Texas Department of Aging
and Disability Services

Form 3671-B
June 2013-E

Community Based Alternatives

Therapy Service Authorization

1. Applicant/Individual	2. Medicaid No.	(THIS SPACE FOR DADS USE ONLY) 3. Effective Date
4. DADS Case Manager		5. Provider Vendor No.

☐ **6. No Therapy Indicated Based on Assessment**

7. RN's Rationale for Referral (if applicable)

☐ **8. Physical Therapy** ☐ **CDS**

9. Name of Physical Therapist	10. Name of Physical Therapy Assistant	11. Date Referred for Therapy Assessment	(FOR DADS USE ONLY) 12. Assessment-Total hours Approved

13. Direct Service Start Date	14. Days/Week	15. Hrs/Visit	16. Total Hrs./Week	17. Stop Date (or duration)	18. Total Hrs. Auth. (Inc. Assessment) (FOR DADS USE ONLY)	19. Provided by: ☐ **1-CBA** ☐ **2-TPR**

☐ **20. Occupational Therapy** ☐ **CDS**

21. Name of Occupational Therapist	22. Name of Occupational Therapy Assistant	23. Date Referred for Therapy Assessment	(FOR DADS USE ONLY) 24. Assessment-Total hours Approved

25. Direct Service Start Date	26. Days/Week	27. Hrs/Visit	28. Total Hrs./Week	29. Stop Date (or duration)	30. Total Hrs. Auth. (Inc. Assessment) (FOR DADS USE ONLY)	31. Provided by: ☐ **1-CBA** ☐ **2-TPR**

☐ **32. Speech Therapy** ☐ **CDS**

33. Name of Speech Therapist	34. Name of Speech Therapy Assistant	35. Date Referred for Therapy Assessment	(FOR DADS USE ONLY) 36. Assessment-Total hours Approved

37. Direct Service Start Date	38. Days/Week	39. Hrs/Visit	40. Total Hrs./Week	41. Stop Date (or duration)	42. Total Hrs. Auth. (Inc. Assessment) (FOR DADS USE ONLY)	43. Provided by: ☐ **1-CBA** ☐ **2-TPR**

44. Description of Direct Service – To be completed by therapist upon assessment, to include clinical impression, reason for referral, assessment of current condition, problem list, treatment plan, short-term, long-term goals, etc. (Attach additional pages, if necessary.):

45. Specifications or Orientation

Number of Hours Specifications: _____ Orientation: _____	Provided by ☐ **Physical Therapist** ☐ **Occupational Therapist** ☐ **Speech Therapist**

CERTIFICATION BY INTERDISCIPLINARY TEAM MEMBERS: The waiver services identified above for this applicant/individual are necessary to prevent nursing facility placement and are appropriate to meet the needs of the applicant/individual in the community.

Signature–HCSSA Nurse Assessor	Date	Signature–Applicant/Individual/ Responsible Party	Date
Signature–DADS Case Manager	Date	Signature–HCSSA Representative (if required)	Date
Signature–Therapist	Date	☐ **Applicant/individual/responsible party and HCSSA representative signatures on Form 3671-2 at initial certification and annual redetermination.**	