

Case Management Agency and Eligibility Information Sharing Form

Member Information				
Last Name:	Fir	rst Name: M.I.:		M.I.:
Medicaid ID#:	Da	te 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				
То:		From:		
Date:		New Case CSR/Existing Case		

Reason for Correspondence:

 \Box ULTC 100.2 Cert Pages Attached

 \Box Provide Monthly Income

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		
То:	From:	
Date:	Medicaid eligible for:	
Waiver:	Gross Monthly Income:	
Income Source:		
□ SSA - Social Security Administration		
SSDI - Social Security Disability Insurance		
SSI - Supplemental Security Information		
Employment		
□ OAP - Old Age Pension		

For Department of Human/Social Services/Medical Assistance Sites
□ AND/AB - Aid to the Needy Disabled/Aid to the Blind
□ Other:
□ 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: