Georgia Department of
Behavioral Health and Developmental Disabilities
Division of Developmental Disabilities

WAIVER SUPPLEMENT SERVICES REFERRAL FORM

Date of Referral: _____

Individual Demographic Information

Individual's Name: _____ DOB: _____
Individual's SS#: _____ Phone #: _____
Address: _____ County: _____
DD/ID Diagnosis: _____

Current Services *(Check all that apply)*

☐ NOW ☐ COMP ☐ Participant Directed* ☐ Exceptional Rate
(Only for services not covered under Services and Goods)

Parent/ Legal Guardian/Representative Information (if applicable)

Name: _____
Phone: _____
Address: _____

Support Services/Goods Needs Identified *(check all that apply)*

Service Requested	Vendor Billing Information
☐ Dental Services	Name: _____
☐ Medical Services	Address: _____
☐ Vision Services	City, State, Zip: _____
☐ Other: *(identify below)*	Invoice Number: _____

_____

Provide Detailed Information and any supporting documentation to include but not limited to Medicaid denial/lack of coverage documentation, and a copy of the bill/invoice, and frequency of service need (i.e. one time, multiple visits, or ongoing):

Has the Request for Additional Services been completed? ☐ Yes ☐ No ☐ NA

Referral Source Information

Support Coordinator: _____

Email Contact: _____ Phone Contact: _____

Program Coordinator Review

☐ Approved
☐ Application Not Complete
☐ Not Approved Reason: _____

_____ _____
Program Coordinator Signature Date