Determination for Medicaid Eligibility

Healthcare Assistance Application

Patient Name: ____

Please answer the following four questions to determine if you must apply for Medicaid.

**** If the answer to question # 1 is “No”, you must apply for Medicaid.

1. Are you a U.S. citizen? ____ Yes ____ No

**** If the answer to any of questions 2, 3 or 4 is “Yes”, you must apply for Medicaid.

2. Are you under 65 and been determined disabled by a physician? ____ Yes ____ No

3. Do you have dependents under the age of 18 living at home? ____ Yes ____ No

4. Are you pregnant? ____ Yes ____ No

Staff is available to help you with Medicaid eligibility. Please contact the Financial Counselor at the appropriate facility.

Note: Medicaid determination is only required for combined account balances of $1,500 or more.

I do certify that the information provided above is true and accurate.

____________________________________ ____________________

Signed Date

Healthcare Assistance Application

Name:___________________________________ Date of Birth: __________________________________

Address:____ _______________________ _________ ___________
Street Address/PO Box City State Zip Code

Phone Number: ________________________ Social Security Number _____________________

Family Members Living In Household:

Dependant Name		Birth Date		Relationship		Social Security Number

*If more attach a sheet

INCOME **PATIENT** **INCOME:** **SPOUSE/OR OTHER DEPENDANT**

	Patient		Spouse/Or Other Dependant
Employer Name:	______________	**Employer Name:**	______________
Address:	______________	**Address:**	______________
City, State, Zip	______________	**City, State, Zip**	______________
Salary: (Gross Monthly)	______________	**Salary: (Gross Monthly)**	______________
	______________		______________

Other Income		Patient's Monthly Income		Spouse/Other Dependent's Monthly Income
Social Security/Pensions/Annuities		$		$
Unemployment or Workmen's Comp Benefits		$		$
Interest/Dividend Income		$		$
Child Support/Alimony		$		$
Veteran's Benefits		$		$
Rental Income		$		$
Other		$		$

ASSETS

Real Estate: Own ____ Rent _____		Bank: Name/Address	
Market Value:	$	Bank: Checking	$
Amount Owed:	$	Savings	$
Auto/Truck/Type:		IRA/Tax Sheltered Annuities:	$
		Life Insurance:	$
Market Value:	$	Money Market:	$
Motorcycles, Boats, Campers, Etc.:		Stocks, Bonds, CD's:	$
		Rental Property Owned:	$
Market Value	$	Business Property Owned:	$
		Other:	$

MONTHLY EXPENSES

Rent or House Payments:	$	Medical Insurance:	$
Electric, Propane, Oil:	$	Life Insurance:	$
Water/Sewer:	$	Other Medical Bills	$
Trash:	$	Entertainment:	
Telephone:	$	Auto Insurance: (Annual) $	$
Mobile Telephone:	$	Property Tax: (Annual) $	$
Child Care:	$	Other Loans:	$
Food and Supplies:	$	Misc.: (Specify)	$
Auto Payments:	$		$
TV, Cable, Dish, etc.:	$		$
Credit Cards:	$	**Total Monthly Expenses**:	$

I/We do hereby certify that the information provided above is accurate and a true representation of my/our financial information. I/We understand that this application must be completed and returned to the Financial Counselor within 90 days of discharge for self pay patients. For patient's covered by insurance the application must be received within 90 days from the date of payment or valid denial. I/We understand that insurance payment or valid denial and completion of this application does not relieve me/us of the financial obligations to Southern Illinois Healthcare. I/We also understand that falsification of any information submitted with this application will result in denial of application.

I/We agree to provide the necessary verification of my/our income and authorize Southern Illinois Healthcare to make all inquires that Southern Illinois Healthcare deems necessary to verify the accuracy of the statements made herein, including but not limited to procuring a credit report from a credit bureau and/or other financial institutions. Southern Illinois Healthcare reserves the right to deny any application upon their review.

Date: _____________________________ Signed: ____

Date: _____________________________ Signed: ____

ADDITIONAL INFORMATION

Please use this form to provide additional information that might aid in the processing of your Healthcare Assistance application.

If any of the following statements or questions applies to your situation, please provide the required information on this form.

1. If your monthly expenses exceed your monthly income, please note how your expenses are being met.

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2. If your tax return is not included, please explain why.

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3. If you have no income how do you support yourself?

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Other:

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