MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SPECIAL HEALTH SERVICES

ADULT BRAIN INJURY PROGRAM DETERMINE STATUS ON WAIT LIST FORM

PARTICIPANT NAME (LAST, FIRST, MI)	DATE OF BIRTH	DCN
PARTICIPANT STREET ADDRESS		DATE
CITY, STATE, ZIP		NAME OF PARTICIPANT'S GUARDIAN (IF APPLICABLE)

INSTRUCTIONS TO PARTICIPANT:

READ EACH STATEMENT BELOW AND THEN SELECT THE MOST APPROPRIATE OPTION FOR YOUR PERSONAL SITUATION IN REGARDS TO YOUR PLACEMENT ON THE ADULT BRAIN INJURY PROGRAM WAIT LIST.

OPTION #1	OPTION #2	OPTION #3
I understand I am eligible to receive paid services through the Adult Brain Injury Program (ABI) at this time but I am requesting to be placed on hold for a maximum of ninety (90) days. I understand that should I exceed 90 days that I will then be placed at the bottom of the wait list.	I understand I am eligible to receive paid services through the Adult Brain Injury Program (ABI) at this time but I am declining said services. I am choosing to be placed at the bottom of the wait list at this time.	I understand I am eligible to receive paid services through the Adult Brain Injury Program (ABI) but I am choosing to be removed from the wait list and paid service status at this time. I understand I am still eligible for service coordination through the Adult Brain Injury Program.
PARTICIPANT SIGNATURE:	PARTICIPANT SIGNATURE:	PARTICIPANT SIGNATURE:
RESPONSIBLE PARTY SIGNATURE:	RESPONSIBLE PARTY SIGNATURE:	RESPONSIBLE PARTY SIGNATURE:

SERVICE COORDINATOR'S COMMENTS:

SERVICE COORDINATOR'S SIGNATURE:	DATE: