DEPARTMENT OF HEALTH AND HOSPITALS
Aging and Adult Services

Community Choices Waiver (CCW)
Nursing/Therapy Payment Authorization Form

Name of Participant: _____

DOB: _____ SSN: _____

Address: _____

Name of Responsible Representative (if applicable): _____

Name of Responsible Representative (if applicable): _____

Name of SCA: _____ Phone # of SCA: _____

Name of SC: _____

Name of Home Health Agency: _____ Phone # of HHA: _____

The following has been approved and Prior Authorization(s) (PAs) can be released for payment:

☐ **I. Home Health Agency (HAA) – Nursing Assessment by R.N. (T1001) (TD)**
Amount authorized per service: $65.22 Date of assessment: _____
Support Coordinator Signature: _____ Date: _____

☐ **II. Home Health Agency (HAA) – Nursing Care by R.N. (T1030)**
Amount authorized per service: $65.22 # of visits authorized: _____ Date of visits: _____
Support Coordinator Signature: _____ Date: _____

☐ **III. Home Health Agency (HAA) – Nursing Assessment by L.P.N. (T1001) (TE)**
Amount authorized per service: $58.00 Date of assessment: _____
Support Coordinator Signature: _____ Date: _____

☐ **IV. Home Health Agency (HAA) – Nursing Care by L.P.N. (T1031)**
Amount authorized per service: $58.00 # of visits authorized: _____ Date of visits: _____
Support Coordinator Signature: _____ Date: _____

☐ **V. Physical Therapy Evaluation, Outpatient (97001) (GP)**
Amount authorized per service: $77.50 Date of assessment: _____
Support Coordinator Signature: _____ Date: _____

☐ **VI. Physical Therapy Re-evaluation, Outpatient (97002) (GP)**
Amount authorized per service: $77.50 Date of assessment: _____
Support Coordinator Signature: _____ Date: _____

☐ **VII. Physical Therapy/In-Home (S9131)**
Amount authorized per visit: $77.50 # of visits authorized: _____ Date of visits: _____
Support Coordinator Signature: _____ Date: _____

Community Choices Waiver (CCW)
Nursing/Therapy Payment Authorization Form

☐ **VIII. Physical Therapy Home Care Training, Family, per session, Outpatient (S5111) (GP)**
Amount authorized per visit: $77.50 # of visits authorized: _____ Date of visits: _____

Support Coordinator Signature: _____ Date: _____

☐ **IX. Physical Therapy Home Care Training, Non-Family, per session, Outpatient (S5116) (GP)**
Amount authorized per visit: $77.50 # of visits authorized: _____ Date of visits: _____

Support Coordinator Signature: _____ Date: _____

☐ **X. Occupational Therapy Evaluation, Outpatient (97003) (GO)**
Amount authorized per service: $77.50 Date of assessment: _____

Support Coordinator Signature: _____ Date: _____

☐ **XI. Occupational Therapy Re-evaluation (97004) (GO)**
Amount authorized per service: $77.50 Date of assessment: _____

Support Coordinator Signature: _____ Date: _____

☐ **XII. Occupational Therapy/In-Home (S9129)**
Amount authorized per visit: $77.50 # of visits authorized: _____ Date of visits: _____

Support Coordinator Signature: _____ Date: _____

☐ **XIII. Occupational Therapy Home Care Training, Family, per session, Outpatient (S5111) (GO)**
Amount authorized per visit: $77.50 # of visits authorized: _____ Date of visits: _____

Support Coordinator Signature: _____ Date: _____

☐ **XIV. Occupational Therapy Home Care Training, Non-Family, per session, Outpatient (S5116) (GO)**
Amount authorized per visit: $77.50 # of visits authorized: _____ Date of visits: _____

Support Coordinator Signature: _____ Date: _____

☐ **XV. Speech/Language/Hearing Evaluation, Outpatient (92506) (GN)**
Amount authorized per service: $77.50 Date of assessment: _____

Support Coordinator Signature: _____ Date: _____

☐ **XVI. Speech/Language/Swallow/Function/Evaluation (92610) (GN)**
Amount authorized per service: $77.50 Date of assessment: _____

Support Coordinator Signature: _____ Date: _____

☐ **XVII. Speech/Language/Hearing, Outpatient (92507) (GN)**
Amount authorized per visit: $77.50 # of visits authorized: _____ Date of visits: _____

Support Coordinator Signature: _____ Date: _____

☐ **XVIII. Speech/Language, Oral Function Therapy, Outpatient (92526) (GN)**
Amount authorized per visit: $77.50 # of visits authorized: _____ Date of visits: _____

Support Coordinator Signature: _____ Date: _____