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 ☐ No ☐ N/A ☐
   - b. Transfer Yes ☐ No ☐ N/A ☐
   - c. Rebuttal Yes ☐ No ☐ N/A ☐
   - d. Burial Exclusion Yes ☐ No ☐ N/A ☐
   - e. DDS determines disability status Yes ☐ No ☐ N/A ☐
   - f. Estate Recovery Yes ☐ No ☐ N/A ☐
   - g. Citizenship/Identity Yes ☐ No ☐ N/A ☐
   - h. State Residence Yes ☐ No ☐ N/A ☐

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:

☐ Blind	☐ Developmentally Disabled	☐ Homebound	☐ Otherwise clearly unable to obtain
☐ Deaf	☐ Unable to speak English	☐ Hospitalized	☐ Other_____
☐ Mentally ill	☐ Unable to read or write	☐ 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 _____