Anoka County
ALTERNATIVE OR SPECIALIZED THERAPY/TRAINING REQUEST

This form MUST be completed by the participant's MN Healthcare Provider (MHCP) physician or nurse practitioner.

Plan Start Date: **Plan End Date:**

Participant Name PMI Date of Birth

Case Manager Support Planner (if applicable)

List all non-experimental therapies, treatments or supports being requested. (Examples include: music therapy, hippotherapy, aromatherapy, therapeutic listening program, massage therapy, aquatic therapy, cognitive/education therapy, behavior therapy, feeding therapy, biofeedback)

What is the expected outcome(s) of this treatment as it relates to the participant's diagnosis, condition, and/or assessed need (E.g. Johnny has autism. Music therapy will help him improve his communication skills)?

The MHCP enrolled provider must INITIAL each box.

The therapy/treatment is NOT considered experimental for the condition being treated.

The therapy/treatment is NOT contraindicated (should not be used) for the condition being requested.

The therapy/treatment IS appropriate for this individual.

The documentation is made within the scope of my practice.

This individual is currently under my care.

Note: *CDCS funds cannot be used to purchase experimental treatments. According to MN Rule 9525.3015, subpart 16, an experimental treatment means: drugs, therapies or treatments that are unproven, have been confined largely to laboratory use or have progressed to limited human application and trials and lack wide recognition from the scientific community as a proven and effective measure of treatment.*

_____ _____

MHCP Enrolled Provider Signature Date

_____ _____

MHCP Enrolled Provider (Printed Name) MHCP Provider Number