**Request for**

**Community Inclusion Services or Individual Supports- Hourly**

 **for Individuals Receiving Individual Supports-Daily**

(Replaces Individual Supports Request Form)

**Use this form when requesting Community Inclusion Servcies (CIS) or Individual Supports (IS) Hourly, at the 15 minute unit rate, for an individual who already receives IS-Daily and is in need of support not covered through IS-Daily.**

Refer to Appendix K in the manual for information on overlapping services. ***Please complete and upload this form to the “Documents Tab” in iRecord when Community Inclusion Services or Individual Supports are entered into the plan AND require Service Review. Title the document CIS/IS Request Form.***

Select One ***(The need for the requested service must be identified in the NJCAT and/or the PCPT)***

**[ ] Community Inclusion Services (2 to 6 individuals)**

**[ ]  Individual Supports**

**[ ]  Individual Supports (Self-Directed Employee)**

**Name of Individual:**       **DDD ID#:**       **Date of Request:**

1. **What is the name of the provider receiving the daily rate?**
2. **What is the name of the provider that will be billing at the 15 minute unit rate?**
3. **Describe in detail the specific service to be provided in 15 minute units, be sure to include where the service will be provided. i.e. gym, religious worship, at class, at home, medical visit etc.**
4. **Where in the NJCAT and/or the PCPT is the need for this service referenced?**
5. **Is this service increasing the participant’s involvement in the community?** **[ ]  YES** **[ ]  NO**
6. **If “YES” explain how.**

1. **Have natural and generic supports been explored?** **[ ]  YES** **[ ]  NO**
	1. **If “NO” please explain why.**
	2. **If “YES” please explain the outcome of the natural and generic support research.**
2. **Provide a weekly schedule here, outlining the days and times the requested service will be used.**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Sunday** | **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** | **Saturday** |
| **AM** |       |       |       |       |       |       |       |
| **PM** |       |       |       |       |       |       |       |

1. ***For CIS only*: does this total more than 30 hours a week?** **[ ]  YES** **[ ]  NO**
2. ***For CIS only*: does this include transportation time to and from the event?** **[ ]  YES** **[ ]  NO**
3. **Indicate the weekly number of Day Habilitation hours in the plan.**
4. **Is this service being requested in lieu of a Day Program?** **[ ]  YES** **[ ]  NO**
5. **Is the individual interested in attending a Day Program?** **[ ]  YES** **[ ]  NO**
6. **If “YES”, list what Day Programs have been explored and the outcome of the referrals.**
7. **Is this service to support the individual at the current place of employment?** **[ ]  YES** **[ ]  NO**

***The questions below require information from the provider receiving the daily rate***

***Please DO NOT include any identifying information related to individuals other than that of the person named above.***

1. **How many individuals live in the group setting? Provide the number here**      **.**
	1. **Is more than one individual living in the same setting using this CIS with the same provider at the same time?**

**[ ]  YES** **[ ]  NO**

* 1. **If the answer is “YES” provide the total number of individuals using CIS with the same provider during the same time?**
1. **Are any other individuals living in this group setting receiving CIS or IS services in addition to the daily rate?** **[ ]  YES** **[ ]  NO**
2. **If “YES”, how many?**
3. **Describe in detail why the individual is in need of CIS or IS when supported through a daily rate.**
4. **Describe in detail why these services can’t be covered in the daily rate?**
5. **Is this request in any way related to staff shortages or staff scheduling by the provider receiving the daily rate?**

***I certify the information provided on this form and any related information is true and accurate. I also acknowledge that false statements or deliberate omissions on this document may be considered Medicaid fraud and subject to investigation by the State of New Jersey.***

**Request completed by:**

**Relationship to Individual:**

**The information on this form has been provided by the following:**

**Full Name of person at agency providing daily rate:**

**Full Name of person at provider agency billing for 15 minute unit rate:**