**Form F Therapy Services**

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| **Legal Business Name of Respondent:** |  |

The Multi-Assistance Center demonstration project will make therapy services and therapy referrals for individuals with intellectual disabilities, developmental disabilities, and individuals with other special needs. These therapy services and referrals may include, but are not limited to:

1. Speech Therapy
2. Occupational Therapy
3. Physical Therapy
4. Family Therapy
5. Please provide up to 1,000 words describing your plan to provide therapy services and referrals. Include a comprehensive list of all therapy services that the Multi-Assistance Center will provide.

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1. Please estimate the following metrics:

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| **Metric** | **FY 2026** | **FY 2027** | **FY 2028** | **FY 2029** | **FY 2030** |
| The number of unique individuals who will receive on-site therapy services |  |  |  |  |  |

1. Outcomes are used by HHSC to define a service that is performed successfully, in relation to the individuals in these services. Please provide both quantifiable and qualitative outcomes for individuals in therapy services.

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