Child In Care
MEDICAID APPLICATION

This form may be used to apply for Medicaid **ONLY,** by either CBC, DJJ, or CINS/FINS agencies.

SECTION ONE: Demographic Information **Current Florida Case #:**

_____
Child's name (please print) Date of Screening/Application

_____
Child's alias, if any (please print) Date of Birth

_____
Social Security Number (SSN) If no SSN, date applied for

NOTE: SSNs are used by the Department for identity verification, income and eligibility verification and other purposes related to the administration of our programs. (Per 42 C.F. R. § 435.910)

U.S. Citizen: ☐ Yes ☐ No **Place of Birth:** ☐ United States ☐ Other

Name of Country:_____ Alien Registration No.:_____

Child's Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Sex:** ☐ Female ☐ Male

Race: ☐ White ☐ Black ☐ Hispanic ☐ Southeast Asian ☐ Asian or Pacific Islander

☐ American Indian/Alaskan Native ..... a. If checked, is the child a member of an organized tribe? ☐ Yes ☐ No

b. If "yes," what is the name of the tribe? _____

c. Did the child get health services from the tribe or a referral? ☐ Yes ☐ No

d. Is the child eligible to get services from the tribe? ☐ Yes ☐ No

☐ Race Unknown ☐ Other Race (specify):_____

SECTION TWO: Removal Information

Presumptively IV-E Eligible: ☐ Yes ☐ No If Yes, explain:_____

_____

Date child was removed from "removal" home:_____

Name and home address of Parent/Guardian with whom child was residing at time of removal:

_____

Was child receiving Medicaid or other public assistance benefits prior to or at date of removal? ☐ Yes ☐ No

If yes, list FLORIDA case number if known:_____

SECTION THREE: Placement Information

_____
Name and Address of Person or Medicaid Allowable Facility where child placed

Date placed in home/facility:_____ Is this a licensed home or Medicaid Allowable Facility? ☐ Yes ☐ No

Date of Expiration of License:_____ Current Board Rate:_____

Did the child have any assets or income? ☐ Yes ☐ No

If yes, list types, gross monthly amount of income and account numbers and names of financial institutions:

SECTION FOUR: Absent Parent Information	
Mother's Name:	SSN (if available):
Alias:	
Address:	
Phone:	
Date of Birth:	
Place of Birth:	
Employer:	
Employer's Address:	
Employer's Phone:	

Father's Name:	SSN (if available):
Alias:	
Address:	
Phone:	
Date of Birth:	
Place of Birth:	
Employer:	
Employer's Address:	
Employer's Phone:	

REASON FOR ABSENCE of both parents: ☐ Court Removal ☐ Desertion ☐ Divorce

☐ Voluntary Removal ☐ Other (explain):_____

- Is paternity an issue for this child? ..... ☐ Yes ☐ No
  (Answer "Yes" if CSE needs to establish paternity for this child.)
  If no, reason:_____
- Does either parent have health/medical insurance? ..... ☐ Yes ☐ No
  If yes, name of carrier:_____
  Policy Number:_____
- Does the policy include the child? ..... ☐ Yes ☐ No

Comments:_____

_____

NOTE: I certify under penalty of perjury that the information on this form is true to the best of my knowledge, including the citizen or noncitizen status of those who are applying for benefits.

_____

Print Name and Signature/Title of Individual Completing Application Date

_____

Name and Address of Organization Telephone Number

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