

AUTHORIZATION REQUEST FORM

Effective 09/01/2014

This form should be completed by the Case Manager, reviewed by the Supervisor and then submitted to the Resource Coordinator.

Client Name:	Client MaineCare #:
Client EIS #:	
Case Manager:	Case Mgr. Email address:
CM Agency:	Case Mgr. Phone #:
Plan Assessment Number: *(the version for proposal(s))	Date CM rec'd proposal from Provider: Proposed start date of services:

Please use the following narrative space to give relevant information to the Resource Coordinator.

- Names of Provider Agencies proposing which services—beginning/increasing/decreasing/ending.
- Your understanding of the Team's and Providers' proposal—BRIEF—keep this form one page.
- Address any other services received—whether proposal will affect those services, or will not.

Attach:

- **OADS Personal Plan Face Sheet—paper copy—Member/Guardian & Case Manager signatures**

Case Manager: _____ **Date Request Submitted:** _____

Supervisor: _____ **Date Reviewed:** _____

Date received by Resource Coordinator: _____