**Completion of all pertinent information on this expedited form is required.**

Service requests for individuals not impacted by COVID-19 follow standard Utilization Review Processes.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Individual Name: | | | DMH ID: | | | Date request submitted: | |
|  | | |  | | |  | |
| Waiver Type: | | Support Coordinator: | | | Support Coordinator Supervisor: | | |
|  | |  | | |  | | |
| If this form is being submitted in follow up to verbal request/approval indicate Designee name and date of approval: | | | | | | | |
| Designee Name: |  | | | Date of Verbal/Email Approval: | | |  |

**REQUESTED SERVICE CHANGES** Temporary services are requested for six months.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| [Existing](#Existing) Service or [New](#New) Service | Provider | Effective Date | Procedure Code | Total [units](#units" \o "Units = (new units per month X 6) + current authorized units.   ) or ISL [hours](#hours) to be Authorized\* |
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**reason for request (provide JUSTIFICATION to Include information on how this request is impacted or due to covid-19 related circumstances)**

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**Authorization and Approval Signatures:** Required for Support Coordination, the individual or guardian and the implementing [provider](#provider" \o "Any provider who is listed on this document under \"Requested Service Changes\" is required to sign or give verbal/email/text approval.)(s).

|  |  |  |  |
| --- | --- | --- | --- |
| Signature or  First and Last Name | Type of contact/How consent was obtained  (ie: phone/text/email/etc.) | Relationship to Service Recipient  (ie: parent/self/etc.) | Date of Contact/Initials of person contacted  (SC typically) |
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| **Decision/Action** |
| **Approve (**UR budget approved and/or authorization approved)  **Referred to Regional Office Director for Additional Review** asdoes not meet criteria for urgent request through this process  **Sent back to SC for submission to regular UR Process** |

|  |  |
| --- | --- |
| Designee Signature | Date Completed |
|  |  |

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| --- |
| UR budget approved and/or authorization approved |

|  |  |
| --- | --- |
| Designee Signature | Date Completed |
|  |  |