

## 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 \_\_\_\_\_

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 \_\_\_\_\_

Worker's Signature \_\_\_\_\_ Client's Signature \_\_\_\_\_ Date \_\_\_\_\_