Medicaid Waiver

Please fill out the information below. Then **print** and either **fax** (518-862-2175), **mail** or **scan & email** to Colleen Dergosits (cdergosits@livingresources.org).

Please remember to include:

- Notice of Decision Letter to show that you are Medicaid Waiver enrolled
- Letter of Determination of Eligibility for OPWDD Services
- Individualized Service Plan (ISP)
- SSI Benefit Letter
- DDP2

Applicant Information

Last Name | First Name

Medicaid Number | TABS ID Number

Do you receive Supplemental Security Income (SSI)? ○ Yes ○ No

Service Coordinator Information

Last Name | First Name

Agency | Phone Number

Additional Agency Information *(if applicable)*

Last Name | First Name

Agency | Phone Number

Applicant Signature | Date

If mailing documents, please send to:

The College Experience Program
Attn: Colleen Dergosits
Living Resources Corporation
300 Washington Avenue Extension
Albany, NY 12203