WAIVER APPLICATION CASE ACTION REPORT

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
AUTISM SERVICES UNIT
SFN 60619 (3-2014)

Clear Fields

☐ Initial Waiver Determination
☐ Redetermination

Name (Last, First, MI)		ID Number	Effective Date
Date of Birth	Next Review Date	Type of Screen ☐ Initial ☐ Rescreening	
Legal County		Screen Code Select One	Screening Team Number
Name of Provider		Level of Care Select One	Level of Support Select One
Provider Number		Date of Screening	Age
Diagnosis Code 1		Diagnosis Code 2	Diagnosis Code 3
Comments-Social Services			
Comments-Medical Nursing			
Diagnosis			
Diet			
Lab		Drugs	
Other Comments			

Medicaid Utilization Review Team Signatures

Name	
Title	Date

Name	
Title	Date

Medicaid Medical Director

Medicaid Medical Director Comments	
Medicaid Medical Director Signature	Date