HAR#: FACS #:

Initial Confirm#: Final Confirm #.

Date:

Medicaid Social Summary

First Name: Last Name:

Address: Phone:

City/State/Zip: County:

Personal Information

Date of Birth: Social Security #:

Marital Status: Does anyone claim you as a dependent:

Tax Filing Status: If joint, name of filing partner:

If claiming dependent under 19, please list insurance type if covered:

Do you have any dependents outside of the household?

Medicare Number: Highest Grade Completed:

Part A: ☐ Effective Date:

Part B: ☐ Effective Date:

Household Members

Name	DOB	SSN	Relationship	Dependent	Apply
				☐	☐
				☐	☐
				☐	☐
				☐	☐

Patient Lives With: Self ☐ Relatives (Friends) ☐ Section 8 Housing ☐ Homeless ☐ Shelter ☐

Financial Information

Is patient receiving SSI/SSDI: Y ☐ N ☐ Monthly Amount: $

Any additional source of income: If so, amount/type: $

Is patient employed: Y ☐ N ☐ Last Date of Employment:

Gross Income: $ Employer:

Please list Child Support Amount/Payee: $

Housing Amount: $ Utilities:

Resources

Bank(s)

If any resources apply to applicant, please list value next to type.

Checking: ☐ Stocks: ☐ KEOGH Plan: ☐

Savings: ☐ Bonds: ☐ IRA/401K: ☐

Cash: ☐ Nursing Home Account: ☐ Burial Account/Life Ins: ☐

Vehicle Make	Model	Year	Purchase Date	Owner

Own More than one Home: Y ☐ N ☐ If so, address:

Own Property: Y ☐ N ☐

Has patient been in a vehicle accident in the past 24 months: Y ☐ N ☐

Lawsuit Expected: Y ☐ N ☐

Any additional information or onset conditions: