MEDICAID RECIPIENT STATUS NOTIFICATION
MR/DD WAIVER PROGRAM

TO:

1. Application Date: ____/____/____

2. Center No. _____

FROM:

Provider #:

****

RECIPIENT STATUS

****

3. _____ / _____ / _____
(First Name) M.I. (Last)

4. Recipient's Date of Birth ____ ____ ____

5. ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
(Recipient's Medicaid Number)

6. ___ ___ ___ ___ ___ ___ ___ ___ ___
(Recipient's Social Security Number)

7. Recipient's Sex ☐ Female ☐ Male

8. ☐ New Admission ☐ Re-Admission ☐ Re-Determination
(Check appropriate admission for recipient)

9. Reference Information: _____
(Name of Responsible Person)

_____
(Address of Responsible Person)

_____

10. Level of Care Determined by Medicaid: ICF/MR

11. Prior Approval Number As Assigned by Medicaid _____

12. Date Approved by Alabama Medicaid Agency _____

13. Authorized Signature _____

WHITE: LTC RECORDS
PINK: REGION
YELLOW: PROVIDER

MRDD-4