CLEAR FORM

HOSPITAL INQUIRY

PROVIDER:		**DATE:**	
LEVEL OF URGENCY	HIGH: ☐ Enter Reason		LOW: ☐
TYPE OF INQUIRY	PROVIDER: ☐ FRC: ☐	CASE # (IF KNOWN)	
RELEASE OF INFORMATION	YES: ☐ ABCDM 228 NO: ☐		
AUTHORIZED REPRESENTATIVE (AR)	MC 382 ☐ **or** SAWS2Plus ☐ **or** SSApp ☐ **and** MC 383 ☐ AR FULL NAME(S)		
PATIENT INFORMATION (IF KNOWN)	LAST	FIRST	MI
	SSN	CIN	DOB
INFORMATION REQUESTED/Additional Comments (EX. CASE STATUS)			
CHANGE IN CIRCUMSTANCE:			
ADD A PERSON, ADDRESS CHANGE, ETC.	☐ ADD A PERSON NAME: DOB: ☐ ADDRESS CHANGE: ☐ INCOME CHANGE ☐ New Hire ☐ No Income ☐ OTHER:		

COUNTY RESPONSE:

PROVIDER INQUIRY: ☐ ELIGIBLE/CIN: ☐ NOT ELIGIBLE

ACTIVE CASE:

YES: ☐ CASE # _____

NO: ☐ DENIED/CLOSED _____
DATE

REASON:

MUST REAPPLY YES: ☐ NO: ☐

RESCIND/DISPO DATE_____

CASE STATUS:

PENDING: ☐ DISCONTINUED: ☐ _____
REASON

GOOD CAUSE GIVEN: YES: ☐ NO: ☐ **MUST REAPPLY**

90 DAY CURE DATE _____

RENEWAL MONTH _____

RETRO APPLICATION DATE(S) _____

PENDING/CURE VERIFICATIONS NEEDED		REQUIRED BY
ADDITIONAL COMMUNICATION		

COUNTY WORKER NAME: **DATE:**