues.

1. Provider and Rate Information: For each service where an outlier rate is being requested, list the specific provider, CLTS Statewide Uniform Rate and units, the outlier rate and units as justified on the corresponding Cost Based Outlier form, [F-02538A](https://www.dhs.wisconsin.gov/forms/f02538a.xlsx), as well as the number of units being requested per week.
2. Rationale: Provide enough detail to explain and justify the need for an outlier rate. The explanation should demonstrate that the child’s circumstances require an outlier rate due to individual need or provider access.
   * For each service where individual care is indicated as the outlier rate reason, describe the participant’s significant behaviors, health care needs, and/or involvement across multiple systems that require frequent, intensive intervention or care, and/or a higher degree of skill or training from caregivers. For child care include the child’s level of care and if the child is under the age of 12 include the parent’s basic cost of care.
   * For each service where provider access is indicated as the outlier rate reason, specify the distance the provider must travel to provide the service to the participant. Additionally, briefly describe the efforts to locate a provider locally.
3. DHS Determination: To be completed by DHS. CWAs leave this area blank.
4. County waiver agencies complete the Outlier Rate Request, [F-02538](https://www.dhs.wisconsin.gov/forms/f02538.docx) to demonstrate the participant’s need for an outlier rate. The provider(s) complete the Cost Based Outlier Form, [F-02538A](https://www.dhs.wisconsin.gov/forms/f02538a.xlsx) and provide supporting documentation to justify the requested rate. Send both forms to [dhscltsrateoutlier@dhs.wisconsin.gov](mailto:dhscltsrateoutlier@dhs.wisconsin.gov).

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|  |  | | |  | | | **Date Completed** | | |
| **PARTICIPANT INFORMATION** | | | | | | | | | |
| Name — Participant | | | Date of Birth | | | | | MCI | |
|  | | |  | | | | |  | |
| **COUNTY WAIVER AGENCY INFORMATION** | | | | | | | | | |
| Name — Agency | | | | | Name — Individual Authorized to Submit F-02538 | | | | |
|  | | | | |  | | | | |
| Email | | | | | Phone Number | | | | |
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| **OUTLIER REQUESTS BY SERVICE** | | | | | | | | | |
| **Click here to select service description** | | Procedure Code | | | | **DHS Determination**  Date: | | | **DHS Staff Initial** |
| Individual care need  Provider access | | CLTS Rate:       per Click here to select unit type | | | | As requested  As modified: | | | Outlier Rate:  $      per  Expiration date: |
| Provider Name: | | Outlier Rate Requested:        per Click here to select unit type | | | |
| Number of Units Requested per Week | | | | Outlier rate denied  Reason rate was denied: | | | |
| Rationale: | | | | | |
| **Click here to select service description** | | Procedure Code | | | | **DHS Determination** Date: | | | **DHS Staff Initial** |
| Individual care need  Provider access | | CLTS Rate:       per Click here to select unit type | | | | As requested  As modified: | | | Outlier Rate:  $      per  Expiration date: |
| Provider Name: | | Outlier Rate Requested:        per Click here to select unit type | | | |
| Number of Units Requested per Week | | | | Outlier rate denied  Reason rate was denied: | | | |
| Rationale: | | | | | |
| **Click here to select service Description** | | Procedure Code | | | | **DHS Determination**  Date: | | | **DHS Staff Initial** |
| Individual care need  Provider access | | CLTS Rate:       per Click here to select unit type | | | | As requested  As modified: | | | Outlier Rate:  $      per  Expiration date: |
| Provider Name: | | Outlier Rate Requested:        per Click here to select unit type | | | |
| Number of Units Requested per Week | | | | Outlier rate denied  Reason rate was denied: | | | |
| Rationale: | | | | | |