

ERROR/UPDATE REPORT

Please fill all the following required information:

Consumer Name: _____ Site Address: _____ Site No: _____
 Provider Name: _____ Provider No: _____ Service Type: _____
 Consumer's Waiver Status: Waiver Non-waiver Operational Month & Year: _____

Please select type of error or reason for update and provide correct information if applicable:		
<input type="checkbox"/> Incorrect Site – Date: __/__/__	<input type="checkbox"/> Incorrect MA#	<input type="checkbox"/> Consumer no longer served – Date: __/__/__
<input type="checkbox"/> New To Agency – Date: __/__/__	<input type="checkbox"/> Incorrect Matrix Level	<input type="checkbox"/> Reimbursable Day Adjustment
<input type="checkbox"/> Incorrect SSN	<input type="checkbox"/> End Date Change Request	<input type="checkbox"/> Other: _____

Agency Comments: 	DDA Comments:
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Attendance Codes By Service	Days of Attendance	Attendance (Total of P)	Absent (Total of V,A,I,W,O)	Allowable (Total of P,V,A,I,W)	Non-Allowable (Total of O,X)
Residential: P,V,A,O	1 2 3 4 5 6 7 8				
Day: P,V,A,I,W,O,X	9 10 11 12 13 14 15 16				
Supported Employment: P,V,A,O,X	17 18 19 20 21 22 23 24				
CSLA: P,N,H,J,F,R,B,X,Z (X: Use for entire month)	25 26 27 28 29 30 31				

Changes requested by: _____ Date: __/__/__ Phone No: ____ - ____ ext. ____ Date Received by Regional Office: __/__/__
 (Agency Staff)
 (Agency Executive Staff) E-mail: _____ Date: __/__/__ Approved: _____ Date: __/__/__
 Signature: _____ (Regional Office Staff)
 Date received by DDA-HQ: __/__/__ Changes made by: _____ Date: __/__/__
 (DDA-HQ Staff)