Cleveland Clinic

MEDICAID SCREENING QUESTIONNAIRE GUIDE

Name:_______________________________ **Account #:** ___________________________

Address:_____________________________ **Date of Service:** ______________________

DOB:_______________________________ **SSN:** _______________________________

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

1. Does the patient have insurance? YES ◯ ◯ NO
If the answer to this question is YES **DO NOT REFER!!!**

2. Has the 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: YES ◯ ◯ NO
   - 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.
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 Dept. Code # __________________

Cleveland Clinic

Public Assistance Consent & Authorization to Release Information

Patient Name ______________________ Medical Record Number ______________________

Social Security Number ______________________ Date of Birth ______________________

I authorize Cleveland Clinic Indian River Hospital 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. Cleveland Clinic Indian River Hospital 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: