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# Payor of Last Resort Waiver Request Form

Service providers must pursue all possible payors before expending Ryan White or State Services dollars. If a service provider is unable to pursue certain third payors, it may apply for a waiver using this form. Petitioning service providers must certify through narrative and documentary evidence that one or more of the following conditions exist:

- The service provider has applied and does not meet the provider standards for approval. (must provide documentation of reason for denial from the third party payor)
- The service provider meets standards for a particular third party payor, but has determined the cost of implementing billing procedures for the payor would exceed reimbursable funds
- The service provider contracts with an off-site private physician who will not pursue billing of particular third party payor(s)
- The service provider has an insufficient number of eligible and potentially eligible clients to warrant becoming a particular third party payor provider

### Client Caseload Analysis

Total number of clients receiving medical services \_\_\_\_\_

Total number of clients receiving or potentially eligible for Medicaid \_\_\_\_\_

Total number of clients receiving or potentially eligible for Medicare \_\_\_\_\_

Total number of clients receiving or potentially eligible for private insurance \_\_\_\_\_

	Name of third party payor	number of clients
a.	_____	_____
b.	_____	_____
c.	_____	_____
d.	_____	_____

# Payor of Last Resort Waiver Request

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## Narrative Support for Request

*Please document justification for all third party payors for which waiver is requested*

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Submitted on behalf of (Performing Agency):

Signed by (Authorized Agent/Title):

\_\_\_\_\_

\_\_\_\_\_

Address: \_\_\_\_\_

Title: \_\_\_\_\_

\_\_\_\_\_

Date: \_\_\_\_\_

**Please submit completed form through the Administrative Agency for forwarding to the DSHS Field Operations Manager for approval**

# Payor of Last Resort Waiver Request

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The HIV/STD Program will review requests for waiver on a case-by-case basis and will determine the appropriateness of a waiver. Approved waivers must be resubmitted every two years. If a waiver is not granted, the Program, in consultation with the Administrative Agency, will determine if the contract/subcontracts may be fully executed, continued, or terminated. The Program may impose conditions of award to pursue Medicaid provider status.

- Approved without conditions. Term of project period \_\_\_\_ / \_\_\_\_ / \_\_\_\_ through \_\_\_\_ / \_\_\_\_ / \_\_\_\_.
- Approved with conditions. Term of project period \_\_\_\_ / \_\_\_\_ / \_\_\_\_ through \_\_\_\_ / \_\_\_\_ / \_\_\_\_.
- Denied.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
printed name

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

Conditions (if any):