APPENDIX H

HOME AND COMMUNITY-BASED WAIVER
NOTIFICATION OF SUSPENSION

1. Client Name: _____

2. Current Residence: _____
   Address
   _____
   City/State/Zip

3. Medicaid Number: _____

4. Provider: _____

5. Home and Community Based Waiver services were suspended for the above referenced individual on _____. Services were resumed on _____.
   Date Date

6. The reason for Suspension: _____
   _____
   _____

7. The maximum length of a suspension is 21 days. Please submit this form as soon as Waiver services resume.

_____
Signature

_____
Date