

MEDICAID SHORT FORM

When completing this form, be sure to include all household members. If you need more space than what is provided, please use additional sheets.

First Name (PATIENT)	MI	Last Name	DOB	Social Security Number
Mailing Address	City	State	Zip	Home #
			Work #	

LIST ALL HOUSEHOLD MEMBERS INFORMATION (use the back of this form if needed)

First Name	MI	Last Name	Relationship to Patient	Race	Sex	Marital Status	DOB	SSN #	US Citizen	Want to Apply

INCOME, SELF EMPLOYMENT, EMPLOYER & LOSS OF INCOME INFORMATION (use the back of this form if needed)

Who is Employed?	Employer Name/Self Employment	Hr rate/Monthly gross	Avg. # Hours wk	Start Date (End Date)	How often Paid

ADDITIONAL INCOME INFORMATION (use the back of this form if needed)

Type of Income	Who receives	Amount	Date Received	Start Date	How often Received
Child Support, SSI, Other					

ASSET INFORMATION

Type of Asset	Who Owns	Bank Name	Amount
Checking Acct			
Saving Acct			
IRA/401K			
Property other than Residential home.			

AUTO INFORMATION

Make/Model/ Year	Who Owns	Monthly Payment	Balance

Monthly Child Care/Day Care Expense	\$
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1. Is anyone in the household pregnant? (Yes/No) Due Date _____ No# of Babies _____
2. Is anyone in your household a non-citizen? (Yes/No) Who: _____ What Country: _____ Date entered _____
3. Is everyone in the household a Florida Resident? (Yes/ No). If no, then who is not a Florida resident? _____
4. Is anyone claiming to be disabled or wants to apply for disability thru Social Security or the State of Florida? (Yes/No), Who:

5. Does anyone in the household need help with medical bills from the past 3 months? (Yes/No), What Month? _____
6. Do you pay Child Support to a child outside the Home (Yes/No) How Much \$ _____
7. Absent Parent's Name: _____ DOB: _____
Absent Parent's Name: _____ DOB: _____
8. Name of School(s) Children Attend: _____