FAX COVER SHEET

Request for Medicaid Eligibility Determination

Medically Indigent Program

This coversheet must be completed prior to submitting the application to Health & Welfare.

TO:	Idaho Department of Health & Welfare	FROM:	
	Medicaid Services Application – Idaho Falls		
	Fax: (208) 528.3771	Fax:	
	Email: SRCU-CntyHospApp@dhw.idaho.gov		
		Email:	

HOSPITAL/COUNTY CONTACT INFORMATION:

Patient's Name: _____

Date(s) Medical Service was provided: _____

Hospital Contact Information:

Hospital Name: _____

Address: _____

Phone: _____

Fax: _____

Email: _____

Contact Person: _____

County Contact Information:

County (Idaho): _____

Phone: _____

Fax: _____

Email: _____

Contact Person: _____

By signing below and requesting a Medicaid eligibility determination under the Medically Indigent Program, county/hospital accepts and acknowledges that they have read, understand, and will comply with the rules promulgated by the Department of Health & Welfare and the Board of the Catastrophic Health Care Cost Program, pursuant to Title 31, Chapter 35, Idaho Code.

_____ _____

Signature of Authorized Representative Title and Date

COMBINED APPLICATION FOR STATE AND COUNTY MEDICAL ASSISTANCE

Date Application Received: _____		Lien Instrument #: _____ Filing Date: _____ UCC Filing Date: _____	
Mark the Type of Application:	☐ Emergency 31-Day ☐ Non-Emergency 10-Day Prior	☐ Additional Request ☐ 180-Day Delayed (Justification Must be Attached)	

By signing below, I acknowledge that by completing this application form, it will be used to determine my eligibility for BOTH County Indigent Medical Assistance and Idaho Health and Welfare Medicaid program. I also accept and acknowledge that I have read, understand, and will comply with rules promulgated by the Department of Health & Welfare and the Board of the Catastrophic Health Care Cost Program, pursuant to Title 31, Chapter 35, Idaho Code.

_____ Applicant's Signature

_____ Co-Applicant's Signature

IMPORTANT NOTICE: If you need any of the following assistance, please ask. These services are free:

- Language Interpreter. (Nosotros proveemos los servicios de un interprete, sin costo alguno.) Call 2-1-1 or 1-800-926-2588 or TDD 208-332-7205.
- Help filling out this form.
- Accommodation for a disability.

INSTRUCTIONS: Read all questions and instructions carefully. Answer each question as completely as possible. If you need to provide more information than space allows, attach extra sheets.

What is your preferred language? Spoken _____ Written _____

Do you want an interpreter if you are interviewed? One will be provided at no cost to you. ☐ No ☐ Yes

¿Usted necesita a intérprete si usted tiene una entrevista? Uno estará disponible en ningún costo para usted. ☐ No ☐ Sí

List an alternate contact person in the event we are unable to reach someone listed on this application.

First Name	Last Name	Phone number	Relationship to patient

Tell Us What Medical Services You are Requesting

DIAGNOSIS / REQUEST:

PROVIDER NAME, ADDRESS, & PHONE	DATES OF SERVICE	TYPE OF SERVICE	AMOUNT
	FROM: TO:		
	FROM: TO:		
	FROM: TO:		
	FROM: TO:		
	FROM: TO:		
	FROM: TO:		
	FROM: TO:		

Tell Us Who You Are

*** If you need to provide more information, please attach extra sheets.**

ATTENTION:
This combined application will be used to determine your program eligibility. Complete the application in its entirety and attach extra sheets if more space is needed.

List every person living in your home.

Add an additional sheet if you need to include more household members. Social Security numbers and citizenship status are required for those applying for services. Use the code key to indicate your Marital Status and Race. **NOTE:** Your responses to Race are optional.

Mark the appropriate box for the patient and anyone applying for Medicaid.

Race Codes:	
White	WH
Black	BL
Asian	AS
American Indian/Alaska Native	AL
Native Hawaiian/Pacific Island	HP
Hispanic/Latino	HL
Marital Status Codes:	
Married	MA
Never Married	NM
Divorced	DI
Separated	SE
Widowed	WI

YOURSELF / APPLICANT ☐ **Mark here if this is the Patient** ☐ **Mark here if you are applying for Medicaid for this person.**

First Name	Middle Initial	Last Name		Date of Birth	Social Security #	Relationship
						SELF
Former Names, if any	Sex ☐ M ☐ F	Pregnant? ☐ Yes ☐ No Due Date	Race	Marital Status	U.S. Citizen? ☐ Yes ☐ No Alien ID #	
Student? ☐ Yes ☐ No Grade: ☐ Full Time ☐ Part Time Name of School:	Primary Doctor / Clinic (first & last name)			Phone Number	Sponsor Name	
	Birth Country	Birth State (if U.S.)		Enrolled Native American Tribe member? ☐ Yes ☐ No Name of Tribe:		
Are you a Veteran? ☐ Yes ☐ No	VA ID#: Type of Discharge:	Registered to Vote? ☐ Yes ☐ No State/County?		Licensed to Drive? ☐ Yes ☐ No State?		

Do you plan to file a federal tax return for the CURRENT YEAR? ☐ Yes. Complete questions a, b, and c. ☐ No. Skip to question c.

a. Filing jointly with a spouse? ☐ Yes ☐ No If yes, name of spouse:

b. Claiming dependents? ☐ Yes ☐ No If yes, name of dependents:

c. Claimed as a dependent on someone's tax return who does not live at the address(es) listed on page 2 of this application? ☐ Yes ☐ No

Daytime Phone Number Type: (work, home, cell)	Message Phone Number Type: (work, home, cell)	Email Address

	City	State	Zip Code	County	From (date):	To:
Physical Address						Present
Mailing Address, if different						Present

CO-APPLICANT / SPOUSE / SIGNIFICANT OTHER ☐ **Mark here if this is the Patient** ☐ **Mark here if you are applying for Medicaid for this person.**

First Name	Middle Initial	Last Name		Date of Birth	Social Security #	Relationship
Former Names, if any	Sex ☐ M ☐ F	Pregnant? ☐ Yes ☐ No Due Date	Race	Marital Status	U.S. Citizen? ☐ Yes ☐ No Alien ID #	
Student? ☐ Yes ☐ No Grade: ☐ Full Time ☐ Part Time Name of School:	Primary Doctor / Clinic (first & last name)			Phone Number	Sponsor Name	
	Birth Country	Birth State (if U.S.)		Enrolled Native American Tribe member? ☐ Yes ☐ No Name of Tribe:		

Does this person plan to file a federal tax return for the CURRENT YEAR? ☐ Yes. Complete questions a, b, and c. ☐ No. Skip to question c.

a. Filing jointly with a spouse? ☐ Yes ☐ No If yes, name of spouse:

b. Claiming dependents? ☐ Yes ☐ No If yes, name of dependents:

c. Claimed as a dependent on someone's tax return who does not live at the address(es) listed on page 2 of this application? ☐ Yes ☐ No

Daytime Phone Number Type: (work, home, cell)	Message Phone Number Type: (work, home, cell)	Email Address

	City	State	Zip Code	County	From (date):	To:
Physical Address						Present
Mailing Address, if different						Present

Tell Us About the People Who Live With You

*** If you need to provide more information, please attach extra sheets.**

OTHER (child, roommate, parent, etc.)	☐ **Mark here if this is the Patient**	☐ **Mark here if you are applying for Medicaid for this person.**

First Name	Middle Initial	Last Name		Date of Birth	Social Security #	Relationship
Former Names, if any	Sex ☐ M ☐ F	Pregnant? ☐ Yes ☐ No Due Date	Race	Marital Status	U.S. Citizen? ☐ Yes ☐ No Alien ID #	
Student? ☐ Yes ☐ No Grade: ☐ Full Time Name of ☐ Part Time School:	Primary Doctor / Clinic (first & last name)			Phone Number	Sponsor Name	
	Birth Country	Birth State (if U.S.)		Enrolled Native American Tribe member? ☐ Yes ☐ No Name of Tribe:		

Does this person plan to file a federal tax return for the CURRENT YEAR? ☐ Yes. Complete questions a, b, and c. ☐ No. Skip to question c.

a. Filing jointly with a spouse? ☐ Yes ☐ No If yes, name of spouse:

b. Claiming dependents? ☐ Yes ☐ No If yes, name of dependents:

c. Claimed as a dependent on someone's tax return who does not live at the address(es) listed on page 2 of this application? ☐ Yes ☐ No

	☐ **Mark here if this is the Patient**	☐ **Mark here if you are applying for Medicaid for this person.**

First Name	Middle Initial	Last Name		Date of Birth	Social Security #	Relationship
Former Names, if any	Sex ☐ M ☐ F	Pregnant? ☐ Yes ☐ No Due Date	Race	Marital Status	U.S. Citizen? ☐ Yes ☐ No Alien ID #	
Student? ☐ Yes ☐ No Grade: ☐ Full Time Name of ☐ Part Time School:	Primary Doctor / Clinic (first & last name)			Phone Number	Sponsor Name	
	Birth Country	Birth State (if U.S.)		Enrolled Native American Tribe member? ☐ Yes ☐ No Name of Tribe:		

Does this person plan to file a federal tax return for the CURRENT YEAR? ☐ Yes. Complete questions a, b, and c. ☐ No. Skip to question c.

a. Filing jointly with a spouse? ☐ Yes ☐ No If yes, name of spouse:

b. Claiming dependents? ☐ Yes ☐ No If yes, name of dependents:

c. Claimed as a dependent on someone's tax return who does not live at the address(es) listed on page 2 of this application? ☐ Yes ☐ No

	☐ **Mark here if this is the Patient**	☐ **Mark here if you are applying for Medicaid for this person.**

First Name	Middle Initial	Last Name		Date of Birth	Social Security #	Relationship
Former Names, if any	Sex ☐ M ☐ F	Pregnant? ☐ Yes ☐ No Due Date	Race	Marital Status	U.S. Citizen? ☐ Yes ☐ No Alien ID #	
Student? ☐ Yes ☐ No Grade: ☐ Full Time Name of ☐ Part Time School:	Primary Doctor / Clinic (first & last name)			Phone Number	Sponsor Name	
	Birth Country	Birth State (if U.S.)		Enrolled Native American Tribe member? ☐ Yes ☐ No Name of Tribe:		

Does this person plan to file a federal tax return for the CURRENT YEAR? ☐ Yes. Complete questions a, b, and c. ☐ No. Skip to question c.

a. Filing jointly with a spouse? ☐ Yes ☐ No If yes, name of spouse:

b. Claiming dependents? ☐ Yes ☐ No If yes, name of dependents:

c. Claimed as a dependent on someone's tax return who does not live at the address(es) listed on page 2 of this application? ☐ Yes ☐ No

	☐ **Mark here if this is the Patient**	☐ **Mark here if you are applying for Medicaid for this person.**

First Name	Middle Initial	Last Name		Date of Birth	Social Security #	Relationship
Former Names, if any	Sex ☐ M ☐ F	Pregnant? ☐ Yes ☐ No Due Date	Race	Marital Status	U.S. Citizen? ☐ Yes ☐ No Alien ID #	
Student? ☐ Yes ☐ No Grade: ☐ Full Time Name of ☐ Part Time School:	Primary Doctor / Clinic (first & last name)			Phone Number	Sponsor Name	
	Birth Country	Birth State (if U.S.)		Enrolled Native American Tribe member? ☐ Yes ☐ No Name of Tribe:		

Does this person plan to file a federal tax return for the CURRENT YEAR? ☐ Yes. Complete questions a, b, and c. ☐ No. Skip to question c.

a. Filing jointly with a spouse? ☐ Yes ☐ No If yes, name of spouse:

b. Claiming dependents? ☐ Yes ☐ No If yes, name of dependents:

c. Claimed as a dependent on someone's tax return who does not live at the address(es) listed on page 2 of this application? ☐ Yes ☐ No

Tell Us About Residency for the Patient

*** If you need to provide more information, please attach extra sheets**

Start with the current Address and work backward for five (5) years.

Physical Address	City	State	Zip Code	County	From (date):	To:
☐ Own? ☐ Rent?	Landlord's Name			Landlord's Phone Number		
Physical Address	City	State	Zip Code	County	From (date):	To:
☐ Own? ☐ Rent?	Landlord's Name			Landlord's Phone Number		
Physical Address	City	State	Zip Code	County	From (date):	To:
☐ Own? ☐ Rent?	Landlord's Name			Landlord's Phone Number		
Physical Address	City	State	Zip Code	County	From (date):	To:
☐ Own? ☐ Rent?	Landlord's Name			Landlord's Phone Number		

Current Services and Health Coverage

*** If you need to provide more information, please attach extra sheets.**

Please check any Programs from the list below that you are currently receiving assistance from. Your answer to this question will not affect your eligibility for benefits.

