SCREENING FOR MEDICAID ELIGIBILITY

Medicaid Team
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PURPOSE: To provide mental health services for adults, youth, and children. All individuals and families with financial needs may enroll in Medicaid and /or Social Security Disability. Our Medicaid team will direct you to staff that will assist you in applying. They will also help you with community and mental health resources.

Name: ______________________ Date of Birth __________ Social Security # __________

Parent/Guardian: ______________________ Day phone # __________ Alternate phone# __________

Address: ____

VMH Unit: ______________ Need for translator ☐ No ☐ Yes, language? __________

1. Is individual interested in applying for: ☐ Medicaid ☐ SSI (Social Security Disability)
2. Are you a legal resident or US citizen? ☐ Yes ☐ No
3. Do you have children under age 18? ☐ Yes ☐ No
4. (Females) Are you Pregnant? ☐ Yes ☐ No
5. Do you have a physical or mental disability that is not related to substance abuse? ☐ Yes ☐ No

Income Eligibility Guidelines for Medicaid

Family Size	Maximum Monthly Income
Single Adult/Disabled Medicaid	$973
Two Adults/Disabled Medicaid	$1,311
Single parent and one child under 6	$1,823
Child is over age 6	$1,744
Family of 3 with child under age 6	$2,293
With child over age 6	$2,194
Family of 4 with child under age 6	$2,763
With child over age 6	$2,644

Other Qualifying Factors

- You have private insurance.
- You have a child with a significant mental problem.
- You have a large family and one income.
- You have family members on prescription medication.
- You have significant medical debts.
- You have an illness that prevents you from being gainfully employed.
- You are a guardian or custodian for a child as a kinship placement.
- You are an 18-year-old student.

I have been informed of the above information. I have also been informed that a Medicaid Eligibility Outreach Worker may contact me. I give Valley Mental Health and related agencies permission to share my information to help me qualify for Medicaid/Social Security.

☐ Yes, I give permission ______________________________ Date __________
Client signature (If under age 18) Parent/Guardian

Program Contact Person ______________________________

Notes:

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