

MEDICAID WAIVER ELIGIBILITY RECORD

DS 3770 (Rev. 10/2016)

Consumer Name	Birthdate	UCI
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Eligible _____ Termination _____ Reactivation _____ Recertification _____
 Date Date Date Date

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

Short Term Absences: Yes No

Specify dates:

Comments (if needed):

Signature and Title (QIDP) 	Date
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