CAH I/II QUARTERLY REPORT

County:_____ [ ] 1 January-March [ ] 2 April-June [ ] 3 July-September [ ] 4 October-December

New Enrollment or Changes During the Quarter

Child's Name (Last, First)	Level of Care (I/II)	D.O.B.	C.I.N.	Case Management Agency	Any changes Y or N	Change Date	Reason for Change/Action:

Contact: cah@health.ny.gov

** Please indicate number for Reason for Change:

A: Discontinuation
1 - Aged Out
2 - Expired
3 - Moved out of State
4 - MA Regular
5 - Other Waiver; i.e., HCBS
6 - Transfer
7 - Hospitalization (over 30 days)
8 - Other

B: Change in Case Management

C: Level of Care Change

D: Re-Assessment

Name of Person Completing Form

Title Date

E-mail Address

Comments: