Trillium HEALTH RESOURCES

Transforming Lives. Building Community Well-Being.

Out of State Travel Request Form

Date of Request: _____

Name of Individual: _____

Dates of Travel: _____ To: _____

From: Destination: _____

1. Natural Supports Traveling with Individual (include relationship to individual):

2. Individual's Daily Needs:

3. Staff Requirements (based on needs above):

4. Why are natural supports unable to meet individual's needs:

5. What services need to be delivered out of state (must not be Respite):

On what schedule will these services be delivered:

Hours	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

- If licensed professionals are involved, Medicaid cannot waiver other state licensure
- laws Medicaid will not be responsible for room, board, or transportation cost
- Provider Agencies, Employers of Record or Agencies With Choice must assume all liability for their staff while out of state
- Individual Support Plans must not be changed to increase services while out of state
- Respite, based on the definition, is not available as natural supports are present during the travel or are not available to individuals receiving Residential Supports.

By signing below, the provider agency agrees with this request and to all above listed conditions:

Agency Supervisor Signature: _____ Date: _____

Agency With Choice Signature: _____ Date: _____

Managing Employer Signature: _____ Date: _____

Send form to:
(PIHP Contact/Address)

PIHP use only:
☐ Approved
☐ Denied

Comments:

_____ _____

Reviewer Signature Date