

## DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES WAITING LIST INFORMATION

- This is a **NEW** Form 909      Date (DD-MMM-YY): \_\_\_/\_\_\_/\_\_\_  
 This is a **CHANGE** to Form 909      Date (DD-MMM-YY): \_\_\_/\_\_\_/\_\_\_  
*(If this is a CHANGE, record only the new/revised information below.)*

NA Score: \_\_\_\_\_

Intake/Waiting List Worker (Form Completed By): \_\_\_\_\_  
 Data Entered By: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Individual's Name: \_\_\_\_\_ ID number: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Date of birth (DD-MMM-YY): \_\_\_/\_\_\_/\_\_\_ IQ: \_\_\_\_\_  
 Age: \_\_\_\_\_ ICD.9 Code: \_\_\_\_\_

<i>Presumptive Eligibility:</i>	<i>Needed Services Information</i>	<i>Start Date (DD-MMM-YY):</i>	<i>Close Date (DD-MMM-YY)</i>
<input type="checkbox"/> BG	<input type="checkbox"/> RHI Immed__Future__	___/___/___	___/___/___
<input type="checkbox"/> BM	<input type="checkbox"/> RHS Immed__Future__	___/___/___	___/___/___
<input type="checkbox"/> PG	<input type="checkbox"/> DSG Immed__Future__	___/___/___	___/___/___
<input type="checkbox"/> PM	<input type="checkbox"/> PAS Immed__Future__	___/___/___	___/___/___
<input type="checkbox"/> PN	<input type="checkbox"/> HHS Immed__Future__	___/___/___	___/___/___
<input type="checkbox"/> SG	<input type="checkbox"/> PPS Immed__Future__	___/___/___	___/___/___
<input type="checkbox"/> SM	<input type="checkbox"/> RSP Immed__Future__	___/___/___	___/___/___
<b>Other:</b>	<input type="checkbox"/> SEI Immed__Future__	___/___/___	___/___/___
<input type="checkbox"/> Transition	<input type="checkbox"/> SLS Immed__Future__	___/___/___	___/___/___
<input type="checkbox"/> Autism	<input type="checkbox"/> COM Immed__Future__	___/___/___	___/___/___
<input type="checkbox"/> Asperger's	<input type="checkbox"/> BCS Immed__Future__	___/___/___	___/___/___
<input type="checkbox"/> ICF/MR	Start Date: ___/___/___ Facility: _____		
<input type="checkbox"/> Nursing Home	Start Date: ___/___/___ Facility: _____		
<input type="checkbox"/> Service Broker	Broker Name: _____		
Broker Start Date:	Start Date: ___/___/___ End Date: ___/___/___		
<b>Disposition:</b> <input type="checkbox"/> Achieved Outcome <input type="checkbox"/> Can't Locate <input type="checkbox"/> Deceased <input type="checkbox"/> Discontinued			
<input type="checkbox"/> Moved Out of Region <input type="checkbox"/> Moved out of State <input type="checkbox"/> Transferred out of Region			

Waiting List Codes	Waiting List Names		
RHI	Community Living- Intensive	PAS	Personal Assistant
RHS	Community Living- Routine	PPS	Professional Parents
DSG	Day Supports	RSP	Respite
PAS	Family Supports/SLN (over 18)	SEI	Supported Employment
HHS	Host Home	SLS	Supported Living (All Types)
COM	Companion	BCS	Behavioral Consultant Services

Waiting List Closure Reasons		
Can't Locate or Contact	Change in Priority	Deceased
Funded (Attrition; Region; DCFS; DYC; ESMC; PAC; Portability)	Moved out of State	Moved to RAS List
Placed in (ICF/MR; Nursing Home; USDC)	No Longer Eligible	Receiving Supports
Survey (Needs Changed; ICF/MR; Nursing Home; USDC)	Needs Changed	Their Request