BROWARD HEALTH

MAPS Case Data Sheet

Patient Number: _____ Corporate ID: _____

Coverage Start Date: _____- Coverage End Date: _____ Plan Code: _____

Have you applied for Healthcare Insurance Exchange? ❑ Yes ❑ No

If yes, what was the outcome? ❑Eligible ❑ Ineligible

Was the Healthcare Ineligibility Letter provided? ❑ Yes ❑ No

Have you applied for Medicaid? ❑ Yes ❑ No

If no, were you screened and deemed technically ineligible? ❑ Yes ❑ No

If yes, what was the outcome? ❑Approved ❑ Denied If denied, reason: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Social Security Number: _____ SIG MR Num.: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____

Spouse Name: _____ DOB: _____ SSN: _____

Guarantor Details –

Guarantor Name: _____ SSN: _____

Guarantor Address: _____

Household Member Details -

Household Member Name	Date of Birth	SSN	Relationship to Applicant

Employment Details –

Member Name: _____ Relationship to Applicant: _____

Employer: _____ Start Date: _____ End Date: _____

Monthly Income: _____ Phone: _____

Member Name: _____ Relationship to Applicant: _____

Employer: _____ Start Date: _____ End Date: _____

Monthly Income: _____ Phone: _____

Member Name: _____ Relationship to Applicant: _____

Employer: _____ Start Date: _____ End Date: _____

Monthly Income: _____ Phone: _____

Member Name: _____ Relationship to Applicant: _____

Employer: _____ Start Date: _____ End Date: _____

Monthly Income: _____ Phone: _____

Patient Details- -

Originating Employee: _____ Annual Income: _____

Family Size: _____ Date of Service: _____ Monthly Income: _____

Percent FPL: _____ Patient Name: _____ Patient Number: _____

Notes & Collected Images - -