Application for Mississippi Medicaid Aged, Blind and Disabled Medicaid Programs

- This application is used for an individual, couple or child to apply for Medicaid due to age or disability.
- Please read each question carefully before answering. The answers given will determine whether or not the person(s) applying will be eligible for Medicaid. A friend or relative may help the applicant complete this form. A Medicaid worker is also available if any help is needed.
- Contact your worker if you want to register to vote or update your voter registration information.

WHEN THE FORM IS COMPLETED AND SIGNED, YOU SHOULD EITHER MAIL IT OR BRING IT TO YOUR MEDICAID REGIONAL OFFICE AT THE FOLLOWING ADDRESS:

For Regional Office Use Only

❑ LTC ❑ Healthy MS Waiver ❑ QMB ❑ SLMB ❑ Disabled Child ❑ SSI Retro ❑QWDI ❑ HCBS Waiver

Worker: _____ Nursing Home: _____

Date of Interview ____/_____/_____

Case Name _____ Case Number _____

Spouse Case Name _____ Case Number _____

Rights & Responsibilities explained at time of interview ❑ Yes ❑ No

In person interview conducted ❑ Yes ❑ No

Pamphlets Given: ❑P1 ❑P2 ❑P3 ❑P4 ❑P5 ❑P6 ❑Cool Kids

Special Needs: Interpreter ❑ Yes, specify_____ ❑ No

If blind, will notices need to be read by phone? ❑ Yes ❑No

- **What is the language most spoken in your home _____. If not English and you need assistance, contact your Regional Office or call 1-800-421-2408. An interpreter service will be provided free of charge.**

If any person applying for Medicaid using this form isblind or hearing impaired, tell us so that any special needs can be evaluated:

☐ **Blind Name of Applicant _____**

☐ **Hearing Impaired Name of Applicant _____**

Are there any other special needs? _____

1. APPLICANT INFORMATION – Enter all information about the 1st applicant

- Applicant's Full Name:_____
  (First) (Middle) (Maiden) (Last)
- Social Security Number: _____-_____-_____ Date of Birth: (mo) _____(day) _____(year) ____
- Marital Status: ☐Single ☐Married ☐Separated ☐Widowed ☐Divorced
- Sex (check one): ☐Male ☐Female
- Race (check one): ☐White ☐Black ☐American Indian/Alaskan Native ☐Hispanic/Latino ☐Asian ☐Other (specify) _____
- Home Address: _____ Apt or Lot# _____
  City: _____ County: _____ State: _____ Zip: _____
- Mailing address (if different from Home address):
  _____
  City: _____ County: _____ State: _____ Zip: _____
  Telephone Number _(____)____-_____ Message # _____ Whose # is this? _____
- Do you live: ☐ at home or apt. ☐ with someone in their home ☐ nursing home ☐ other _____
  _____
- Do you plan to enter a nursing facility? ☐ Yes ☐ No If yes, when? _____
- Do you have Medicare Part A? ☐Yes ☐No; Give us the Health Insurance Claim # as shown on your Medicare card:
  Do you have Medicare Part B? ☐Yes ☐No _____
  Do you have other health insurance? ☐Yes ☐No If yes, complete the following:
  _____
  Insurance Company Group or Policy # Beginning Date If expected to end, when?
- Are you a U. S. Citizen? ☐ Yes ☐ No. If not, are you a qualified alien? ☐ Yes ☐ No (Not required for aliens seeking Emergency Medicaid services).
- If someone with personal knowledge of your financial and non-financial situation is acting on your behalf, complete the following: (Note: This person should act for all applying.)
  Name of Designated Representative:_____
  Address:_____
  Telephone #:_____ Relationship to applicant:_____
- Have you given written power of attorney to anyone? ☐Yes ☐No If you marked "Yes", please answer the following:
  Name/Address/ Phone #:_____
  _____
- Do you have a court appointed guardian or conservator? ☐Yes ☐No If you marked "Yes", please answer the following: Name/Address/Phone #: _____

- Are you the beneficiary of a trust? ☐Yes ☐No If you marked "Yes", please give the trustee's: Name/Address/Phone #: _____

  _____
- If you are under the age of 65, what is your disability? _____
- List members of your household. If you are in a nursing facility, list the people living in your home prior to client entering the nursing facility:

  _____

  _____

2. APPLICANT INFORMATION – Enter all information about the 2nd applicant (Spouse or child applying with a parent) **– If spouse is not applying, skip to Section 3**.

- Applicant's Full Name: _____
  (First) (Middle) (Maiden) (Last)
- Social Security Number: _____-_____-_____ Date of Birth: (mo) _____(day) _____(year) ____
- Marital Status: ☐Single ☐Married ☐Separated ☐Widowed ☐Divorced
- Sex (check one): ☐Male ☐ Female
- Race (check one): ☐White ☐Black ☐American Indian/Alaskan Native ☐Hispanic/Latino ☐Asian ☐Other (specify) _____
- Home Address (if different from Applicant #1): _____ Apt or Lot# _____
  City: _____ County: _____ State: _____ Zip: _____
- What is your current mailing address (if different from home address above)? _____

  _____City_____ County_____State_____ Zip _____

  Telephone Number (____)____-_____ Message # _____ Whose # is this? _____
- Do you live: ☐ at home or apt. ☐ with someone in their home ☐ nursing home ☐ other _____

  _____
- Do you plan to enter a nursing facility? ☐ Yes ☐ No If yes, when? _____
- Do you have Medicare Part A? ☐Yes ☐No; Give us the Health Insurance Claim # as shown on your Medicare card:

  Do you have Medicare Part B? ☐Yes ☐No _____

  Do you have other health insurance? ☐Yes ☐No If yes, complete the following:

  _____
  Insurance Company Group or Policy # Beginning Date If expected to end, when?
- Are you a U. S. Citizen? ☐ Yes ☐ No. If not, are you a qualified alien? ☐ Yes ☐No (Not required for aliens seeking Emergency Medicaid services.
- Have you given written power of attorney to anyone? ☐Yes ☐No If you marked "Yes", please answer the following:

  Name/Address/ Phone #: _____

  _____
- Do you have a court appointed guardian or conservator? ☐Yes ☐No If you marked "Yes", please answer the following: Name/Address/Phone #: _____

  _____
- Are you the beneficiary of a trust? ☐Yes ☐No If you marked "Yes", please give the trustee's: Name/Address/Phone #: _____

  _____
- If you are under the age of 65, what is your disability? _____

3. SPOUSE OR PARENT INFORMATION (IF NOT APPLYING)

Complete spouse information even if spouse is deceased.

- Full Name of Spouse/Parent _____
- Social Security Number* _____-____-_____ Date of Birth _____/___/_____ Date of Death _____/_____/_____
  (* Not required if not applying.)
- Current Address (if different from applicant) _____
  City _____ State _____ Zip _____
  Telephone # (____) ____-_____
- Has spouse ever received Medicaid? ☐ Yes ☐ No
- If applicant has ever been widowed or divorced, give the following information for **all** previous marriages:

Former Spouse's Name				*How Long Married*	*How Marriage ended (Death or Divorce)*
First	*Middle*	*Maiden*	*Last*		

4. VETERAN STATUS

- Is applicant or spouse a veteran? Applicant: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No
- Has applicant ever been married to a veteran? ☐ Yes ☐ No
- Is applicant a dependent of a veteran? ☐ Yes ☐ No

If you answered "Yes" to any of the above questions, please complete the following:

Name of Veteran_____

Applicant's Relationship to Veteran_____

Veteran's Service Number or Claim Number_____

Branch of Service_____ Date(s) of Service_____

Has applicant ever applied for VA benefits? ☐ Yes ☐ No If yes, we will need proof of the VA decision.

