Facility Name _____
Facility Address _____

List of Medicaid-Eligible Residents
With Custom or Non-Custom Motorized Wheelchairs

Complete the information below if there are new Medicaid-eligible residents who have received a custom or non-custom motorized wheelchair since your last list was submitted to the Department of Healthcare and Family Services. You must indicate by check mark whether the resident has a custom or non-custom motorized wheelchair.

☐ **Check here if you have no new Medicaid-eligible residents who have received a custom or non-custom motorized wheelchair.**

Resident Name	Resident Identification Number	Custom Motorized Wheelchair	Non-custom Motorized Wheelchair

Signed: _____Date: _____
Authorized Facility Representative

Fax the form to 217-524-7114, or mail to:

Department of Healthcare and Family Services
Bureau of Long Term Care
201 South Grand Avenue East
Springfield, IL 62763