TO: Autism Waiver Providers

RE: Autism Waiver Semi-Annual and Annual Provider Reports

As a reminder, Autism Waiver providers are required to submit written reports regarding the status and progress of each Connecticut Medical Assistance Program (CMAP) client to whom they provide Autism Waiver services. Providers are required to submit reports for each six (6) month review and annual review of a client's participation in the Autism Waiver program. The reports are to be submitted to the appropriate Autism Waiver Case Manager for each client. **See Appendix D of the 1915(c) HCBS Waiver.**

Providers who have any questions regarding this requirement may contact the client's Autism Waiver Case Manager at the Department of Social Services (DSS), or Amy Dumont, DSS Program Manager. Ms. Dumont can be reached at Amy.Dumont@ct.gov, or (860) 424-5173.

Inquiries may also be made to the DSS Community Options mailbox at AutismCaseManagementDSS@ct.gov.

Connecticut Department of Social Services
Autism Spectrum Disorder Waiver
Individual Plan Review

Service Provider Report

Individual Name: _____

DSS Case Manager: _____

Period Covered: **Annual Review:** _____ **6 Month Review:** _____ **Other:** _____

Provider Agency: _____

Provider Contact: _____

Significant Updates or Changes in Individual's Status

Was there a change in the individual's condition during this time period? Yes_____ No_____

Was this change reported to the DSS Case Manager? Yes_____ No_____

Reported by: _____ **Date/Time:** _____

NOTE: You are required to immediately report to the DSS Case Manager any significant change in the individual's health or functioning, and any safety issue or hospitalization. You are also required to immediately report to the DSS Case Manager any change in your ability to provide services to the individual, such as your unexpected absence, the individual refuses services, or the individual is not home.

Type of ASD Waiver Services:

Service	Agency	Self-Hire	Service	Agency	Self Hire
Life Skills Coach			Respite in home/out of home		
Job Coach			Social Skills Group		
Behavior Management			Assistive Technology		
Community Mentor			Non-Medical Transportation		
Individual Goods & Services					

Number of Service Hours per week: _____ **Number of Visits per week:** _____

Connecticut Department of Social Services
Autism Spectrum Disorder Waiver
Individual Plan Review

Outcome #	Outcome	Progress towards reaching outcome (List objectives)	Status (Met, Partially Met, Unmet) Attach data to this sheet

Review Form Completed by: _____

Signature:_____ Date: _____