

**Case Information**

To:

From:

Mail Code: \_\_\_\_\_

Mail Code: \_\_\_\_\_

Case Name	Category	Case No.	Category	Case No.
Address (Street, City, State, ZIP Code)			Area Code and Telephone No.	

**Please check all that apply.**

- |   |  |   |  |   |
|---|--|---|--|---|
| <input type="checkbox"/> Absent Parent            | <input type="checkbox"/> Change in Address/<br>Telephone | <input type="checkbox"/> Change in<br>Circumstances | <input type="checkbox"/> Child Care                      | <input type="checkbox"/> Community<br>Placement Resources |
| <input type="checkbox"/> Deductions               | <input type="checkbox"/> Employment<br>Services          | <input type="checkbox"/> EPSDT                      | <input type="checkbox"/> Family Health<br>Services Nurse | <input type="checkbox"/> Family Planning                  |
| <input type="checkbox"/> Household<br>Composition | <input type="checkbox"/> Income                          | <input type="checkbox"/> LTSS Information<br>Shared | <input type="checkbox"/> Medicaid                        | <input type="checkbox"/> Medical/Disability               |
| <input type="checkbox"/> MERP Shared              | <input type="checkbox"/> Nursing Care/Level<br>of Care   | <input type="checkbox"/> Protective Services        | <input type="checkbox"/> Refugee Services                | <input type="checkbox"/> Resources                        |
| <input type="checkbox"/> Support Services         | <input type="checkbox"/> TANF                            | <input type="checkbox"/> Other _____                |  |   |

Comments/Response

Area Code and Telephone No.

\_\_\_\_\_  
Signature\_\_\_\_\_  
Date**Response**

To:

From:

Mail Code: \_\_\_\_\_

Mail Code: \_\_\_\_\_

Comments/Response

Area Code and Telephone No.

\_\_\_\_\_  
Signature\_\_\_\_\_  
Date