Applicants Name:_____ DOB: _____/_____/_____

Applicant's Address: _____ City: _____ State: ___

Applicant's Home Phone #: (_____) _____ Cell (_____) _____

Acct # :_____Today's Date:_____SSN:_____/_____/_____

Information Supplied by:_____ Relationship to Patient: _____

The Medical Center, Navicent Health Financial Assistance Application

SECTION 1 – INSURANCE INFORMATION

1. Does the applicant have insurance? ☐Yes ☐No If yes, Company Name: _____
   Name of Insured: _____ Relationship: _____
   ID#_____ GRP#_____ **(obtain copy of front and back of insurance card)**
2. Is the applicant pregnant OR a minor child under the age of 19 years? ☐Yes ☐No If yes, applicant may be eligible for Medicaid or CHIP
3. Is the applicant between the ages of 18 and 26? ☐Yes ☐No If yes, obtain parents name, employer and insurance information along with copies of cards
   Parent Name:_____ Phone # _____
   Employer: _____
4. Is the applicant a ☐citizen or ☐permanent resident of the United States? ☐Yes ☐No If no, patient may be eligible for Emergency Medicaid
5. Has the applicant applied for insurance offered through the Affordable Care Act at www.healthcare.gov ? ☐Yes ☐No

SECTION 2 – MEDICAL INFORMATION

6. Is diagnosis terminal or will length of illness possibly exceed 12 months? ☐Yes ☐No If yes, may meet disability requirements for Medicaid and perhaps SSI/SSDI as well. (Refer patient to DECO for complete MA application and Disability referral.)
7. Does the applicant have any of the following conditions? Check all that apply and fill in the blank for any diagnosis not listed.

☐Low birth weight/premature	☐Diabetes	☐Walker	☐Mass / Tumor
☐Dialysis	☐Respiratory Disorder	☐Cane	_____
☐HIV/AIDS	☐Depression/Bipolar	☐Prosthetic	_____
☐Heart Attack	☐Anxiety Disorder	☐Liver Disease	_____
☐Heart Disease	☐Mental Retardation	☐Cancer	_____
☐Blindness	☐Other Mental Disorder	☐Major organ transplant	
☐High Blood Pressure	☐Severe Arthritis	☐Major organ failure	
☐Stroke	☐Spinal Disorder/lback pain	☐Seizure Disorder	
☐Asthma	☐Amputation	☐Other chronic illness	

Use the space below to elaborate on any of the above diagnoses or any other conditions not listed.

_____

_____

8. What is the applicant's height? _____ What is the applicant's weight? _____
9. What Medications is the applicant taking?

Medication	Dosage	Prescribed By	Prescribed For

10. If applicant is eligible for Supplemental Security Income or Disability, do they wish to apply? ☐Yes ☐No
    a. Explain to the applicant the benefits of applying i.e. potential monthly income of ~$600 for SSI and eligibility for interim cash assistance such as IDA, TDAP, etc.

11. Has the applicant been hospitalized for any reason in the past 48 months? ☐Yes ☐No If yes, Where, When & Why?_____

_____

12. List any doctor / facility that is currently treating applicant

Doctor/Facility/Clinic Name	Address	Phone	Treated for

13. Has applicant ever applied for Medical Assistance SSDI or SSI in the past? ☐Yes ☐No If yes, which programs and location (county/state)?

_____

If yes, does applicant have an attorney? ☐Yes ☐No If yes, name / address / phone number: _____

_____

SECTION 3 – HOUSEHOLD INFORMATION

14. Is spouse in the home? ☐Yes ☐No If no spouse, then single parents may investigate Aid for Dependant Children Medicaid
15. Number of persons living in household _____ (List each individual below. If additional room is needed, attach paper with information)

Name	Relationship	Age	Employer	Yearly Income Before Taxes

List the names and ages of all your children under 18 not living in the household: (if patient is approved for SSI their child may also receive a check)

Name Age Address Living with:

_____

_____

_____

16. Is applicant a Veteran? ☐Yes ☐No (If yes, investigate VA benefits. Contact local V.A. hospital.)
17. Has applicant, spouse or parents left a job within the last 18 months in which health benefits were provided? ☐Yes ☐No
    a. If yes, applicant may qualify for COBRA benefits. Enter previous employer's information below.

