

Name: _____

Trip duration, location and purpose:

Check all supports and services that you intend to utilize while out of state:

Community Habilitation Staff

Respite Staff

Projected Staff Schedule

Date							
Number of Hours							

IDGS

OTPS

<input type="checkbox"/> Community Classes	<input type="checkbox"/> Staff Activity Fee
<input type="checkbox"/> Coaching/Education	<input type="checkbox"/> Personal use transportation
<input type="checkbox"/> Memberships	<input type="checkbox"/> Board Stipend
<input type="checkbox"/> IDGS Transportation	<input type="checkbox"/> Clothing

Yes No Do these expenses meet all criteria outlined in the Self Direction guidance and AIM Services Inc. policies.

Necessary OTPS expense criteria:

- Yes No 1. Be related to a valued outcome in the person’s plan.
- Yes No 2. Increase the person’s independence and/or health and safety.
- Yes No 3. Not be an OTPS excluded item.
- Yes No 4. Not be funded through any other source.

Other pertinent information to be considered:

Person/Designee Signature: _____

Submission Date: _____

FI Approval: _____

Date approved: _____