Voucher Approval Request

This form must be submitted to and approved by the DDD Medicaid Eligibility Helpdesk ([DDD.MediEligHelpdesk@dhs.nj.gov](mailto:DDD.MediEligHelpdesk@dhs.nj.gov)) before submitting a Payment Voucher

Date:

# Agency Information

Agency Name:

Agency Type (select one ):  Provider Agency  Support Coordination Agency

Agency Representative:       Email:

# Individual and Service Information

DDD ID:       First and Last Name Initials:

Waiver Program (select one): Community Care Program Supports Program Supports + PDN

Waiver Service(s) Provided Voucher Start Date Voucher End Date

(1)

(2)

(3)

(4)

# Medicaid Termination Information

Medicaid Termination Date:

Reason for Termination:

Describe efforts made to reinstate Medicaid:

# For DDD Use Only

Voucher Request Status: Approved Denied Month(s)/Year Voucher is approved:

Comments:

DDD staff:

Title:       Date:

Date Medicaid Only Application submitted to Medicaid by Waiver Unit (if applicable):

Date Medicaid Reinstated: