LITTLE TRAVERSE BAY BANDS OF ODAWA INDIANS
Purchased/Referred Care Program
1260 Ajijaak Avenue
Petoskey, MI 49770
P: 231-242-1600
F: 231-242-1617

PRESCREEN FORM

For Medical Assistance Programs and Medicare Cost Sharing Programs

IMPORTANT NOTE: This form and any necessary documents required to complete it will be subject to strict confidentiality and is only used *to determine* if you are eligible for medical assistance or cost-sharing programs.
This form is not an application for any benefits.

1ST ADULT INFORMATION

Name: _____

Date of Birth: _____

SSN: _____

Employer Information (Name, phone #):

_____

_____

2ND ADULT INFORMATION

Name: _____

Date of Birth: _____

SSN: _____

Employer Information (Name, phone #):

_____

_____

DEPENDENTS UNDER 18 YEARS OLD

Name: _____
DOB: _____

Name: _____
DOB: _____

Name: _____
DOB: _____

Name: _____
DOB: _____

Name: _____
DOB: _____

DEPENDENTS UNDER 18 YEARS OLD

Name: _____
DOB: _____

Name: _____
DOB: _____

Name: _____
DOB: _____

Name: _____
DOB: _____

Name: _____
DOB: _____

Chart # _____

TYPE OF ANNUAL INCOME RECEIVED FOR HOUSEHOLD

	1st Adult	2nd Adult	Other Household Member
NAME:			
EMPLOYMENT *(MONTHLY EARNED INCOME)*			
TANF			
GENERAL ASSISTANCE			
SOCIAL SECURITY			
SOCIAL SECURITY DISABILITY			
S.S.I.			
UNEMPLOYMENT			
SELF-EMPLOYMENT			
WORKMAN'S COMP			
VA BENEFIT			
PENSION			
RETIREMENT *(INCLUDE NAME OF COMPANY)*			
CHILD SUPPORT			
OTHER *(PLEASE SPECIFY)*			
TOTALS			

Total Annual Household Income: $ _____

Is anyone in the household pregnant? ☐ YES ☐ NO

Has a benefit search been completed to rule out any other insurance coverage? ☐ YES ☐ NO

Chart #_____

REQUIRED DOCUMENTATION:

- Last 30 days proof of income for household members. Acceptable forms of evidence:
    - Paystubs from employer
    - Tax return from the previous year - *Only if income is expected to remain similar to the prior year*
    - Current Calendar Year Benefit Letter(s) - *only if receiving income from sources such as Social Security or Disability* - **must** turn in a benefits letter for each benefit received.
    - *For Self-Employment:* bank statements, receipts, and/or contracts

By signing this application, I acknowledge that I have completed this form to the best of my knowledge. I know that I may be subject to penalties under state and federal law if I provide false or untrue information.

I understand that a change in my information could affect the eligibility of member(s) of my household. It is my responsibility to notify LTBB PRC of any changes different from what I wrote on this form.

I understand that if I **do** qualify for Medicaid, I am required to complete a Medicaid application and submit proof of applying within ten days to LTBB PRC upon receiving notification for eligibility. I am responsible for submitting all requested documentation to the Michigan Department of Health and Human Services to ensure my application does not result in a denial for insufficient information. *I understand that if I do not comply, I will be responsible for all payments for services outside the LTBB Health Department until I have completed my Medicaid application in its entirety.*

I understand that if I **do not** qualify for Medicaid, I must complete this form annually to satisfy PRC's federal regulations. *I understand that if I do not comply, I will be responsible for all payments for services outside the LTBB Health Department until I have completed this form.*

Patient Name:_____

Patient Date of Birth:_____

Patient Signature:_____

Application Date:_____

Chart #_____