Community Living Assistance and Support Services (CLASS)

Request for Adaptive Aids, Medical Supplies, Minor Home Modifications or Dental Services/Sedation

1. Individual's Name			2. Medicaid No.		3. Age
4. Individual's Address (Street, City, State, ZIP)					
5. DSA Name	6. DSA Vendor No	7. DSA Telephone No.	8. CMA Name	9. CMA Vendor No.	10. CMA Telephone No.

11. Type of Item/Service Requested (check one)

☐ Adaptive Aid ☐ Medical Supplies ☐ Minor Home Modifications ☐ Dental Services ☐ Dental Sedation

12. Description of Item/Service requested (list only one item):

Part A: To be Completed by the Individual/LAR

13. Related Condition(s):

14. Describe and explain functional limitations:

15. Describe the benefits of the Item/Service:

_____ Signature - Individual/LAR

_____ Date

Part B: To be Completed by the Case Manager

16. List non-CLASS resources and the status of each non-CLASS resource (attach written documentation):

17. CMA Action Taken: ☐ Proceed ☐ Deny

Reason for denial (include applicable language from TAC, Waiver or CLASS Provider Manual):

_____ Signature - Case Manager

_____ Date

☐ Form 3624 sent to Individual/LAR

Individual's Name	Medicaid No.	Date

Part C: To be Completed by an Appropriate Professional (Practicing within the scope of his/her license)

18. Professional's Name	19. Telephone No.	20. License No.
21. Type of Profession	22. Fax No.	
23. Diagnosis and explain functional limitations:		
24. Describe Items/Service being recommended:		
25. Explain how the Item/Service will benefit the individual (medical treatment, rehabilitation, habilitation, ability to compensate, etc.):		
26. Describe relevant behavior issues related to the Item/Service requested:		
_____ Signature and Professional Title		_____ Date

Part D: To be Completed by DSA Representative

27. DSA Action Taken: ☐ Proceed ☐ Deny
Reason for denial (include applicable language from TAC, Waiver or CLASS Provider Manual:
_____ Signature - DSA Representative _____ Date

Additional Comments: