

Intensive Technical Assistance Request Form

Dates can be entered or picked from calendar

Date: _____ Sex: Male Female Phone: _____

Person for whom ITA is requested:

Date of Birth: _____ Person's address: _____

Funding County: _____ Residing County: _____

County Coordinator: _____ County e-mail: _____

Current Diagnosis: _____

Is this a HCSIS Corrective Action? Yes No

Does this person have a mental health diagnosis? Yes No

Is the Criminal Justice System involved? Yes No

Does this person live in a:

Community Family Living With On Other
Home Provider Family Own

Agency

Support Coordinator

Name: _____ Name: _____

Title: _____ Title: _____

Address: _____ Address: _____

Phone: _____ Phone: _____

E-mail: _____ E-mail: _____

Support Coordinator Supervisor

Name: _____ E-mail: _____

Request for iPad: Yes No

Reason for Request: _____

Person for whom ITA is requested:

Must be completed by member of Management Oversight Committee

Acuity Level and Approval

1. Low Risk Request for Education
2. Mild Risk- Person/Team Requires Assistance
3. Moderate Risk- Medically/Behaviorally Complex
4. High Risk- Risk of Discharge/Danger to Community/Self/Others/Acute Medical

Coordinator Name:

Approval: Yes No

Comments:

**Please submit all completed forms to the person's funding county AE for approval.
AE's with your approval, please submit request to kfisher@MilestonePA.org**