REQUEST FOR OUT-OF-STATE TRAVEL

Date of Request: ________________

Name of Individual: ____

Dates of Travel from: ______________________ to: ______________________

Destination: ____

Natural Supports Traveling with Individual (include relationship to individual):

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1. Individual's Daily Needs:

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____

2. Staff Requirements (based on needs above):

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3. Why are natural supports unable to meet individual's needs?

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4. What services need to be delivered out-of-state (must be habilitative service)?

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On what schedule will these services be delivered:

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Hours							

- If licensed professionals are involved, Medicaid cannot waiver other state licensure laws
- Medicaid will not be responsible for room, board, or transportation cost
- Provider Agencies must assume all liability for their staff while out-of-state
- Treatment plans must not be changed to increase services while out-of-state
- Respite, based on the definition, would not be an appropriate service since natural supports are present during the travel

By signing below, the Employer of Record agrees with this request and to all above listed conditions:

Signature	Date
Reviewer Signature	Date

Send form to: Care Coordinator
Comments:

TRILLIUM Use
☐ Approved ☐ Denied