Form 8606-A
August 2011-E

Community Living Assistance and Support Services (CLASS)

Therapy Justifications – Attachment to IPP

Individual's Name		Medicaid No.
Case Management Agency (CMA) Name	**CMA Vendor No.**	**Requested Skilled or Specialized Therapy**

List non-waiver resources that were exhausted:

Signature – Case Manager

Date

To be Completed by the Appropriate Professional

Diagnosis:

Brief description of need for services:

Specific qualifying conditions requiring treatment:

Describe or attach the interventions planned with baseline data and goals and objectives outlined in observable and measurable terms. Also include a plan for implementation and the scope, duration, amount, frequency and location of service.

Can components of the requested service be delivered by someone other than a therapist? ☐ **Yes** ☐ **No**

If no, please describe the components that require a licensed/certified professional:

Describe a plan for transferring the therapy services to a non-therapist and changing the role of the therapist to a supervisory role of the non-therapist:

Signature – Professional

Title

Date

Printed Name of Professional	Area Code and Telephone No.	License No. (if applicable)