METABOLIC FORMULA FINANCIAL ASSISTANCE

State Form 57152 (7-21)

Reset Form

Metabolic formula may be covered by Medicaid and Children Special Healthcare Services (CSHCS). The Genomics and Newborn Screening (GNBS) Program will pay the costs of metabolic formula not covered by a family's health insurance, Medicaid, CSHCS, or other third-party payor. Families are responsible for applying to Medicaid and CSHCS prior to applying for GNBS assistance. Eligible families must pay the remaining costs after GNBS assistance based on income, household size, and the federal poverty level.

Eligibility for Medicaid and CSHCS is based on income, household size, and the federal poverty level. Families must apply for Medicaid and show proof of application when applying for CSHCS. The CSHCS application (State Form 49006) may be found online at https://www.in.gov/isdh/23685.htm. For more information about Medicaid eligibility, please contact the MCH MOMS Helpline at 1-844-MCH-MOMS (1-844-624-6667).

PATIENT/PARENT CONTACT INFORMATION

Patient Name:		Patient's Date of Birth *(month, day, year)*:
Address *(number and street)*:		
City:	State:	ZIP Code:
Patient Diagnosis/Reason Followed in Metabolic Clinic:		
Parent/Legal Guardian Name(s):		Telephone Number:
Address *(number and street) (if different from above)*:		
City:	State:	ZIP Code:

HOUSEHOLD INFORMATION

Please list ALL family members at home with first and last names and relationship to patient in the spaces below. If you need additional space, please use the Additional Information box on the back.

Full Name *(first and last)*	Relationship	Full Name *(first and last)*	Relationship
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

Adjusted Gross Income for the most recent tax year: $

Your Adjusted Gross Income can be found on the first page of your federal Income Tax Form 1040.

INSURANCE AND OTHER FINANCIAL ASSISTANCE INFORMATION

Medicaid Eligible: ☐ Yes ☐ No ☐Unsure	Medicaid Recipient/Billing Number:	Begin Date:	End Date:
Health Insurance Coverage: ☐ Yes ☐ No	Health Insurance Company Name and Policy Number:	Begin Date:	End Date:
Insurance the Same as Last Year: ☐Yes ☐No	General Metabolic Care Approved by Insurance: ☐ Yes ☐ No ☐Unsure	Metabolic Formula Covered: ☐Yes ☐No ☐Unsure	
Deductible Amount:	What percentage of the cost for metabolic formula must you pay after you have met your deductible for the year?		
Children's Special Health Care Services Application Approved: ☐Yes ☐ No ☐Unsure		Date Approved/Denied *(mmddyyyy)*:	

This information is true and correct to the best of my knowledge.

Parent/Guardian Printed Name:	Date *(month, day, year)*:
Parent/Guardian Signature:	

Additional Information: