|  |  |
| --- | --- |
| 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: |       |