Patient Care Core Eligibility Recertification

Name: ____DOB: ______________________

Mailing Address__________________________________ City: ____________ Zip: ________

Primary Phone: _______________________ Alternate Phone: __________________________

Doctor's Name: ____

Case Manager's Name: ______________________ Agency: ____________________________

Section 1: RESIDENCY	**Check the document type.**
Have you moved/changed where you live? ☐ No, my address has not changed. If no, go to Section 2: HOUSEHOLD SIZE. ☐ Yes, my address has changed. If yes, please check the document type in the box to the right.	☐ Current Florida driver's license ☐ Current Florida Identification Card (ID) ☐ Utility bill ☐ Pay stub with name and address ☐ Housing, rental, or mortgage agreement ☐ Recent school records ☐ Bank statement ☐ Client support letter ☐ Property tax receipt or W-2 Form ☐ Unemployment document ☐ Current voter registration card ☐ Official correspondence ☐ Florida Medicaid Managed System (FLMMIS) ☐ Medical Eligibility Verification System (MEVSNET) ☐ Supplemental Nutritional Assistance Program (SNAP) ☐ Statement from shelter/case manager
Section 2: HOUSEHOLD SIZE	
Has your household size changed? ☐ No, my household size has not changed. If no, go to Section 3: INCOME. ☐ Yes, my household size has changed. If yes, please check the document type in the box to the right.	☐ Marriage license/Domestic Partner registration form ☐ Birth certificates ☐ Tax return ☐ Divorce decree ☐ Death certificate ☐ Adult living with client and claims the client as a dependent on taxes ☐ Adult living with client and has legal custody of client.

Section 3: INCOME	
Has your income changed? ☐ No, my income has not changed. If no, go to Section 4: HEALTH INSURANCE. ☐ Yes, my income has changed. If yes, please check the document type in the box to the right.	☐ Copy of most recent pay stubs for the last month ☐ Copy of most recent annual disability, SSI, retirement, pension, VA, child support/alimony, unemployment benefits, etc. ☐ Profit and Loss Statement from self-employment ☐ Statement of no income ☐ Three (3) months of bank statements ☐ Client support letter
Section 4: HEALTH INSURANCE	
Has your insurance status changed? ☐ No, my insurance has not changed. ☐ Yes, my insurance has changed. If yes, please check the document type in the box to the right. Go to Section 5: ATTESTATION.	☐ Proof of Medicaid ☐ Employer insurance verification ☐ Current insurance benefits package information ☐ Florida Medicaid Managed Information System (FLMMIS) ☐ Medical Eligibility Verification System (MEVSNET) ☐ Medicare ☐ Federally Facilitated Marketplace ☐ Loss/Cancellation of insurance

Section 5: ATTESTATION

Please attest to the following statement:

- The information provided is true, correct, and complete to the best of my knowledge.
- I understand that my records are protected under State and Federal laws and cannot be shared without my written consent.
- I understand that information can be released for billing, chart audits, program monitoring/quality improvement, data reporting, and other purposes necessary to facilitate the provision of program services.
- I also understand that I may change my consent at any time, in writing.

(Client Name) verified the above information on (Date).

Form Completed By: ____

Staff Name: ___________________________ Staff Signature: ___________________________

Agency Name: ___________________________ Agency Phone: ___________________________

Date: ________________________________