Community Choices Waiver Case Manager/Delegate Request Form

Agency Name: _____

Request of Case Manager (CM)

CM name: _____

CM e-mail address: _____

CM Type:

- ☐ *Registered Nurse
- ☐ Independent Living Specialist
- ☐ *Licensed Practical Nurse
- ☐ *Occupational Therapist
- ☐ *Social Worker
- ☐ *Licensed Counselor
- ☐ Access Care Coordinator
- ☐ Other, specify_____

☐ Resume attached ☐ *If credential is required, license/Diploma attached

CM will be providing: ☐ Case Management Agency ☐ Case Management ALF ☐ Case Management Participant directed

Will provide Case Management in the following counties (please list):

_____

Request for Delegate

Delegate Name: _____

Delegate e-mail address: _____

Delegate Type: ☐ Agency Owner ☐ Office Manager ☐ Administrative Specialist ☐ Other, specify _____

Case Management Agency Approval, ie, Agency Owner, DON:

Print Name _____ **Title** _____

Signature: _____

Date: _____ **Phone Number:** _____

Waiver office use only:		
Approved/Denied	Date:	By Whom:
Entered into IMPROV:	Date:	By Whom:
Entered Case Manager Document::	Date:	By Whom:
Entered into Gateway:	Date:	By Whom:
Entered into EMWS:	Date:	By Whom: