**Please submit Waiver Support Application to CMHSP Contact for WSA**

Date Submitted: \_\_\_\_\_\_\_\_\_\_\_\_\_\_PIHP/CMHSP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Individual Plan of Service**

IPOS Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

IPOS End Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Service Level: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ABA Service State Date: \_\_\_\_\_\_\_\_\_\_

(Enter the date the direct ABA services began or the expected date authorized services are scheduled to begin)

97153/97154/0373T (Hours per week):

(If the hours per week equals zero, select the appropriate Auxiliary services and document in the notes field as to why zero)

Auxiliary Services: --- 97151 (behavior Identification assessment)

 --- 97156/97157 (Family Training)

 --- 0372T (Social skills group)

Informed of right to choose services and providers (Y/N): \_\_\_\_\_\_\_\_\_

Agency Providing ABA services: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supervisor of ABA services: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Credentials: \_\_\_\_\_\_\_\_\_\_\_

\*Telepractice: (Check all that apply)

[ ] Clinical observation and direction/home care training to home care client.

[ ] Family support/home care training (only individual family modality allowed for Telepractice.

Notes: Any additional IPOS details if necessary:

**\*Telepractice services must be prior authorized by MDHHS**. For this to occur the attached IPOS must clearly detail the anticipated amount, scope and duration of telepractice services to be requested. Remember to **complete the Telepractice tab if using telepractice and add a comment indicating why**.