NEW YORK STATE DEPARTMENT OF HEALTH
Office of Medicaid Management
Bureau of Long Term Care

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER

SERVICE PROVIDER CONTACT LIST (T)

Participant _____ Date _____

Service Coordinator

Name _____ Telephone _____

Supervisor _____ Telephone _____

Provider Agency _____

Service _____

Name _____ Telephone _____

Supervisor _____ Telephone _____

Regional Resource Development Specialist (RRDS)

Name _____ Telephone _____

Supervisor _____ Telephone _____

Quality Management Specialist (QMS)

Name _____ Telephone _____

Complaint Line 1-800-228-8201

NOTE: A current copy of this document must be readily available in the participant's home.

SERVICE PROVIDER CONTACT LIST (cont'd)

Service _____

Name_____Telephone_____

Supervisor _____ Telephone_____

Service _____

Name_____Telephone_____

Supervisor _____ Telephone_____

Service _____

Name _____ Telephone_____

Supervisor _____ Telephone_____

Service_____

Name _____ Telephone_____

Supervisor _____ Telephone _____

Service _____

Name_____ Telephone_____

Supervisor _____ Telephone_____

Other _____ Telephone_____

Other _____ Telephone_____

Other _____ Telephone_____

Other _____ Telephone_____