



Case Management Agency and Eligibility Information Sharing Form

Member Information		
Last Name:	First Name:	M.I.:
Medicaid ID#:	Date of Birth:	
SSN:		

Physical Address		
Address:		
Address 2:		
Town/City:	State:	Zip:

Mailing Address		
Address:		
Address 2:		
Town/City:	State:	Zip:

Contact Information	
Member Home Phone:	Member Cell Phone:
Contact Person:	
Relation:	Contact Phone:

For Case Management Agency	
To:	From:
Date:	<input type="checkbox"/> New Case <input type="checkbox"/> CSR/Existing Case
Reason for Correspondence:	
<input type="checkbox"/> ULTC 100.2 Cert Pages Attached <input type="checkbox"/> Provide Monthly Income <input type="checkbox"/> Complete HCA Grant Computation	

For Case Management Agency

Approved for the following:

Waiver:

Effective Date:

Case Closed Due To:

Comments/Notes:

Reply Requested:

Yes

No

Case Manager Signature:

For Department of Human/Social Services/Medical Assistance Sites

To:

From:

Date:

Medicaid Eligible for:

Waiver:

Gross Monthly Income:

Income Source:

SSA - Social Security Administration

SSDI - Social Security Disability Insurance

SSI - Supplemental Security Information

Pension

Employment

OAP - Old Age Pension

AND/AB - Aid to the Needy Disabled/Aid to the Blind

Other:

For Department of Human/Social Services/Medical Assistance Sites

HCA Grant Computation Attached

County Requests:

Send ULTC 100.2 Cert Pages

Complete Level of Care Intake

Ineligible due to:

Effective Date:

Comments/Notes:

Reply Request: Yes No

County Worker Signature: