



Disability Services Division

Home Care Nursing (HCN) Hardship Waiver Application

What is a Hardship Waiver?

A Hardship Waiver allows the provision of Home Care nursing services to a person authorized to receive services by a relative, family foster parent or guardian who meets certain criteria and, therefore is eligible to receive reimbursement for these services.

Who may apply for a Hardship Waiver?

An eligible nurse who is a:

1. Parent of a minor child
2. Spouse of the recipient
3. Legal guardian or conservator
4. Family foster parent of a minor child

Eligibility requirements:

- Currently licensed in Minnesota as a registered nurse (RN) or licensed practical nurse (LPN)
- Pass a criminal background check
- Employed by a HCN agency
- May only be employed by one agency
- Expect to continue non-reimbursed family responsibilities of primary caregiver and emergency backup caregiver.

The parent, spouse, family foster parent or legal guardian applying must meet at least one of the following criteria:

- Resigned from full-time or part time employment to provide HCN
- Changed from full-time employment to part-time position with less compensation to provide HCN
- Took leave of absence without pay to provide HCN
- Needed to provide an adequate number of qualified nurses to meet the needs of a person because of labor conditions, intermittent hours of care needed or special language needs.

Are there any limitations

HCN services that are authorized and provided:

- Must be necessary to prevent hospitalization of the person
- Are not legally required services
- Cannot be provided in lieu of nursing services covered and available through other third party payers, including Medicare
- May not exceed 50% of the total authorized nursing hours being billed to MN Medical Assistance or eight hours per day, whichever is less, up to a maximum of 40 hours in a seven day period regardless of the number of children or adults who receive services
- Must be included in the service agreement
- Must not have been determined by the HCN agency, case manager, or physician to be unsafe or to be found not following physician orders.

What are the provider qualifications?

The HCN must be employed by one of the following:

- Medicare Certified Home Health Agency
- HCN agency with Class A licensure.

What is the process for requesting a hardship waiver?

The HCN agency is responsible for providing a copy of this application to the consumer and relative, family foster parent or guardian.

The HCN agency is responsible for submitting the application to DHS for authorization.

How do I submit the Hardship Waiver form?

Submit to:

**Minnesota Department of Human Services,
Disabilities Services Division (DSD)
P.O. Box 64967
St. Paul, Minnesota 55164-0967
or send via fax to 651-431-7575**

HCN Hardship Waiver Application Form



Recipient Information (print or type legibly)

LAST NAME, FIRST NAME MI		DATE OF BIRTH (MM/DD/YYYY)	
STREET ADDRESS	CITY	STATE	ZIP CODE
TELEPHONE NUMBER (ALL 10 DIGITS REQUIRED)	PMI# (8 DIGITS REQUIRED)		

Home Care Nurse

Relationship to recipient	1. Parent of a minor child 3. Legal guardian or conservator	2. Spouse of the recipient 4. Family foster parent of a minor child	
HCN FIRST NAME/LAST NAME	TELEPHONE NUMBER (ALL 10 DIGITS REQUIRED)		
STREET ADDRESS	CITY	STATE	ZIP CODE
MN NURSING LICENSE #	EXPIRATION (mm/dd/yyyy)		

Relative, family foster parent or guardian meets the following hardship criteria

Resigns from full-time/part time employment to provide care for the recipient.
Goes from full-time employment to part-time employment resulting in less compensation to provide care for the recipient.
Takes a leave of absence without pay to provide care for the recipient.
Is needed because of labor conditions.
Is needed for special language needs.
Is needed for intermittent hours of care.

I certify that I meet the requirements allowing a provider to bill Medical Assistance (MA) for Home Care Nursing Services (HCN) under the hardship waiver.

SIGNATURE OF NURSE	DATE (mm/dd/yyyy)
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A criminal background check has been requested for the relative, family foster parent or guardian

CURRENT AGENCY OR PROVIDER NAME	PHONE NUMBER (ALL 10 DIGITS REQUIRED)		
STREET ADDRESS	CITY	STATE	ZIP CODE

To the best of my knowledge, the above information on the hardship circumstance is true and correct.

SIGNATURE OF PERSON SUBMITTING REPORT	DATE (mm/dd/yyyy)
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