PRIOR AUTHORIZATION ADDITIONAL INFORMATION FORM
Supplemental Habilitation & Additional Individualized Staffing

Please attach to form MA 97

1. Individual's Name: _____ 2. MCI (Recipient) Number: _____
3. SCO Contact Name & E-Mail Adress: _____
4. Provider Agency's Name: _____
5. MPI Number: _____ 6. Service Location Code: _____
7. Provider Contact Name & E-Mail: _____
8. Provider's Address: _____
9. Administrative Entity Name: _____
10. AE Contact Name & E-Mail Address: _____

Please indicate the requested service(s): (Check One)

11. ☐ **W 7070** Supplemental Habilitation 1:1
12. ☐ **W 7084** Supplemental Habilitation 2:1
13. ☐ **W 7085** Additional Individualized Staffing 1:1
14. ☐ **W 7086** Additional Individualized Staffing 2:1
15. **Begin Date** _____ 16. **Anticipated End Date** _____
17. **Describe in detail** the individual's need for Supplemental Habilitation or Additional Individualized Staffing:

The following have been verified:

18. ☐ Yes ☐ No ISP includes the necessary documentation as outlined in the timeline.
19. ☐ Yes ☐ No Current staffing pattern supports need for additional staff.
20. ☐ Yes ☐ No Provider confirms that current agency resources do not exist to meet need.