TRINITY
IOWA HEALTH SYSTEM

A better experience.

SELF PAY FORM

Patient name: _____

Account # _____

1. Has patient applied for Medicaid within the past 3 months already? Yes ___ No ___

2. Check the following if applicable.

Medicaid categories:

____ Patient is currently 18 or under and currently lives in Illinois

____ Patient is currently 20 or under and currently lives in Iowa

____ Patient is a pregnant woman

____ Patient is a caretaker of a minor child who lives full time in the household

- **(ex: grandparents raising children in place of parents)**

____ Patient is age 65 or over

____ Patient is disabled

- **(per guidelines of social security)**

____ Parent with underage biological or adopted children living in home full time

____ Step-parent

- **(person legally married to patient's biological parent)**

____ Patient is considered legally blind

SOURCE: Trinity Regional Health System, Rock Island, IL