**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*