Medina County
board of developmental disabilities

Provider Revision Request:

This revision request form is only for use when a change to the ISP needs to occur outside of a team meeting; revision timeframes will be followed when requests are made during team meetings

Individual's Name:		Provider:		Today's Date:	
Person Completing Form:		Provider E-mail:		Provider Phone #:	
Span Start Date:		Revision Effective **Start** Date:		Revision Effective **End** Date:	

Instructions

1. Except in cases of emergency, revisions should be requested prior to implementation.
2. Revision requests must be submitted 30 days prior to the effective date of change to ensure payment.
3. This form must be E-mailed to the revisionrequest@mcbdd.org email.

DETAILS:
Why Are You Submitting This Revision Request?

Section A: Moving Units

Units can be moved between splits in the detail lines of PAS (such as fiscal year split between 6/30 and 7/1). Units CANNOT be moved for service code ADL.

Service/ Billing Code	From PAS line(s) (TO/FROM dates)	Total Units Currently Authorized	# Units to move	TO PAS line(s) TO/FROM dates	# Units moved to this PAS line

Section B: Change in residential schedule

Describe In Detail What Needs To Be Changed (i.e. "add 15 minutes to Wed. AM schedule")

Section C: All other change requests

Use for changes to unscheduled HPC or drop-in HPC, HPC mileage, Foster Care, Meals, Respite, Adult Day, Vocational Habilitation, Group Employment Supports, Individual Employment Support etc.

Explain why this change is needed for health and safety of the individual. What occurred in the individual's life?

Service/Billing Code	PAS Span	Units Authorized	Ratio	Request Units to Increase or Decrease	Total Units with Request

TO BE COMPLETED BY MCBDD ONLY after cost increase has been reviewed

Does this request require: **1.** AAI Override? **Y N** **2.** Prior Authorization? **Y N** **3.** Budget Override? **Y N**

Request was made timely: Yes _____ No _____ Request approved: Yes _____ No _____

Will this cost increase cause overtime for an independent provider: Yes _____ No _____

Reason if not approved:

_____

_____

_____

SSA Name: SSA Signature: Date: