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| **CES Waiver face sheet** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| ***FOR DDS USE ONLY:***  **REFERRAL SOURCE:** ICF/HDC  Nursing Home  ASH  Group Home/Apt  DCFS  APS  Community  **SERVICES REQUESTED:** Admission to Group Home  Admission to Supervised Apartment  Regular Request List | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **WAIVER CONSUMER INFORMATION:** | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | **DAte:** | | | | |  | | | | | | |
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| Individual’s Name | | | | | | | | | | | | | | | | | | | | | | |  | Medicaid # | | | | | | | |  | Social Security # | | | | | | | |
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| Date of Birth | | | | | | | |  | Race/Gender  (Optional) | | | | | | | | | | | |  | Primary Phone Number | | | | | | | | |  | Secondary Phone Number | | | | | | | | |
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| Physical Address | | | | | | | | |  | City, State, Zip Code | | | | | | | | | | | | | | | | | | | | |  | County | | | | | | | | |
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| Mailing Address | | | | | | | | |  | City, State, Zip Code | | | | | | | | | | | | | | | | | | | | |  |  | | | | | | | | |
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| Facility Name, if Applicable | | | | | | | | | | | | | | | | | | | |  | Facility Address | | | | | | | | | | | | | | | | | | | |
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| **CONTACT INFORMATION:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Guardianship: | | | | | | Self | | | | Guardian or Power of Attorney | | | | | | | | | | | | | | | | | | Other contact (Explain Below) | | | | | | | | | | | | |
|  |  |  |  |  |  |  |  |  |  | *(Power of Attorney which conveys same rights as guardianship)* | | | | | | | | | | | | | | | | | | | | | |  |  |  |  |  |  |  |  |  |
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| Contact’s/ Guardian’s/Power of Attorney’s Name | | | | | | | | | | | | | | | | | | | | | | |  | Relationship | | | | | | |  | County | | | | | | | | |
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| Contact’s/ Guardian’s/Power of Attorney’s Street Address | | | | | | | | | | | | | | | | | | | |  | City, State, Zip Code | | | | | | | | | | | | | | | | | | | |
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| Contact’s/ Guardian’s/Power of Attorney’s Mailing Address | | | | | | | | | | | | | | | | | | | |  | City, State, Zip Code | | | | | | | | | | | | | | | | | | | |
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| Contact’s/ Guardian’s/Power of Attorney’s Home Phone | | | | | | | | | | | |  | Contact’s/ Guardian’s/Power of Attorney’s Work Phone and Extension | | | | | | | | | | | | | | |  | Contact’s/ Guardian’s/Power of Attorney’s Cell Phone | | | | | | | | | | | |
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| Contact’s/ Guardian’s/Power of Attorney’s E-mail Address | | | | | | | | | | | | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **SUBMITTED by** DDS Intake & Referral Specialist | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | Date | | | | | | |
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| **RECEIVED by** Waiver Application Unit Specialist | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | Date | | | | | | |
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| **INSTRUCTIONS FOR COMPLETION**  **OF THE CES WAIVER FACE SHEET** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **For DDS USE ONLY Section:** Must be completed by DDS Intake and Referral Specialist.  The Referral Source must indicate where the referral originated.  The Services Requested must indicate the choice of service selected by applicant/guardian. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **WAIVER CONSUMER INFORMATION Section:** This is the applicant’s information and all fields must be completed in its entirety, please note that disclosure of race and gender are optional. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **CONTACT INFORMATION Section:** Please indicate guardian or contact person if applicable, and complete all fields in its entirety. If the applicant does not have a contact or guardian, indicate self and no further information is needed. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| DDS Intake and Referral Specialist must sign and date prior to submitting to Waiver Unit.  Waiver Application Specialist must sign and date once received. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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