Louisiana Department of Health
Office for Citizens with Developmental Disabilities

CHILDREN'S CHOICE WAIVER THERAPY REQUEST FORM

Instructions: This form is to be used for all Children's Choice Therapy requests.

Support Coordinator will:

1. Obtain Doctor's Letter or Prescription of medical necessity for therapy services;
2. Obtain Service Providers' Plan of Care with stated services, where services are provided, the number of units to be used and the dates of services (Note: Service Provider's plan should include goals and outcome to be achieved.); and
3. Submit revision request for therapy to LGE for approval.

Support Coordinator will:

Section 1: Complete Therapy Request Form and obtain all signatures from participant/family/guardian and the enrolled service provider. (Note: All signatures are mandatory.)

Local Governing Entities will:

Section 2: Forward completed request form to Statistical Resources, Inc. (SRI) with approved revision for prior authorization.

SECTION 1 – COMPLETED BY SUPPORT COORDINATOR

Participant's Name:	SSN #:	
Address:		
Support Coordination Agency:	Phone #: ( )	Fax #: ( )
Provider Agency:	Phone #: ( )	
Address:	Provider #:	

Therapy	# of Units Requested	Date of Services
Sensory Integration		
Aquatic Therapy		
Art Therapy		
Music Therapy		
Hippotherapy		
Therapeutic Horseback Riding		

Service cannot be provided at same time as any other waiver or state plan service. Service cannot be provided in a school setting. All authorized therapy services are to be completed in the current approved POC year. **Exhausting available funds through the use of therapies does not qualify as justification for crisis designation.**

Funds Available? ☐ Yes ☐ No Children's Choice Current Balance: $

All available Medicaid State Plan and services provided through a program funded under the Individual with Disabilities Education Act (IDEA; 20 U.S.C. 1401 et seq.) must be utilized before accessing these services. All services must be outlined on the Plan of Care to prevent duplication of services. Have these services been requested through the Individual with Disabilities Education Act (IDEA) or Medicaid State Plan?

☐ YES (if denied, submit documentation with request)

☐ NO Why? _____

Provider Agency Agreement Signature:_____ Date: _____

Providers are NOT to begin therapy services without having received Prior Authorization.

Support Coordination Agency Agreement Signature: Date:

Participant/Family Agreement Signature: Date:

SECTION 2 - AGREEMENT AND PRIOR APPROVAL DETAILS COMPLETED BY WAIVER OFFICE

Procedure Code:	**Approved Amount: $**
Waiver Office Prior Approval Signature:	**Date of Prior Approval:**