SCREENING FOR MEDICAID ELIGIBILITY

Medicaid Team
1141 East 3900 South Ste. A180
Salt Lake City, UT 84124
Phone: 801-293-7410 Fax: 801-293-7406

VBH CLIENT ID _____

PURPOSE: To provide needed mental health services for adults, youth, and children. All individuals and families with financial needs are encouraged to enroll in Medicaid.

Name: _____ Date of Birth _____ Social Security # _____

Parent/Guardian: _____ Day phone # _____ Alternate phone# _____

Address: _____

VMH Unit: _____ Need for translator ☐ Yes ☐ No If yes, language? _____

1. Is individual or family interested in applying for: ☐Medicaid
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 Expansion/Disabled	$1415/1064
Two Adults Expansion/Disabled	$1911/1437
Single parent and one child:	
Child is under age 6	$1,997
Child is over age 6	$1,911
Family of 3 with child under age 6	$2516
With child over age 6	$2408
Family of 4 with child under age 6	$3035
With child over age 6	$2904

I have been informed of the above information. I have also been informed that a Medicaid Eligibility Outreach Worker may be contacting me. In efforts to help qualify for Medicaid I give permission for Valley Behavioral Health to share the above and all necessary information with the related agencies and for the related agencies to share information with Valley Behavioral Health.

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

☐ No, I do not give permission _____ Date _____
Client signature (If under age 18) Parent/Guardian

Unit Contact Person _____ Date _____

03/2020