Medicaid Case Questionnaire

(Privacy Act Release must be obtained for every case)

Name:_____

Address:_____

Phone Number:(_____)_____

Social Security Number:_____-_____-_____

Case Number(if applicable):_____

Type of Case: _____Medically Needy Application

_____ Medicaid Waiver Application

_____Other_____

Description of Case: _____

_____

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*****Note: Please make certain you print a Privacy Act form to complete, sign and mail to the state office nearest you. There is a map of the state which will help you make that determination, along with the addresses of each state office.**