LOUISIANA DEPARTMENT OF HEALTH
Office for Citizens with Developmental Disabilities

MONITORED IN-HOME CAREGIVING SERVICES FORM

New Opportunities Waiver (NOW) ☐ Residential Options Waiver (ROW) ☐

Name of Participant: _____

DOB: _____ Address: _____

Name of Personal Representative (if applicable): _____

Name of SCA: _____ SCA Phone Number: _____

Name of SC: _____

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

☐ **MIHC Intake and Assessment (T1028)** Amount Authorized: $250.00

Name of MIHC Provider: _____

Phone Number: _____

Date of Initial Contact by MIHC Provider: _____

Completion date of the MIHC Assessment: _____

Participant is MIHC Eligible: ☐ Yes ☐ No

Participant is receiving Hospice Care ☐ Yes ☐ No

MIHC Provider Signature & Date: _____

TO BE COMPLETED BY SUPPORT COORDINATOR

NOW SIS Level	MIHC Level
ROW I-Cap Score	MIHC Level

If yes, Anticipated MIHC start date: _____Unknown_____

Signature of Support Coordinator: _____

SC Supervisor Signature: _____

Date: _____

TO BE COMPLETED BY HUMAN SERVICES DISTRICT OR AUTHORITY

Approval_____ Denial_____ (return to Support Coordinator for additional information)

HSD/A Signature: _____ Date:_____

Note: Submit form to SRI with revision request for Prior Authorization release.