

UNDUE HARDSHIP DECISION FORM

CAO Name: _____

Address: _____

CAO FAX #: _____

Date Undue Hardship Waiver Requested: _____

Client's name: _____ Cty/Case #: _____

The CAO has reviewed the undue hardship request and all supporting documents for the period of _____ to _____. The CAO recommends the following:

Approval/Denial	_____	_____
	IMCW Signature	Date

Approval/Denial	_____	_____
	IMC Supervisor Signature	Date

Forwarded to Bureau of Policy, Division of Health Services on: _____

The attached request for Undue Hardship is:

Approved for the following time frame: _____ to _____

Denied for the following time frame: _____ to _____

Reason for decision: _____

_____	_____
Bureau of Policy Signature	Date