2.9.2

Protocol–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: Date ABA services began or the expected date of authorized service commencement.

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