



## WORKSHEET FOR MASSHEALTH/FREE CARE SCREENING

*Note to the patient:* This worksheet is not an application. However, the information that you provide herewith will help us to assist you with your MassHealth/Free Care eligibility. We still need to do the on-line application with you and you will need to provide income verification, if any, to complete this process. Thank you.

### APPLICANT INFORMATION

First name \_\_\_\_\_ Last name \_\_\_\_\_  
 SS# \_\_\_\_\_ Date of birth \_\_\_\_\_ US citizen? \_\_\_\_\_  
 Home address: \_\_\_\_\_ Homeless? YES / NO  
 Mailing address if different: \_\_\_\_\_  
 Tel. (home/work) \_\_\_\_\_ (Male/Female) Pregnant? \_\_\_\_\_

### OTHER FAMILY MEMBERS (spouse or children under 19 living with you)

Name _____	SS# _____	Date of birth _____
Name _____	SS# _____	Date of birth _____
Name _____	SS# _____	Date of birth _____
Name _____	SS# _____	Date of birth _____

### WORKING

Who is working in the family?

1. \_\_\_\_\_ (Circle one: full time/part time/self employed)

Number of hours per week: \_\_\_\_\_ Amount paid per hour: \$ \_\_\_\_\_

Date began getting this amount of pay: \_\_\_\_\_

Employer name/address/tel.: \_\_\_\_\_

**IF SELF-EMPLOYED**, annual income after deductions: \$ \_\_\_\_\_

2. \_\_\_\_\_ (Circle one: full time/part time/self employed)

Number of hours per week: \_\_\_\_\_ Amount paid per hour: \$ \_\_\_\_\_

Date began getting this amount of pay: \_\_\_\_\_

Employer name/address/tel.: \_\_\_\_\_

### NOT WORKING

Are you **unemployed**, working from time to time, or retired? YES / NO (circle one)

How much did you earn approximately in the past 12 months? \$ \_\_\_\_\_

Do you get unemployment benefits? YES / NO How much a week?: \$ \_\_\_\_\_

### MISCELLANEOUS

- Do you or any family member have any other income (*pension, Social Security, rentals, worker's compensation, child support, alimony, etc.*)? YES / NO
- Are you covered by any health insurance? YES / NO
- Are you a full-time college student? YES / NO
- Have you applied for MassHealth/Free Care before? YES / NO (if yes, when? \_\_\_\_\_)

The above information is true to the best of my knowledge.

Patient's signature: \_\_\_\_\_ Date: \_\_\_\_\_