☐ Other State's Assistance Programs ☐ Children's or Adult Developmental Disabilities ☐ Infant and Toddler
☐ Children's or Adult Mental Health ☐ Foster Care or Adoption Assistance

Has anyone in your home *ever* received assistance from another state? ☐ Yes ☐ No
If yes, from where? City _____ State _____ County _____ When? _____

List anyone in your home that:

	NAME OF HOUSEHOLD MEMBER	DATE APPLICATION FILED	CURRENT STATUS OF APPLICATION
Has a disability			
Receives or has applied for Social Security			
Receives or has applied for Medicare			
Has applied for Medicaid in the past Year			
Has applied for Crime Victims in the past Year			
Needs medical assistance at home			
Lives with a relative who provides medical care			
Lives in a medical care facility	Name of Facility:		

Are you a dependant of a full-time State employee? ☐ Yes ☐ No

Does anyone applying for **State Department of Health and Welfare** health coverage need help paying medical bills from the last three months? ☐ Yes ☐ No If Yes, who? _____

List gross income amount (before taxes) received by your family in each of the last three months.

$	$	$
Last Month	Two Months Ago	Three Months Ago

Would you like Healthy Connections to choose a doctor for you? ☐ Yes ☐ No

Do you have health insurance that covers inpatient/outpatient hospital, physician's medical and surgical, lab, and x-ray services? ☐ Yes ☐ No

List everyone in your household who has had health insurance in the past six (6) months.

NAME OF PERSON(S) INSURED	DATE INSURANCE ENDED	REASON INSURANCE ENDED	NAME OF INSURANCE COMPANY	TYPE OF COVERAGE & POLICY NUMBER

If insurance ended due to loss of employment, have you received notification of COBRA? ☐ Yes ☐ No
Does anyone in your household have access to any health insurance coverage not listed above? ☐ Yes ☐ No

Legal Information

*** If you need to provide more information, please attach extra sheets.**

Has anyone in your household been convicted of a felony involving drugs? ☐ Yes ☐ No
If Yes, who: _____ Year: _____
Is anyone fleeing to avoid felony prosecution or jail time? ☐ Yes ☐ No If Yes, who: _____
Is anyone currently violating conditions of probation or parole? ☐ Yes ☐ No If Yes, who: _____
Has anyone been disqualified from public assistance due to an intentional program violation? ☐ Yes ☐ No
If Yes, who: _____ Year: _____ Where: _____

List any pending actions (such as lawsuits, inheritance, accident claim, insurance settlement, etc.) that may result in the receipt of money by anyone in your household.

NAME OF HOUSEHOLD MEMBER	TYPE OF ACTION	BEGINNING DATE OF ACTION	CURRENT STATUS OF ACTION	CLAIM NUMBER

List the name, address, and phone number of your attorney. _____
_____

List anyone in your household who has *ever* been disqualified from an assistance program.

NAME OF HOUSEHOLD MEMBER	NAME OF PROGRAM	DATE DISQUALIFIED	REASON

General Information

*** If you need to provide more information, please attach extra sheets.**

Do you have any children in your home? ☐ Yes ☐ No
If YES, do any of them have a parent NOT living with them? ☐ Yes ☐ No

** If you answered "yes" you will be required to give information about the absent parent(s) to Child Support Services and open a Child Support case unless you fear harm to yourself or your children. If you have questions about Child Support Cooperation, please call 1-800-356-9868 for more information.

CHILD'S NAME	ABSENT PARENT'S NAME	ABSENT PARENT'S SSN	ABSENT PARENT'S DOB

Please list each person in your household that pays or receives child support.

NAME	PAYS/RECEIVES	AMOUNT

List everyone in your home who PAYS child or adult care expenses due to work or school.

Name:	Reason for Care: ☐ Work ☐ Work Search ☐ School	Name of Child/Adult in Care:	Amount Paid: $ How Often?
Name of Care Provider:	Do you get help paying for care? ☐ No ☐ Yes	If yes, how much do you receive? $	
	Name of Person / Agency paying:		
Name:	Reason for Care: ☐ Work ☐ Work Search ☐ School	Name of Child/Adult in Care:	Amount Paid: $ How Often?
Name of Care Provider:	Do you get help paying for care? ☐ No ☐ Yes	If yes, how much do you receive? $	
	Name of Person / Agency paying:		

Tell Us About Your Income and Resources * If you need to provide more information, please attach extra sheets.

Earned Income: List all employment information for each person in your household.

