**CAH I & II Quarterly Report**

**County:** _____ ***Quarter:** _____ (Due the 6th of the following month)

| Child's Name | Level of Care | D.O.B. | S.S.N. | C.I.N. | DSS-639 | | Case Management Agency Change Date | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Group | Exp. Date | | New Case Management Agency | Suspend Date | **Reason for Suspension. Please indicate by number listed below. |
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Contact: Maria Dowling (518) 486-6562 or mad14@health.state.ny.us

*Quarterly Reports due for the following quarters: January-March, April-June, July-September and October-December.

**Please indicate number for Reason for Suspension:

1 - Aged Out
2 - Expired
3 - Moved out of State
4 - MA Regular
5 - Other Waiver; i.e. HCBS
6 - Discharged
7 - Other

Comments:

_____
Name of Person Completing Form

_____/_____
Title Date

(_____)_____
Telephone Number

_____
E-mail Address