Medicaid Application Assistance Form

Patient Information:

Name: John Doe		
Date of Birth: 05/15/1980		
Address: 123 Main Street		
City: Anytown	State: XYZ	ZIP Code: 12345
Phone Number: 12345		
Email Address: johndoe@email.com		

Insurance Information:

Do you currently have any health insurance coverage?	☑ Yes ☐ No
If yes, please provide details:	Employer-sponsored insurance through ABC Company
If no, have you applied for Medicaid before?	☐ Yes ☑ No
If yes, please provide any previous Medicaid identification numbers:	N/A

Financial Information:

Household Size (including yourself):	1
Total Household Income (before taxes) per month:	$2,000
Are you employed?	☑ Yes ☐ No

If yes, please provide employer name and contact information:	ABC Company, (555) 987-6543
Do you receive any other sources of income?	☐ Yes ☑ No
If yes, please specify:	N/A

Medical History:

List any chronic medical conditions:	Hypertension
Are you currently under the care of a healthcare provider?	☑ Yes ☐ No
If yes, please provide their name and contact information:	Dr. Jane Smith, (555) 234-5678
List any current medications you are taking:	Lisinopril 10mg daily
Have you been hospitalized in the past year?	☐ Yes ☑ No

Declaration:

I, John Doe, declare that the information provided in this Medicaid Application Assistance Form is true and accurate to the best of my knowledge. I understand that providing false information may result in denial of benefits. I authorize Dr. Marie Parnell to assist me in completing and submitting this application.

Patient Signature:

John Doe

Provider Signature:

Dr. Marie Parnell

Date:

02/14/2024