4.00

APPENDIX 16

STRUCTURED FAMILY CAREGIVING WAIVER DIAGNOSIS VERIFICATION FORM

When further information is needed to verify a participant has a diagnosis of either Alzheimer's or a dementia related disorder, the Structured Family Caregiving Waiver (SFCW) Diagnosis Verification Form shall be sent to a participant's healthcare professional, such as a Physician, Nurse Practitioner, or Physician Assistant. After the Division of Senior and Disability Services (DSDS) staff have confirmed the participant's diagnosis cannot be determined by using a diagnosis provided in the electronic case management system by the participant's healthcare professional, or the inability to confirm diagnosis by the healthcare professional by telephone, the DSDS staff shall send the SFCW Diagnosis Verification Form.

The DSDS staff shall contact the healthcare professional's office to obtain the appropriate email or fax number and inform them DSDS staff will be sending this form to obtain the opinion of the healthcare professional.

NUMBER OF COPIES

One copy of the form shall be completed per healthcare professional.

INSTRUCTIONS

NAME: Enter the name of the healthcare professional this form is being sent to.

ADDRESS: Enter the healthcare professional's street address.

ADDRESS (SUITE, BOX): Enter the suite or PO Box for the healthcare professional.

CITY: Enter the city where the healthcare professional's office is located.

STATE: Enter the state where the healthcare professional's office is located.

ZIP CODE: Enter the zip code where the healthcare professional's office is located.

EMAIL ADDRESS: Enter the email address of the healthcare professional.

PHONE NUMBER: Enter the telephone number of the healthcare professional.

FAX NUMBER: Enter the fax number of the healthcare professional.

PARTICIPANT NAME: Enter the participant's name.

DATE OF BIRTH: Enter the participant's date of birth.

DCN: Enter the participant's Departmental Client Number (DCN).

CHECKBOX SECTION: The healthcare professional shall answer the question about the participant's diagnosis being either Alzheimer's or a related dementia disorder by marking YES or NO.

- If the answer is YES, the healthcare professional is encouraged to provide an explanation of the reason in the space provided.

DIAGNOSIS: The healthcare professional completing the form shall enter the participant's diagnosis.

ICD-10 CODE: The healthcare professional completing the form shall enter the participant's ICD-10 code.

HEALTHCARE PROFESSIONAL NAME (PRINT): The healthcare professional completing the form shall print their name.

HEALTHCARE PROFESSIONAL SIGNATURE: The healthcare professional completing the form shall sign their name.

DATE: The healthcare professional completing the form shall enter the date they signed the form.

DSDS STAFF NAME (PRINT): The DSDS staff completing the form shall print their name.

DSDS STAFF SIGNATURE: The DSDS staff completing the form shall sign their name.

DATE: Enter the date the DSDS staff sent the form to the healthcare professional.

EMAIL ADDRESS: Enter the email address of the DSDS staff.

FAX NUMBER: Enter the fax number of the DSDS staff.

PHONE NUMBER: Enter the telephone number of the DSDS staff.

A copy of the SFCW Diagnosis Verification Form shall be scanned into the participant's electronic case record.