2.9.1

Form – MDHHS Waiver Support Application (WSA) Database NorthCare Network Autism IPOS (Filled out by Care Coordinator)

Please submit Waiver Support Application to CMHSP Contact for WSA

Date Submitted: _____ **PIHP/CMHSP:** _____

Contact Name: _____ **Title:** _____

Contact Phone: _____ **Contact Email:** _____

Child's Name: _____ **Case ID#** _____

Individual Plan of Service

Please enter all information for each field

ABA Service Start Date: _____ **Amount (Hours per week):**_____

Informed of right to choose services providers (Y/N):_____ **Level of Intensity (EIBI/ABI):**_____

Agency Providing ABA services: _____

Supervisor of ABA services:_____ **Credential (LP, LLP, BCBA, CMHP):**_____

Notes: Any additional IPOS details if necessary