**HCS CPGC QUARTERLY REPORT**

*Due By the 15th Day of Quarterly Designated Month*

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| **Quarter Designation:** | [ ]  January [ ]  April [ ]  July [ ]  October**YEAR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Contractor Name:** |  |
| **Contractor Address:** |  |
| **Contactor Phone Number:** |  |
| **Medicaid Client Name:** |  |
| **Medicaid Client ID Number:** |  |
| **Court Cause Number:** |  |
| **Change In Circumstance:** [ ]  YES [ ]  NO |  If yes, explain: |
| **Appropriate To Modify, Limit, or Terminate Order:**[ ]  YES [ ]  NO | If yes, explain anticipated modifications, limitations, or restrictions, or termination being requested: If yes, has CPG initiated motion for such modification, limitation, restriction, or termination: [ ]  YES [ ]  NO |
| **Date:** | **Contractor Signature:** |