



JUVENILE REHABILITATION ADMINISTRATION
MEDICAL ASSISTANCE ADMINISTRATION
MEDICAL SERVICES AUTHORIZATION

NEW CASE

CASE NUMBER	AUTHORIZING AGENCY		
PROVIDER			TELEPHONE NUMBER (AND AREA CODE)
STREET ADDRESS	CITY	ZIP CODE	
WA			

YOUTH/CLIENT

NAME	BIRTHDATE (MM/DD/YYYY)	SOCIAL SECURITY NUMBER	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	US CITIZEN <input type="checkbox"/> Yes <input type="checkbox"/> No
MEDICAL ELIGIBILITY Begin date: _____ End date: _____ Date authorized or certified: _____				
PRIVATE INSURANCE <input type="checkbox"/> Yes <input type="checkbox"/> No	SUBSCRIBER'S NAME		ID NUMBER	
INSURANCE COMPANY'S NAME				

CERTIFICATION

I certify the above youth to be medically eligible based upon his/her placement in this JRA group home.

SIGNATURE	DATE	PRINTED NAME
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EXISTING CASE: TO CHANGE ABOVE DATA OR TERMINATE ELIGIBILITY

MEDICAL ELIGIBILITY Begin date: _____ End date: _____		
SIGNATURE	DATE	PRINTED NAME

RELEASED TO:
 Self Parent(s) Community Facility Division of Children and Family Services (DCFS) care/group home
 Institution Other:

STREET ADDRESS	CITY	ZIP CODE
WA		
RELEASE TELEPHONE NUMBER (AND AREA CODE)	YOUTH'S GROSS MONTHLY INCOME \$	TYPE OF INCOME

NOTES