Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

I. Request Information

A. The **State** of [ ] requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Waiver Title (*optional*): [ ]

C. CMS Waiver Number: [ ]

D. Amendment Number (*Assigned by CMS*): [ ] WVR_AMND_NUM

E.1 Proposed Effective Date: [ ] WVR_AMND_PRPSD_EFFDATE

E.2 Approved Effective Date *(CMS Use):* [ ] WVR_AMND_APPRVD_EFFDATE

E.3 Approved Effective Date of Waiver being Amended *(CMS Use):* WVR_AMND_APPRVD_EFFDATE_ORIG

II. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

WVR_AMND_SHRT_DESC

III. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☐ Waiver Application — WVR_AMND_WVR_APP	WVR_AMND_WVR_APP_SUBSCTN
☐ Appendix A – Waiver Administration and Operation — WVR_AMND_WVR_APPNDX_A	WVR_AMND_APPDNX_A_SUBSCTN
☐ Appendix B – Participant Access and Eligibility — WVR_AMND_WVR_APPNDX_B	WVR_AMND_APPDNX_B_SUBSCTN
☐ Appendix C – Participant Services — WVR_AMND_WVR_APPNDX_C	WVR_AMND_APPDNX_C_SUBSCTN
☐ Appendix D – Participant Centered Service Planning and Delivery	WVR_AMND_APPDNX_D_SUBSCTN
☐ Appendix E – Participant Direction of Services — WVR_AMND_WVR_APPNDX_E	WVR_AMND_APPDNX_E_SUBSCTN
☐ Appendix F – Participant Rights — WVR_AMND_WVR_APPNDX_F	WVR_AMND_APPDNX_F_SUBSCTN
☐ Appendix G – Participant Safeguards — WVR_AMND_WVR_APPNDX_G	WVR_AMND_APPDNX_G_SUBSCTN
☐ Appendix I – Financial Accountability — WVR_AMND_WVR_APPNDX_I	WVR_AMND_APPDNX_I_SUBSCTN
☐ Appendix J – Cost-Neutrality Demonstration — WVR_AMND_WVR_APPNDX_J	WVR_AMND_APPDNX_J_SUBSCTN

WVR_AMND_WVR_APPNDX_D

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

☐	Modify target group(s) WVR_AMND_TGT_GROUP
☐	Modify Medicaid eligibility WVR_AMND_MEDICAID_ELIG
☐	Add/delete services WVR_AMND_ADD_RMV_SRVCS
☐	Revise service specifications WVR_AMND_CHNG_SRVC_PRVSNS
☐	Revise provider qualifications WVR_AMND_CHNG_PRVDR_RULES
☐	Increase/decrease number of participants WVR_AMND_CHNG_PTCPNT_CNTS
☐	Revise cost neutrality demonstration WVR_AMND_CHNG_CST_NTRLTY
☐	Add participant-direction of services WVR_AMND_ADD_PTCPNT_DIR
☐	Other (specify): WVR_AMND_OTHER
	WVR_AMND_OTHER_DESC

IV. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding this amendment is:

First Name:	
Last Name	
Title:	
Agency:	
Address 1:	
Address 2:	
City	
State	
Zip Code	
Telephone:	
E-mail	
Fax Number	

B. If applicable, the operating agency representative with whom CMS should communicate regarding this amendment is:

First Name:	
Last Name	
Title:	
Agency:	
Address 1:	
Address 2:	
City	
State	
Zip Code	
Telephone:	
E-mail	
Fax Number	

V. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the State's request to amend its approved waiver under §1915(c) of the Social Security Act. The State affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The State further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The State certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:

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State Medicaid Director or Designee

Date:	

First Name:	
Last Name	
Title:	
Agency:	
Address 1:	
Address 2:	
City	
State	
Zip Code	
Telephone:	
E-mail	
Fax Number	