MEDICAID WAIVER ELIGIBILITY RECORD

DS 3770 (Rev. 10/2016)

Reset Form

Consumer Name	Birthdate	UCI

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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