HVDDSO Day Habilitation /Prevocational Services
Request and Authorization Form

This form is completed to request that an individual be enrolled in OMRDD-funded Day Habilitation and Prevocational services, provided by your agency. This form ***must*** be accompanied by a completed ISP or Addendum reflecting the waiver service being requested. The DDSO decision will be returned to the provider agency. ***For TABS data entry for those individuals approved for services and enrolled in the waiver, the provider agency must send a completed DDPI and this form, with Section 5 completed by the DDSO, to:*** **John Grande, HVDDSO Records Dep't, PO Box 470, 2 Wilbur Rd., Thiells, N.Y. 10984**

SECTION 1: Consumer Information (name as it appears on Medicaid card)

Name: _____ TABS ID (if known): _____ DOB:_____

HCBS WAIVER ENROLLMENT: ☐ YES ☐ NOT ELIGIBLE – Lives in an ICF

☐ NO **:Attach a copy of the dated Assoc. Commissioner's approval for 100% state funded DH/PV.**

NOTE: BACKFILLS INTO MIRRORED SERVICES REQUIRE PRIOR APPROVAL BY THE ASSOCIATE COMMISSIONER.

Parent/Guardian Name: _____

Address: _____

_____

Is the person Aging Out: ☐ Yes ☐ No NYS-CARES: ☐ Yes ☐ No

SECTION 2: Day Habilitation/Pre-Voc Agency Information

Agency Name: _____ Contact Person:_____

Phone No.: _____ Fax No.: _____

SECTION 3: Requested Service

Service Type	Duration		"Master" Program Code
☐ Group Day Habilitation	☐ Full-time	☐ Part-time	_____
☐ Supplemental Group Day Hab	☐ Full-time	☐ Part-time	_____
☐ Prevocational	☐ Full-time	☐ Part-time	_____
☐ Individual Day Hab	# of Hours	_____	_____
☐ Supplemental Individual Day Hab	# of Hours	_____	_____

Requested start date of enrollment: _____

Program Location: _____

Does the person receiving the day service live in a certified setting? ie IRA, ICF, Family Care. ☐ Yes ☐ No

SECTION 4: Unit Allocation: To Be Completed by the Agency

☐ This agency is able to accommodate this consumer within our existing units because:

☐ Backfill Name of person being backfilled: _____
# of Existing Units used:_____

☐ Transfer Name of former provider: _____
Reason for transfer: _____

☐ This agency is not able to accommodate this consumer within existing units.

☐ # of Additional DH Units Needed: _____

SECTION 5: To Be Completed by the DDSO:

☐ Approved Number of Units: DH: _____ PV: _____ Start Date: _____

☐ Not Approved Reason_____

_____ _____

Signature of Hudson Valley DDSO, DDPS II or designee Date

REVISED: 02/06/08 lw