Application for JCM Clinical Exception for OT/PT/SLP Service
(More than 58 hours of service)

To be completed by requesting therapist

Individual:	**Date application submitted:**
DOB:	**CARMP:** Yes ☐ No ☐ *TBD ☐
ISP Budget Year: ______/________/________ to: ______/_______/__________	

** To Be Developed*

Therapist:	**Agency:**
Therapist Phone #:	**Therapist Fax #:**
Therapist E-Mail:	

Case Manager:	**CM Agency:**
CM Phone #:	**CM Fax #:**
CM E-Mail:	

Service Type Requested:

☐ **OT/OTA**	☐ **PT/PTA**	☐ **SLP**

Current Budget Units Approved and Additional Clinical Exception Units Requested

	Current Approved Budget for OT/PT/SLP	**Additional Unit Request for Clinical Exception OT/PT/SLP**	**Current Approved Budget for OTA/PTA**	**Additional Unit Request for Clinical Exception OTA/PTA**	**Totals**
***Standard Rate**					
***Incentive Rate**					

* *Note: Replace with Clinical Rate and Integrated Rate if still on 2007 Standards.*

Therapist History:

I have been providing therapy for this individual for:			
< 1 year_____	**1 to 2 years _____**	**3 to 4 years _____**	**5 years or more _____**

***Justification for Request (Required):**

Explain why more than 58 hours of service are needed to implement the attached Therapy Intervention Plan.
Justification for Request:
Therapist's Signature:

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Required Information must be attached or the request will NOT be considered (Please initial each item below to indicate that they are attached):

_______ Therapy Intervention Plan (part of the Therapy Documentation Form)
_______ Current Therapy Initial Evaluation or Therapy Annual Re-evaluation Report

FOR CLINICAL REVIEWER ONLY

☐**Approved**	☐ **Partially Approved**	☐ **Denied**
Reviewer Comments:		
Reviewer's Signature:		
Date of Review:		

JCM Clinical Exception Application Distribution:

- ✓ Mail, SCOMM, or Fax this form with signature or digital signature AND required documentation to:
  Clinical Services Bureau, Attn: Therapy Services Coordinator,
  5301 Central Ave NE, Suite 1700, Albuquerque, NM 87108
  Fax: 505-841-2987
- ✓ Mail, SCOMM, or Fax a copy of this form to the applicable CSB Therapy Consultant
- ✓ Mail, SCOMM, or Fax a copy of this form to the Case Manager

CONTACTS:
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