



Waiver Programs  
Texas Department of Aging and Disability Services

WAIV-REG2	<b>Consumer Enrollment</b> (Action Code L01)	Rev. 2/08				
<table style="width: 100%; border: none;"> <tr> <td style="width: 30%;"><b>Action</b></td> <td style="width: 20%;">Add: <input type="checkbox"/></td> <td style="width: 20%;">Change: <input type="checkbox"/></td> <td style="width: 30%;">Delete: <input type="checkbox"/></td> </tr> </table>			<b>Action</b>	Add: <input type="checkbox"/>	Change: <input type="checkbox"/>	Delete: <input type="checkbox"/>
<b>Action</b>	Add: <input type="checkbox"/>	Change: <input type="checkbox"/>	Delete: <input type="checkbox"/>			
Last Name/	<input type="text"/>	Client ID	<input type="text"/>			
Suffix	<input type="text"/>	First Name	<input type="text"/>			
Middle Name	<input type="text"/>	Local Case Number	<input type="text"/>			
Component	<input type="text"/>	Waiver Type	<input type="checkbox"/>			
1 = HCS	4 = TXHML	Prior Discharge From a Medicaid Certified NF or ICF-MR?	<input type="checkbox"/> (Y = Yes, N = No)			
Admitted From	<input type="checkbox"/>	<b>Enter either:</b>				
1 = Community	2 = ICF-MR	Slot Type	<input type="text"/>			
3 = State School	4 = Refinance	<b>or</b>				
5 = State Hospital	MFP Demo?	Slot Tracking Number	<input type="text"/>			
(Y = Yes, N = No - Is person participating in the Money Follows the Person Demonstration Project?)	<input type="checkbox"/>	County of Service	<input type="text"/>			
<b>Guardian</b>						
Last Name	_____	Suffix	_____			
First Name	_____	Middle Initial	____			
C/O	_____	Phone	(____) _____			
Street	_____					
City	_____	State	_____ Zip Code _____			
Completed By: _____		Date: _____				