RESPITE AUTHORIZATION - AUTISM WAIVER

DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 60620 (2-2025)

Clear Fields

Name of Client (Last, First)		Medicaid ID		Date of Birth
Authorization Period Begins: Ends:	Region	Screening Date	Name of Legal Guardian	
Agency		Name of Service Manager		

Individual Budget

Self-Directed Respite (160 units per month maximum usage)	Authorized Budget/ Month	Authorized Budget/ Quarter
Project Units (one unit = 15 minutes)		
Unit Wages and Fringe Benefits Allowance		
Total Allocated Waiver Dollars		

	Units/Month	Units/Quarter
Provider Managed Respite (160 units per month maximum usage)		
Project Units/Budget Period (one unit = 15 minutes)		
Administrative Reimbursement/15 minute unit		
Service Management	64	192

☐ RD-1 (21-50) ☐ RD-2 (51-70) ☐ RD-3 (71+)

Right to Appeal, Denial, Reduction or Termination: Your need for self-directed supports has been reviewed based on the following criteria: 1) degree of disability and specific support needs, 2) family stress, 3) availability of information supports, 4) need for a specially trained caregiver, and 5) risk of out-of-home placement. The above criteria are outlined in North Dakota's Home and Community Based Services waiver. If you disagree with the proposed individual budget, you may request a hearing before the Department of Health and Human Services. 42 CFR (Code of Federal Regulations) Subpart EE provides an opportunity for a fair hearing to any person if the state agency takes action to suspend, terminate or reduce services of Medicaid eligibility or covered services. Please contact your autism services unit manager for instructions on how to request a hearing. You must request a hearing in writing within 30 days of the date of this notice. Hearing requests must be forwarded to: Appeals Supervisor, Department of Health and Human Services, 600 E. Blvd, Ave, Dept. 325, Bismarck, ND 58505-0250. You may represent yourself at the hearing or you may have an attorney, relative, friend or any other person assist you. If you request a hearing before the date of action, we will not terminate or reduce services until a decision is rendered after the hearing, or you withdraw the request for a hearing, you fail to appear at a hearing, or it is decided that the only issue in the appeal is one of federal or state law/policy. You are advised, however, that if the hearing decision by the Department of Health and Human Services is not in your favor, the total additional amount paid with Medicaid funds on your behalf may be considered an overpayment subject to recovery.

I understand that I must work cooperatively with my Fiscal Agent and Service Manager and follow all Self-Directed Supports - Respite program policies. I also agree to submit all billings by the date specified for each contract period (July-Sept by Oct 31, Oct-Dec by Jan 31, Jan-March by April 30, April - June by July 10). I understand that I must sign, date and return the authorization to the Service Manager for processing, but this signature does not affect my right to appeal.

By typing my name below, I am signing this application form electronically. I agree that my electronic signature is the legal equivalent of my handwritten signature. I attest, subject to the penalties of perjury that I am the individual completing this application and that I have provided accurate information.

Signature of Legal Guardian	Date
Approved By Provider Executive Director or Designee	Date

APPROVAL

Approved By Provider State Autism Coordinator	Date