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| cid:image002.jpg@01DA9C9B.873348C0 | **Restoration of Rollover Units Request** |

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| **Section 1: Identifying Information** | |
| Individual’s name: Enter text.  DDD ID: Enter text. | Date of request submission: Enter date.  Individualized Service Plan end date: Enter text. |
| Support Coordination Agency: Enter text. | |
| Support Coordinator’s name:  Enter text. | Phone number: Enter text.  Email address: Enter text. |

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| **Section 2: Budget Status *(Answer both questions.)*** | |
| This individual’s budget is **fully** expended. | Yes  No |
| This individual’s budget has **available** funding to cover unused units requested. | Yes  No |

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| **Section 3: Service Details** | |
| Plan ID #: Enter text.  Outcome #: Choose / Service #: Choose  Procedure Code: Enter text.  Service Start Date: Enter date.  Service End Date: Enter date. | Total Units Authorized: Enter text.  Total Rollover (unused) Units: Enter text.  Units Requested for Restoration: Enter text.  Date of Plan Revision Submission: Enter date. |

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| **Section 4: Self-Directed Employee (SDE) Information *(if applicable)*** |
| *To add rows for additional SDEs, click in the bottom row and click the blue plus sign* (**+**) *on the right*. |
| SDE name: Enter text.  Fiscal Intermediary: Choose an item. |
| SDE name: Enter text.  Fiscal Intermediary: Choose an item. |
| SDE name: Enter text.  Fiscal Intermediary: Choose an item. |

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| **Section 5: Vendor Information *(if applicable)*** |
| Vendor name: Enter text.  Vendor representative: Enter text. |

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| **Section 6: Justification / Evidence of Rollover Units** |
| Please provide a clear explanation for the request:  Enter text. |

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| **Section 7: Support Coordinator Attestation** | |
| **By submitting this form, the Support Coordinator attests to the following:**   * The information on this form was compiled in collaboration with the individual/legal guardian, the vendor, and/or SDEs, and includes verification of timesheet submissions to ensure an accurate rollover units request. * To the best of my knowledge, all information on this form is accurate and true. * I acknowledge that deliberate false statements or omissions on this form may be considered Medicaid fraud and subject to investigation.   **Special Note:** The Division will be conducting random sample audits with all contracted fiscal agents to ensure Medicaid fraud is not occurring. | |
| Support Coordinator’s name: Enter text. | Date: Enter date. |

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| **Section 8: Division Review *(Division Use Only)*** | |
| Reviewer name: Enter text. | Date: Enter date. |
| Division Status: Approved  Not Approved  iRecord updated: Yes  No | |
| Comments:  Enter text. | |