MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
DIVISION OF SENIOR AND DISABILITY SERVICES

STRUCTURED FAMILY CAREGIVING WAIVER DIAGNOSIS VERIFICATION FORM

HEALTHCARE PROFESSIONAL INFORMATION

NAME		
ADDRESS	ADDRESS (SUITE, BOX)	
CITY	STATE	ZIP CODE
EMAIL ADDRESS	PHONE NUMBER	FAX NUMBER

Your patient below has requested Home and Community Based services (HCBS). HCBS are authorized for reimbursement through Medicaid for participants who require nursing facility level of care. The services provide assistance with activities of daily living and/or instrumental activities of daily living in the home and community as an alternative to nursing facility placement.

Your patient has authorized DSDS to contact you to obtain information to assist in determining program eligibility. Please complete the below information within 10 days and return this form (by email or fax) to the staff listed at the bottom of this page.

If you have additional information, please include that information in the space provided for HEALTHCARE PROFESSIONAL COMMENTS. Thank you.

PARTICIPANT INFORMATION

PARTICIPANT NAME	DOB	DCN

This participant is requesting the Structured Family Caregiving Waiver (SFCW). To enroll in the SFCW, the participant must have a diagnosis of Alzheimer's disease or a related disorder as defined by state statute 172.800 RSMo.

172.800 RSMo defines these as diseases resulting from significant destruction of brain tissue and characterized by a decline of memory and other intellectual functions. These diseases include but are not limited to progressive, degenerative and dementing illnesses such as presenile and senile dementias, Alzheimer's disease and other related disorders.

DIAGNOSIS	ICD-10 CODE

HEALTHCARE PROFESSIONAL COMMENTS

HEALTHCARE PROFESSIONAL NAME (PRINT)

HEALTHCARE PROFESSIONAL SIGNATURE	DATE

DSDS INFORMATION

DSDS STAFF NAME AND TITLE (PRINT)

DSDS STAFF SIGNATURE	DATE

EMAIL ADDRESS	FAX NUMBER	PHONE NUMBER