

DOCUMENTATION OF NEED

CASE NAME _____ CASE NO. _____ DATE _____

ADDRESS _____ TELEPHONE _____

APPLICANTS	DOB	RELATIONSHIP TO CASEHEAD	SEX F/M	INCOME TYPE/AMOUNT	PREGNANT? IF YES, DUE DATE	DISABLED? YES/NO	MEDICARE YES/NO	RESERVE TYPE/AMOUNT	CHILDCARE AMOUNT
1.									
2.									
3.									
4.									
5.									
6.									
OTHER HOUSEHOLD MEMBERS									
1.									
2.									

BUDGET COMPLETED/ATTACHED: YES NO RETRO ONGOING _____

1. Did you explain:
- | | | | |
|-------------------------|---|-------------------------------------|---|
| a. Reduction of Reserve | Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> | e. DDS determines disability status | Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> |
| b. Transfer | Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> | f. Estate Recovery | Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> |
| c. Rebuttal | Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> | g. Citizenship/Identity | Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> |
| d. Burial Exclusion | Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> | h. State Residence | Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> |

2. Does the applicant have retro need? Yes No
- Applicant _____ Month _____ Amount _____ Where _____
- Applicant _____ Month _____ Amount _____ Where _____
- Applicant _____ Month _____ Amount _____ Where _____
- Applicant _____ Month _____ Amount _____ Where _____

3. Does the applicant have old bills? Yes No
Applicant _____ Month _____ Amount _____ Where _____

Applicant _____ Month _____ Amount _____ Where _____

4. Does the applicant have any current bills? Yes No
Applicant _____ Month _____ Amount _____ Where _____

Applicant _____ Month _____ Amount _____ Where _____

5. Does the applicant have anticipated medical bills? Yes No
Applicant _____ Month _____ Amount _____ Where _____

Applicant _____ Month _____ Amount _____ Where _____

6. Based on observation, knowledge of client, and case record information, does the client have a condition listed below requiring the agency to obtain the necessary information?
Yes No

A. Check the condition that applies:

- | | | | |
|---------------------------------------|---|--|---|
| <input type="checkbox"/> Blind | <input type="checkbox"/> Developmentally Disabled | <input type="checkbox"/> Homebound | <input type="checkbox"/> Otherwise clearly unable to obtain |
| <input type="checkbox"/> Deaf | <input type="checkbox"/> Unable to speak English | <input type="checkbox"/> Hospitalized | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Mentally ill | <input type="checkbox"/> Unable to read or write | <input type="checkbox"/> Institutionalized | _____ |

B. Does the representative accept responsibility for obtaining information? Yes No Explain _____

7. Was the DMA-5097 completed? Yes No _____

8. Other agency records checked:

	Date Checked	No Record
Work First	_____	_____
Medicaid	_____	_____
Food Stamps	_____	_____
Services	_____	_____

9. Referral made? Yes If yes, state reason for referral below. No

Referral to Medicaid Work First _____

MAD: _____ MAF: _____

MPW: _____ FPW: _____

MIC: _____ WFFA: _____

MAA/MQB _____ NCHC: _____

Worker's Signature _____ Client's Signature _____ Date _____