Request for Wait List Removal

CDDO111

Name _____ Date _____

Case Manager _____ DOB _____

Medicaid # _____ KAMIS # _____

I understand that by signing below I am choosing to remove the person indicated above from the statewide HCBS I/DD Waiver waiting list and that the person will need to reapply for HCBS I/DD Waiver eligibility should services be needed in the future. I understand the current wait for HCBS/IDD funding is years and this request would remove the person from the opportunity to receive HCBS/IDD funding.

To be placed back on the waiting list, eligibility for the person may need to be re-determined and a new state assessment completed before the individual can be placed on the waiting list. The date of request for HCBS/IDD funding would be no earlier than the date the new state assessment is completed.

I understand to reapply I will need to the CDDO at 620-431-7796.

Person's Signature: _____

Guardian's Signature: _____

Case Manager's Signature: _____

Date Received:	
Date notification sent to KDADS:	
Date CDDO database updated:	
CDDO Staff:	

Approved: 9/1/2017