MEDICAL ASSISTANCE REFERRAL

Date received by DCF:

Please mail form to: ***This referral is from:***

DCF Office Address:	Name and Address of Referral Source:

Name of Person Completing Form _____ Date (mm/dd/yyy) _____ Phone Number (including area code) _____

1. The person listed below is being referred for an eligibility determination for: ☐ Newborn eligibility ☐ Medicaid ☐ Emergency Medicaid for Aliens ☐ Nursing Home Care ☐ Unborn ☐ Other:_____

Is individual a pregnant woman? ☐ Yes ☐ No

If yes, give due date:_____. List her Medicaid ID number (if known):_____

Priority: (check only one) ☐ Inpatient hospital ☐ Pregnant woman ☐ Dialysis outpatient hospital ☐ Cancer ☐ All others

The following are attached: ☐ Application ☐ Medical Information ☐ Statement of Emergency (*include dates of the emergency only) ☐ Medical Bills ☐ Registration Form ☐ Proof of Pregnancy ☐ Web Application Submitted ☐ Other:_____

Complete the following information about the person being referred:

a) _____
Last Name First Maiden name

b) _____
Address

c) _____
City State Zip Code

d) _____ **e)** _____
Social Security Number Telephone Number

f) Number of children under age 21 in the home:_____

g) If individual is mother of newborn, give:

_____ _____
Name of newborn Date of Birth (mm/dd/yyyy)

_____
Medicaid ID number of mother

h) Current Status of Individual: ☐ Outpatient ☐ Inpatient:_____
Unit Wing Room No.

If patient cannot be interviewed, give name and phone number of relative or friend, if known:

_____ _____
First Name Last Name Phone Number

Date discharged:_____ if discharged to other than home, give address and phone number where can be reached.

_____
Address

_____

_____
Phone Number

i) Marital Status: ☐ single ☐ married ☐ separated ☐ divorced ☐ widowed

j) Gross Income: Individual receives approximately:

$_____ Social Security (monthly)

$_____ other income (monthly)

k) The individual is (check all appropriate boxes):
☐ age 65 or older ☐ blind ☐ pregnant
☐ totally and permanently disabled
☐ new mother who receives cash assistance or SSI
☐ not currently receiving Medicaid benefits through cash assistance, SSI or Medically Needy

l) Approximate amount of bill: $_____

For RPICC County Health Department Use Only: Date that Presumptive Eligibility Pregnant Woman coverage was determined (mm/dd/yy):_____. **Note:** Application worksheet and Notice **MUST** be attached

2. This Section Completed By DCF:

The following action has been taken on this referral: ☐ Unable to locate ☐ Declined to apply ☐ Application denied ☐ Enrolled in Medically Needy Program with a share of cost ☐ Eligible for Medicaid for the following periods (use mm/dd/yy format): Medicaid Number:_____

beginning _____ through _____ beginning _____ through _____

_____ _____ _____ _____
Authorized Signature Unit Telephone Date

CF-ES 2039, Aug 2018 [65A-1.400, 65A-1.205, F.A.C.] [*Per 42 CFR 440.255, limited services are available to certain aliens to treat an emergency medical condition.]