IRCHD Indian River County Hospital District

MENTAL HEALTH ASSOCIATION IN INDIAN RIVER COUNTY

APPLICANT PRE-SCREEN ELIGIBILITY DETERMINATION

The District has the obligation to provide medical care to the impoverished sick of Indian River County under the provisions of Section 20, Florida Statutes Chapter 61-2275, as amended.

The Health Care Financial Assistance ID Program was established to assist Indian River County residents who are in need of medical services but do not have the ability to pay. In order to determine if the applicant is eligible for Medicaid, the following questions should be asked during the interview process:

Medicaid Eligibility Questions:

1) Is the applicant pregnant? Yes/No
2) Is the applicant over the age of 65? Yes/No
3) Is the applicant age 20 or Younger? Yes/No
4) Does the applicant have dependent (biological or step) children age 17 or younger living in their household? Yes/No
5) Does the applicant receive a Social Security disability check? Yes/No

District Healthcare Financial Assistance Questions:

6) Does the applicant currently reside in Indian River County? Yes/No
7) Does this applicant meet income Guideline for their household size? Yes/No

If Answers to Question 1-7 are NO, Applicant does not qualify for Medicaid or District Health Care Financial Assistance

If Answers to Question 1-5 are YES, but Answers to Question 6-7 are NO, Applicant does not qualify for District Health Care Financial Assistance. Patient meets Medicaid criteria and must apply at myflorida.com/accessflorida.

1. Have you or your family ever applied for Medicaid? ☐ No ☐ Yes, When?_____
2. Do you or a family member have Medicaid ***-Share of Cost*** ☐ No ☐ Yes, Amount: $_____
3. Do you have any other health insurance? ☐ No ☐ Yes, Carrier/Effective Date?:_____

_____

If applicant does not qualify for Medicaid please proceed to the Health Care Financial Assistance ID Program Application.

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MENTAL HEALTH ASSOCIATION IN INDIAN RIVER COUNTY

APPLICATION
HEALTH CARE FINANCIAL ASSISTANCE ID Program

Applicant Name: _____

Marital Status: Single Married Widowed Divorced Separated

Mailing Address:_____ City_____, FL/ZIP_____

Street Address: _____ City_____, FL/ZIP_____

How Long a Resident of Indian River County _____ Year(s) _____ Month(s)

Home Phone: _____ Cell Phone: _____

Please list immediate family members living with you.
(Immediate family = You, spouse or significant other, & children)

Family /Personal Information

Family Member Name Include Maiden Name	Relationship	Date of Birth	Social Security #	Medical Insurance Y/N	US Citizen Y/N	Employed Y/N
	APPLICANT					

TOTAL Number of Family Members: _____

Income & Employment Information

_____ _____ _____
Applicant's/Guarantor Occupation Employer Name & Address Monthly Income

_____ _____ _____
Spouse Occupation Employer Name & Address Monthly Income

_____ _____ _____
Other Source of Income Monthly Income

Monthly Deductions for Childcare Expenses / Spousal Support

Court Ordered Child Support $_____ / month

Court Ordered Spousal Support $_____ / month

Comments:_____

_____

_____

I certify that the information listed above is true and correct to the best of my knowledge, I understand that in accordance with SECT.817.50, of the Florida State Statute, providing false information to defraud a hospital for the purpose of obtaining goods or services is a MISDEMEANOR in the second degree. I also understand that any insurance money or liability recovery which may be paid or due me at a later date for services must be paid to Indian River Medical Center. Failure to forward any third party recovery amount to the Medical Center will result in the immediate revocation of the approval for Indigent Care.

_____ _____

Patient Signature Provider Witness Signature Date

** A PROOF OF RESIDENCY IS REQUIRED **

In order for this application to be approved, a photo identification and a current proof of residency must be attached.

Application Check list:

☐ Authorization Release Form

☐ Application for Healthcare Financial Assistance

☐ Applicant's photo ID or 2 alternative non-photo IDs

☐ Income Verification for last 4 weeks

☐ Letter of Support (if applicable)

☐ Proof of Residency - Current

☐ Proof of Residency - Current

2 Proof of Indian River County Residency

Documents must match applicant's listed address

☐ Utility Bill ☐ Telephone Bill

☐ Tax Bill ☐ Rent Receipt

☐ Drivers License ☐ Medical Bill

☐ Other_____

FOR OFFICE USE ONLY:

Yearly Income _____ Family Size _____

☐ APPROVED
(Within Income Guidelines & Proof of Residency Attached)

☐ DENIED
Reason: _____

Patient Sticker or Patient Name, Account #