Application for Medicaid

N.C. Department of Health and Human Services

This application is intended for medical assistance for the Aged, Blind and Disabled or those who want Family Planning services. A different application form is available for children and families who need Medicaid. Children under age 21 and adults with children in their care may be eligible for Medicaid without being blind, disabled or age 65 and older. You will need to list all family members who are applying for medical assistance. In addition, to ensure the applicants receive all possible assistance, list other persons in the home. Do not give us social security numbers, citizenship, or immigration status for these other persons.

If you have questions about Medicaid programs for which you may be eligible, please contact the Department of Social Services in the county where you live and ask to speak with a Medicaid caseworker.

Just mail or drop off the completed application at the department of social services in the county where you live. You can find address and phone number in your phone book under "County Government."

If you want to apply for Work First Family Assistance, Food Stamps, or Special Assistance (to pay for care in an Adult Care Home,) you must see a worker and complete an application at the Department of Social Services.

IMPORTANT NOTICE

IF YOU CHOOSE TO PICK UP THIS APPLICATION AT THE DSS OFFICE:

You or your representative have the right to make an application and have a face-to-face interview for Medicaid on the day you go into the department of social services requesting medical or financial assistance.

If you cannot stay to see a worker to apply for Medicaid, but you want a face-to-face interview, you can schedule an appointment. Please see the receptionist if you want to schedule an appointment.

If you do not want a face-to-face interview and you complete an application and return it later, there is some information you should know:

- The date of your application is the date the Department of Social Services gets your complete application.
- Medicaid coverage can be requested for any medical bills incurred up to three months prior to the month of application.
- The date your Medicaid is started is based on the date of your application. If you wait until next month to return your complete application, Medicaid may not be able to help pay for medical services you received in earlier months.
- If you are unable or need help to complete the application or to obtain requested information, contact the department of social services and speak with a Medicaid caseworker.
- You will receive a telephone follow-up call within two workdays.

What is Medicaid?

Medicaid is a health insurance program for those with income below amounts set by the federal and state government or with large unmet medical needs.

Who can get Medicaid?

- Individuals or couples who are elderly (age 65 or older)
- Individuals who are visually impaired (blind)
- Individuals who need help in their home to care for themselves (CAP)
- Individuals who need help caring for themselves (nursing home or long-term care assistance)
- Individuals or couples who are physically or mentally disabled
- Individuals or couples who would like to receive family planning services
- Children under age 21 and adults with children in their care
- Pregnant Women

See page 3 for what the state of North Carolina considers to be disabled and a description of the CAP program.

What will Medicaid pay for?

Medicaid can help pay for certain medical expenses such as:

- Doctor Bills
- Hospital Bills
- Prescriptions (*Excluding prescriptions for Medicare beneficiaries effective 01/01/06)*
- Vision Care
- Dental Care
- Medicare Premiums
- Nursing Home Care (LTC)
- Personal Care Services (PCS), Medical Equipment, and Other Home Health Services
- In home care under the Community Alternatives Program (CAP)
- Mental Health Care
- Most medically necessary services for children under age 21

Who can answer my questions about Medicaid?

You can contact your local county department of social services, call the Medicaid Eligibility Unit through the DHHS Customer Service Center, at 1-800-662-7030 or 1-877-452-2514 for the deaf or hearing impaired. The DHHS Customer Service Center is operational Monday through Friday (except state holidays). You can also visit DMA's website at http://www.ncdhhs.gov/dma/.

What is the Community Alternatives Program (CAP)?

The Community Alternatives Program (CAP) allows some Medicaid recipients who require institutional care (placement in a hospital, nursing home, or ICF-MR) to remain at home if their care can be provided safely and at less expense in the community with CAP services. CAP participants must meet all CAP eligibility requirements.

How do I know if I am disabled?

An individual may be eligible for Medicaid if he is disabled according to the Social Security definition of disability. A child must meet Social Security's childhood disability rules. If you are disabled you:

- Are unable to work for at least one year due to your medical problem, or
- Have a medical problem that may result in death.

If you receive a Social Security (RSDI) or Supplemental Security Income (SSI) check because you are disabled you are automatically considered to meet the disability requirement for Adult Medicaid. Other individuals who apply for Medicaid and are over age 21, under age 65, and do not have children in their care, must be found to be disabled. This requirement does not apply to Family Planning Services only.

How do I apply for assistance?

You will need to:

- Answer the questions in sections 1 through 15 in a legible manner.
- Sign the application.
- Bring or mail this application to your county department of social services (DSS) in the county where you live. If you need help locating your county DSS office, please call the DSS office, or the DHHS Customer Service at 1-800-662-7030.
- Provide the needed items to complete your application. If you do not have all of the needed information and need help getting the information, return the application and ask your Medicaid worker at DSS for assistance.

Once your application is received by your county department of social services, a case worker will call you to discuss your application in detail.

What if I need help completing this application?

Visit or call your county DSS. If you do not know where your county DSS is, call the DHHS Customer Service toll-free at 1-800-662-7030 to find your county DSS.

What do I do after I fill out this application?

- Tear off pages 1 through 8 and keep them for your records.
- Be sure that you answer all questions in sections 1 through 15.
- Attach any documentation or verifications needed to process your application if you have them.
- **Remember to sign and date page 18 because your application can not be processed without your signature.**
- Bring or mail the Medicaid application to your county DSS.

How long will it take to process my application?

Once your application is received, we will begin processing it.

- If you are 65 or older, a child, or caretaker of a child, it can take up to 45 days to process your application.
- If you are under age 65 and have no child in your care, it can take up to 90 days to process your application.
- If we need additional information, we will contact you by telephone or mail. The sooner we get the information, the sooner we can let you know if you can get Medicaid.

What are my rights?

- To apply for Medicaid, and, if found ineligible, you may reapply at any time.
- To apply for other assistance like Food Stamps or Work First Family Assistance.
- To have any person help you with this application or participate in the interview for determination of eligibility.
- To be protected against discrimination on the grounds of race, creed, or national origin by Title VI of the Civil Rights Act of 1964.
- To have any information given to the agency kept in confidence.
- To be given information by Social Services about Medicaid and other available assistance.
- To get assistance from the department of social services in completing this application or in getting information needed to process the application.
- To withdraw from the Medicaid program at any time.
- To receive assistance, if found eligible.
- To have your eligibility for Medicaid considered under all categories.

What are my responsibilities?

- To provide the county department of social services (DSS), as well as state and federal officials, upon request, the information necessary to determine eligibility.
- To report to the DSS any change in my situation within 10 calendar days of the change.
- To report to the DSS if I receive benefits in error.
- To agree, by signing this form, that all information that I have provided is true and a complete statement of fact according to the best of my knowledge and that I understand it is against the law to willfully withhold information or make false statements. I am subject to prosecution if I do.
- To understand that any Medicaid ID card I receive is to be used only for the person listed on the ID card. I understand it is against the law to give my ID card to someone whose name is not listed on it and that I may be prosecuted for fraud if I let someone else use my ID card.
- To understand if any resources are transferred out of the applicant's name without receiving fair market value for the resources, it could result in a period of ineligibility for long-term medical care, such as in a nursing facility, or for in-home care. I understand all transfer of resources must be reported when making this application and any new transfers must be reported to my worker within 10 calendar days.
- To understand any child or spousal support (money) which is paid directly to me must be reported to the county department of social services and will be counted as income when determining eligibility for Medicaid benefits for the person for whom it is received.
- North Carolina must be named remainder beneficiary for annuities purchased after November 1, 2007. Contact the county DSS for more information.

Medical/ Financial Records

I understand that my medical and financial records must be made available to the agency and the State by any provider from whom I have received medical care services. I hereby agree to the release of those records by those providers when requested by the agency and the State. The privacy of this information is protected by law.

Assignment of Rights

I understand that by accepting medical assistance, I agree to give back to the State any and all money that is received by me or anyone listed on this application from any insurance company for payment of medical and/or hospital bills for which the medical assistance program has or will make payment. I agree to assign the State of North Carolina as the Remainder Beneficiary of any annuities that I may have. In addition, I agree that all medical payments or medical support paid or owed due to a court order for me or anyone listed on this application must be sent to the State to repay past or current medical expenses paid by the State. This includes insurance settlements resulting from an accident. I further agree to notify the county department of social services if I or anyone listed on this application is involved in an accident. I understand that this assignment of rights continues as long as I or anyone listed on this application receive Medicaid and is based on federal regulations.