Patient/Applicant			Spouse/Significant Other/Co-Applicant		
Current Employer Name:		Phone No:	Current Employer Name:		Phone No:
Address (street, city, state, zip)			Address (street, city, state, zip)		
Hours per Week:	Hourly Rate:	Monthly Gross:	Hours per Week:	Hourly Rate:	Monthly Gross:
List Dates of Employment: From: To:			List Dates of Employment: From: To:		
Previous Employer Name:		Phone No:	Previous Employer Name:		Phone No:
Address (street, city, state, zip)			Address (street, city, state, zip)		
Hours per Week:	Hourly Rate:	Monthly Gross:	Hours per Week:	Hourly Rate:	Monthly Gross:
List Dates of Employment: From: To:			List Dates of Employment: From: To:		
Other Household Member			**Other Household Member**		
Current Employer Name:		Phone No:	Current Employer Name:		Phone No:
Address (street, city, state, zip)			Address (street, city, state, zip)		
Hours per Week:	Hourly Rate:	Monthly Gross:	Hours per Week:	Hourly Rate:	Monthly Gross:
List Dates of Employment: From: To:			List Dates of Employment: From: To:		
Other Household Member			**Other Household Member**		
Current Employer Name:		Phone No:	Current Employer Name:		Phone No:
Address (street, city, state, zip)			Address (street, city, state, zip)		
Hours per Week:	Hourly Rate:	Monthly Gross:	Hours per Week:	Hourly Rate:	Monthly Gross:
List Dates of Employment: From: To:			List Dates of Employment: From: To:		

Is anyone in the household self-employed? ☐ Yes ☐ No Who? _____

Name of Business _____ Years in Business _____

Unearned Income Is anyone receiving income from the following sources? Check all that apply.

- ☐ Social Security / SSI / SSD
- ☐ Veteran's Benefits
- ☐ Food Stamps
- ☐ Cash Assistance / TAFI
- ☐ Worker's Compensation
- ☐ Child Support
- ☐ Alimony
- ☐ Employer Disability
- ☐ Crime Victims
- ☐ Unemployment
- ☐ Energy Assistance
- ☐ School Financial Aid
- ☐ Retirement
- ☐ Tribal/BIA Assistance
- ☐ Commodities
- ☐ Rental / Escrow
- ☐ Inheritance / Trust
- ☐ Loans / Gifts
- ☐ Insurance Settlements
- ☐ Church
- ☐ Income Tax Refunds/Earned Income Credit
- ☐ Interest/Dividends
- ☐ Other

Please provide details for any unearned income marked above.

SOURCE OF UNEARNED INCOME	PERSON RECEIVING INCOME	AMOUNT	HOW OFTEN RECEIVED?

ASSETS

*** If you need to provide more information, please attach extra sheets.**

List all assets for anyone in your household. Include anything you have or your name appears on, even as a co-signer.

ITEM	HAVE IT? (CHECK)	ITEM DESCRIPTION / ACCOUNT NUMBERS	OWNER(S) / NAME(S) ON ACCOUNT	BANK NAME / ITEM OR ACCOUNT LOCATION	VALUE / AMOUNT	AMOUNT OWED
Cash						
Checking Acct.						
Savings Acct.						
Line of Credit						
CDs / Mutual Funds						
Stocks / Bonds						
Trusts / Annuities						
Retirement (IRA, 401K, etc.)						
Credit Cards						
Credit Cards						
Other Financial						
Home / Residence						
Land						
Rental Property						
Vehicle(s)						
Vehicle(s)						
Recreational Vehicles (Camper, Trailer, ATVs, etc.)						
Livestock / Tools of Trade						
Mining Claims						
Burial Plots / Burial Funds						
Life Insurance						
Other						

List anyone in your household who has sold, transferred or given away any cash, property, or assets in the past 5 years.

NAME OF PERSON(S)	DATE OF TRANSACTION	WHAT ASSETS	$$ RECEIVED	FAIR MARKET VALUE

Tell Us About Your Expenses

*** If you need to provide more information, please attach extra sheets.**

List all expenses for anyone in your household. Include anything you have or your name appears on, even as a co-signer.

