|  |  |  |
| --- | --- | --- |
| Provider Name |  | Send to: resource coordinator  DHHS OADS Central Office  41 Anthony Avenue, SHS 11  Augusta, Maine 04333-011  207-287-9200 [**ResourceCoordinator-OADS@maine.gov**](mailto:ResourceCoordinator-OADS@maine.gov) |
| Contact Person |  |
| Phone & Email |  |

|  |  |
| --- | --- |
| **Procedure Code**  **(enter the procedure code)** | **Section of MaineCare Policy and Description**  **Enter the section of policy and description:** |
| **Example:**  **T2016 U9** | **Example:**  **Section 18- Home Support- Level II** |
|  |  |
|  |  |
|  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Current Enrolled Location address | NPI # | Date Alt. Care Site Operational | Alt. Care Site Address | Alt. Care Site Capacity |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

|  |  |
| --- | --- |
| Approved by: | Date: |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Individuals Served in Alternative Settings** | | | | |
| Individuals Last Name | Individuals First Name | Authorized Location Site | Alternative Setting Address | Dates of Service |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

|  |  |
| --- | --- |
| Alternative Setting Requirements | Response (y/n) |
| 1. The settings is approved prior to billing |  |
| 1. The individual approves of the change in setting |  |
| 1. The legal representative approves of the change in setting (as applicable) |  |
| 1. There is no duplication in billing |  |

|  |  |  |
| --- | --- | --- |
| Agency Name: | Provider attests the information above to be true and accurate and the provider has verified no duplicative billing | Date: |
| Authorized Agency Representative Name: | Signature: |  |