JJA NOTICE OF CHANGE IN IV-E/ MEDICAID ELIGIBILITY OR CSE STATUS

County

I. Identifying Information: ______ **DCF Client ID Number (if known)** ______

Youth's Name **Date of Birth:** **SSN:**

II. Placement Change:

Type of Placement:

- ☐ Independent Living
- ☐ Juvenile Correctional Facility*
- ☐ Jail/Detention *
- ☐ Runaway*
- ☐ Parents*
- ☐ All Foster Homes except Relative
- ☐ Relative Home (non parent)
- ☐ YRC I
- ☐ YRC II
- ☐ PRTF
- ☐ Emergency Shelter
- ☐ Kinship/Non- Relative Kinship Care
- ☐ Residential Maternity Care
- ☐ TLP/CIP
- ☐ Others: _____

* Ineligible for Medicaid

Date Placed: ______

Previous Placement Name ______
Address: ______
Address: ______
From: ______ **To:** ______

Current Placement Name: ______
Address: ______
Address: ______
From: ______

Medicaid Card Mailing Address (if different):

- ☐ Send Medicaid card to the current placement address indicated above
- ☐ Send Medicaid card to the following location:

Name: ______
Address: ______
Address: ______
Address: ______

III. Changes in SSI:

- ☐ Youth began receiving SSI Benefits effective: ______
- ☐ Youth's SSI Benefits terminated effective (Attach Social Security Notice as verification)

IV. Changes in Health Insurance:

- ☐ Policy Terminated effective: ______
- ☐ New Policy effective (provide details below, attach front and back copies of card.):

HMO / PPO: ☐ Yes ☐ No	If HMO / PPO, Name of Primary Care Physician:			
Name of Insurance Company:		Insurance Company's Address:		
Employer:				
Medical: ☐ Yes ☐ No	Hospital: ☐ Yes ☐ No	Dental: ☐ Yes ☐ No	Policy #:	Group #:
Name of Policy Holder:		Relationship to Youth:		

V. Custody:

JJA Relieved of Custody / Date (Attach court order if available):

VI. Comments:

(This form supersedes CFS 4016 REV 7/10)

JJA Case Manager Name	**Phone Number**	**Date**

Distribution: DCF Local Office, CSE Local Office, Juvenile's File