West Virginia Department of Health and Human Resources

Children with Disabilities Community Services Program (CDCSP) Information Sheet

Initial ☐ Annual Renewal ☐

ICF/IID ☐ Acute Care Hospital ☐ Nursing Facility ☐

Name: _____

Address: _____

_____

DATE OF BIRTH: _____

SSN: _____

MEDICAID #: _____

STATE THAT ISSUED MEDICAID CARD: ☐

PARENTS' NAMES: _____

TELEPHONE(S) #: _____

E-MAIL ADDRESSES: _____

COUNTY: (CHILD RESIDES) _____

DATE COMPLETED: _____ **COMPLETED BY:** _____