Social Security Numbers

I understand that I must furnish all social security numbers used by me to determine my eligibility for assistance if I am applying for myself. I understand that if anyone else wants to apply for assistance their social security number must also be furnished. I also understand these social security numbers will be used in matching information with the Social Security Administration (SSA), Internal Revenue Service (IRS), Employment Security Commission (ESC), Department of Transportation (DOT), out of state welfare and ESC agencies, and any other agencies, when applicable. If I do not want these social security numbers used in the matches, I understand that I have the right to request my assistance to be denied, terminated or withdrawn.

Estate Recovery Notice

I understand that Federal and State laws require the Division of Medical Assistance (DMA) to file a claim against the estate of certain individuals to recover the amount paid by the Medicaid program during the time the individual received assistance with certain medical services. Ask your Medicaid case worker for specific information regarding which services are applicable to estate recovery.

If You Request A Hearing

If you do not agree with a decision we make about your case, you can request a hearing. You can request this in person, by telephone or in writing. You must ask for this hearing within sixty days of when we tell you in writing of our decision on your application. You have the right to examine your case record and documents used before your hearing.

You can have a household member or someone you ask to represent you, like a friend or relative. You also have the right to have an attorney or other legal representative represent you at the hearing. Free legal aid may be available. Call 1-866-219-5262 for more information.

Citizenship, Identity and Immigration Status

I understand that the county DSS worker will verify citizenship, identity, and immigration status to determine which Medicaid program the applicant may qualify for. Household members listed on the application, but are not applying for Medicaid, will not be subject to this verification. In order to receive services, the applicant's identity must be confirmed. In order to receive regular Medicaid, the applicant must be a citizen or have a qualified alien status. If citizenship or immigration status makes the applicant not eligible for regular Medicaid, the applicant can apply for Emergency Medicaid services.

If the county DSS worker is unable to verify citizenship, identity, and/or immigration status, the applicant may need to provide additional documentation. If the alien applicant has no documents to establish qualified alien status, contact a county DSS worker for assistance. If not eligible for regular Medicaid, I understand that persons applying for Emergency Medicaid services only are not required to declare or provide documentation of their immigration status or Social Security Number. These individuals must meet all other Medicaid eligibility requirements, and qualify for one of the Medicaid coverage groups.

Residence

I hereby certify under penalty of perjury that I and all the persons for whom I am making an application are living in North Carolina with the intention of remaining permanently or for an indefinite period, in the state seeking employment, or have a job commitment.

To verify North Carolina residency, provide two different documents from the following list:

- **A valid North Carolina driver license or other identification card issued by the North Carolina Division of Motor Vehicles.**
- **A current North Carolina rent, lease, mortgage payment receipt, or current utility bill in the name of the applicant or the applicant's legal spouse, showing a North Carolina address.**
- **A current North Carolina motor vehicle registration in the applicant's name and showing the applicant's current North Carolina address.**
- **A document verifying that the applicant is employed in North Carolina.**
- **One or more documents proving that the applicant's home in the applicant's prior state of residence has ended, such as closing of a bank account, termination of employment, or sale of a home.**
- **The tax records of the applicant or the applicant's legal spouse, showing a current North Carolina address.**
- **A document showing that the applicant has registered with a public or private employment service in North Carolina.**
- **A document showing that the applicant has enrolled his children in a public or private school or a child care facility located in North Carolina.**
- **A document showing that the applicant is receiving public assistance (such as Food Stamps) or other services which require proof of residence in North Carolina. Work First and Energy Assistance do not currently require proof of NC residency.**
- **Records from a health department or other health care provider located in North Carolina which shows the applicant's current North Carolina address.**

- **A written declaration from an individual who has a social, family, or economic relationship with the applicant, and who has personal knowledge of the applicant's intent to live in North Carolina permanently, for an indefinite period of time, or residing in North Carolina in order to seek employment or with a job commitment.**
- **A current North Carolina voter registration card.**
- **A document from the U.S. Department of Veteran's Affairs, U.S. Military or the U.S. Department of Homeland Security, verifying the applicant's intent to live in North Carolina permanently or for an indefinite period of time, or that the applicant is residing in North Carolina to seek employment or has a job commitment.**
- **Official North Carolina school records, signed by school officials, or diplomas issued by North Carolina schools (including secondary schools, colleges, universities, community colleges), verifying the applicant's intent to live in North Carolina permanently or for an indefinite period of time, or that the applicant is residing in North Carolina to seek employment or has a job commitment.**
- **A document issued by the Mexican consular or other foreign consulate verifying the applicant's intent to live in North Carolina permanently or for an indefinite period of time, or that the applicant is residing in North Carolina to seek employment or has a job commitment.**

If you do not have two of these documents, contact the county DSS for assistance.

MEDICAL TRANSPORTATION ASSISTANCE NOTICE OF RIGHTS

The following information regarding medical transportation was explained to me. I understand that:

- If I receive Medicaid or have presumptive eligibility and do not have a way to get to the doctor or to other medical services, social services will help me arrange suitable transportation.
- I can receive transportation assistance only after I am authorized for Medicaid or found to be presumptively eligible.
- Medical transportation expenses that I am responsible for paying can be used to meet a deductible, including transportation expenses for anyone who is financially responsible for me.
- I have the right to ask for help with transportation. I understand that if transportation is provided, it will be to the nearest appropriate medical provider of my choice, by the least expensive method suitable to my individual needs.
- I, or someone acting on my behalf, may contact DSS by mail, phone, or in person to ask for help with transportation to the doctor or other medical services.
- Except for emergencies, I must request transportation assistance as far in advance of my appointments as possible. Otherwise, my appointment(s) may have to be rescheduled.
- I understand that I am **not** eligible for transportation assistance:
  - if I am authorized for Medicare-Aid (M-QB);
  - while my application is pending (before a decision is made)
  - while I am on a deductible for Medicaid; OR
  - while I am authorized for NC Health Choice.
- I have the right to a written notice of decision on my request within 10 work days, and I have the right to have a local hearing to appeal the decision if I disagree.

NOTE: You will need 2 first class stamps to mail this application. If you include additional information (pay stubs, bank statements, etc.) with the Medicaid application, additional postage may be needed. It is recommended that you contact the post office to verify the amount of postage needed.

*Tear off pages 1 through 6 and keep them for your records.

Application for Adult Medicaid

North Carolina Department of Health and Human Services

For Official Use Only
County DSS: _____
Date Received: _____
Case #: _____
DSS _____ Aging _____ Mail In _____

I am applying for Medicaid for myself.	☐ Yes	☐ No
I am applying for Medicaid for my spouse.	☐ Yes	☐ No
I am age 65 or older.	☐ Yes	☐ No
My spouse is age 65 or older.	☐ Yes	☐ No
I am blind.	☐ Yes	☐ No
My spouse is blind.	☐ Yes	☐ No
I am disabled.	☐ Yes	☐ No
My spouse is disabled	☐ Yes	☐ No
My child is disabled.	☐ Yes	☐ No
I am applying for Medicaid for a child or children in my care. List children below:	☐ Yes	☐ No

Name	DOB	Sex	Social Security Number	Citizen?		
					☐ Yes	☐ No
					☐ Yes	☐ No

I need help with nursing home care.	☐ Yes	☐ No
My spouse needs help with nursing home care.	☐ Yes	☐ No
I am applying for the Community Alternatives Program (CAP).	☐ Yes	☐ No
My spouse is applying for the Community Alternatives Program (CAP).	☐ Yes	☐ No
My child is applying for the Community Alternatives Program (CAP).	☐ Yes	☐ No

Medicaid Family Planning Waiver Services

To be eligible for Medicaid Family Planning Waiver services, you must be a woman age 19 through 55 or a man age 19 through 60 and have not had a medical procedure that would prevent you from having a baby or fathering a baby.

Do you wish to apply for the Medicaid Family Planning Waiver? ☐ Yes ☐ No

If yes, for whom _____ Social Security # _____

1. Tell us about you.

Applicant's Name

First _____ Middle _____ Maiden _____ Last _____

Social Security Number

___ ___ ___

(Not required if you are not applying for Medicaid for yourself, you are applying for Medicaid someone else, or you are applying for Emergency Medicaid.)

Sex
☐ Male
☐ Female

Date of Birth

_____ / _____ / _____
Month Date Year

Please indicate your race(s) _____

Asian= A
White or Caucasian = W
Black or African American = B
American Indian or Alaska Native = I
Native Hawaiian or
Other Pacific Islander = P

Hispanic/Latino?
☐ Yes ☐ No

If yes, specify by circling the code below:

Hispanic Cuban= C
Hispanic Mexican= M
Hispanic Puerto Rican= P
Hispanic Other= H

Do you speak English?
☐ Yes ☐ No

What language do you prefer to speak if not English?

_____

Are you a Veteran?
☐ Yes ☐ No

Have you served in the armed forces?
☐ Yes ☐ No

I am a U.S. Citizen.
☐ Yes ☐ No

ARE YOU:
☐ Married
☐ Widowed
☐ Single
☐ Divorced
☐ Separated (When? _____)

Do you live with your spouse?
☐ Yes ☐ No

If you live with your spouse:
Spouse's Name:

_____
First Middle Maiden Last

Date of Birth: _____

Sex: _____

***Complete section 2 on the next page, only if you want to apply for Adult Medicaid for your spouse.**

2. Tell us about your spouse.

First	Middle	Maiden	Last

Social Security Number
___ ___ ___
(Not required if your spouse does not want Medicaid.)

Sex
☐ Male
☐ Female

Date of Birth
Month ___ Date ___ Year ___

Please indicate your spouse's race(s) _____

Asian= A
White or Caucasian = W
Black or African American= B
American Indian or Alaska Native= I
Native Hawaiian or Other Pacific Islander= P

Hispanic/Latino?

☐ Yes ☐ No

If yes, specify by circling the code below:

Hispanic Cuban= C
Hispanic Mexican= M
Hispanic Puerto Rican = P
Hispanic Other= H

Does your spouse speak English?

☐ Yes

☐ No

What language does your spouse prefer to speak if not English?

Is your spouse a Veteran?

☐ Yes ☐ No

Has the spouse served in the armed forces?

☐ Yes ☐ No

My spouse is a U.S. Citizen.

☐ Yes ☐ No

(Not required if your spouse does not want regular Medicaid or if applying for emergency Medicaid.)

*Please provide documentation of citizenship, identity and/or qualified immigration status for any person applying for Medicaid. Persons applying for Emergency Medicaid services only are not required to provide documentation of citizenship or immigration status.

First	Middle	Last	Alien Registration Number Applicant Only

Does anyone live with you other than your spouse? ☐ Yes ☐ No

If YES, Who? _____ Relationship: _____

If YES, Who? _____ Relationship: _____

If YES, Who? _____ Relationship: _____

3. Tell us where you live.

Mailing Address (include apartment number, in care of, etc.)	
City, State, County, Zip Code	Home Phone (or number where you can be reached between 8am – 5pm)
Give the address where you actually live, *if different than your mailing address*:	
Do you live in a nursing home? If yes, please indicate the name of the home, city and phone number.	Name: City: Phone Number:
Do you and your spouse intend to remain in North Carolina? ☐ Yes ☐ No	

4. Tell us about your dependents.

Does anyone live with you and depend on you (or your spouse) to provide at least one-half of their financial support? ☐ Yes ☐ No

If YES, Who? _____

Relationship: _____ Date of Birth _____

5. Tell us if you or your spouse have any unpaid medical bills.

Do you, your spouse, or children need help paying medical bills for services received during the ***last three calendar months*****?** ☐ Yes ☐ No

If YES, please provide a copy of the medical bills from the *last three months or fill out the information below*.

Do you, your spouse, or children have any old, unpaid (medical bills you have not paid yet) medical bills?

- The medical bills must be less than 2 years old, or
- If the medical bills are over 2 years old, you must have made a payment on them within the past 2 years.

☐ Yes ☐ No

If YES, please provide us with a copy of the medical bills you are being billed for or fill out the information below. Bills used to meet a deductible will not be paid by Medicaid.

***If you do not have copies of your medical bills, please fill out the chart below**.

Who owes the bill(s) Please give us the Patient's name	List the name of the doctor, clinic, hospital, telephone number and city where treated.	Date of medical treatment

6. Tell us if you, your spouse, or child need help with transportation to medical services.

If you are found eligible for full Medicaid benefits, you have the right to assistance with medical transportation.

Do you, your spouse, or child need help with transportation to medical services? ☐ Yes ☐ No

7. Tell us about you, your spouse's, and your minor children's income.

Income refers to all the money that you, your spouse, and your minor children receive such as Social Security benefits, SSI benefits, retirement benefits, Veteran's benefits, etc.

If you, your spouse, or your children (if living together) receive income from any of the sources listed below, please enter the total monthly income. ***Do not list wages or self-employment***.

Type of Income:		Amount:	Who gets it:	How often:
Social Security	☐ Yes ☐ No	$		
Supplemental Security Income	☐ Yes ☐ No	$		
Veteran's Benefits	☐ Yes ☐ No	$		
Retirement Benefits	☐ Yes ☐ No	$		
Railroad Retirement	☐ Yes ☐ No	$		
Annuities	☐ Yes ☐ No	$		
Civil Service	☐ Yes ☐ No	$		
Pensions	☐ Yes ☐ No	$		
Dividends/Interest Income from Trusts	☐ Yes ☐ No	$		
Income from Promissory Notes	☐ Yes ☐ No	$		
Disability Insurance	☐ Yes ☐ No	$		
Support/Alimony	☐ Yes ☐ No	$		
Land Lease Rentals	☐ Yes ☐ No	$		
Rentals Roomers/Boarders	☐ Yes ☐ No	$		
Other	☐ Yes ☐ No	$		

Are you self-employed? ☐ Yes ☐ No

Do you have any Farm or Rental Income? ☐ Yes ☐ No

If YES, please attach last year's income tax return or proof of your income and expenses for the past 12 months if you have that information.

8. Tell us if you or your spouse work.

Do you or your spouse work? ☐ Yes ☐ No

If YES, please complete the following chart.

***List wages for you and your spouse *(*if your spouse lives with you and works) including Farm or Rental income.**

Name (who works)	Employer's Name and Phone Number	Amount you earn before taxes (gross)	How often are you paid?	Hours worked per week
		$		
		$		
		$		
		$		
		$		

***Please attach last month's pay stubs or copies of them if you have that information. If you do not have this information, we will contact your employer for the information.**

9. Does anyone give you or your spouse money?

Does anyone give you cash or pay bills for you to help you or your spouse (if married and living together) pay for any of your household expenses including food, mortgage, rent, heating, fuel, gas, electricity, water, or property taxes? ☐ Yes ☐ No

Do not include food stamps, help from a housing agency, an energy assistance program, or Meals on Wheels.

Complete the chart below if you answered yes to the above question.

***Please tell us who gives you money.**

Who receives the Help?	Who Gives You Help (name, address and phone number)	How much do you receive?	How often do you receive it?
		$	
		$	
		$	
		$	
		$	

Do you receive this help in the form of cash, check, or do they pay your bills directly? _____

10. Tell us about you and your spouse's assets.

Assets are **"What you own or are buying."** This can include: money in the bank, cash on hand, life insurance, real property (house or land) and personal property (car).

Please complete the chart below. Indicate if you or your spouse **(if married and living together)** have any assets listed in the chart below. Include items that either of you own jointly or with another person.

Type of Account:		Owner	Account #	Bank/ Company	Amount:
Cash	☐ Yes ☐ No				$
Checking	☐ Yes ☐ No				$
Savings	☐ Yes ☐ No				$
Money Market	☐ Yes ☐ No				$
Burial Contract	☐ Yes ☐ No				$
Safety Deposit Box	☐ Yes ☐ No				$
Certificates of Deposit	☐ Yes ☐ No				$
Stocks	☐ Yes ☐ No				$
Trusts	☐ Yes ☐ No				$
Bonds	☐ Yes ☐ No				$
Mutual Funds	☐ Yes ☐ No				$
Annuities	☐ Yes ☐ No				$
401 K, Keough	☐ Yes ☐ No				$
Retirement Accounts	☐ Yes ☐ No				$
Promissory Notes	☐ Yes ☐ No				$
Other Account	☐ Yes ☐ No				$

***Please attach copies of any information if you have them, to verify any assets you have listed.**

Do you or your spouse own or are you buying any land, buildings, time-shares or jointly held real estate (heir property), including where you live? ☐ Yes ☐ No

***If YES, list below:**

Owner/Owners or Buyer's Names:	List address/location of what you own or are buying:

***Do you or your spouse own any life insurance?**

Owner (list name)	Company Name and Address	Policy Number	Face Value	Cash Value
			$	$
			$	$

***Do you or your spouse own any of the following items in the chart below?**

Asset		Year	Make	Model	Owner (list name)	Value
Car	☐ Yes ☐ No					$
Car	☐ Yes ☐ No					$
Trucks	☐ Yes ☐ No					$
Boats	☐ Yes ☐ No					$
Campers	☐ Yes ☐ No					$
Motorcycles	☐ Yes ☐ No					$
Mobile Homes	☐ Yes ☐ No					$
Tractor/Trailers	☐ Yes ☐ No					$
Motorized Vehicles	☐ Yes ☐ No					$
Other – If additional space is needed, please attach the information to the application.	☐ Yes ☐ No					$

11. Tell us about any transfer of assets.

Have you or your spouse transferred, given away or sold anything of value in the last 3 years or given money to a trust in the last 5 years? ☐ Yes ☐ No

Examples of anything transferred, given away, or sold: cash, annuity, house, mobile home, car, tractor, livestock, motorized vehicles, land, time-shares or property.

***If Yes, please complete the chart below.**

What did you or your spouse give away?	Value	To Whom?	Their relationship to you?	When?	How much did you receive?
	$				$
	$				$
	$				$

12. Tell us if you, your spouse, or your child have any health insurance, including Medicare.

The provision of Social Security Numbers as insurance policy identifiers is voluntary for non-applicant spouses or children.

Do **you** have health insurance, Medicare or a Medicare HMO? ☐ Yes ☐ No

If yes, which one(s) _____

Medicare claim number: _____

Insurance company: _____ Policy number(s): _____

Policy Holder's Name: _____ Date of Birth: _____ Relationship: _____

How much do you pay for private health insurance? _____ How often? _____

Does **your** spouse have health insurance, Medicare or a Medicare HMO? ☐ Yes ☐ No

If yes, which one(s) _____

Medicare claim number: _____

Insurance company: _____ Policy number(s): _____

Policy Holder's Name: _____ Date of Birth: _____ Relationship: _____

How much does your spouse pay for private health insurance? _____ How often? _____

Do **your** children have health insurance? ☐ Yes ☐ No

If yes, Name of Insurance Company: _____ Policy number: _____

Policy Holder's Name: _____ Date of Birth: _____ Relationship: _____

Are you or your spouse enrolled in a Prescription Drug Plan? ☐ Yes ☐ No

If yes, please list the plan(s) you are enrolled with. _____

13. Tell us if you, your spouse, or your child have been in any accidents.

Have you, your spouse, or your child had an accident in the past 12 months? ☐ Yes ☐ No

14. Tell us if you need help paying your telephone bill or getting telephone service.

The ***Lifeline/Link-up Assistance Program*** is for low-income individuals. The program serves recipients of the Food Assistance, Work First Family Assistance, Medicaid and Low Income Home Energy Assistance Programs, which includes the Low Income Energy Assistance Program, Crisis Intervention Program and Weatherization.

Lifeline can help pay a portion of your local telephone bill. If you are eligible, Lifeline will give you a credit each month on your local telephone bill.

Link-Up is a program that can help pay to connect your telephone service. Do you or your spouse have telephone service in your name? ☐ Yes ☐ No

If yes, in **whose name(s)** is the telephone bill? _____

What company provides your local telephone service? _____

15. Do you want us to contact someone else to complete this application?

If you want us to contact someone else (family member, friend, representative, Power of Attorney or someone who knows your situation) to complete this application, please provide the person's name, a daytime phone number, address, and their relationship to you. If we have additional questions, we will contact the person you list below to complete the application.

Name: _____

Address: _____

Telephone: _____ Relationship to (you) applicant(s): _____

Signature

YOU MUST READ, SIGN AND DATE THIS PAGE.

Your application for Medicaid cannot be processed without your signature.

I authorize the release of any information necessary to establish Medicaid and Lifeline/Link-up eligibility. I understand this information may include medical or non-medical information, including such collateral sources as banks, employers, and insurance companies. This authorization may be reproduced and is valid for one year from the date of signature.

I understand social security numbers are used to do computer matches with the Internal Revenue Service, the Social Security Administration, Department of Labor, other government agencies and private financial institutions. The Department of Health and Human Services and federal officials may check with people to prove the information I have given. If I give incorrect information, my application may be denied and I may be charged with giving false information. I understand the questions on this form. I certify, under penalty of perjury, that all my answers are correct and complete as far as I know. I understand the Department has the right to collect from other available insurance sources or from settlement(s) for accidents or injuries when Medicaid paid for expenses.

Signature of Applicant or Person Signing on Behalf of Applicant:

_____ **Date:** _____

Home Phone Number: _____

OR

Signature of person filling out this form (if not applicant): _____

Relationship _____ **Home Phone Number:** _____