

La Casa, Inc.

Consumer Directed Medicaid Service Facilitation for CL & FIS Waivers and EPSDT Programs Referral Form

In order to open and schedule the Initial meeting for Service Facilitation services the following must be completed:

1. What Community Service Board are you with and Fax Number?

2. Case Manager Name and phone number?

3. What specific Consumer Directed service is it that they have requested to implement?

- Personal Care
- Respite
- Companion Care

4. What is the name, address and phone number of the individual and family member contact so we can make initial contact to schedule the Comprehensive visit?

Recipient: _____ Contact: _____

Address: _____

City/State/Zip: _____

Phone #: _____ CSP Date: _____

Medicaid #: _____ DOB: _____ SS #: _____

5. Are they currently receiving ID/DD Waiver services or newly enrolled?

6. Is there any other pertinent or pressing information or issue that we need to know? (I.e. any pending issues, strange circumstances/problems, good/bad meeting dates and times, who would you like to coordinate the meeting you or the SF, etc.):

Please forward the following documents to us prior to the meeting via fax, #804-497-7401 or place in WAMS using Provider #0087437031 for all CD Cases.

1. Most recent copy of the DMAS-225(for Initial Waiver startups)
2. Most recent CSP/Shared Plan (Part 3 Shared Plan needed for Initial meeting needs to be uploaded in WAMS)