

DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)
Complementary Therapies Agreement

CLIENT'S NAME		DATE
		DATE OF BIRTH
Verification of CIIBS Waiver Funding (all must apply)		
<input type="checkbox"/> Identified services are not available under the CIIBS waiver participant's private health insurance or any other liable third party payer.		
<input type="checkbox"/> Identified services do not place or duplicate any paid or unpaid supports and services such as Occupational Therapy, Physical Therapy, or Behavioral Health supports.		
<input type="checkbox"/> Services address a need identified in the waiver participant's Person Centered Service Plan.		
<input type="checkbox"/> The person Centered Service Plan (PCSP) is attached.		
ADDITIONAL INFORMATION/ SPECIAL INSTRUCTIONS (PROVIDE ANY ADDITIONAL INFORMATION NOT ALREADY INDICATED IN THE PCSP)		
Service to be Provided		
<input type="checkbox"/> Music Therapy <input type="checkbox"/> Equine Therapy		
ADDITIONAL INFORMATION/ SPECIAL INSTRUCTIONS (PROVIDE ANY ADDITIONAL INFORMATION NOT ALREADY INDICATED IN THE PCSP)		
VENDOR CONTRACT RATE	FREQUENCY (ONE TIME, WEEKLY, MONTHLY)	Not to exceed hours or \$
Duration: Begin Date End Date (not to exceed annual plan date)		
Provider Reports		
These services require submission of certain assessments, plans, and reports. Plans and progress reports must conform to the contract specifications and are due as described in the provider's contract or otherwise directed by DDA. Payment will not be authorized without receipt and review of these reports.		
Please submit: <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Other:		
CASE RESOURCE MANAGER'S SIGNATURE DATE		PRINTED NAME
Approved By:		

Supporting documents attached.
Copy to file.

Instructions for CRM for Complementary Therapy Services

When do I use this memo?

Complete this memo after you have received prior approval for Equine or Music Therapy. Attach this memo to the PCSP and send it to the identified service provider.

Why do I need to use this memo?

You are responsible for the oversight of planned services. It is important to communicate what services you expect from the service provider and their reporting requirements.

Who completes this form?

The case manager is responsible for filling out this form prior to authorizing services.