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MEDICAL ASSISTANCE REFERRAL

Date received by C&F:

Please mail form to:

C&F District/Region/Local Office Address:

This referral is from:

Name and Address of Referral Agency:

Name of Person Completing Form _____ Date _____ Phone Number _____

1. The following individual is being referred for an eligibility determination for: ☐ Newborn eligibility ☐ Medicaid ☐ Emergency Medicaid for Aliens ☐ Nursing Home Care ☐ Unborn ☐ Other:_____

Is individual a pregnant woman? ☐ Yes ☐ No

If yes, give due date:_____ and the Medicaid number of the woman:_____

Priority: (check only one) ☐ Inpatient hospital ☐ Pregnant woman ☐ Dialysis/cancer outpatient ☐ All others

The following are attached: ☐ Application ☐ Medical Information ☐ Proof of Emergency ☐ Medical Bills ☐ Registration Form ☐ Proof of Pregnancy ☐ Other:_____

Give the following information about the individual being referred:

a) _____
Last Name First Maiden name

b) _____
Address

c) _____
City State Zip Code

d) _____ Social Security Number **e)** _____ Telephone Number

f) Number of children under age 21 in the home:_____

g) If individual is mother of newborn, give:

_____ Name of newborn _____ Date of Birth

_____ Medicaid ID number of mother

h) Current Status of Individual: ☐ Outpatient ☐ Inpatient: _____ Unit _____ Wing _____ Room No.

If patient cannot be interviewed, give name and phone number of relative or friend, if known:

_____ First Name _____ Last Name _____ Phone Number

Date discharged:_____ if discharged to other than home, give address and phone number where can be reached.

_____ Address

_____ Phone Number

i) Marital Status: ☐ single ☐ married ☐ separated ☐ divorced ☐ widowed

j) Gross Income: Individual receives approximately:

$_____ Social Security (monthly)

$_____ other income (monthly)

k) The individual is (check all appropriate boxes):

☐ age 65 or older ☐ blind ☐ pregnant ☐ totally and permanently disabled ☐ new mother who receives cash assistance or SSI ☐ not currently receiving Medicaid benefits through cash assistance, SSI or Medically Needy

l) Approximate amount of bill: $_____

For RPICC County Health Department Use Only: Date that Presumptive Eligibility Pregnant Woman coverage was determined (mm/dd/yy):_____. **Note:** Application worksheet and Notice **MUST** be attached

2. This Section Completed By DCF:

The following action has been taken on this referral: ☐ Unable to locate ☐ Declined to apply ☐ Application denied ☐ Enrolled in Medically Needy Program with a share of cost ☐ Eligible for Medicaid for the following periods (use mm/dd/yy format): Medicaid Number:_____

beginning _____ through _____ beginning _____ through _____

_____ Authorized Signature _____ Unit _____ Telephone _____ Date