TEXAS Department of Aging and Disability Services

Form 2402
September 2014-E

Medically Dependent Children Program

Consumer Directed Services Option – Services Authorization

Section I Individual Information

Name	Medicaid Number	IPC Begin Date	IPC End Date

Mailing Address, City, ZIP Code	County	Area Code/Telephone Number

Section II Service Authorized (Service Group 18)

Begin Date: _____ End Date: _____

Respite:	☐ 11ZV – Attendant	Units: _____	Unit Rate: _____	Amount Authorized: _____
	☐ 11NV – LVN	Units: _____	Unit Rate: _____	Amount Authorized: _____
	☐ 11NVS – Specialized LVN	Units: _____	Unit Rate: _____	Amount Authorized: _____
	☐ 11PV – RN	Units: _____	Unit Rate: _____	Amount Authorized: _____
	☐ 11PVS – Specialized RN	Units: _____	Unit Rate: _____	Amount Authorized: _____
Flexible Family Support:	☐ 11UV – Attendant	Units: _____	Unit Rate: _____	Amount Authorized: _____
	☐ 11SV – LVN	Units: _____	Unit Rate: _____	Amount Authorized: _____
	☐ 11SVS – Specialized LVN	Units: _____	Unit Rate: _____	Amount Authorized: _____
	☐ 11TV – RN	Units: _____	Unit Rate: _____	Amount Authorized: _____
	☐ 11TVS – Specialized RN	Units: _____	Unit Rate: _____	Amount Authorized: _____
Employment Assistance:	☐ 54V	Units: _____	Unit Rate: _____	Amount Authorized: _____
Supported Employment:	☐ 37V	Units: _____	Unit Rate: _____	Amount Authorized: _____

Individuals/employers may not exceed the total units/amount authorized. **Employers may only request payment for hours of service delivered to the individual named above.**

Comments:

Section III Signatures

Case Manager

Typed/Printed Name	Area Code/Telephone Number
Mailing Address, City, ZIP Code	Area Code/Fax Number

_____ Signature – Case Manager

_____ Date

Financial Management Service Provider

Review this form and sign in the space below. Within 14 days of receipt of this form, return the original to the case manager. Keep a copy for your records.

Typed/Printed Name	Area Code/Telephone Number

_____ Signature – Provider Contact

_____ Date