|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name of participant whose case was placed in abeyance: | | | | | | | | | |  | | |
|  | | | | | | | | | | | | |
| Medicaid Number: | |  | | | | | | | | | | |
|  | | | | | | | | | | | | |
| Date Placed in Abeyance: | | |  | | | | | | | | | |
|  | | | | | | | | | | | | |
| Reason Placed in Abeyance: | | | |  | | | | | | | | |
|  | | | | | | | | | | | | |
| Where Person is Currently Placed? | | | | | | |  | | | | |
|  | | | | | | | | | | | | |
| Dates of Monitoring Contacts: | | | |  | | | | | | | | |
|  | | | | | | | | | | | | |
| Who was Contacted and Relationship? | | | | | | | |  | | | | |
|  | | | | | | | | | | | | |
| Who Performed Contact? | | |  | | | | | | | | | |
|  | | | | | | | | | | | | |
| Was this Contact by DDS Staff  or Provider | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| Narrative: | | | | | | | | | | | | |
|  | Identify Waiver Provider: | | | |  | | | | | | | |
|  | Who is responsible for ongoing monitoring? | | | | | | | |  | | | |
|  | Projected date of return to waiver or end of abeyance: | | | | | | | | | |  | |
|  | Current Status of participant: | | | | |  | | | | | | |