

# Government Programs: LTSS Agency Directed Services Request Form CCC Plus Waiver (all ages)

**Optima Health Community Care**

*Please submit via fax to 757-837-4702 or 1-844-828-0600*

Member Name / Last, First	Member ID / Policy #	Date of Birth / Age	Today's Date

Requesting Agency: (Full Name) \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Optima Provider #: \_\_\_\_\_ NPI #: \_\_\_\_\_ Tax ID#: \_\_\_\_\_

Person Completing Form: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Requested Codes: ☐ T1019 ☐ T1005

Date of Service: From \_\_\_\_\_ to: \_\_\_\_\_

Number of Personal Care Hours requested per week: \_\_\_\_\_

Number of Respite Hours per fiscal year: \_\_\_\_\_

- only unused respite hours will be approved

- ☐ **DMAS 97 A/B**
- ☐ **DMAS 99 Community Based Care Recipient Assessment Report**
- ☐ **DMAS 100 (if requesting Supervision hours)**
- ☐ **Employment Verification (if requesting Supervision hours)**
- ☐ **LTSS Prescreening for new/transfer request**