Medicaid Application Assistance Form

Patient Information:

Name:		
Date of Birth:		
Address:		
City:	State:	ZIP Code:
Phone Number:		
Email Address:		

Insurance Information:

Do you currently have any health insurance coverage?	☐ Yes ☐ No
If yes, please provide details:	
If no, have you applied for Medicaid before?	☐ Yes ☐ No
If yes, please provide any previous Medicaid identification numbers:	

Financial Information:

Household Size (including yourself):	
Total Household Income (before taxes) per month:	
Are you employed?	☐ Yes ☐ No

If yes, please provide employer name and contact information:	
Do you receive any other sources of income?	☐ Yes ☐ No
If yes, please specify:	

Medical History:

List any chronic medical conditions:	
Are you currently under the care of a healthcare provider?	☐ Yes ☐ No
If yes, please provide their name and contact information:	
List any current medications you are taking:	
Have you been hospitalized in the past year?	☐ Yes ☐ No

Declaration:

I, _____, 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 _____ to assist me in completing and submitting this application.

Patient Signature:

_____

Provider Signature:

_____

Date:

_____