TEXAS
Department of Aging and Disability Services

COMMISSIONER
Jon Weizenbaum

Fax Cover Sheet

Specialized Services Request

Date: _____

To: _____

Area Code and Fax No.: _____

Office Area Code and Telephone No.: _____

Number of Pages Including Cover: _____

Check the correct box for the authorization request attached:

- ☐ Physical Therapy (PT)
- ☐ Occupational Therapy (OT)
- ☐ Speech Therapy

From: _____

Nursing Facility Representative: _____

Title of Nursing Facility Representative: _____

Area Code and Fax No.: _____

Office Area Code and Telephone No.: _____

Notes/Additional Comments:

Confidential Information: This communication (including any attached documentation) contains privileged and/or confidential information. If you are not an intended recipient of this communication, please be advised that any disclosure, dissemination, distribution, copying or other use of this communication or any attached document is strictly prohibited. If you have received this communication in error, please notify the sender immediately and promptly destroy all copies of this communication and any attached documentation.

Texas Department of Aging
and Disability Services

Form 2465
October 2013-E

S

Specialized

Attention: PASRR Unit

Specialized Services Request

Area Code and Telephone No.: 512-438-3190

Area Code and Fax No.: 512-438-2180

S

Specialized

This form **will not** be reviewed unless it is **complete**.

The individual must have a diagnosis of severe mental illness, an intellectual disability before age 18 or developmental disability (related condition) before age 22 to qualify for PASRR Specialized Services.

Date of Evaluation	Check One: ☐ Physical Therapy (PT) ☐ Speech Therapy (ST) ☐ Occupational Therapy (OT)	☐ New (submit initial evaluation)* ☐ Recertification (do not send plan of care) ☐ Restart (submit evaluation)

Name	Social Security No.	Date of Birth	Medicaid No.

Primary Diagnosis	First Date of Primary Diagnosis

Other Medical Diagnoses

Nursing Facility	City	Vendor No.	Date Admitted	Admitted From

Area Code and Telephone No.	Area Code and Fax No.	Medicare Provider No.

Medicaid Provider No.	Therapist

Note: ROM, splinting, positioning, wound care, pain management, sensory stimulation and/or staff/ family training are not covered in this program.

Functional Status at Present (in measurable terms): **Do not crowd information**

1) _____

2) _____

3) _____

4) _____

5) _____

Goals (in measurable terms): **Do not crowd information**

1) _____

2) _____

3) _____

4) _____

5) _____

Orientation and Ability to Participate **(Required)** _____

***Authorization of services does not guarantee payment.**