Exception Request for Duplicative IMPACT Plus Therapy Services

Agency Name: _____

Date of Request: _____

Child's Name: _____

MAID Number: _____

Specialized Need to Be Addressed:

_____

_____

_____

_____

Agency Expected to Provide the Duplicative Service:

_____

Name/Credentials/Training of Therapist:

_____

Plan for Treatment (duration, services to be provided, goals of therapy, etc.):

_____

_____

_____

_____

Signature: _____ Date: _____

For Office Use Only

- ☐ Approved:
- ☐ Not Approved: