REQUEST FOR POST AUTHORIZATION REIMBURSEMENT FOR EMERGENCY HOURS WORKED FOR HURRICANE GUSTAV

(Hours Worked Above Hours Approved in CPOC)

Check one of the following services provided. NOTE: Use one procedure code per completed form .

	NOW WAIVER	CODE		CHILDREN'S CHOICE WAIVER	CODE
	ATTENDANT CARE SERVICE **DAY**	S5125 U1		ATTENDANT CARE SERVICE DAY	S5125
	ATTENDANT CARE SERVICE **DAY- 2 PERSON**	S5125 UN		CENTER BASED RESPITE	T1005 HQ
	ATTENDANT CARE SERVICE **DAY- 3 PERSON**	S5125 UP		**ELDERLY/DISABLED ADULT WAIVER**	
	ATTENDANT CARE SERVICE **NIGHT**	S5125 UJ		COMPANION CARE	S5135
	ATTENDANT CARE SERVICE **NIGHT- 2 PERSON**	S5125 UJUN		LONG TERM PCS	T019
	ATTENDANT CARE SERVICE **NIGHT- 3 PERSON**	S5125 UJUP			

COMPLETION OF THIS FORM DOES NOT SUBSTITUTE FOR NORMAL DOCUMENTATION REQUIREMENTS.
PLEASE LIST ONLY HOURS WORKED ABOVE THOSE IN THE APPROVED CPOC.
REAL TIME MUST BE RECORDED - ROUNDING UP OR DOWN IS NOT ACCEPTED.

RECIPIENT:_____ SS#: _____
(PLEASE PRINT FULL NAME)

PROVIDER:_____ PROVIDER #:_____
(PLEASE PRINT FULL NAME)

WEEK ALWAYS STARTS ON MONDAY ____/____/____ WEEK ALWAYS ENDS ON SUNDAY____/____/____

DATE	PLACE OF SERVICE S = Shelter H = Home SH = Staff Home OS = Out of State O = Other_____		TIME IN	TIME OUT	TOTAL
	PLACE OF SERVICE	EMPLOYEE NAME	AM/PM	AM/PM	TIME
			TOTAL HOURS		

JUSTIFICATION (Why were these services needed above CPOC hours?)

I, the undersigned, certify to that I have read the contents of this form, and the information contained herein is true, correct and complete.

PROVIDER SIGNATURE:_____DATE:_____

SUPPORT COORDINATION REVIEW OF SERVICES Regional Office Approval Date
SIGNATURE:_____DATE_____

ssued Date: 09/10/2008