



Children's Health and Rehabilitation Services
3824 W. Princeton Circle
Denver, CO 80236
303-866-7450

Children's Extensive Support Waiver *COUNTY NOTIFICATION FORM*

NAME: _____

DOB: _____

MEDICAID ID#: _____

SSN: _____

- This recipient has been enrolled in the **HCB-CES** Program effective _____/_____/_____;
A COPY OF THE APPROVED ULTC-100 IS ENCLOSED.
- This recipient is no longer receiving HCB-CES services effective _____/_____/_____;
due to (reason): _____
- This recipient had the following income for the period _____/_____/_____ to _____/_____/_____

<i>Net Wages</i>	\$ _____
<i>SSI</i>	\$ _____
<i>SSDI</i>	\$ _____
<i>RR</i>	\$ _____
<i>VA</i>	\$ _____
<i>VA Aid & Attendance</i>	\$ _____
<i>Other</i>	\$ _____
<i>Total</i>	\$ _____

Case Management Agency: _____

Case Manager Signature: _____ Date: _____