

HOME AND COMMUNITY BASED SERVICES REQUEST FOR PRIOR AUTHORIZATION

I. INDIVIDUAL'S INFORMATION		
Name _____		County _____
(Last)	(First)	
Medicaid # _____		
II. TYPE OF REQUEST	COST/HOURS	COST SHEET ATTACHED
Specialized Medical Equipment	_____	_____
Over Cost <input type="checkbox"/> One time purchase	_____	_____
<input type="checkbox"/> Intensive 90 days	_____	_____
Other	_____	_____
III. NARRATIVE REQUEST AND JUSTIFICATION		

IV. REQUESTER		
_____		_____
Name	Phone	Date
V. COMMUNITY PROGRAM OFFICER		
<input type="checkbox"/> Concur	<input type="checkbox"/> Do not concur	Time Period _____
Comment: _____		

_____		_____
Community Program Officer		Date

Send copy to Program Manager