CFS 2015
Rev. 4/99

Illinois Department of Public Aid

REQUEST FOR MEDICAL ASSISTANCE (CATEGORY 98) **DATE __/__/____**

1. CHILD'S NAME:_____

2. CHILD'S CASE ID #: _____

3. DATE OF BIRTH: __/__/____ 4. RACE: _____ 5. SEX: _____

6. DATE OF PLACEMENT: __/__/____

7. PLACEMENT NAME: _____

_____

_____

8. REGION/SITE/FIELD: _____/_____/_____ 9. TEMP MEDICAL CARD #: _____

10. CALLER'S NAME:_____ _____ 11. PHONE #: - -

11. COMMENTS: _____

_____

_____

_____
DCFS Staff Signature

DATA INPUT OPERATOR FACT SHEET **DATE _____/_____/_____**

OPERATOR:_____

1. R.I.N. FOUND: _____ YES or _____ NO 2. FOUND ON A DPA GRANT: _____ YES or _____ NO

3. ENTERED ON CYCIS: _____ YES 4. OPEN/CLOSE CASE: _____ YES

5. ORIGINAL R.I.N. #:_____

6. COMMENTS _____

_____

_____