Occupation Time employed there Rate of pay

Previous Employer Address Phone Number

18. Is applicant between the ages of 50 and 64? ☐Yes ☐No

If a Disability referral is being made, complete the information below.

1. Is the applicant ☐Single ☐Married ☐Divorced ☐Widowed - **Maiden Name**:_____
2. Would the applicant prefer an in office or telephone interview to apply for Disability/SSI benefits?

☐ In office **(preferred)** ☐Telephone interview : (_____) _____ phone # for interview

Last grade completed in school : _____ Date last worked: ___/_____/_____

Place of Birth: City State Mother's Maiden Name Father's Name

Spouse's Name Spouse's DOB Spouse's SSN

Spouses Employer Address Phone Number

Occupation Time employed there Rate of pay

Current Monthly Household Income (earned or unearned) Type of income (IDA, TANF, child support, spouses income, work)

Life insurance carrier Cash Value Pension Amount

SECTION 4 – ASSET & LIABILITY INFORMATION

Account:	Account #	Bank	Account Holder	Current Balance
Checking				
Savings				
Trust Fund				
IRA				
Certificate of Deposit				
Food Stamps		N/A		
Real Estate Owned		Rental Income: $	Address:	

Expenses: Rent? Yes ☐ No ☐ Amount: _____ Name on lease: _____

Own? Yes ☐ No ☐ Mortgage amount: _____ Name on Title: _____

Automobile(s): Yes ☐ No ☐ Make/ Model _____ _____ Year _____Pymt:_____ Balance:_____

Yes ☐ No ☐ Make/Model _____ _____ Year _____ Pymt:_____ Balance:_____

TPL Screening/Information

Motor Vehicle Accident:

1. Is your visit the result of a motorized vehicle accident? ☐Yes ☐No Circle one: Auto Motorcycle ATV Moped Pedestrian Bicycle
2. Has a police report been filed? ☐Yes ☐No Were you the driver ☐Yes ☐No Were you a passenger ☐Yes ☐No
3. If yes, name of Law enforcement agency: _____Case # _____
4. Has an insurance claim been filed? ☐Yes ☐No Insurance Company: _____
   Agent Name: _____ Phone #: _____
   Name of Insured: _____
5. Date and time of accident/injury: _____Location of the accident/injury (specific address) _____
6. Describe how the accident/injury occurred: _____

_____

7. Do you carry personal injury coverage on your personal auto insurance? ☐Yes ☐No
8. Name of <u>your</u> auto insurance company, address, phone number and policy number: _____

_____

9. Is another party responsible for the accident/injury? If yes, please provide their name and address: _____

_____

10. Is another insurance company involved in the case? If yes, please provide name and phone number: _____

_____

Work Related Accident:

1. Did the accident/injury occur at work: ☐Yes ☐No Date and Time of Injury: _____
2. Injured person's place of employment at time of incident: _____
3. Was an incident report filed with employer? ☐Yes ☐No
4. Name of Supervisor / Contact Person: _____ Phone: _____
5. Was the incident reported to the Police Department? ☐Yes ☐No
6. If yes, name of Law Enforcement Agency: _____ Report number:_____

Victim of Crime:

1. Is applicant a victim of crime? ☐Yes ☐No

If yes, then a police report must be filed within 72 hours of the crime to pursue Crime Victims Program.

2. Date and Time of Injury: _____ Location of the accident/injury _____
(specific address)
3. Has a police report been filed as result of crime? ☐Yes ☐No If yes, name of Law Enforcement Agency: _____
4. Describe how the accident/injury occurred: _____

_____

Legal Action (Answers required for all TPL listed above)

1. Have you commenced legal action? ☐Yes ☐No Do you intend to take legal action? ☐Yes ☐No
2. If you have consulted an attorney, please furnish name, address and phone number: _____
3. Have you been contacted by an attorney or representative of an insurance company about this matter? ☐Yes ☐No
4. If yes, please furnish name address and phone number: _____
5. Have you received a settlement for injury? ☐Yes ☐No If yes, provide: Amount of settlement: _____Date of settlement:_____

SECTION 5 – FACILITY & REVIEWER INFORMATION

I certify that the information provided to the interviewer is accurate to the best of my ability.

_____ _____
Applicant's Signature Date

_____ _____
Reviewer's Name and Title Date

_(_____)_____
Reviewer's Phone Number