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| Provider Name: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
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| Name of Individual Provider is Unable to Serve: | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |
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| Medicaid Number: | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
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| Date of DDS Referral to Provider: | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
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| Date of Notice of Inability to Serve Person: | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
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| Services Provider is Unable to Provide: | | | | | | | | | | | Supportive Living  Adaptive Equipment  Environmental Modifications  Care Coordination  Supported Employment  Consultation  Crisis Intervention  Specialized Medical Supplies | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | Supplemental Support Services | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | Respite Care | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | Transitional Care Coordination | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | Community Transition Services | | | | | | | | | | | | | | | | | | |
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| Reason(s) Unable to Serve: | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
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| Provider Name and Staff Name | | | | | | | | | | | | | | |  |  |  |  |  |  |  | Date | | | | | | | |
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