We will consider this application without regard to race, color, sex, age, disability, religion, national origin or political belief.

MEDICAID APPLICATION

☐ Pregnant Woman ☐ Families w/Children – LIM

Check block(s) that apply to you: ☐ Children) Only - RSM ☐ Chafee Independence Program Medicaid

Were you in foster care on your 18th birthday? ☐ Yes ☐ No In which state?_____

FOR COUNTY USE ONLY:
Date Received in County Dept

PLEASE NOTE: A Face to Face interview is not required for Medicaid applications. Please answer all questions as completely and accurately as possible. If you cannot understand or complete this application, please notify DFCS staff and assistance will be provided free of charge.

Your Name: (Please Print) FIRST	M.I.	Last	Maiden (if applicable)	Today's Date:	
Mailing Address:			City:	State:	Zip Code:
Residence Address (if different from Mailing Address):			Phone Number(s):	E-mail Address:	

Please list all persons living with you for whom you want Medicaid. List yourself if you want Medicaid for yourself.

First Name	MI	Last Name	Suffix (Jr.)	Race	Sex M/F	Date of Birth	Relationship to You	Social Security Number	Is this Person a U.S. Citizen? (Y/N) (you may qualify for Medicaid even if you answer No)	Does the Father of this child live in your home? (Y/N)	Does the Mother of this child live in your home? (Y/N)

Please list all persons living with you for whom you DON'T want Medicaid. List yourself if you don't want Medicaid. You do not have to provide a SSN or immigration status information for any person who is not asking for Medicaid. If provided, we will use the SSN for computer matches with other agencies and it may help us process your child's application. We will NOT share your information with the Department of Homeland Security (formerly the INS).

Is anyone in the household pregnant? ☐ Yes ☐ No If yes, who is pregnant? _____ Due Date: _____ Please attach verification of pregnancy if available.

Do you have any unpaid medical bills from the past three months? ☐ Yes ☐ No If yes, which months? _____

Does anyone in your household have Health Insurance? ☐ Yes ☐ No If yes, list Insurance Company and policy number:

Have you or anyone in your household been diagnosed with Breast or Cervical Cancer? ☐ Yes ☐ No If yes, have you received Women's Health Medicaid previously? ☐ Yes ☐ No