

Potential Medicaid Waiver Form

Instructions: This form is to be completed for each client for whom indigent funding is sought. New Forms must be submitted and Medicaid re-applied for annually. If not signed electronically, forms should be printed and signed. Please note that the Board is the payer of last resort.

To complete this form, select the desired field and type your response. For fields containing a drop-down list, click the drop-down arrow, and select your response from the list provided. Date fields contain drop-down calendars for your convenience. Required fields are indicated with an asterisk (*) and must be completed. Forms missing required fields cannot be processed.

AGENCY INFORMATION

*Requesting Agency Name

*Requesting Agency UPI

*Date of Submission

*Form Type

CLIENT INFORMATION

*Client Last Name

*Client First Name

*Client UCI Number (If Applicable)

MEDICAID ELIGIBILITY INFORMATION

*Date of Most Recent Medicaid Application (If Applicable)

*Date of Most Recent Medicaid Denial (If Applicable)

*Reason for Potential Medicaid Waiver Request

*Name of Other Insurance Coverage (Including Medicare)

Additional Information (Please include if selecting Medicaid Expansion Clinical Override Code (MECO))

SIGNATURES

I certify that the above information is correct to the best of my knowledge. I understand that the financial assistance funds that I may receive for services are limited and may become unavailable during the course of my treatment. I understand that completing this form does not guarantee that financial assistance funds will be approved or available.

*Client Signature (If service is Telehealth, indicate whether the client has been notified and has given verbal agreement.)

*Client Signature Date

*Requesting Agency Staff Signature

*Requesting Agency Staff Signature Date

TO BE COMPLETED BY BOARD STAFF

*Waiver End Date

APPROVED

DENIED

Notes