MEDICAID/CHIP PAYMENT ERROR RATE MEASUREMENT (PERM) PROGRAM

PERM REQUEST FOR RECORDS *COVER SHEET*

PERM-ID:

Date:

Patient Name:	**Provider Number:**
Date of Birth:	**Provider Name:**
Recipient ID:	
Date(s) of Service:	
Category 13: Day Habilitation and Waiver Programs, Adult Day Care and Foster Care	
Record Submission Due Date:	

Please submit all *applicable* documents, for the requested **date(s) of service,** from the listing below as well as any other supporting documentation your state may require your facility to keep.

Day Habilitation and Waiver Programs, Adult Day Care and Foster Care:

Home & Community Based Services (HCBS) Waiver:

- Daily Progress Notes, Flowsheets, Worksheets, and Records
- Daily Attendance Logs (*with start & stop times per date*)

Case Management / Supervisory Visit Notes *(with start & stop times per date)*

DME Signature Log / Proof of Delivery

Physician Referral or Order for Services

- Individual Education Plan (IEP);
- Individual Service Plan (ISP); or
- Individual Program Plan (IPP)

Service / Treatment Plan and Goals: ***Covering* the requested Date(s) of Service**

Transportation Provider's Account Ledger

Billing Statements

Ground Mileage / Air Mileage Details

Total Time Spent for Units Billed *(i.e. 15 min., 30 min., 1 hr., 1 visit, etc.)*

Please review the **Instructions for Submitting Requested Record/Documentation**, included in this packet, before submitting documentation. Documents **must be** submitted with this **PERM Cover Sheet** as the first page. The PERM Review Contractor office uses this sheet to confirm receipt of your documents.