COLORADO
Department of Health Care Policy & Financing

Case Management Agency and Eligibility Information Sharing Form

Applicant or Member's Information

First Name: Last Name: State ID: SSN:

Physical Address: Town/City: State: Zip Code:

Mailing Address: Town/City: State: Zip Code:

County: Home Phone: Cell Phone: DOB:

Contact Person: Contact Phone:

For Case Management Agency

To: From: Date:

☐ New Case ☐ CSR/Existing Case Reason for Correspondence: Select

☐ ULTC 100.2 Cert Pages Attached ☐ Please Provide Monthly Income ☐ Please complete HCA grant computation

Approved for the following: Select Waiver: Select

Effective date: Case closed due to: Select

Comments/ Notes:

Reply Requested: ☐ Yes ☐ No Case Manager Signature: _____

For Department of Human/Social Services/Medical Assistance Sites

To: From: Date:

Medicaid eligible for: Select Waiver: Select

Gross Monthly Income: Income Source(s): ☐ SSA ☐ SSDI ☐ SSI ☐ Pension ☐ Employment ☐ OAP ☐ AND/AB ☐ Other

☐ HCA Grant Computation Attached

☐ Please send ULTC 100.2 cert. pages

☐ Please complete Level of Care Intake

Ineligible due to: Select Effective date:

Comments/ Notes:

Reply Requested: ☐ Yes ☐ No County Worker Signature: _____