MEDICAID SCREENING QUESTIONNAIRE GUIDE

Name:_____ **Account #:** _____

Address:_____ **Date of Service:** _____

SS#/DOB: _____

What telephone # and time of day best to contact: tele #_____ **time:**_____

1.	Does the patient have insurance? If the answer to this question is YES **DO NOT REFER!!!**	YES	NO
2.	Has the HCAP/FAP applications been secured?	YES	NO

MEDICAID FOR WOMEN, CHILDREN AND FAMILY PROGRAMS – If yes to any question, refer immediately.

1.	Is the patient under the age of 18?	YES	NO
2.	Is the patient between ages 18 and under 21?	YES	NO
3.	Is the patient pregnant?	YES	NO
4.	Does the patient have any biological or adoptive children in household under 18 years of age?	YES	NO

MEDICAID FOR THE AGED, BLIND, & DISABLED – If yes to any question, refer immediately.

1.	Is the patient currently receiving SSI or SSD?	YES	NO
2.	Does the patient have any of the following conditions: Total Deafness Total Blindness Confinement to bed or wheelchair due to condition. A stroke occurring three months ago, resulting in inability to walk independently. Amputation of leg at hip Cerebral Palsy, Muscular Dystrophy, or Muscular Atrophy, Down Syndrome Requires hospice care for cancer Severe prematurity Spinal Injury resulting in the inability to walk.	YES	NO
3.	Is the patient 65 or older and not on Medicare?	YES	NO
4.	Have you been deemed Disabled by a Physician for at least a year?	YES	NO

IF THE ANSWER IS YES TO ANY OF THE ABOVE QUESTIONS, REFER ACCOUNT TO FASU FOR MEDICAID ELIGIBILITY ASSISTANCE. MAKE SURE TO SEND THE COMPLETED, SIGNED APPLICATION FOR FINANCIAL ASSISTANCE WITH THIS REFERRAL.

Patient has the following previous dates of service: _____

Person Referring Account _____ Extension _____

Email it to FASU @IRMC.CC or Fax #_____ Dept. Code #

PLACE PATIENT LABEL HERE

Public Assistance Consent & Authorization to Release Information

Patient Name _____ Medical Record Number _____

Social Security Number _____ Date of Birth _____

I authorize Indian River Medical Center to act as my designated representative in establishing eligibility for any and all programs for which I may be considered. This authorization includes securing information from and providing to, the Department of Children and Family Services and the Social Security Administration. Indian River Medical Center is authorized to act on behalf to request and represent me at hearings, conferences, and/or other meetings that pertain to me. I hereby authorize the release of the following information:

Information to be released: (check all that apply)

- ✓ Social Security Administration
- ✓ Employment Verification/Payroll Records
- ✓ Insurance Policy Verification
- ✓ Pension/Retirement Verification
- ✓ Worker's Comp Verification
- ✓ Food stamp eligible months and amount
- ✓ Department of Family and Children Services
- ✓ Bank or Credit Union Account Verification
- ✓ Household Verification
- ✓ VA Benefits Verification
- ✓ Medical Records from Treating Facility
- ✓ Assets

A copy or fax of this authorization will serve as the original. I understand that I may revoke this authorization at any time by saying so in writing with the date and my signature. Any information released before the time of cancellation cannot be revoked, the facility, its employees, and physicians are hereby released from and legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature: _____ email to FASU@IRMC.CC

Date: _____ Case Number: _____

Agency Information:	
ESS Specialist's Name: _____ ESS Specialist's Signature: _____ Date: _____	Office Address/Phone Number: