DEVELOPMENTAL DISABILITIES ADMINISTRATION

COMMUNITY PATHWAYS WAIVER – Traditional Service Model

Reporting Form

TO: Terri Hartman
DDA Waiver Unit
201 W. Preston Street, 4th Floor
Baltimore, Maryland 21201
Phone: (410) 767-5421 FAX: (410) 767-5850
Email: Waiver.DDA@maryland.gov

INDIVIDUAL INFORMATION:

_____ Last Name _____ First Name _____ Middle Name/Initial

_____ Medical Assistance Number _____ Social Security Number _____ Jurisdiction/County

☐ Remains with _____ (Residential Provider) or _____ (Day Provider) with a change of site address:
Address: _____ City: _____ Zip Code: _____
Date of Change: _____ Jurisdiction/County: _____

☐ Effective _____ (Date) has had a change in waiver service:
From _____ (Type of Service) to _____ (Type of Service) (Please write provider/address change above.)
Examples: Residential Habilitation to Personal Supports; Supported Employment to Day Habilitation; FISS to Personal Supports

☐ Has moved from _____ (Residential Provider) and/or _____ (Day Provider) to a new waiver provider:
Provider: _____
Site Address: _____ City: _____ Zip Code: _____
Date of Change: _____ Jurisdiction/County: _____

☐ Has had a change in Resource Coordination Agency from _____ to
_____ (Resource Coordination Agency), _____ (Address)

☐ Has been admitted to:
☐ Nursing Facility: _____ (Name of Facility) **Admission Date**: _____ **Time**: _____
Discharge Date: _____ **Time**: _____
☐ Chronic Rehabilitation Facility: _____ (Name of Facility) **Admission Date**: _____ **Time**: _____
Discharge Date: _____ **Time**: _____
☐ Other: _____ (Name) **Admission Date**: _____ **Time**: _____
Discharge Date: _____ **Time**: _____

_____ Completed By _____ Agency _____ Date