WAIVER SERVICES CONTACT LIST
HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
TRAUMATIC BRAIN INJURY (TBI)

NOTE: A current copy of this document must be readily available in the participant's home.

In case of fire or emergency call 911

Participant: _____ **Date**: _____

Participant Signature: _____

Protective Oversight Contact: _____ **Phone**: _____

Signature: _____

Service Coordinator

Name: **Telephone:**

Supervisor: **Telephone:**

Supervisor: **Telephone:**

Agency: . **Hours of Operation:** 9:00 am to 5:00 pm

Days of Operation (circle days) **Mon Tues Wed Thurs Fri Sat Sun**

Regional Resource Development Specialist (RRDS)

Name: **Telephone:**

Supervisor: **Telephone:**

Agency: **Hours of Operation:** 9am to 5pm

Days of Operation: **Mon Tues Wed Thurs Fri**

Complaint Line

Hours of Operation

Days of Operation: **Mon Tues Wed Thurs Fri**

WAIVER CONTACT LIST (cont'd)

Service

Name **Telephone**
Supervisor **Telephone**

Agency **Hours of Operation 9 AM to 5PM with 24 hr on call**

Days of Operation (circle days) **Mon Tues Wed Thurs Fri Sat Sun**

Service

Name **Telephone**
Supervisor **Telephone**

Agency **Hours of Operation 9 AM to 5PM with 24 hr on call**

Days of Operation (circle days) **Mon Tues Wed Thurs Fri Sat Sun**

Service: _____

Name: _____ **Telephone:** : _____
Supervisor: _____ **Telephone:** _____

Agency: _____ **Hours of Operation:** 9 AM to 5 PM

Days of Operation (circle days) **Mon Tues Wed Thurs Fri**

Service

Name **Telephone**
Supervisor **Telephone**

Agency **Hours of Operation 9 AM to 5PM with 24 hr on call**

Days of Operation (circle days) **Mon Tues Wed Thurs Fri Sat Sun**