5. RETROACTIVE MEDICAID

Medicaid may be able to cover the applicant in the 3 months prior to the date of this Medicaid application (if needed) or the date an application was filed for SSI if the applicant is eligible & received services covered by Medicaid during the 3 month retroactive period.

- **Does applicant #1 want to apply for retroactive Medicaid?** ☐ Yes ☐ No
- **Does applicant #2 want to apply for retroactive Medicaid?** ☐ Yes ☐ No

6. RESOURCES - This is real or personal property owned or being bought by the applicant, spouse or parent(s) of a child.

Does applicant or spouse / parent(s) **own** or is applicant / spouse / parent(s) **buying** any of the following types of resources:

- **RETIREMENT FUNDS** (IRA, Keough Plan, state, federal or municipal retirement or private pension funds)

  ☐ Yes ☐ No If yes, has applicant applied for income from retirement funds? ☐ Yes ☐ No

- **SAFE DEPOSIT BOX** ☐ Yes ☐ No If yes, at what bank? _____

- **BANK ACCOUNTS** (Checking, Savings, CDs, Christmas Club, Patient Accounts, etc.) ☐ Yes ☐ No

If yes, complete the following: Name of Bank _____

Type of Account /Account Number *Balance* *Type of Ownership* *Interest Paid How Often*

_____ _____ ☐ Joint ☐ Individual _____

_____ _____ ☐ Joint ☐ Individual _____

Name of Bank _____

Type of Account /Account Number *Balance* *Type of Ownership* *Interest Paid How Often*

_____ _____ ☐ Joint ☐ Individual _____

_____ _____ ☐ Joint ☐ Individual

- **PROMISSORY NOTES, LOANS OR PROPERTY AGREEMENTS** ☐ Yes ☐ No If yes,

Principal balance_____ Does Note produce income? ☐ Yes ☐ No

Amount of income $_____ How often_____

- **STOCKS, BONDS & SAVINGS BONDS** ☐ Yes ☐ No If yes, describe the type and number owned & the value _____

- **HOME P ROPERTY** ☐ Yes ☐ No If yes, what State_____ County_____

Address / location_____

Type of ownership: ☐ Sole ☐ Shared ☐ Life Estate ☐ Other (describe)_____

- **OTHER REAL PROPERTY** ☐ Yes ☐ No If yes, number of other properties _____

Address/location_____

County _____ State_____

Type of ownership: ☐ Sole ☐ Shared ☐ Life Estate ☐ Heir Interest ☐ Other (describe) _____

Explain how property is used: _____

Does property produce income? ☐ Yes ☐ No If yes, include amount of income $_____ .

How often? _____

- **HOUSEHOLD GOODS / PERSONAL PROPERTY** (Includes boats, campers, recreational vehicles, or any other personal effects of substantial value.) ☐ Yes ☐ No If yes, what is owned?_____

Describe: make_____ model_____ year_____ value_____

- **AUTOMOBILE (S)** - (This includes any cars, trucks, motorcycles or farm machinery). ☐ Yes ☐ No If yes,

Type of Vehicle *Model / Year* *Amount Owed* *Use of Vehicle*

_____

☐ Employment ☐ Medical ☐ Other

_____

☐ Employment ☐ Medical ☐ Other

_____

☐ Employment ☐ Medical ☐ Other

- **LIFE INSURANCE** ☐ Yes ☐ No If yes,

  Insured *Owner* *Face Value* *Insurance Company* *Type of Policy*

  _____

  ☐ Whole Life ☐ Term

  _____

  ☐ Whole Life ☐ Term

  _____

  ☐ Whole Life ☐ Term

- **BURIAL SPACES** (Includes burial plots or spaces) ☐ Yes ☐ No

  Number of gravesites owned_____ Location of cemetery_____

  Are these gravesites used / intended for use by applicant's family? ☐ Yes ☐ No

- **BURIAL FUNDS** Are there funds set aside for burial? ☐ Yes ☐ No

  How are the funds set up? ☐ Cash ☐ Burial Insurance or Contract ☐ Other

  Value of funds $_____ Can funds be cashed in? ☐ Yes ☐ No

- **OTHER** Are there any other resources owned or being bought that are not shown above? ☐ Yes ☐ No

