State of Missouri

Department of Mental Health

Division of Developmental Disabilities

**FY22 Southeast Missouri Autism Project (SEMAP) Provider Services Selection Form**

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| **Name** Click or tap here to enter text. | **DMH ID** Click or tap here to enter text. | **Plan Type** Choose an item. |

**Before selecting services and providers:**

1. Review [Support Coordinator Roles & Responsibilities](https://dmh.mo.gov/dev-disabilities/autism/southeast/support), and the [SEMAP FY22 Service Directory](https://dmh.mo.gov/dev-disabilities/autism/southeast/support)
2. For new plans or initial services, see *Providers’ Authorization Requirements Appendix* (attached below)
3. Individuals enrolled in a Medicaid Waiver may not receive SEMAP services available through their waiver

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| Multiple providers may be selected **per service** in this section |
| **X** | **Codes** | **Specialized Autism Services** |  **Select Provider(s)** |
|[ ]  19F001 | Assessment  | Choose an item.Choose an item. | Choose an item. |
|[ ]  19F001 T | Assessment Telehealth | Choose an item. |
|[ ]  52A00H | Community Inclusion Individual | Choose an item. | Choose an item. |
|[ ]  53A00H | Community Inclusion Group | Choose an item. |
|[ ]  35B001 | Family Resource Services  | Choose an item.Choose an item. | Choose an item. |
|[ ]  35B001 T | Family Resource Services Telehealth | Choose an item.Choose an item. | Choose an item. |
|[ ]  35B00T | Family Resource Services Phone Support  | Choose an item.Choose an item. | Choose an item. |
|[ ]  512A0H | Music Therapy Individual | Choose an item. | Choose an item. |
|[ ]  512A0H T | Music Therapy Individual Telehealth | Choose an item. | Choose an item. |
|[ ]  512A2H | Music Therapy Group | Choose an item. | Choose an item. |
|[ ]  512A2H T | Music Therapy Group Telehealth | Choose an item. | Choose an item. |
|[ ]  94200A | Parent Training Individual | Choose an item. | Choose an item. |
|[ ]  94200A T | Parent Training Individual Telehealth | Choose an item. | Choose an item. |
|[ ]  94200H | Parent Training Group | Choose an item. | Choose an item. |
|[ ]  94200H T | Parent Training Group Telehealth | Choose an item. | Choose an item. |
|[ ]  440400 | Respite Individual | Choose an item.Choose an item. | Choose an item. |
|[ ]  440500 | Respite Group | Choose an item. | Choose an item. |
|[ ]  15100H | Social Skills Groups | Choose an item. | Choose an item. |
|[ ]  15100H T | Social Skills Groups Telehealth | Choose an item. |
|[ ]  51030H | Therapeutic Camps | Choose an item. |
| Only 1 provider may be selected **per service** in this section. |
| **X** | **Codes** | **Specialized Autism Services** | **Select Provider** |
|[ ]  942A0H | ASD Training Individual | Choose an item. |
|[ ]  942A0H T | ASD Training Individual Telehealth | Choose an item. |
|[ ]  943A0H | ASD Training Group | Choose an item. |
|[ ]  943A0H T | ASD Training Group Telehealth | Choose an item. |
|[ ]  491611 | ABA Consultation & Intervention | Choose an item. |
|[ ]  491611 T | ABA Consultation & Intervention Telehealth | Choose an item. |
|[ ]  491640 | ABA Registered Behavior Technician | Choose an item. |
|[ ]  35C00H | Counseling Individual | Choose an item. |
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| This section continued on the next page |
| **Name:** Click or tap here to enter text. | **DMH ID:** Click or tap here to enter text. | **Plan Type:** Choose an item. |
| **This section continued from previous page:** Only 1 provider may be selected per service in this section |
|[ ]  35C00H T | Counseling Individual Telehealth | Choose an item. |
|[ ]  36C00H | Counseling Group | Choose an item. |
|[ ]  36C00H T | Counseling Group Telehealth | Choose an item. |
|[ ]  580300 | Pre-employment ILS Individual | Choose an item. |
|[ ]  580300 T | Pre-employment ILS Individual Telehealth | Choose an item. |
|[ ]  580500 | Pre-employment ILS Group | Choose an item. |
|[ ]  580500 T | Pre-employment ILS Group Telehealth | Choose an item. |
|[ ]  57031J | Employment: Prevocational Services Individual | Choose an item. |
|[ ]  57031J T | Employment: Prevocational Services Individual Telehealth | Choose an item. |
|[ ]  57031S  | Employment: Prevocational Services Group  | Choose an item. |
|[ ]  57031S T  | Employment: Prevocational Services Group Telehealth | Choose an item. |
|[ ]  58050H | Employment: Career Planning Individual | Choose an item. |
|[ ]  58050H T | Employment: Career Planning Individual Telehealth | Choose an item. |
|[ ]  58081H | Employment: Job Development Individual | Choose an item. |
|[ ]  58081H T | Employment: Job Development Individual Telehealth | Choose an item. |
|[ ]  58060H | Employment: Individual Supported Employment | Choose an item. |
|[ ]  58060H T | Employment: Individual Supported Employment | Choose an item. |
|[ ]  890400 | Employment: Transportation | Choose an item. |
|[ ]  15103H | Social Skills: Curriculum Based | Choose an item. |
|[ ]  15103H T | Social Skills: Curriculum Based Telehealth | Choose an item. |
|[ ]  73001H | Social Skills: SLP Individual | Choose an item. |
|[ ]  73001H T | Social Skills: SLP Individual Telehealth | Choose an item. |
|[ ]  73002H | Social Skills: SLP Group | Choose an item. |
|[ ]  73010H | Speech Implementer | Choose an item. |
|[ ]  15001H | AAC Assessment | Choose an item. |
|[ ]  46100H | Transition Planning | Choose an item. |
|[ ]  46100H T | Transition Planning Telehealth | Choose an item. |

