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| Provider Name: |       |
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| Name of Individual Provider is Unable to Serve: |       |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Medicaid Number: |       |
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| Date of DDS Referral to Provider: |       |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Date of Notice of Inability to Serve Person: |       |
|  |  |
| Services Provider is Unable to Provide: | [ ]  Supportive Living [ ]  Adaptive Equipment[ ]  Environmental Modifications [ ]  Care Coordination [ ]  Supported Employment[ ]  Consultation [ ]  Crisis Intervention [ ]  Specialized Medical Supplies |
|  | [ ]  Supplemental Support Services |
|  | [ ]  Respite Care |
|  | [ ]  Transitional Care Coordination |
|  | [ ]  Community Transition Services |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Reason(s) Unable to Serve: |       |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|       |  |  |  |  |  |  |  |       |
| Provider Name and Staff Name |  |  |  |  |  |  |  | Date |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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