CHOICES FOR CARE
Moderate Needs Group Wait List

ONLY LIST PEOPLE WHO ARE WAITING. TAKE NAMES OFF LIST WHEN FUNDED.

Report Due by the 15th of the following month.

Total # of Individuals on Wait List:_____

Provider Name: _____

Reporting Month/Year: _____ (Includes all people waiting as of the last day of reporting month)

Name of Applicant	Date of Application	ONLY give reason not able to serve. (e.g., funding not available; no ADS capacity)	Community Medicaid (Y/N)	Comments

Return to Colleen Forkas at colleen.forkas@state.vt.us.
If unable to email, fax one copy to Colleen at 802-871-3052.