State of Illinois
Department of Human Services - Division of Developmental Disabilities

Medicaid Waiver Therapy Prior Approval Request

Basic Information:

Name of Individual: ______________________ Social Security Number: ______________________

Recipient I.D. Number: ______________________ Date of Request: ______________________

(Check one therapy requested): ☐ **Occupational Therapy** ☐ **Physical Therapy** ☐ **Speech Therapy**

Name of Primary Provider: ______________________

Primary Waiver Service (Check One)
☐ 24 Hour/Host Family CILA ☐ Intermittent CILA ☐ Family CILA
☐ CLF ☐ Child HBS ☐ Adult HBS ☐ DT/SEP
☐ 65H Intermittent CILA ☐ Child Group Home
☐ Other (Specify): ______________________

DHS Network:
☐ Central ☐ Northwest ☐ Metro-North Chicago ☐ Metro-North Suburbs
☐ North Central ☐ South ☐ Metro-South Chicago ☐ Metro-South Suburbs

Name of Therapist: ______________________

Telephone # of Therapist: ______________________ Fax # of Therapist: ______________________

Address of Therapist: ______________________

City: ______________________ State: ______________________ Zip: ______________________

Required Attachments for All Therapy (OT/PT/Speech) Services:

____ **Therapy Evaluation**, signed and dated by the licensed occupational therapist, physical therapist or speech therapist who did the evaluation.

___________ The evaluation identifies individual therapeutic goals and objectives.

___________ The evaluation identifies specific needed therapeutic services.

___________ The evaluation clearly identifies the reasons why the services are needed (whether because of chronic conditions related to his/her developmental disability or because of an injury or hospitalization or other specific cause).

___________ The evaluation includes an HFS denial, if the individual was referred to HFS or if the individual is being terminated from HFS-funded restorative services because no further progress is being made.

___________ **Physician's Therapy Order**

Additional Attachments (If more than 26 Hours of Therapy per Fiscal Year is Requested):

___________ Physician's letter describing the need and what improvement is expected due to the additional hours to justify why 26 hours of therapy are insufficient.

___________ **Current Individual Service Plan.**

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Certification by Therapist and Primary Provider:

I certify that the information on this request is accurate to the best of my knowledge and the individual is not receiving therapy services funded by the Department of Healthcare and Family Services (HFS) under the Medicaid State Plan.

Therapist's Signature: ____ Date: ______________________

Agency Staff Signature: ____ Date: ______________________

Network Action - State Use Only (Check One):

____________Incomplete, return to therapist with missing information marked on page one.

____________Denied because need is restorative, return to therapist to submit to HFS for Medicaid State Plan prior approval.

____________Complete and approved for basic 26 hours per state fiscal year.

____________Complete and referred for clinical review for over 26 hours per state fiscal year (not to exceed 52).

____________Denied because documentation does not support need

Recommended Effective Date:

Network Facilitator Signature: _______________________________________ Date: ______________________

Clinical Services Recommendation - State Use Only (Check One):

___________ Need for additional hours of therapy is substantiated. Approved for hours (not to exceed 52) of therapy per state fiscal year.

___________**Denied because of documentation does not support need**

Recommended Effective Date:

Clinical Services Signature: ____ Date: ______________________