Application for Eligibility Determination/Redetermination

AA. Client Identifying Information

1. Client Name
2. Social Security Number
3. Client Street Address
4. Client City, State, Zip Code

BB. Client Eligibility for CBMRDD Services

1. Date of Application: _____/_____/_____
2. Eligibility verified from CBMRDD based upon:

☐ OEDI ☐ COEDI ☐ Enrolled in CBMRDD Programs as of 7-1-91

3. Type of Application:

☐ Initial (1st time to receive TTXX Services) ☐ REDETERMINATION

CC. Client's Need (describe briefly)

DD. Program Goal(s) Targeted to Applicant (check one)

___ **1**. Self-Support ___ **2**. Self-Sufficiency ___ **3a**. Protection-Children ___ **3b**. Protection-Adult ___ **3c**. Preserving Families ___ **4**. Community Based Care ___ **5**. Institutional Care

EE. Objective of Services (one service per line)

	Title XX Service Name & 5 Digit Code
1.	
2.	

FF. Service Category

☐ Income Eligibility:

Fee for Service:

☐ CBMRDD Rate Schedule **or**

☐ CDJFS Rate Schedule

☐ Service Included CSSP Profile

Free for Service:

☐ CBMRDD Rate Schedule **or**

☐ CDJFS Rate Schedule

☐ Service Included CSSP Profile

Document	Date Mo	Day	Yr	Amount indicated on Document (Write in and check)
1. Pay Check Stub				$ .00 Per _____ Week _____ Month _____ Year
2. SSI				$ .00 Per _____ Week _____ Month _____ Year
3. Other - Describe				$ .00 Per _____ Week _____ Month _____ Year

☐ Without Regard to Income:
Service Included CSSP Profile Yes ☐ No ☐ **If no, service cannot be billed to TTXX**

GG. Verification

I certify that the information given in this report is accurate, and I will report within two weeks any changes of the above information.

Signature: _____ Date: _____
Client or Authorized Representative or Head of Household

FOR TITLE XX PROVIDER ONLY

Provider name	Provider TTXX Contract No.

Action (Determination required within 30 days. Must provide written notification of decision and applicant's right to State Hearing):

☐ Approved; Notice given ☐ Disapproved; Form DHS-7334 completed and provided to the applicant

☐ Determination/Redetermination Appealed (Appeal Summary form DHS-4067 attached)

☐ Appeal Approved ☐ Appeal Denied

Reviewer's Signature: _____ Date: _____