



Community Living Assistance and Support Services (CLASS)  
**Therapy Justifications – Attachment to IPP**

Individual's Name XXXXXX		Medicaid No.
Case Management Agency (CMA) Name	CMA Vendor No.	Requested Skilled or Specialized Therapy Aquatic Therapy
List non-waiver resources that were exhausted:		

\_\_\_\_\_  
Signature – Case Manager

\_\_\_\_\_  
Date

**To be Completed by the Appropriate Professional**

Diagnosis: Cerebral Palsy
Brief description of need for services: William demonstrates physical, cognitive, communication, & social deficits that impair ability to engage in home and community leisure interests.
Specific qualifying conditions requiring treatment: William has poor ROM/flexibility, poor carryover of new learning, poor endurance, poor energy conservation skills, poor pain management skills, poor muscle strength/tone, weakness on R side, poor motor skills/functioning, and poor reciprocal movements.
Describe or attach the interventions planned with baseline data and goals and objectives outlined in observable and measurable terms. Also include a plan for implementation and the scope, duration, amount, frequency and location of service. Frequency: 1 hr/1X a week/52 weeks Location of service: Community Pool/West Gray Multipurpose Center See attached addendum
Can components of the requested service be delivered by someone other than a therapist? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If no, please describe the components that require a licensed/certified professional: A.C.T.R.S. must meet educational, experiential, & assessment standards as set forth by a national governing certification agency. A.C.T.R.S. must follow practice standards & code of ethics that are not required of paraprofessionals and family members. A paraprofessional is not required to carry liability coverage and may not have the understanding of therapeutic approaches related to medical issues.
Describe a plan for transferring the therapy services to a non-therapist and changing the role of the therapist to a supervisory role of the non-therapist: N/A - these services must be provided by a licensed or certified professional.

*[Handwritten Signature]*  
\_\_\_\_\_  
Signature – Professional

LMT  
\_\_\_\_\_  
Title

5/31/25  
\_\_\_\_\_  
Date

Printed Name of Professional XXXX	Area Code and Telephone No. XXX-XXX-XXXX	License No. (if applicable) MTXXXX
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