



Community Living Assistance and Support Services (CLASS)
Therapy Justifications - Attachment to IPP

Individual's Name Ruben L Neira		Medicaid No. *****
Case Management Agency (CMA) Name	CMA Vendor No.	Requested Skilled or Specialized Therapy MUSIC THERAPY
List non-waiver resources that were exhausted:		

Signature - Case Manager

Date

To be Completed by the Appropriate Professional

Diagnosis:

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Brief description of need for services:

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Specific qualifying conditions requiring treatment:

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Describe or attach the interventions planned with baseline data and goals and objectives outlined in observable and measurable terms. Also include a plan for implementation and the scope, duration, amount, frequency and location of service.

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Can components of the requested service be delivered by someone other than a therapist?

☐ Yes

☐ No

If no, please describe the components that require a licensed/certified professional:

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Describe a plan for transferring the therapy services to a non-therapist and changing the role of the therapist to a supervisory role of the non-therapist:

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Music Therapist

Signature - Professional

Title

Date

Printed Name of Professional Marcie Friedman	Area Code and Telephone No.	License No. (if applicable) TX123456789 (State License Nbr)
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Addendum - 8606-A

Therapy Evaluation ☐ Initial ☐ Annual

Client: Ruben L Neira
Therapist: Marcie Friedman

Diagnosis: _____
Discipline: MUSIC THERAPY

Client's Diagnosis Of Results In: - (Describe how the diagnosis interferes with the client's ability to perform ADLs or interferes with quality of life)

Recommended frequency of visits:
Duration: _____
Amount: _____ Location: _____

Therapist Signature: _____ Date: _____