**Waiver CAT Form**

|  |  |
| --- | --- |
| Client Name: | Last 4 of SSN: |

|  |  |
| --- | --- |
| Application Date: | Referral Date: |
| EDD: | CAT Code: |

Interpreter:  Y /  N

DON Score:

Needs Master File:  Y /  N

Intensive Case Work:  Y /  N

Medicaid Assistance Provided:  Y /  N

New Application or Redetermination (Circle One)

Uploaded to Report Uploader:  Y /  N Date Uploaded: \_\_\_\_\_\_\_\_\_\_\_\_

Waiver Services:

|  |  |  |
| --- | --- | --- |
| IHS: | EHRS/AMD: | ADS: |

Change of Provider:  Y /  N

Other Services:

MMG

HDM

Funding

Processing Date:

MCO:

Case Manager:

*Billing Updates: Check all that apply, if applicable*

*Needs CMIS Updated:*

*Address*  *ER Contact Info*

*Marital Status*  *Phone*

*Name*  *SSN*

*Multiple CATs*