State of Illinois
Department of Human Services - Division of Developmental Disabilities

HOME BASED SERVICES TURNAROUND FORM

Basic Information:

Name of Individual: ______________________ Social Security Number: ______________

Recipient I.D. Number: ______________________

Primary Waiver Service (Check One) ☐ Child HBS ☐ Adult HBS ☐ DT/SEP

☐ Other (Specify): ______________________

New Address: ______________________

County: ______________________

ICAP Score/ Date (Please attach ICAP summary): ______________________

Ambulatory: Yes ☐ No ☐

Self-Directed Assistance Agency: ______________________

Provider/ISC/SDA/PSW Contact information

Name: ______________________

Telephone Number: ______________________

Email Address: ______________________