Department of Medical Assistance Services

DD Waiver Supporting Documentation

IDENTIFYING INFORMATION		
Individuals Name:	Medicaid Number:	Date of Birth:
Service Provider Name :		Medicaid Provider Number:
SUPPORTING DOCUMENTATION	Initial _____	Modification _____

Effective dates of this documentation:

Assessment of individual. Include individual's history, functional level and reason for beginning or continuing services. Include any goals/objectives met by recipient while receiving services since last modification, if applicable:

Long term goals with time frames for achievement:

Short term goals with time frames for achievement:

Modalities:

Frequency And Duration:

Is the individual receiving services from other agencies or organizations? If so, services must be coordinated between the agencies. Specify the other agencies involved in the recipient's care and efforts to coordinate services.

End of Service date If services are needed for less than one year (Include anticipated functional level at discharge):

Service Provider Signature: I certify that the above service is medically necessary.	Date:
Physician Signature (If receiving Nursing Services):	Date:

* To ensure proper completion of this form, refer to the Supporting Documentation Instructions.

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Addendum

Individual Name:	Medicaid Number:	Date of Birth:

Service:

Assessment of recipient (continued):

Long term goals with time frames for achievement (continued):

Short term goals with time frames for achievement (continued):

Modalities (continued):

Frequency and Duration::

Coordination between Agencies (continued):

Service Provider Signature:	Date:
Physician Signature (Skilled Nursing Only):	Date:

Department of Medical Assistance Services
Instructions for Completing the DD Waiver Supporting Documentation Form

IDENTIFYING INFORMATION

- Individual's Name - Enter the individual's first and last name.
- Medicaid Number - Enter the recipient's 12-digit Medicaid number.
- Date of Birth - Enter the individual's date of birth.
- Service Provider Name - Enter the name of the provider.
- Medicaid Provider Number - Enter the 7-digit Medicaid provider number.

SUPPORTING DOCUMENTATION

- Supporting Documentation – If this supporting documentation is for the initial CSP, check 'initial'; for a modification to the CSP, check 'modification and explain why it is a modification.'
- Effective dates of this supporting documentation - Enter the dates that this supporting documentation is effective.
- Service -Provider must complete a separate supporting documentation for each discipline. Indicate whether the service is individual, group, or both.
- How long has recipient received services of this type - Enter the amount of time the recipient has received these services. You may enter the start of care date.
- Assessment of recipient (reason for beginning or continuing services) - For the initial CSP supporting documentation, enter the recipient's medical history, functional level and reason for referral. Enter the major functional limitations in objective, measurable terms. Include only relevant surgical procedures, prior hospitalization and/or services for the same condition. Include only pertinent baseline tests and measurements from which to judge future progress or lack of progress.
- Long term goals with time frames for achievement - Enter measurable, functional, consumer-oriented long term goals. Include time frames for achievement.
- Short term goals with time frames for achievement - Enter measurable, functional, consumer-oriented short term goals. Include time frames for achievement.
- Plan/Modalities – Describe the services that are to be provided and include all modalities that are to be used by the provider.
- Frequency and Duration - Enter the frequency of services to be rendered (e.g., 3x/week). Also, include an estimate of the length of time the services are to be rendered.
- Is the recipient receiving services from other agencies? If so, services must be coordinated between the agencies. Specify the other agencies involved in the recipient's care and efforts to coordinate services - There must be demonstrated coordination between the agencies involved in the recipient's care. Specify which other agencies are involved and what coordination is being done with the other agencies (e.g., correspondence, telephone calls between providers, etc.)
- Discharge plan/estimated discharge date (include anticipated functional level at discharge) - Enter the estimated date of discharge from services for the recipient. Also, include anticipated functional levels at discharge and need for future services.
- Physician signature and date - Physician must review, and fully sign and date the supporting documentation for skilled nursing services.