

ClientId	First Name	Last Name	DOB	Medicaid #	AKA or Middle Initial

Client treatment table

Resident County	Admit Date	Discharge Date	Service Type:	Program Name:	Guardianship:	Date Received:	Packet Complete? If Yes Check E I
Lane							
Approved for Screening	Date of Decision:	Denial? If Yes Check <input type="checkbox"/>	Reason for Denial:				
Comments							