WAIVER CONTACT LIST

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
NURSING HOME TRANSITION AND DIVERSION

Date: _____

Participant: _____

Service Coordinator

Name: _____ **Telephone** _____

Supervisor: _____ **Telephone:** _____

Provider Agency: _____

Regional Resource Development Specialist (RRDS)

Name: _____ **Telephone:** _____

Supervisor: _____ **Telephone:** _____

Quality Management Specialist (QMS)

Name_____ **Telephone:** _____

Supervisor: _____

Complaint Line: _____

WAIVER CONTACT LIST (cont'd)

Service: ____________________

Agency Name: ____________________ **Telephone:** ____________________

Staff Name: ____________________ **Supervisor:** ____________________

Service: ____________________

Agency Name: ____________________ **Telephone:** ____________________

Staff Name: ____________________ **Supervisor:** ____________________

Service: ____________________

Agency Name: ____________________ **Telephone:** ____________________

Staff Name: ____________________ **Supervisor:** ____________________

Service: ____________________

Agency Name: ____________________ **Telephone:** ____________________

Staff Name: ____________________ **Supervisor:** ____________________

Service: ____________________

Agency Name: ____________________ **Telephone:** ____________________

Staff Name: ____________________ **Supervisor:** ____________________

Service: ____________________

Agency Name: ____________________ **Telephone:** ____________________

Staff Name: ____________________ **Supervisor:** ____________________

Other: ____________________ **Telephone:** ____________________

Other: ____________________ **Telephone:** ____________________