DOCUMENTATION OF FIRST USE OF MEDICAID BENEFITS

Name:

Individual Affected:

Check the appropriate box:

☐ Guardian/appellant
☐ Power of attorney
☐ Agent

If guardian/appellant, provide the name of the guardian/appellant and the relationship to the individual:

__________________________  _____________________________
Name of Guardian/Appellant  Relationship to Individual

Phone:

If power of attorney, provide the name of the individual with power of attorney and the relationship to the individual:

__________________________  _____________________________
Name of Individual with Power of Attorney  Relationship to Individual

Phone:

If agent, provide the name of the agent and the relationship to the individual:

__________________________  _____________________________
Name of Agent  Relationship to Individual

Phone:

Note: For questions related to a specific Medicaid benefit, contact the appropriate Medicaid program at:

WAC 388-845-1000 or WAC 388-845-1015

Date of First Use:

Signature of Individual:

Signature of Guardian/Appellant:

Signature of Power of Attorney:

Signature of Agent:

__________________________  _____________________________
Signature  Printed Name

__________________________  _____________________________
Signature  Printed Name

__________________________  _____________________________
Signature  Printed Name

__________________________  _____________________________
Signature  Printed Name

Date:

Printed Name:

If additional information is needed, please contact the appropriate Medicaid program at:

WAC 388-845-1000 or WAC 388-845-1015

Authorization:

Printed Name:

Date:

If additional information is needed, please contact the appropriate Medicaid program at:

WAC 388-845-1000 or WAC 388-845-1015

Authorization:

Printed Name:

Date:

Printed Name:

Date:

Printed Name:

Date:

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INSTRUCTIONS

When do I use this form?

You must use this form before approving the authorization and payment of extended state plan services as a waiver service.

What options do I have for getting this form completed?

- You may complete this form during an interview or telephone discussion with the person/family/legal representative or
- You can mail it out to be completed and returned by mail. When mailing the form, include a self-addressed return envelope.

Do I need additional verification of this information?

You must determine if this notice provides you sufficient information. You may need to call the therapist/clinic for further information or verification.

Do I need to do anything else if one of the reasons on this form is checked?

If you are exempting use of first use of Medicaid because there is no Medicaid provider available or willing to do this service within 60 miles of the person’s home, you must request an exception through CMIS.

Do I have to use Medicaid contracted therapist when authorizing Waiver services?

You can use any ADSA contracted therapist when authorizing waiver services. If the person wants to continue with their Medicaid contracted therapist, the therapist must have an ADSA contract before you can authorize services through the waiver.