Hamilton County Developmental Disabilities Services
INDEPENDENT PROVIDER WORKSHEET

Individual _____ Provider _____

My Plan Span Start Date _____ Worksheet effective date _____

To be completed by SSA

Funding Source ☐ I/ O ☐ L1 ☐ Local/ Levy

Reason for Worksheet ☐ Re-determination ☐ Initial services ☐ Change in services/provider ☐ Add provider

☐ Ending services Provider _____ Date ended _____

SECTION 1: SERVICES

SERVICE	RATIO	MILES PER MONTH	RATIO FOR MILES

☐ CHECK THIS BOX IF SERVICES ARE HPC & ANSWER QUESTION BELOW

Number of Hours Per Week for this individual _____

If less than 15 Hours (Drop-In) move to Section 2

If over 15 Hours, complete CPT Meeting or Schedule on form CSDHW001-B

SECTION 2: PROVIDER'S TOTAL HOURS

Indicate all hours that you currently work with people as a provider. This should include anyone served regardless of waiver or county. Additionally, include anyone supported through Medicaid State Plan.

Do you work with individuals outside of Hamilton County? ☐ YES ☐ NO If Yes, # of people _____

Do you work with other individuals in Hamilton County? ☐ YES ☐ NO If Yes, # of people _____

Total number of people served in **ALL** counties _____ Total number of hours authorized in **ALL** counties per week _____

Comments _____

Provider Signature _____ Date _____

SSA Signature _____ Date _____