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 at least one of the following exemption criteria. For each criterion checked, explain why 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.
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