Print Form

The Division of Medical Assistance

Home & Community Care Section

CAP/DA Assessment Only Reimbursement Request

ADMINISTRATIVE MEMORANDUM

Subject: Assessment Only Reimbursement for non-participation in the CAP/DA Waiver

Date:

Date of prior-approved FL-2:

Medicaid Program Category:

Date of the assessment:

Date of the adverse notice to beneficiary:

Beneficiary name:

Medicaid #:

Program Type: ☐ CAP/DA ☐ CAP Choice ☐ MFP Designation

Brief explanation for non-CAP participation:

Requestor name:

Lead Agency:

Lead Agency address:

FOR CONTROLLER USE ONLY

Date:

To: Ken Eason
DHHS/Controller's Office

From:
Through:

Subject: Assessment Only Claim Reimbursement
Program: ☐CAP DA-Choice ☐ MFP
Company #:
Account #:
Center #:

Please prepare a check for an assessment only claim for the above beneficiary listed and mail the check along with this administrative memorandum to [Name of Lead Agency]. Check the "**mailed box**" when task is completed and send a copy of the check (paper or

electronic record) along with the administrative memorandum to the attention of WRenia Bratts-Brown in the Home and Community Care Section at DMA for file maintenance.

	Name of Agency	**Tax #**	**Dates of Claim**		**Amount**	**Beneficiary & MID**
☐ Mailed					$	

Please account to assure that a claim for the same dates was not previously paid.

FOR DMA USE ONLY

An assessment only claim request has been approved for [Beneficiary's name & MID] for dates of [Dates] in the amount of $[Amount].

_____
Signature