Hamilton County Developmental Disabilities Services
Adult Day Array Worksheet - Waiver Services
Will only be authorized when approved by Service & Support Administrator

Individual: ______ SSA: ______

My Plan Span: ______ to ______ Effective Date: ______

Day Array Provider: ______ Program/ Employer: ______

Funding Source/Worksheet Intent - To Be Completed By SSA Only

FUNDING: ☐ SELF Waiver ☐ Individual Options Waiver ☐ Level One Waiver

☐ Re-determination
☐ Change in services/provider
☐ Initial services
☐ Add provider
☐ AAI Override (N/A for Redeterminations)
☐ Ending services
Provider: ______ Date ended: ______

County Of Service

☐ Hamilton
☐ Other
Specify If Not Hamilton County: ______

Path to Employment (select one)

☐ 1. I have a job but would like a better one or to move up.
☐ 2. I want a job! I need help finding one.
☐ 3. I'm not sure about work. I need help to learn more.
☐ 4. I don't think I want to work. I may not know enough about it.

On "Path 4" & receiving Voc. Hab? When will team next meet to reevaluate? ______

Service To Be Authorized

☐ Adult Day Support
☐ Vocational Habilitation
☐ Group Employment Support
☐ Adult Day Support/Vocational Habilitation Combination
☐ Career Planning* - Complete CSDW003B & Attach
*There are 9 Career Planning services
☐ Individual Employment Support: (List Hours Per Span Below) Hours Per Span: ______

Community Integration

Will The ADA Provider Be Providing "Community Integration"? ☐ YES ☐ NO

If "YES", What Percentage Of Time Will Be Spent Providing Community Integration? ☐ 25% ☐ 50% ☐ 100% Other: ______

If Providing "Community Integration", Will The Provider Bill The Add-On? ☐ YES ☐ NO

Days Of Service | Total Hours Per Day Of Service

☐ Monday	☐ Tuesday	☐ Wednesday	☐ Thursday	☐ Friday	☐ Saturday	☐ Sunday
Hrs./Day	Hrs./Day	Hrs./Day	Hrs./Day	Hrs./Day	Hrs./Day	Hrs./Day

Behavior & Medical Rate Add-On

This individual qualifies for a Behavior Rate Add-On. The provider will bill for the Add-On. ☐ YES ☐ NO ☐ N/A

This individual qualifies for a Medical Rate Add-On. The provider will bill for the Add-On. ☐ YES ☐ NO ☐ N/A

Additional Comments: ______

Name of Person Completing Worksheet: ______ Date: ______

Contact Information For Person Completing Worksheet: ______

Service & Support Administrator Signature: ______ Date: ______

SSA Supervisor Signature (required): ______ Date: ______