Department of Health and Human Services
**Division of Behavioral Health**

NEBRASKA
Good Life. Great Mission.

# Age Waiver Request

Date of Request: | Region: *Choose Region*

Provider: | Provider Contact:

Provider Address:

Provider Phone Number: | Provider Email:

Individual's Name: | Date of Birth: | Age Today:

☐ By checking this box, you confirm that this youth is NOT a State Ward and/or services are NOT Medicaid covered. Youth meets financial and clinical eligibility criteria.
*If youth has insurance coverage, provide the denial of service(s) requested.*

| | | Location of Service | CDS Encounter # |
|---|---|---|---|
| Request for Authorized Service | Select Service | | |
| Request for Registered Service | Select Service | | *Do NOT Enter Registered in CDS Prior to Approval* |

***Narrative:*** *For all services provide a brief summary based on the sections below.*

Describe services the youth is currently receiving and what barriers are present in current service array.

Explain how treatment and/or rehabilitation needs can best be met in adult services.

Describe program modifications and/or enhancements that will ensure service is person centered & developmentally appropriate.

**Provider Name:** | **Provider Signature:**

**Instructions:** Form should be saved for provider records and submitted via secure email to assigned field representative. Copy Network Administrator for region.

**This section for DBH use only:**

☐ This request for an age waiver as written above has been APPROVED.
For Authorized Services: (a) Locate in CDS (b) Put approval date in CDS notes (c) ADMIT YOUTH INTO SERVICES
For Registered Services: (a) Enter into CDS (b) Put approval date in CDS notes (c) ADMIT YOUTH INTO SERVICES

☐ This request for an Age Waiver as written above has been DENIED.
Denial Instructions: (a) Put denial date in CDS (b) End Encounter.

Comments:

**DBH Representative Signature:**_____