



NC Innovations Out-of-State Travel Request Form

Note: This form is only for NC Innovations Waiver services. Prior approval from Partners is required before services can be provided during out-of-state travel. Please **complete all sections** of this form in full.

Send completed form to: IDDSupport@PartnersBHM.org

- Licensed professionals must still follow all applicable state licensure laws. Medicaid does not waive these requirements.
- Medicaid does not cover the cost of room, board or transportation.
- Provider agencies, Employers of Record or Agencies With Choice are responsible for all liability related to their staff while providing services out of state.
- Individual Support Plans must not be changed to increase services during out-of-state travel.
- Respite services are not available during travel. This is because natural supports are expected to be present, or the individual is receiving Residential Supports where respite is not applicable.

Request Information						
Date of Request:		Dates of Travel:	From:	To:		
Member Name:					Member Record #:	
	<i>First</i>		<i>Last</i>			
Destination:						
Service Information						
1. Natural supports traveling with the member (Include names and relationship to member):						
2. Member's daily needs (Describe support needs during travel):						
3. Staff requirements (Based on the needs listed above):						
4. Why are natural supports unable to meet the member's needs?						
5. Services to be provided out of state (Services must be included in the member's plan and cannot include Respite):						
6. Service schedule during travel (Enter the days and hours services will be provided):						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Provider Agreement and Signatures		
Provider Agency Supervisor		
By signing below, the provider agency confirms agreement with this request and all listed conditions.		
Agency Supervisor (Print Name):		
Agency Supervisor Signature:		Date:
Agency Supervisor Email:		Phone:
Other Signatures		
Agency With Choice Signature:		Date:
Employer of Record Signature:		Date:
PIHP USE ONLY		
☐ Approved ☐ Denied	Comments:	
Reviewer Signature:		Date: