**Division of Developmental Disabilities ISP Amendment: Health Assessment Coordination (HAC)**

**Completion of all pertinent information on this amendment is required for section 4b of** **Procedure 86.**

**Individual Name**:       **DMH ID**:       **Date Request Submitted**:

**Waiver Type**:       **Support Coordinator**:

**Support Coordinator Supervisor**:       **Guardian (if applicable)**:

**REQUESTED SERVICE CHANGE:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **New** **Service** | **Provider** | **Effective Date** | **Procedure Code** | Total **Units** to be Authorized – (number of months until the end of the current ISP year - a partial month is counted as 1 unit) | **Unit Cost** | **Total Cost** = Units x Unit Cost |
| HAC | Station MD |  | 99499 |  | $72 |  |

**reason for request:**

|  |
| --- |
| My planning team and I have concluded that I will benefit from access to a consultative telemedicine service available 24 hours a day 7 days a week designed for individuals with Intellectual/Developmental Disabilities (I/DD) receiving Home and Community Based (HCBS) Waiver services. This service will meet a need for disability-specific advice on when best to seek additional or in-person treatment, to coordinate care with local emergency departments, urgent care facilities, and primary care physicians to enable real time support, consultation and coordination on health issues and to assist individuals, families and support providers to understand presenting health symptoms and to identify the most appropriate next steps.  I chose Station MD as my provider upon contact with Station MD. |

**Authorization and Approval Signatures:** Required for Support Coordinator, the individual or guardian.

|  |  |  |
| --- | --- | --- |
| Signature | Title | Date |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

7/1/2023