  If yes, specify _____

- **Has applicant or spouse sold or given as a gift any resource (including cash) to anyone in the last 5 years?**

  ☐ **Yes** ☐ **No** **If yes, specify:**_____

  Type of Resource Transferred *Date* *Person to Whom Transferred* *Amount of Compensation*

  _____

  _____

7. INCOME AND WORK HISTORY

- Does applicant, spouse or parent(s) work? ☐ Yes ☐ No

  If yes, name of person who works_____

  Employer_____

  Total wages (before deductions) $_____ Paid how often_____

  If paid weekly or biweekly, what is day of week check is received? _____

- Was applicant, spouse or parent(s) self-employed at any time this or last year? ☐ Yes ☐ No

  If yes, type of business_____

  Amount earned $_____ Paid how often_____

- If applicant, spouse or parent(s) do not currently work, what is date last employed?_____

  Employer_____

- Did applicant / spouse file state or federal income tax last year? ☐ Yes ☐ No

- Complete the next two questions only if applicant is in a nursing facility.

  - -If applicant has a spouse living at home, does applicant wish to make income available to the community spouse?

    ☐ Yes ☐ No

  - -Does applicant receive sheltered workshop earnings or any income from work therapy? ☐ Yes ☐ No

    If yes, what are the monthly earnings? $_____

List below all other types of money received by the applicant, his/her spouse, or any dependent child. If this is an application for a child, each parent must account for his/her income.

		Source of Income	*Applicant*	*Parent(s) or Spouse*	*Children (Under 18)*	*Claim Numbers*
☐ Yes	☐ No	Social Security	$	$	$	
☐ Yes	☐ No	SSI	$	$	$	
☐ Yes	☐ No	VA Pension/Compensation	$	$	$	
☐ Yes	☐ No	VA Insurance	$	$	$	
☐ Yes	☐ No	Military Retirement	$	$	$	
☐ Yes	☐ No	Railroad Retirement	$	$	$	
☐ Yes	☐ No	State Retirement	$	$	$	
☐ Yes	☐ No	Municipal Retirement	$	$	$	
☐ Yes	☐ No	Civil Service Retirement	$	$	$	
☐ Yes	☐ No	Private Retirement	$	$	$	
☐ Yes	☐ No	Unemployment Compensation	$	$	$	
☐ Yes	☐ No	Rental Income	$	$	$	
☐ Yes	☐ No	Workers' Compensation	$	$	$	
☐ Yes	☐ No	Interest Income	$	$	$	
☐ Yes	☐ No	Trust Income	$	$	$	
☐ Yes	☐ No	Dividends	$	$	$	
☐ Yes	☐ No	Income from Promissory Note	$	$	$	
☐ Yes	☐ No	Oil, Gas, Mineral Royalties	$	$	$	
☐ Yes	☐ No	Child Support/Alimony	$	$	$	
☐ Yes	☐ No	Cash Contributions	$	$	$	
☐ Yes	☐ No	Other	$	$	$	

