COLORADO
Department of Health Care Policy & Financing

Case Management Agency and Eligibility Information Sharing Form

Member Information		
Last Name:	First Name:	M.I.:
Medicaid ID#:	Date 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	
To:	From:
Date:	☐ New Case ☐ CSR/Existing Case
Reason for Correspondence:	
☐ ULTC 100.2 Cert Pages Attached ☐ 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	
To:	From:
Date:	Medicaid eligible for:
Waiver:	Gross Monthly Income:
Income Source: ☐ SSA – Social Security Administration ☐ SSDI – Social Security Disability Insurance ☐ SSI – Supplemental Security Information ☐ Pension ☐ 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: