TEXAS Health and Human Services
Case Management for Children and Pregnant Women

CM-02A
08/22

MIGRANT INFORMATION FORM

CLIENT NAME: _____ MEDICAID NUMBER: _____

FAMILY MEMBERS THAT MIGRATE	
NAME	**NAME**

SOURCE(S) OF PAYMENT FOR MEDICAL CARE IF FAMILY MIGRATES OUTSIDE OF TEXAS: ☐ N/A MIGRATES ONLY INSIDE TEXAS

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MIGRATING SCHEDULE	
LOCATION	**MONTHS AT LOCATION**
1	
2	
3	

COMPLETE THE FOLLOWING SECTIONS FOR EACH LOCATION LISTED ABOVE:

LOCATION #1			
WHERE CLIENT/FAMILY LIVES:	ADDRESS: CITY/STATE/ZIP:		
CONTACT PERSONS:	**NAME**		**PHONE NUMBER**
MEDICAL PROVIDERS:		**NAME**	**PHONE NUMBER**
	MEDICAL		
	DENTAL		
	SPECIALIST		
	OTHER		
SCHOOL ATTENDS:			

CLIENT NAME: **MEDICAID NUMBER:**

LOCATION #2			
WHERE CLIENT/FAMILY LIVES:	ADDRESS: CITY/STATE/ZIP:		
CONTACT PERSONS:	**NAME**		**PHONE NUMBER**
MEDICAL PROVIDERS:		**NAME**	**PHONE NUMBER**
	MEDICAL		
	DENTAL		
	SPECIALIST		
	OTHER		
SCHOOL ATTENDS:			

LOCATION #3			
WHERE CLIENT/FAMILY LIVES:	ADDRESS: CITY/STATE/ZIP:		
CONTACT PERSONS:	**NAME**		**PHONE NUMBER**
MEDICAL PROVIDERS:		**NAME**	**PHONE NUMBER**
	MEDICAL		
	DENTAL		
	SPECIALIST		
	OTHER		
SCHOOL ATTENDS:			

ORGANIZATIONS THAT PROVIDE ASSISTANCE TO FAMILY:

- ☐ I.S.D. MIGRANT SERVICES/EDUCATION SERVICE CENTERS
- ☐ ACCELERATED SERVICES FROM MEDICAID MANAGED CARE PROVIDER
- ☐ UNITED FARM WORKERS
- ☐ MIGRANT HEALTH CENTER
- ☐ NATIONAL CENTER FOR FARM WORKER HEALTH
- ☐ OTHER:

CASE MANAGER SIGNATURE

DATE