 Date Submitted _____

**CHOICES WAIVER**
**HOME/COMMUNITY-BASED SERVICES**

**EFFECTIVE DATE FOR INITIAL HCBS ELIGIBILITY**

**To:** **,** DSS Medical Caseworker

**From:** **,** DHS DDD QDDP/QUALIFIED STAFF

**Name:**

**Medicaid Number:**

☐ **Child** **or** ☐ **Adult**

**Provider:**

☐ Case Management Provider:
☐ Community Support Provider:

☐ Has been determined eligible to receive Home and Community-Based Services.

**Initial HCBS effective:**

**OR**

☐ Has been determined ineligible to receive Home and Community-Based Services.

**Initial HCBS denied:**

Please make the appropriate changes to initiate reimbursement of services. If you have any questions, please contact the DHS DDD staff listed above at the Division of Developmental Disabilities at (605) 773-3438.

cc: DDD file
Provider
DDD fiscal manager

DDD Use Only:

☐ Transferred from another CSP or FS 360:
☐ Transferred from SDDC
☐ Return from a Skilled Nursing Facility
☐ SMART Review _____