Instructions for the Service Authorization Form

Service Coordinators are to use this form to communicate important, accurate, consistent and easy to use information about participant services to the direct service provider of the participant's choice. The information entered on this form will be the same information documented in the participant's approved ISP. This form is to be completed for new service plans, when there is a change in services (both permanent and temporary), at the time of annual reassessment, and when there is termination of services.

This form is to be completed in its entirety—do not leave any section blank. If an item does not apply or there is no information to add, place "N/A" in the field.

Section I: Demographics

Date: Enter the date the form is completed.

Check if this is an Annual Renewal, New Referral, Temporary Change, Revision (change in need) or Termination.

Consumer's Name: Enter the consumer's name (If there is question that the provider might be uncertain of the participant's gender, please indicate "Mr. or Ms." in front of the name).

DOB: Enter the consumer's date of birth.

Address: Enter the consumer's physical address where services will be provided. Enter the consumer's phone # and Email.

Primary Contact: (Relationship to consumer): Enter the individual who is the primary contact for any information regarding the participant's services. This can be the participant. If you enter a name other than the participant, enter the relationship to the participant. Enter the primary contact's phone # and Email.

Primary Care Physician: Enter the Primary Care physician name. Enter the Primary Care Physician Phone/FAX/Email.

ICD Diagnosis: Enter the appropriate ICD-9 diagnosis code. Effective October 1, 2014, the ICD-10 diagnosis code must be entered.

Medical Assistance Number (10-digits): Enter the 10-digit MA Number.

Provider Name: Enter the name of the provider that is authorized to provide the service.

Program Name: Check the appropriate program.

Section II: Service Authorized:

Check the authorized service. If you click on a box in error, clicking the box a second time will remove the "X."

Services that do not have a **(*)** or a **(**)** do not require the second page to be completed.

Section III: Details

Total Number of approved units per week: Enter the total number of units per week. If the unit of service is monthly, indicate so and simply document that amount in this box.

Service Provision Dates:

Annual Renewal: At the time of Annual Renewal, if there are no changes in service, the SC will issue a new form with the updated effective dates and any updated demographic or contact information. If there is a change in service, check the Revision box as well and enter the updated information on the rest of the form.

For a New Plan: Enter the authorized service begin and end dates as indicated in the approved ISP in either HCSIS or SAMS. The begin date will be the date OLTL approved the plan.

Temporary Change: If it is a temporary change that can be authorized by a SC supervisor, enter the date the SC supervisor authorized the change and the date the service will end.

Revision: If it is a Revision (change in need) enter the date the change was authorized by OLTL and the end date.

Termination: Enter the service termination date.

Preferred Schedule: Enter the days of the week and approximate times during the day the participant is to receive the services as it appears in the approved ISP.

Desired Outcome of service: Enter the participant's goal as it appears in the approved ISP.

Service Coordinator: Enter the SC's name.

SC Agency: Enter the SC Agency.

SC Phone/Email: Enter the SC phone # and Email.

Special Conditions/Instructions: Enter any special conditions or instructions that the provider will need to know in order to successfully provide the service authorized.

Individualized backup plan: Enter the participant's individualized back-up plan as it appears in the approved ISP.

Unique Circumstances: (Allergies, smoking, pets, children under 18, etc.): Enter any unique circumstances that the provider will need to know in order to successfully provide the service authorized.

Section IV (2nd page)

Check the applicable activities and beside note details for each of the items checked. If you click on a box in error, clicking the box a second time will remove the "X."

Services from Section II that do not have a **(*)** or a **(**)** do not require the second page to be completed.