Medicaid Intake Form

Applicant's Information			
Name			
First:	Middle Initial:	Last:	Suffix:
Contact Information			
Primary Residence			
Street Address:	City:	State:	Zip Code:
Mailing Address (Leave blank if same as above)			
Street Address:	City:	State:	Zip Code:
Email:	Phone Number:		
Misc.			
Gender: ☐Male ☐Female	Date of Birth:	Country of Birth:	
Social Security Number:	Maiden Name or Previous SSN:	Marital Status:	
Living Arrangement:	Florida Resident: ☐Yes ☐No	U.S. Citizen: ☐Yes ☐No	
Have you ever been determined by Social Security Administration (SSA) as Disabled or Blind? ☐Yes ☐No			
Do you receive Supplemental Security Income Benefits? ☐Yes ☐No			
Spouse's Information			
First Name:	Middle Initial:	Last Name:	Suffix:

Gender: ☐Male ☐Female	Date of Birth:	Social Security Number:	Maiden Name or Previous SSN:

Other People in Your Household			
Name (First, Middle Initial, Last, Suffix):			
Gender:	☐Male ☐Female	☐Male ☐Female	☐Male ☐Female
Date of Birth:			
Marital Status:			
Relationship to you:			
Living Arrangement:			
Maiden Name or Prior SSN:			
FL Resident:	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
U.S. Citizen:	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Have any of your children or dependents been determined disabled by the SSA?			☐Yes ☐No
Please use this area to add additional information			

Liquid Assets				
Cash				
How much cash do you have on hand and not in the bank?				$_____
Are there any other owners of this asset? If yes, what percent do you own?				
Bank Accounts				
Type of Account:	Name of Bank:	Account Number:	Other Owners:	Amount:
				$_____
				$_____
				$_____
				$_____
Other Liquid Assets (Burial Contracts, IRA or Annuity, Stocks or Bonds/Investment Accounts, Tax Shelter Accounts, Trust Funds, etc.)				
Type of Account:	Name of Bank:	Account Number:	Other Owners:	Amount:
				$
				$
				$
				$
				$
				$
Would you like to designate any of the accounts for burial? If Yes, please list:				

Sold, Traded, Given Away, or Transferred Assets (Within Past 5 Years)				
Type of Asset:	Date of Transfer:	What was the Value of the Asset at the Time of Transfer:	To Whom was it Transferred to:	Why was it Transferred:

Cash Settlements (Benefits, Child Support, Inheritance, Law Suit, Lottery, etc.)					
Type of Settlement:	Date Acquired:	Expected/ Received:	Personal Death or Wrongful Injury:	Designating for Burial:	Amount:
		☐Expected ☐Received	☐Yes ☐No	☐Yes ☐No	$
		☐Expected ☐Received	☐Yes ☐No	☐Yes ☐No	$
		☐Expected ☐Received	☐Yes ☐No	☐Yes ☐No	$
		☐Expected ☐Received	☐Yes ☐No	☐Yes ☐No	$

Please use this area to add additional information

Income/Assets

Life Insurance

Type:	Policy Number:	Face Value (Minimum):
		$
		$
		$

Vehicles

Year:	Current Tag:	Other Owners:	Value:
	☐Yes ☐No		$
	☐Yes ☐No		$
	☐Yes ☐No		$

Real Estate

Type:	Address:	Other Owners:	Rental:	Approx. Value:
Primary Residence			☐Yes ☐ No	$
			☐Yes ☐ No	$
			☐Yes ☐ No	$

Business Assets

Type:	Other Owners:	Value:
		$
		$

Current/New Job

Name of Employer:	Date Started:	How Often Are You are Paid:	Hours/Week:	Average Paycheck Before Deductions:
				$

Self Employment

Type:	Hours/Month:	Income from Farming?	Monthly Income/Expenses Amount:
		☐Yes ☐No	$

Income from Other Sources (Child Support, Supplemental Needs Trust, Social Security Administration, etc.)			
Type:	Start Date:	How Often:	Amount:
			$
			$
			$
			$

Pending Benefits	
Type:	Date:

Expenses	
Housing Expenses	
Type:	Monthly Payment Amount:
	$
	$
	$
	$
	$
Utility Expenses	
Type:	Monthly Payment Amount:
	$
	$
	$
	$
	$
	$

Medical Expenses			
Type:	Name of Provider:	Monthly Payment:	Total Amount Billed:
			$
			$
			$

Past Medical Expenses	
Past Medical Expenses:	Name of Months Still Unpaid:

Medicare Expenses	
What is your Medicare Number?	
Are you entitled to or receiving Medicare Part A?	☐Yes ☐No
If yes, Begin Date:	
Premium Amount:	$_____
Who Pays:	
Are you entitled to or receiving Medicare Part B?	☐Yes ☐No
If yes, Begin Date:	
Premium Amount:	$_____
Who Pays:	
Are you entitled to or receiving Medicare Supplemental?	☐Yes ☐No
If yes, Name of Company:	
Premium Amount:	$_____
Are you entitled to or receiving Prescription Drug Insurance?	☐Yes ☐No
If yes, Name of Company:	
Premium Amount:	$_____

Health Insurance Expenses	
Does anyone have or pay for health insurance?	☐Yes ☐No
Has anyone in your home been offered health insurance through their current employer but declined coverage?	☐Yes ☐No
Please use this area to add additional information	