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NJ Department of Human Services

Division of Developmental Disabilities

[www.nj.gov/humanservices/ddd](http://www.nj.gov/humanservices/ddd)

**Request to Submit Voucher for Payment**

**Date:**

**AGENCY INFORMATION**

**Agency Name:**

**(Check one): Support Coordination Agency       Provider Agency**

**Agency Representative Name:**

**Email Address:**

**INDIVIDUAL & SERVICE INFORMATION**

**DDD ID:**

**First Name Initial / Last Name Initial**

**Waiver Program (Check one): CCP       Supports Program       Supports Program + PDN**

**Waiver Service(s) Provided: Start Date End Date**

(1)

(2)

(3)

(4)

**MEDICAID INFORMATION**

**Medicaid Termination Date:**

**Reason for Termination:**

**Please describe efforts made to reinstate Medicaid:**

**FOR DDD USE ONLY**

**Voucher Request Status: Approved       Denied:**

**Month(s) /Year Voucher is approved:**

**Comments:**

**Determination made by (DDD staff):**

**Title:**

**Date:**

**MEDICAID INFORMATION**

**Date Medicaid Only Application submitted to Medicaid by Waiver Unit (if applicable):**

**Date Medicaid Reinstated:**