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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 |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **WAIVER CONSUMER INFORMATION:** |  | **DAte:** |       |
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|       |  |       |  |       |
| Individual’s Name |  | Medicaid # |  | Social Security # |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|       |  |      /      |  | (   )    -     |  | (   )    -     |
| Date of Birth |  | Race/Gender(Optional) |  | Primary Phone Number |  | Secondary Phone Number |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|       |  |       |  |       |
| Physical Address |  | City, State, Zip Code |  | County |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|       |  |       |  |  |
| Mailing Address |  | City, State, Zip Code |  |  |
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|       |  |       |
| Facility Name, if Applicable |  | Facility Address |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **CONTACT INFORMATION:** |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Guardianship: | [ ]  Self | [ ]  Guardian or Power of Attorney | [ ]  Other contact (Explain Below) |
|  |  |  |  |  |  |  |  |  |  | *(Power of Attorney which conveys same rights as guardianship)* |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|       |  |       |  |       |
| Contact’s/ Guardian’s/Power of Attorney’s Name |  | Relationship |  | County |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|       |  |       |
| Contact’s/ Guardian’s/Power of Attorney’s Street Address |  | City, State, Zip Code |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|       |  |       |
| Contact’s/ Guardian’s/Power of Attorney’s Mailing Address |  | City, State, Zip Code |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| (   )    -     |  | (   )    -     |      |  | (   )    -     |
| 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 |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 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 |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **INSTRUCTIONS FOR COMPLETION****OF THE CES WAIVER FACE SHEET** |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **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. |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **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. |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **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. |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| DDS Intake and Referral Specialist must sign and date prior to submitting to Waiver Unit.Waiver Application Specialist must sign and date once received. |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |