Case #
CCYA/JPO:
CAO:

CCYA/JPO REQUEST FOR CAO ACTION

CCYA/JPO FILL OUT FORM WITH AS MUCH INFORMATION AS AVAILABLE AND FORWARD TO CAO WITHIN 5 DAYS

(SEE BACK OF FORM FOR CODE INFORMATION)

I. ACTION REQUESTED (COMPLETED BY CCYA/JPO) – CHECK ALL THAT APPLY

❒ Automatic Enrollment In Medicaid ❒ Notification Of Change Or Additional Information ❒ Medicaid Non-IV-E Redetermination–TPL form attached

❒ Notification Of "Age Out" ❒ Notification Of Change In Placement/Discharge ❒ Subsidized Permanent Legal Custodianship Release

II. IDENTIFYING INFORMATION (COMPLETED BY CCYA/JPO)

1. Child's Name (Last, First, MI):		2. Race:	3. Social Security Number:	4. Date Of Birth: _____/_____/_____
5. Sex: ❒ Male ❒ Female	6. Does CCYA/JPO Have An Access Card For The Child: ❒ Yes ❒ No ❒ Unknown	7. Access Card And Issue #:	8. Does The Child Have Any Income: ❒ Yes ❒ No ❒ Unknown	
9. Specify Monthly Gross Income And Type:				

III. PLACEMENT/REMOVAL INFORMATION (COMPLETED BY CCYA/JPO)

A. NOTICE OF CHILD'S INITIAL REMOVAL:

1. Date Of Initial Removal: _____/_____/_____ 2. Date Of Initial Placement:_____/_____/_____
3. Relative/Caretaker From Whom Child Was Removed:

RELATIVE/CARETAKER NAME (LAST, FIRST, MI) AND ADDRESS:	SOCIAL SECURITY NUMBER:	RELATIONSHIP TO CHILD:

B. CHILD IS IN SUBSTITUTE CARE PLACEMENT:

1. Substitute Care Provider:

NAME OF SUBSTITUTE CARE PROVIDER:	ADDRESS:

2. Effective Date: _____/_____/_____ 3. County Code Where Placed: ☐ 4. Placement Facility Code: ☐

C. CHILD IS NO LONGER IN SUBSTITUTE CARE PLACEMENT:

1. Name, Address And Relationship Of The Caretaker To Whom Child Was Returned:

RELATIVE/CARETAKER NAME (LAST, FIRST, MI) AND ADDRESS:	SOCIAL SECURITY NUMBER:	RELATIONSHIP TO CHILD:

2. Effective Date: _____/_____/_____ 3. County Code Where Child Returned: ☐

D. CCYA/JPO INFORMATION AND AUTHORIZATION:

NAME: (PLEASE PRINT)	SIGNATURE:	DATE:	PHONE:

IV. CAO – COMPLETED BY CAO

A. INITIAL ACTION:

1. Child Is From A Household That Receives: ❒ TANF ❒ Food Stamps ❒ Medicaid ❒ No Income Maintenance Benefits
2. Child Receiving SSI: ❑ No ❑ Yes Monthly Amount:_____
3. Automatic Medicaid Enrollment Authorization:
   Recipient # (10 Digit): _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ Card Issue # (Two Digit): _____ _____
4. Child Is Currently Enrolled In A MCO/HMO And/Or Has Private Insurance: ❒ No ❒ Yes
   Name Of MCO/HMO:_____ Policy #: _____

B. MEDICAID REDETERMINATION NON-IV-E CHILDREN:

❒ Child Is Medicaid Eligible ❒ Child Is Not Medicaid Eligible, Reason:_____

C. CONFIRM ADDITIONAL INFORMATION/UPDATES OR CHANGES ON CIS RECORD:

❒ County Where Placed:_____

❒ Facility Placement Code: _____

D. CAO INFORMATION/AUTHORIZATION:

NAME: (PLEASE PRINT)	SIGNATURE:	DATE:	PHONE:

CODES:

PLACEMENT FACILITY CODE:

02 - SUBSTITUTE CARE PLACEMENT FROM COUNTY TO COUNTY WITHIN A MANDATORY MANAGED CARE (HEALTHCHOICES) ZONE

03 – SUBSTITUTE CARE PLACEMENT – COUNTY NOT IN MANDATORY MANAGED CARE

55 – BH MEDICALLY NECESSARY RTF, D&A PLACEMENT FROM COUNTY TO COUNTY WITHIN THE SAME MANDATORY MANAGED CARE (HEALTHCHOICES) ZONE

56 – BH MEDICALLY NECESSARY RTF PLACEMENT FROM COUNTY NOT IN MANDATORY MANAGED CARE (HEALTHCHOICES) ZONE TO A COUNTY WITHIN A HEALTHCHOICES ZONE OR ANOTHER COUNTY NOT IN A HEATHCHOICES ZONE; OR FROM A COUNTY WITHIN ONE HEALTHCHOICES ZONE TO A COUNTY WITHIN A DIFFERENT HEALTHCHOICES ZONE.

57 – BH MEDICALLY NECESSARY PLACEMENT INTO A NON-HOSPITAL D&A FACILITY FROM COUNTY TO COUNTY WITHIN THE SAME MANDATORY MANAGED CARE (HEALTHCHOICES) ZONE

58 – BH MEDICALLY NECESSARY PLACEMENT INTO A NON-HOSPITAL D&A FACILITY FROM COUNTY NOT IN MANDATORY MANAGED CARE (HEALTHCHOICES) ZONE TO A COUNTY WITHIN A HEALTHCHOICES ZONE OR ANOTHER COUNTY NOT IN A HEATHCHOICES ZONE; OR FROM A COUNTY WITHIN ONE HEALTHCHOICES ZONE TO A COUNTY WITHIN A DIFFERENT HEALTHCHOICES ZONE.

73 – YDC/YFC

74 – JDC

98 – MEDICALLY NECESSARY OUT-OF-STATE RTF PLACEMENT

99 – PLACEMENT OUT OF STATE INCLUDING NON-HOSPITAL D&A FACILITIES REGARDLESS OF MEDICAL NECESSITY.

RACE:

WH-WHITE **PI**-PACIFIC ISLANDER **AS**-ASIAN **AI**-AMERICAN INDIAN/ALASKAN NATIVE

BL-BLACK **HI**-HISPANIC/LATINO **UN**-UNABLE TO DETERMINE **O**-OTHER_____