Individual Supports Prior Approval Request Form

Prior Approval Type (check all that apply)**:**

☐ Overtime ☐ Overlapping Hours (2:1) ☐ Vendor/Provider Reimbursement/Purchase (Requires Vendor Packet)
☐ Incapacitated Caregiver/EOR ☐ State Funded ☐ Vehicle/Environmental Modifications
☐ Individual Goods & Services (Pls Attach Professional Recommendations/Certifications /Licensures/) ☐ Paid Representative
☐ Exceeds Waiver Cap or Cost Standard ☐ Other (Explain in Support Request)

If more than one box is checked, please complete the following information for each request.

Effective Date:

End Date:

Please note information is required in at least one of the Amount fields

Amount in Dollars:

Amount in Hours:

The Budget RDID is an identifier for the specific service and funding which connects the prior approval to the appropriate budget line. To locate it, copy the relevant budget line from the individual's budget and paste it into Excel starting in column A. The previously hidden RDID will appear in column N. Copy it to complete the box below. If you have not identified a budget line, leave these boxes blank for the SD Director to complete.

Budget RDID:

Service Name:

Prior Approval must be secured before the cost of prior approval items, goods, services, rates, or fees may be entered into the individual budget system. **Note**: Prior Approvals cannot exceed a 3 yr. approval period.
The following criteria must be met for a prior approval request to be considered:

1. Relates directly to the persons disability
2. Relates directly to a specific need identified in the individual's plan or plan summary
3. Funds necessary to support the requested items, goods, services, rates or fees must already be in the individual's existing budget or have been allocated by the Planning Resource Allocation Team (PRAT).

The following criteria shall be used to further evaluate requests for prior approval:

- Represents a one-time investment, that will lead to less dependence on the department in the future.
- Prevents or minimizes a health or safety risk to the individual.
- Directly supports the individual's ability to maintain his or her home or work/day arrangement.
- Represents a significantly cost-effective support arrangement.

I.C.2.PR.009 Attachment B
10.6.2006
Revised 5.2007
Revised 7.1.2008
Revised 12.15.2010
Revised 11.22.2024

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Region: West Date:	Contact Person: Person for whom request is made: DDS #:	Phone:
Support Requested: Describe the requested items, goods, services, rates, or fees. Breakout one-time costs and ongoing costs.		Cost:
Rationale/Justification: Please describe how the requested expense meets the prior approval criteria.		

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Upon completing the previous sections, please submit to the regional Self-Determination Director, or designee, for approval. The sections that follow are for administrative review and approval use only.

Regional Decision: *(approvals are limited to a period of no greater than 3 years)*

Select Decision

Date:

Qualifications:

Additional Comments:

Name of Approver

Approved Prior Approvals should be emailed to ctdds@gtsd.org