

NM DD Waiver Outside Reviewer Cover Sheet

Date:
Child
3 Day Imminent
5 Day Imminent
Crisis Supports
Retro Must be sent through DDS

Individual's Information		Prior Yr/Annual Review or Current Billable/Revision PA#:	
Last Name:		First Name:	
Mailing Address:*		DOB:	
City:		State: NM	
Zip:			
*Please provide mailing address where OR will send individuals RFI and Budget determinations			

Guardian's Information			
Last Name:		First Name:	
Address:		City:	
State:		Zip:	

Case Manager:		Email:	
Agency:		Phone:	

Annual <i>*see note at end of coversheet</i>			
Additional Notes:		ISP Begin Date:	
		ISP End Date:	
		Initial Allocation	
		New CCS/CIE service (PCA N/A)	
		Previous recipient of Supported Living, category H and 55 or older	

Revisions <i>*see note at end of coversheet</i>				
End/Close a service		Initial Eval	Adding new service(s)	Transfer/Change provider
Decreasing units		Increasing units	Provider ID correction only	
Revision #	Transfer to/from Mi Via*	LCA change*	Closing BWS*	
Explain Revision:				*include PA begin and end dates

RFI Response	
REF# (cut/paste from RFI email)	
Additional Notes:	

Justification and additional notes	
<p><i>*When applicable, include justification for imminent/crisis supports in text box below or by additional letter. Documents submitted must support justification.</i></p>	