

## SCREENING FOR MEDICAID ELIGIBILITY

## **Medicaid Team**

1020 South Main St. Ste. 100 Salt Lake City, UT Phone: 801-293-7410

Name:		Date of E	Birth	,
Parent/Guardian:		Day pho	ne #	
Addr	ress:			
VMH	Unit:	Need for translator	Yes No If yes	s, language?
1.	Is individual or family interested in	n applying for:	☐Medicaid	
2.	2. Are you a legal resident or US citizen?		☐ Yes ☐ No	
3. Do you have children under age 18?		8?	☐ Yes ☐ No	
4.	(Females) are you Pregnant?		☐ Yes ☐ No	
5. Do you have a physical or mental disab to substance abuse?		disability that is not related	☐ Yes ☐ No	
	Income Eligibility Guideline	s for Medicaid		
Sin	Family Size gle Adult Expansion/Disabled	Maximum Monthly Income \$1616/\$1215		
	o Adults Expansion/Disabled	\$2186/1644		
	gle parent and one child:	1		
	Child is under age 6	\$2285		
	Child is over age 6	\$2186		
Family of 3 with child under age 6		\$2880		
	With child over age 6	\$2756		
Far	mily of 4 with child under age 6	\$3475		
	With child over age 6	\$3325		
me.		d I give permission for Valley	Behavioral Health to	Eligibility Outreach Worker may be contacting share the above and all necessary information avioral Health.
□ Y	es, I give permission			Date
	Client s	ignature (If under age 18) Pa	rent/Guardian	

\_Date \_\_\_\_\_

Unit Contact Person \_\_\_