

## Moderate Needs Program Service Request & Authorization Form

***Completed by the Moderate Needs Case Manager after completing an assessment, person-centered plan AND confirming funding with each provider. For new applicants, submit to DAIL with complete enrollment packet.***

Applicant Name: \_\_\_\_\_

Last 4 of SS#: \_\_\_\_\_ ICD-9 Code: \_\_\_\_\_ ICD-10 Code: \_\_\_\_\_

Check one:     New Applicant       Annual Review       Service Change       Reinstatement

Wait List Applicant:  Yes     No      Requested Start Date: \_\_\_\_\_

**Person-centered plan completed AND funding confirmed with each provider for the following services:**

Service	Provider/Agency Name	Volume
<input checked="" type="checkbox"/> Case Management (revenue code 070)	Name: _____	Up to 12 hrs/calendar year
<input type="checkbox"/> Flexible Funding (revenue code 071)	<b>Case Management Agency</b>	Up to \$_____ yr
<input type="checkbox"/> Adult Day Services (revenue code 096)	Name: _____	Up to _____ hrs/week
<input type="checkbox"/> Adult Day Non-Medicaid Transport (revenue code 071)	<b>Adult Day Provider</b>	Up to \$_____ week
<input type="checkbox"/> Homemaker Services (revenue code 095)	Name: _____	Up to _____ hrs/week

***NOTE: Services must be based on a person-centered plan and are subject to available funds. Participants must contact their case manager regarding changes.***

Case Manager Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

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

Applicant Legal Rep Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**\*\*DAIL Authorization\*\***

This person meets eligibility for Moderate Needs Services and is approved for services identified on this request.

Authorization Start Date: \_\_\_\_\_ / End Date: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

***Case Manager must submit annual review within one month before end date.***

*(Copy to the participant, case manager and applicable providers.)*