**Long Term Services Benefit Specifications and Provider Qualifications**

For each Long Term Service and Support (home and community-based service) that the State proposes to include in the Demonstration, provide a description of the amount, duration and scope of the service and any authorization requirements under the Demonstration. Also provide the provider specifications and qualifications for the benefit or service.

**Name of Service:**

**Scope of Benefit/Service**, *including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit’s scope:*

**Amount of Benefit/Service** – *Describe any limitations on the amount of service provided under the demonstration:*

Benefit Amount: per [ ]  Day [ ]  Week [ ]  Month [ ]  Year

[ ]  Other, describe:

**Duration of Benefit/Service:** *Describe any limitations on the duration of the service under the demonstration:*

|  |  |  |
| --- | --- | --- |
|  | Day(s) |  |
|  | Week(s) |
|  | Month(s) |
|  | (Other) |  |

**Authorization Requirements:** *Describe any prior, concurrent or post-authorization requirements, if any:*

**Provider Specifications and Qualifications**

Provider Category(s):

[ ]  Individual (list types) [ ]  Agency (list types of agencies)

The service may be provided by a:

[ ]  Legally Responsible Person [ ]  Relative/Legal Guardian

*Description of allowable providers:*

*Specify the types of providers of this benefit or service and their required qualifications:*

1. Provider Type:

License Required: [ ]  Yes [ ]  No

Certificate Required: [ ]  Yes [ ]  No

Describe:

Other Qualifications Required for this Provider Type (please describe):

1. Provider Type:

License Required: [ ]  Yes [ ]  No

Certificate Required: [ ]  Yes [ ]  No

Describe:

Other Qualifications Required for this Provider Type (please describe):

1. Provider Type:

License Required: [ ]  Yes [ ]  No

Certificate Required: [ ]  Yes [ ]  No

Describe:

Other Qualifications Required for this Provider Type (please describe):

1. Provider Type:

License Required: [ ]  Yes [ ]  No

Certificate Required: [ ]  Yes [ ]  No

Describe:

Other Qualifications Required for this Provider Type (please describe):