ITEM	MONTHLY AMOUNT	BALANCE OWED	NAME(S) ON ACCOUNT	PAID TO:	OFFICE USE ONLY
Rent or Mortgage Subsidized? ☐ Yes ☐ No					
2nd Mortgage					
Space Rent					
Food					
Non-Food					
Electricity					
Heat – (Source?)					
Water / Sewer / Trash					
Telephone (Base Rate)					
Health / Accident Insurance					
Home Owners / Renters Insurance					
Life Insurance					
Auto Insurance					
Car Payment					
Fuel					
Alternate Transportation (Bus, Taxi, etc.)					
Hospitals					
Doctors					
Medications					
Dental					
Property Taxes					
Payroll Taxes (for business owners or self-employed)					
Education Expenses					
Child Care Subsidized? ☐ Yes ☐ No					
Dues and Tithing					
Child Support					
Garnishment					
Fines					
Other					
Other					
TOTAL EXPENSES					

Patient Rights and Responsibilities for State and County Assistance

The Applicant must read, or have read to them, and initial each of the following statements acknowledging they understand and accept these rights and responsibilities.

For State Assistance:

_____ I could be sanctioned and required to return any Medicaid benefits I receive if my information is not true. Sanctions may include administrative, civil or criminal actions against me, including prosecution.

_____ I consent to the gathering, use and disclosure of my information by the Idaho Department of Health and Welfare. I understand the information is needed for the purposed of providing benefits or services, obtaining payment for my benefits or services, and for normal business operations of the Department.

_____ I have the right to revoke this consent, in writing at any time except t the extent the Department has already used and disclosed my information in reliance on this consent. If I revoke this consent, the Department may not provide me further benefits or services.

_____ I understand that I will be notified of the right to appeal Department decision and I can contact the Department for information on the appeal process.

_____ My signature indicates I have received a copy of the Department Privacy Practices.

_____ I have read and understand the plan choices and that I might be responsible for paying part of the cost of my health plan.

_____ By applying for benefits for a minor child, a medical support case must be opened, when applicable. If I am receiving benefits for myself, failure to cooperate with Child Support Services may result in loss or decrease of my benefits.

_____ If a third party is responsible for my disease or injury, I give to Medicaid any rights I may have, or may acquire in the future to be compensated by that responsible party for any Medicaid benefits I receive.

_____ My signature or the signature of my representative authorizes State offices to communicate with insurance companies related to my medical assistance.

_____ I have the right to choose my Healthy Connections Primary Care Doctor, to request referrals for services, and to change my doctor/clinic if my circumstances change. I understand that if I do not request a Primary Care Doctor, one will be assigned to me.

_____ If I receive Medicaid after age 55, my estate may be subject to recovery of medical expenses paid on my behalf, and that any transfer of assets may be set aside by a court if I do not receive adequate value.

_____ If I receive Medicaid/Cash Assistance, I am required to report changes in my circumstances including income, assets and living situations within ten (10) days of the change.

_____ If I am determined eligible for Medicaid, I choose the plan that is based on my health needs, unless I tell my Self-Reliance worker otherwise.

_____ If I receive a Child Support payment in error, Child Support Services will withhold future payments to recover the amount unless I submit written instructions to the contrary.

_____ My signature certifies that the listed citizenship / immigration status is correct for each person applying.

For County Assistance:

_____ An automatic lien will attach to my real and personal property, insurance benefits, and any additional resources or assets I own.

_____ I must complete the entire application within the timelines allowed by Law.

_____ I must cooperate with the investigation of my application by providing documentation and submitting to an interview.

_____ I am obligated to reimburse the County for any assistance requested and provided on my behalf.

_____ I must notify the County if I receive resources after filing an application with the County.

_____ To assist in determining my eligibility, I consent to the gathering, use, and disclosure of my personal and financial information by the County.

_____ A provider may file an application on my behalf as a third party applicant.

_____ I will be notified of the County's decisions and that I may appeal an adverse decision of the Board of County Commissioners within 28 days of the date of determination.

_____ I may seek judicial review of the County's final determination denying my application.

_____ If I fail to cooperate with the County, make a material misstatement or material omission, my application will be denied and I will be ineligible for non-emergency services for up to two (2) years.

_____ If I do not provide required material information or if I divest myself of resources within one (1) year prior to filing an application in order to become eligible for County assistance, my application will be denied.

_____ If I am sanctioned by federal or state authorities and lose medical benefits, I will be ineligible for County Assistance for the period of the sanction.

_____ If I give false or misleading information to a hospital, county, to its agent, or to any person in order to receive County assistance, or fail to disclose resources or benefits available to me as payment or reimbursement, I will be guilty of a misdemeanor and punishable under the law.

