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| C:\Users\carrcw9\Desktop\State Seal.jpg | MISSOURI DEPARTMENT OF SOCIAL SERVICES  MISSOURI MEDICAID AUDIT & COMPLIANCE  **ANNUAL SERVICE REPORT FOR CONSUMER DIRECTED SERVICES (CDS) VENDOR** |

**Provide three examples of positive impacts on Medicaid consumers’ outcomes through the CDS services provided by your agency during the past calendar year (Three for your agency – not three for each consumer). Continue on additional sheets if needed. Do not include any name or DCN numbers.**

**1.**

**2.**

**3.**

**ANNUAL CERTIFICATION**

**I certify, to the best of my knowledge and belief, that all quarterly CDS service and financial reports required by 19 CSR 15-8.400 were submitted to Missouri Medicaid Audit & Compliance during the past calendar year.**

**☐ Check this box if you did not have any authorized CDS clients during the past calendar year.**

**Reports that are not complete, signed, and/or include the printed name and title of the submitter will be rejected.**

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| **SIGNATURE OF AUTHORIZING CERTIFYING OFFICIAL** | **DATE THIS REPORT WAS SUBMITTED** |
| **TYPED OR PRINTED NAME AND TITLE OF PERSON SIGNING** | **BUSINESS TELEPHONE NUMBER** |
| **FULL LEGAL NAME OF CDS VENDOR** | |
| **NPI** | |
| **PROVIDER EMAIL** | |

**Please submit this report with your 4th quarter CDS service and financial reports to:**

**Email:** [**MMAC.CDS@DSS.MO.GOV**](mailto:MMAC.CDS@DSS.MO.GOV) **Fax: 573-526-4375**

**Missouri Medicaid Audit & Compliance, P.O. Box 6500, Jefferson City, MO 65102**