|  |  |
| --- | --- |
| **Provider/Agency Name:** |   |

Please indicate the services you wish to add to or remove from your certification, as well as the towns or counties that will be affected. If you choose to provide services in a county, you must be prepared to deliver services in all areas of the county. Please refer to the Comprehensive and Support Waiver Service Index for a definition of the service being added, as well as the qualifications required in order to provide the service.

[ ]  Please include my name on the publicly available provider list.

[ ]  I plan to provide services to my child or ward (please review Chapter 45, Section 31 to ensure compliance with Department of Health Medicaid Rules.)

|  |  |  |  |
| --- | --- | --- | --- |
| **Remove** | **Add** | **Service**  | **City(ies) or County(ies)**  |
| [ ]  | [ ]  | Adult Day Services |   |
| [ ]  | [ ]  | \*Behavioral Support  |   |
| [ ]  | [ ]  | \*Case Management |   |
| [ ]  | [ ]  | Child Habilitation |   |
| [ ]  | [ ]  | \*Cognitive Retraining |   |
| [ ]  | [ ]  | Community LivingLevel:  |   |
| [ ]  | [ ]  | Community Support |   |
| [ ]  | [ ]  | Companion |   |
| [ ]  | [ ]  | Crisis Intervention Support |   |
| [ ]  | [ ]  | \*+Dietician |  |
| [ ]  | [ ]  | \*Environmental Modification |   |
| [ ]  | [ ]  | +Homemaker |  |
| [ ]  | [ ]  | Individual Habilitation Training |   |
| [ ]  | [ ]  | \*+Occupational Therapy |  |
| [ ]  | [ ]  | Personal Care |   |
| [ ]  | [ ]  | \*+Physical Therapy |  |
| [ ]  | [ ]  | Respite |   |
| [ ]  | [ ]  | \*+Skilled Nursing |  |
| [ ]  | [ ]  | \*Specialized Equipment |   |
| [ ]  | [ ]  | \*+Speech. Language, & Hearing |  |
| [ ]  | [ ]  | Supported Employment |   |
| [ ]  | [ ]  | \*Transportation |   |

*\* Additional credentials or licensing is required in order to provide this service*

*+ These services will be eliminated effective February 1, 2021*

**Signature Date:**