Applicant's Name: _____ Co-Applicant's Name: _____

Applicant's Signature: _____ Co-Applicant's Signature: _____

****** IF BY A THIRD PARTY APPLICANT ON BEHALF OF THE APPLICANT:***

Printed Name of Third Party Applicant	Date	Name of Facility
Signature of Third Party Applicant	Phone	Address of Facility

RELEASE OF INFORMATION

Patient's Name: _____ **County:** _____

Applicant's Name: _____ **Co-Applicant's Name:** _____

I/we authorize and request any hospital, doctor, or other person that has provided care to the above named patient ("Providers") to release medical records to representatives of the State or the County as the records are pertinent to the investigation and eligibility determination of medical indigency pursuant to Chapter 35, Title 31 Idaho Code. I acknowledge that some records pertaining to treatment I have received for which I am seeking payment from the State or the County may include information that is protected under the Federal Law. Specific authorization is given to release information concerning a federal-assisted drug or alcohol abuse program, drug-alcohol abuse information, mental health information, HIV information, or any other information that may be protected by law. I understand that I am waiving the confidentiality of such records for the limited purpose of this application for medical indigency and any supplements or amendments thereto. I acknowledge that the State or the County may disclose any information received to my providers participating in the medical indigency process and to representatives of the State Catastrophic Health Care Cost Program. I acknowledge that the purpose of the release is to determine whether or not I meet the statutory requirements for medical indigency assistance from the State or the County.

Federally protected records obtained as authorized by this release will be maintained in accordance with federal confidentiality regulations (Title 42CFR) which prohibits re-disclosure.

I/we also request my/our relatives, banker(s), credit union(s), financial or investment institution(s), physician(s), hospital(s), creditor(s), credit reporting agencies, and any other persons or organizations including the State Department of Health and Welfare, Social Security Administration, Public Health Districts, Veterans Administration, Crime Victims Compensation Program, Idaho Industrial Commission, utility companies or departments, law enforcement agencies, courts, Idaho Department of Labor, or employer(s), having any information concerning me/us or my/our circumstances to provide the information to such representative of the State or the County, inasmuch as it is pertinent to this application.

I/we hereby authorize the State or the County and its representatives to release pertinent information regarding this application, the contents thereof and action taken thereon to all parties of interest as provided by Chapter 35, Title 31, Idaho Code. I/we acknowledge that my/our medical indigency application waives any confidentiality granted by state law to the extent necessary to carry out the intent of Idaho Code 31-3504 regarding such applications. I/we hereby authorize a copy of this agreement to be used when necessary and give it full force as the original.

I/we understand that I/we may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that unless consent is sooner revoked; this release is valid as long as it is pertinent to this application, post-application reimbursement, or collection activity.

_____ _____
Signature of Patient Date

_____ _____
Signature of Applicant Date

_____ _____
Signature of Co-Applicant Date

STATE OF IDAHO)
):SS.
County of _____)

On this _____ day of _____, 20_____, _____ personally appeared before me and proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to this instrument and acknowledged to me that he/she/they executed the same.

Subscribed and sworn before me:

_____
Notary Public for the State of Idaho

(SEAL)

Residing In: _____
My Commission Expires On: _____

This authorization conforms to the regulations promulgated under Section 333 of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, and Section 408 of the Drug Abuse Offense and Treatment Act of 1972 and the Health Insurance Portability and Accountability Act of 1996.

REQUIRED INFORMATION

The following information is required when applying for assistance. You must provide proof of ALL income, resources, assets, benefits, and expenses of ALL household members. Failure to provide verification of all items listed may result in denial of your application. Bring your verifications with you to your scheduled interview. (The documentation should include your name, your monthly payment amount, and the balance owing. If you get a monthly billing statement for the expense, bring in the statement for the most recent month. Otherwise, bring in the applicable lease or contract agreement.)

IDENTIFICATION:

- **Picture ID** (Driver's license, school I.D., etc.) for All members of the household.
- **Social Security cards** for All members of the household.
- **Citizenship and Residency Documentation** for All members of the household. (VISA, Resident Alien Card, etc.)
- **Veteran's Status** (DD214, military discharge papers)

INCOME / ASSETS / BENEFITS:

- **Verification of all household income for the past six (6) months** including but is not limited to:

