Georgia Department of Human Services

# Interim Review of Eligibility

| TANF AU No. | Medicaid AU No | . FS AU No. | Others |
|---|---|---|---|
| Date of Contact: | □ Home: | □ Office: | □ Telephone: □ Other: |
| Name of Client: | | | Copy forwarded to: |
| Address: | | | Telephone No. |
| County of Residence: | | | |
| Reason for Interim Review: | | | |
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| Case Action Taken | | | |
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| Case Manager's Signature: | | Date: | |