



Applicant or Client'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: _____
 ULTC 100.2 Cert Pages Attached _____ Please Provide Monthly Income _____ Please complete HCA grant computation _____

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(s): _____ SSA/SSDI/SSI/Pension/Employment/OAP/AND/AB/Other _____
 HCA Grant Computation Attached _____ Please send ULTC 100.2 cert. pages _____

Ineligible due to: _____ Effective date: _____

Comments/Notes: _____

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