For initial plans or initial services with a provider

1. See the below attached **Providers’ Authorization Requirements Appendix**
2. Complete the **FY22 Provider Referral/Enrollment Form** below

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|  | State of MissouriDepartment of Mental HealthDivision of Developmental Disabilities**Southeast Missouri Autism Project** **FY22 Provider Referral/Enrollment Form** |

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| The *Provider Referral/Enrollment* form is only needed for a referral/enrollment with a provider the individual is not currently enrolled with (CIMOR code 52070A). Please review [Support Coordinator Roles & Responsibilities](https://dmh.mo.gov/dev-disabilities/autism/southeast/support) at <https://dmh.mo.gov/dev-disabilities/autism/southeast/support>.  |
| Name Click or tap here to enter text. | Provider Referral/Enrollment Reason Choose an item. |
| DMH ID Click or tap here to enter text. | Regional Office Choose an item. | Medicaid Number Click or tap here to enter text. |
| Referral Date Click or tap here to enter text. | Date of Birth Click or tap here to enter text. |
| Living Arrangement Choose an item. | Communication MethodChoose an item. |
| Referral/Enrollment Request for Choose an item. | Referral/Enrollment Request for Choose an item. | Referral/Enrollment Request for Choose an item. |
| **Parent/Guardian Contact Information** |
| Name Click or tap here to enter text. |
| Street Address Click or tap here to enter text. |
| City, State Zip Click or tap here to enter text. | County Click or tap here to enter text. |
| Is Guardian someone other than parent? Choose an item. If yes, explain Click or tap here to enter text. |
| Guardian’s Preferred Contact Method | Time of day to contact |
| [ ]  Home/Cell phone Click or tap here to enter text. | Click or tap here to enter text. |
| [ ]  Work phone Click or tap here to enter text. | Click or tap here to enter text. |
| [ ]  Email Click or tap here to enter text. | Click or tap here to enter text. |
| **Individual/Parent/Guardian/Designated Representative Certification & Signature(s)** I certify that I have selected the provider(s) and services(s) on this document based on identified needs. |
| Individual Signature | Date Click or tap to enter a date. |
| Parent/Guardian/Designated Representative Signature | Date Click or tap to enter a date. |
| **Support Coordinator Certification & Signature**1. I certify that the individual/parent/guardian/designated representative has selected the provider(s) and service(s) in this document based on identified needs.
2. I certify that the need for each service has been justified in the ISP.
3. I certify any request for multiple providers for a service has been justified in the ISP.
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| Support Coordinator Name Click or tap here to enter text.  |
| Email Click or tap here to enter text. | Phone Click or tap here to enter text. |
| Support Coordinator Signature | Date Click or tap to enter a date. |

**Providers’ Authorization Requirements Appendix**

Only needed for initial plans or initial services with a new provider.

 ***Blue Sky Community Services (Blue Sky)***

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| **Codes** | **Required Specialized Autism Services**  |
| 19F001 | Autism Assessment |

 ***EasterSeals Midwest (EasterSeals)***

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| **Codes** | **Required Specialized Autism Services**  |
| 35B001 | Family Resource Services |
| 35B00T | Family Resource Services Phone |
| 94200A | Parent Training Individual |
| 94200H | Parent Training Group |
| 440400 | Respite Individual  |
| 440500 | Respite Group |
| 15100H | Social Skills Groups |

 ***Southeast Missouri State University Autism Center (SEMO)***

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| **Type of Service Needed** | **Service Codes** | **Required****Specialized Autism Services** |
| AllServices | 19F001 | Autism Assessment |
| 942A0H | ASD Training Individual |
| 943A0H | ASD Training Group |
| 35B001 | Family Resource Services |
| 35B00T | Family Resource Services Phone |
| 15100H | Social Skills Group |
| ABA | 491611 | Consultation & Intervention |
| 491640 | Registered Behavior Technician  |
| 491611 T | Telehealth |
| Counseling | 35C00H | Counseling Individual |
| 36C00H  | Counseling Group |
| 35C00H T | Telehealth |
| Speech | 73001H | Social Skills: SLP Individual |
| 73002H | Social Skills: SLP Group |
| 73010H | Speech Implementer |
| 15001H | AAC Assessment |
| 73001H T | Telehealth |
|  | 51030H | Therapeutic Camps |

