

**Authorization for Community Care Services**

Service Name:

1. Date	2. Contract Number	3. Type of Authorization <input type="checkbox"/> 1 New <input type="checkbox"/> 2 Update <input type="checkbox"/> 3 Terminate	4. Begin Date	5. End Date	6. Term Code
7. Individual Name	8. Individual Number	9. 2060 Score	10. Priority	11. County	12. Agency <b>324</b>

13. Provider Address	SERVICE						COPAYMENT		
	14. RUG	15. Fund Code	16. Group <b>7</b>	17. Code	18. Units	19. Unit Type	20. Initial Amount	21. Ongoing Amount	22. % CMPAS Only

23a. For <b>PAS</b> check one: <input type="checkbox"/> CAS <input type="checkbox"/> PHC <input type="checkbox"/> FC	Check if CDS <input type="checkbox"/> CDS	23b. For <b>DAHS</b> check one: <input type="checkbox"/> Title XIX <input type="checkbox"/> Title XX
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24. Service Items - Personal Assistance Services Only (check all that apply):

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|--------------------------------------|--|---------------------------------------|--|--|
| <input type="checkbox"/> 01 Bathing  | <input type="checkbox"/> 04 Feeding/Eating             | <input type="checkbox"/> 08 Toileting | <input type="checkbox"/> 12 Cleaning         | <input type="checkbox"/> 15 Escort                                   |
| <input type="checkbox"/> 02 Dressing | <input type="checkbox"/> 06 Grooming/Shaving/Oral Care | <input type="checkbox"/> 10 Transfer  | <input type="checkbox"/> 13 Laundry          | <input type="checkbox"/> 16 Shopping                                 |
| <input type="checkbox"/> 03 Exercise | <input type="checkbox"/> 07 Routine Hair/Skin Care     | <input type="checkbox"/> 11 Walking   | <input type="checkbox"/> 14 Meal Preparation | <input type="checkbox"/> 17 Assist with Self-Administered Medication |

25. Comments:

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**Authorizing Agents (as applicable)**

26. Case Manager	27. Telephone Number (with area code and extension)	28. Mail Code	29. BJN
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30. Case Manager Address
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31. Practitioner	32. Telephone Number (with area code and extension)	33. License No	34. Date of Order
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35. Nurse	36. Telephone Number (with area code and extension)	37. Mail Code	38. BJN
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39. Nurse Address
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40. Diagnosis:

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**Contracted Agency May Complete This Section and Return a Copy to DADS .....** Service Initiation Date

Schedule	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Total Hours

Agency Contact Person	Telephone No. (with area code and ext.)
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Comments:

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Signature — Agency Representative\_\_\_\_\_  
Date