START CORP. "CREATING OPPORTUNITIES"

Medicaid Pre-Screening Form
Start Community Health Centers

Complete form for applicant and include a copy of photo ID or proof of residency if not a US Citizen.
If the applicant is a minor, list parent/guardian as head of household, then add children below.
If the applicant is homeless, provide a COMPLETE mailing address below.
Submit completed application to: shonell.thomas@startcorp.org

Name:		DOB:
Address:		Social Security #:
City:	Zip Code:	Is the applicant homeless?: ☐ Yes ☐ No
Phone #:		Sex: ☐ Male ☐ Female ☐ Other
Marital Status: ☐ Married ☐ Separated ☐ Single		If married, do you live with your spouse? ☐ Yes ☐ No
If you live with your spouse, provide name of spouse:		
Spouse DOB:		Spouse Social Security #:

If children live in the home, provide the following and select yes or no if applying for coverage:

Child Name	Child DOB	Child Social Security #	Yes	No

Who is requesting coverage? List all family members requesting:

Is the applicant employed? ☐ YES ☐ NO	If yes, employer name:
Start Date:	Monthly income after taxes:
Is the applicant currently pregnant: ☐ Yes ☐ No	If yes, what is the expected due date?
	Number of babies expected during the pregnancy:

By signing below, I confirm that the above information is true and correct.

Applicant Name | Patient/Legal Representative Signature | Date