Department of Health & Human Services Office of Aging and Disability Services

AUTHORIZATION REQUEST FORM

Effective 05/05/2015

Client Name: Click here to enter text.	***Client EIS #:***Click here to enter text.
Plan Assessment Number: Click here to enter text.	***Client MaineCare #:***Click here to enter text.
Case Manager: Click here to enter text. **CM Agency:** Click here to enter text.	**Case Mgr. Email address:**Click here to enter text. **Case Mgr. Phone #:**Click here to enter text.
Initial Classification Choose an item. **Termination from Waiver Reason** Choose an item. **Term Date:** Click here to enter a date. **Date CM rec'd proposal from Provider**:Click here to enter a date.	**Proposed start date of services:** Click here to enter a date. **Date Resource Coordinator Rec'd Document:** _____

The current services are as follows:

Type of Service	Hours	Provider	Notes
Choose an item.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Choose an item.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Choose an item.	Click here to enter text.	Click here to enter text.	Click here to enter text.

I am proposing the following changes :

Type of Service	Hours	Provider	Notes
Choose an item.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Choose an item.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Choose an item.	Click here to enter text.	Click here to enter text.	Click here to enter text.

If Shared Living, please provide address of new residence:

Click here to enter text.

Include: OADS Personal Plan Face Sheet—paper copy—Member/Guardian & Case Manager signatures
If initial Classification, must include Choice Letter
If new work support proposal, must include VR release letter

Case Manager: _____Date Request Submitted: _____

Supervisor: _____ Date Reviewed: _____