OPC LME Developmental Disabilities Services Authorization Request Form (DDARF)

03-21-07

(If completed electronically, navigate the form with mouse, tab, or arrows. Do NOT use 'spacebar' or 'Enter')

Client Demographics:

Client's Name: (*Last, First, MI*) _____ Date of Birth: _____ Client's OPC Medical Record #: _____

Last Name, First Name Middle Initial

Social Security #: _____ Medicaid ID #: _____ Client's County of Residence: ☐ **ORANGE** ☐ **PERSON** ☐ **CHATHAM**

Financial Information:

☐Private Insurance ☐Medicare ☐Health Choice ☐Medicaid ☐IPRS Have efforts been made to seek entitlements (Medicaid, SSI, HealthChoice, etc.)?: ☐Yes ☐ No. If "Yes", then, ☐pending ☐denied ☐other – explain: _____ If "No", please explain: _____

Eligibility Status: ☒MR/DD ☒Head Injury ☐Date of Head Injury: _____ NC-SNAP Score (*Updated whenever a significant change & at least yearly*) _____

Diagnoses (*Include both the codes and the written out diagnosis for all for Axis I, II, & III diagnoses*):

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Requestor: Requesting Agency Name: _____ Fax #: _____

Name of Requestor: _____ Position: _____

Requestor's Phone Number: _____ Phone Extension: _____ Email: _____

SERVICE AUTHORIZATION REQUEST **REQUESTED START DATE**: _____

Provider Agency: _____ Contact: _____ Fax No: _____

Service	Code	Serv. Unit	# Units per Day,Wk, or Month
	H2014HM	**Hour**	per **week**
			per
			per
			per
			per
			per

LME USE ONLY - Authorization Approval

# Units	Auth. Start Date	Auth. End Date

Additional Comments: _____

OPC Care Management FAX: **(919) 913-4004**

_____ **Signature of Requestor** _____ **Date** _____ **Signature of Authorizer** ____/____/____ **Date**