Moderate Needs Program
Service Request & Authorization Form

Completed by the Moderate Needs Case Manager after completing an assessment, person-centered plan AND confirming funding with each provider. For new applicants, submit to DAIL with complete enrollment packet.

Applicant Name: _____

Last 4 of SS#:_____ ICD-9 Code: _____ ICD-10 Code: _____

Check one: ❑New Applicant ❑Annual Review ❑Service Change ❑Reinstatement

Wait List Applicant: ❑Yes ❑No Requested Start Date: _____

Person-centered plan completed AND funding confirmed with each provider for the following services:

Service	Provider/Agency Name	Volume
☒ Case Management (*revenue code 070*)	Name:_____	Up to 12 hrs/calendar year
❑Flexible Funding (*revenue code 071*)	***Case Management Agency***	Up to $_____ yr
❑ Adult Day Services (*revenue code 096*)	Name:_____	Up to _____ hrs/week
❑ Adult Day Non-Medicaid Transport (*revenue code 071*)	***Adult Day Provider***	Up to $_____ week
❑ Homemaker Services (*revenue code 095*)	Name:_____	Up to _____ hrs/week

NOTE: Services must be based on a person-centered plan and are subject to available funds. Participants must contact their case manager regarding changes.

Case Manager Name: _____ Phone #:_____

Signature: _____ Date: _____

Applicant Legal Rep Signature: _____ Date: _____

*****DAIL Authorization*****

This person meets eligibility for Moderate Needs Services and is approved for services identified on this request.

Authorization Start Date: _____ / End Date:_____

_____ _____

Signature *Date*

Case Manager must submit annual review within one month before end date.

(Copy to the participant, case manager and applicable providers.)