Wage Stubs/ Employer Earning Statements	Health Insurance or Life Insurance	Rental Income/ Escrow Income
Self Employment Records (i.e. Year-to-date Profit and Loss Statement)	Survivor Benefits	Land-Trust Payments/ Per-Capita Payments
Unemployment Benefits	Food Stamps Benefits	Garnishment Income
Retirement Pension	TAFI Benefits	Investment Income
IRA or other Retirement Income	ICCP Benefits	Cash Settlement Payments
Worker's Compensation	SSI/ SSD/ Social Security Retirement	School Financial Aid/ Scholarships/ Loans
Crime Victims Compensation	Alimony	Family Financial Assistance
Veteran Disability/ Pension	Child Support	Other

- **Federal** and **State tax returns** for the most recent year filed.
- **Bank / Credit Union / Investment Income statements** for all checking, savings, money market accounts, IRAs, certificates of deposit, stocks, bonds, mutual funds, real estate, retirement investments etc. (If you don't have these, please get a print-out from your bank/credit union, brokerage firm / investment house)
- **Verification of any assistance received from other agencies or assistance programs** including, but not limited to:

Energy Assistance	SEICCA	Aid for Friends
Subsidized Housing	Project Share	Salvation Army
Phone Assistance	Church Assistance	St. Vincent DePaul

EXPENSES:

- **Provide all medical bills (immediately, upon receipt) to the county for which assistance is requested.**
- **Proof of *all* monthly household expenses and *all* outstanding debts** including, but not limited to:

Rental Lease	Water/sewer/garbage	Child Support	Transportation
Lot Space Lease	Telephone	Child Care	Taxes
Mortgage	Food	Medications	Court-Ordered Fines
Heating	Non-Food Grocery	Insurance	Loan Payments
Electricity	Car payment	Doctor / Hospital	Other

ALSO: Any and all other information requested by the Idaho Department of Health and Welfare and/or the County Indigent Program.

DO I HAVE TO BE A CITIZEN?

According to the U.S. Citizenship and Immigration Services, if you do NOT have a green card, members of your family who are eligible can use non-cash benefits, including Medicaid, Food Stamps, WIC, housing assistance, energy benefits, job training, child care, disaster relief, public health assistance, etc., without hurting your chances of getting a green card, becoming a U.S. citizen, or sponsoring relatives in the future.

DO I HAVE TO RELEASE MY SOCIAL SECURITY NUMBER (SSN) AND CITIZENSHIP STATUS?

Some family members of applicants may choose not to apply for Health and Welfare services. In that case, they do not have to provide a SSN or citizenship or immigration status. Benefits to applicants will not be delayed or denied because some family members do not apply.

Anyone who applies for services, except child care, must have a SSN or apply for one. If you want Emergency Medicaid only or you are a victim of domestic violence, you may not have to give a SSN or immigration status. You only have to give us citizenship or immigration status information for persons who want help, except when applying for child care.

We can help you apply for a SSN, and benefits will not be denied or delayed while the application is being processed. We need the SSN to help you establish paternity, get Child Support, and change or enforce Child Support orders, including medical insurance coverage for a child. SSN's will not be given to the U.S. Citizen and Immigration Services.

IS THERE EQUAL OPPORTUNITY FOR APPLICANTS?

In accordance with federal law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy, the Department of Health and Welfare is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. Under the Food Stamp Act and USDA policy, discrimination is prohibited also on the basis of religion or political beliefs.

To file a complaint of discrimination, contact USDA or HHS:

USDA, Director, Office of Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410 (800) 795-3272 (Voice) (202) 720-6382 (TTY) USDA & HHS are equal opportunity providers and employers.	U.S. Department of Health & Human Services Room 506 F, 200 Independence Avenue, SW Washington, D.C. 20201 ocrcomplain@hhs.gov (202) 619-0403 (Voice) (202) 619-3257 (TTY)

IDAHO MEDICAID PLAN CHOICE

If you are eligible for Medicaid, you have the right to choose the plan that is based on your health needs. Idaho Medicaid offers the Medicaid Basic Plan and the Medicaid Enhanced Plan to meet different health needs.

- **The Medicaid Basic Plan** is for low-income children and working-age adults with average health needs. This plan provides complete health, prevention, and wellness benefits for children and adults who don't have special health needs.
- **The Medicaid Enhanced Plan** is for individuals with disabilities or special health needs. This plan includes all benefits in the Basic Plan, plus additional benefits.

You may choose NOT to enroll in the plan that meets your health needs. You may choose to enroll in Standard Medicaid instead. Standard Medicaid does not include prescription drugs, certain prevention and wellness benefits, therapies, dental services, vision services, and other services. If you do not want to enroll in the benefit plan that meets your health needs, you must inform your Self-Reliance worker.