UAS Request Form

Please complete the following areas and return to the appropriate Lead RDS (Lisa Howard, TBI or Kara Torrisi, NHTD) and Jeanette Dickerson via email

NHTD waiver ☐ **Date:** _____

TBI waiver ☐

Applicant/Participant Name:
DOB:
Medicaid/CIN Number:
Address:
Phone Number:
Alternate Phone Number:
Family/Emergency Contact Information:

Service Coordination Agency & Phone Number:
Service Coordinator Name:
Service Coordinator Supervisor Name:

Other information applicable to scheduling & conducting assessment:

Type of UAS: Initial UAS assessment ☐ Annual UAS assessment ☐ Re-assessment (due to not meeting LOC) ☐
Date of last UAS/LOC:
Date Current LOC is expiring:

Date Received by RRDC/Nurse Evaluator: _____

(For RRDC to complete)