

MEDICAID WAIVER ELIGIBILITY RECORD
DS 3770 (Rev. 5/2001) (Electronic Version)

Eligible _____ Termination _____ Reactivation _____ Recertification _____
Date Date Date Date

STATE VERIFICATION:

ALL LEVEL OF CARE QUALIFYING DEFICITS: (Includes special health care requirements.)

Short Term Absences: Yes No
(Specify dates.)

Comments:

 _____ Date _____
Signature and Title (QMRP)

 _____ Date _____
Signature Date

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STATE VERIFICATION:

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Eligibility Group	UCI	Social Security Number	Birthdate	Consumer Name
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