Questionnaire for Potential Medicaid Eligibility

Patients please note, *This is* NOT *an Application for Medicaid!*

FIN Number_____ Patient's Age_____

Iredell Health System, IHS, would like to assist you with applying for medical coverage for hospital-related expenses. This is a service provided to you free of charge by IHS. While we cannot guarantee medical coverage will be granted, we do promise we will assist you with the application process and communicate the outcomes.

Please answer the following questions to expedite our application process:

	(Circle one)
Is the patient pregnant?	**YES or NO**
Does the patient have any children 18 years old or younger living with him or her? (Biological, stepchildren, Guardianship or Primary care giver)	**YES or NO**
Is the patient receiving any disability benefits from Social Security?	**YES or NO**
Is the patient blind or has the patient applied for disability?	**YES or NO**
Has the patient ever had Medicaid in the past?	**YES or NO**

If you answered "**yes**" to any of the above questions, you will be contacted by a representative of IHS. You may also contact IHS at your earliest convenience Monday through Friday between the hours of 8:00 AM and 5:00 PM to discuss the Medicaid application process. **Please remember, this is a free service offered by Iredell Health System.**

Best phone number to reach the patient: _____ Best time of day? _____

I grant permission for the Department of Social Services to release information to Iredell Health System to assist in my application for all programs for which I may qualify.

_____ _____

Patient / Guardian Signature **Date**