ID/DD Waiver
Service Authorization

Rev 01/17

To: _____ **From:** _____

Name of Agency — Support Coordination Department

Re: _____ _____

Individual's Name — IDD Waiver Support Coordinator

_____ _____

Medicaid Number — IDD Waiver Support Coordinator Phone/e-mail

_____

Individual's Address and Phone Number

☐ **Change in type(s)/amount(s) of service**

Procedure Code	Service	Amount	Frequency		Authorized Start Date	End Date
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ID/DD Waiver Support Coordinator Comments/Information

Can the agency provide the service(s) requested? ☐ **Yes** ☐ **No**

Agency Comments

_____ _____

Signature of Authorized Agency Representative — Date

To Be Completed by Support Coordinator

_____ _____

Date Received from Agency — Support Coordinator Signature