Request for Single Case Agreement
Residential Habilitation

Type of Request: ☐ Initial ☐ Continuation

Name of Person: _____

Medicaid ID Number: _____

Residential Habilitation Model (*current or proposed*): _____

Residential Habilitation Provider (*if known*): _____

Current tier of Residential Habilitation *(approved or authorized)*: _____

Established rate for the tier of Residential Habilitation (*without SCA*): _____

If this is an initial request, indicate the amount of funding per daily unit being requested:

_____

If this request is for a continuation, indicate the current amount of funding per daily unit covered by the SCA:

_____

Indicate the nature of the additional support's services for which the SCA is needed:

☐ Additional staff support (must provide specific current and/or proposed staffing schedules which highlight the additional staffing for which SCA is requested or has been approved)

☐ 1 to 1 staff support (must specifically define 1:1 {within arm's length, within same room, etc.} and must provide staffing schedule highlighting the 1:1 staffing coverage)

☐ Professional services (e.g., nursing, dietician, IBI, etc.)

☐ Single occupancy environment

☐ Other: Describe: _____