Form I.D.
D

ELIGIBILITY INFORMATION SYSTEM

CHECKS/REPLACEMENT I.D. CARDS FOR

CASE HEAD/PAYEE NAME:				CASE I.D.	CD	COUNTY NUMBER	COUNTY CASE NUMBER	DISTRICT NUMBER
FIRST	MI	LAST	JR/SR/ETC.					

A	ADDRESS LINE 1	ADDRESS LINES 2

CITY	STATE	ZIP CODE	SUBSTITUTE PAYEE NAME CODE	FIRST	MI	LAST	JR/SR/ETC.

USE SECTION B FOR id CARD REPLACEMENT ONLY

PERIOD AUTHORIZED		AID				INDIVIDUAL I.D.'S OF THOSE ELIGIBLE FOR PERIOD AUTHORIZED					
FROM	THRU	PROG	CAT	MED CLS	SSI		MED		MED		MED
						CD	☐ A ☐ B	CD	☐ A ☐ B	CD	☐ A ☐ B
ISSUE CARD	☐ YES ☐ NO	PAY TYPE	☐ PML	☐ DB		CD	☐ A ☐ B	CD	☐ A ☐ B	CD	☐ A ☐ B
ISSUE CARD	☐ YES ☐ NO	PAY TYPE	☐ PML	☐ DB		CD	☐ A ☐ B	CD	☐ A ☐ B	CD	☐ A ☐ B
ISSUE CARD	☐ YES ☐ NO	PAY TYPE	☐ PML	☐ DB		CD	☐ A ☐ B	CD	☐ A ☐ B	CD	☐ A ☐ B

TYPE	DATE		AMOUNT	AID		COUNT		COUNTY CHECK NUMBER	CODE	DATE ISSUED FOR				
	MONTH	YEAR		PROG	CAT.	A	CH			DOCICILIARY RATE	AMB CAP	CAT OF ASST		LVL OF CARE

We certify that the above recipients are eligible for the checks and/or Cards for the period(s) listed.

I affirm that this is a true and accurate statement of Expenditure for the above stated month(s) and year.

County Worker ____________ Date

County Director ____________ Date

County Finance Office ____________ Date