8. STATEMENT OF RESIDENCY

Does applicant plan to remain in Mississippi? ☐ Yes ☐ No

9. ASSIGNMENT OF RIGHTS TO THIRD PARTY PAYMENT, COOPERATION REQUIREMENT & ESTATE RECOVERY REQUIREMENT

- Medicaid does not pay medical expenses that a third party, such as a private health insurance company, is supposed to pay. All persons applying for Medicaid benefits are required to assign the Division of Medicaid any rights they may have to medical support or other third party payments for medical care. When you sign this Application for Medicaid benefits, you are assigning the Division of Medicaid all rights to collect or receive any such payments for the time you are (were) on Medicaid.
- *I understand that by applying for Medicaid benefits I agree to cooperate with the Division of Medicaid in identifying and providing information to help pursue any third party who may be responsible for providing medical support for me. If I am signing this Application on behalf of another person, I agree to cooperate in identifying and obtaining information to pursue any third party who may be responsible for providing medical support for them.*
- I understand that if I am eligible to enroll in any insurance or benefit plan offered by my employer or my spouse's employer, I am required to enroll in that plan.
- *I understand that upon my death the Division of Medicaid has the legal right to seek recovery from my estate for services paid by Medicaid in the absence of a legal surviving spouse or a legal surviving dependent. Consideration will be made for hardship cases. An estate consists of real & personal property. The Estate Recovery provision applies to Medicaid recipients age 55 or older and in a nursing facility or enrolled in a Home & Community Based Services Waiver program at the time of death.*

10. PRIVACY ACT AND USE OF SOCIAL SECURITY NUMBERS

The Division of Medicaid is authorized to request the information on this form. The primary use of this information is to determine eligibility for Medicaid and is protected by law from disclosure to unauthorized persons. It is possible that this form may be used to determine another person's right to Medicaid benefits. Pursuant to the authority found in federal law at 42 U.S.C. 1320b-7(a) and federal regulations at 42 CFR 435.910, you are required to disclose the Social Security Number (SSN) for each person applying for Medicaid. This is a mandatory requirement in order to be eligible for Medicaid benefits, unless an applicant is a non-qualified alien seeking emergency Medicaid services. If you cannot recall the SSN for each applicant or if the applicant does not have a SSN, the agency can assist you in applying for an SSN for each applicant. If the applicant has a well established religious objection for not providing his or her SSN, he or she should state the basis for such objection and the agency will review this request. The SSN will be used to verify information such as assets, income and insurance coverage and to help maintain files regarding eligibility pursuant to the authority described in federal regulations 42 CFR 435.940 through 42 CFR 435.960. Consistent with Federal Law, Section 1940 of the Social Security Act (42 USC 1396w), which mandates asset verification services by all state Medicaid agencies, and Mississippi House Bill 1391, the the SSN will be used for electronic verification of disclosed and undisclosed assets. The SSN may also be used to match with records within the State Medicaid agency and in other state, federal, and/or local agencies, such as the Social Security Administration, Internal Revenue Services, and Employment Security as well as banks and other financial institutions.

11. APPLICANT RIGHTS, RESPONSIBILITIES AND CERTIFICATIONS

- Adults eligible for Medicaid should get a yearly health screening (physical exam) from your doctor or clinic. This exam will not count against your annual doctor visit limit, under Medicaid.
- *Information you share is confidential. Your medical information can only be released if needed to administer the Medicaid program. If you receive care or treatment under Medicaid, you authorize the health care provider to release to Medicaid your medical records and information relating to your diagnosis, examination and treatment.*
- Information that you may give may be reviewed and verified by state and federal staff. You must fully cooperate with state and federal workers if your case is reviewed. No additional permission is needed to get verification or other information.
  - *Your application will be considered without regard to race, color, sex, age, handicap, religion, national origin, political belief, or Limited English Proficiency.*
  - An annual review is required for all recipients of Medicaid. Failure to complete the review process may result in the termination of benefits for the individual(s) due for review.
  - *Face to face interviews are required for new applications and may be required for annual reviews*.
  - You may ask for a hearing if you are not satisfied with any action taken by the State of Mississippi in connection with your application for health benefits.
  - *If this Application for Medicaid or other information shows that the applicant(s) may be eligible for payments or benefits from other sources, the applicant(s) are required to apply for the benefits when notified by the Division of Medicaid*.
  - The Medicaid Regional Office must be notified immediately if there is a change in the applicant's address, living arrangement, family size, income or resources. Also, the regional office must be notified if the applicant is discharged from a hospital or nursing home or if the applicant moves from one medical facility to another.
  - *If this Application is for someone who is blind or disabled, the Regional Office must be notified of any improvement in the recipient's medical condition or if the recipient returns to work.*
  - The applicant's case may be selected for quality control purposes in a state and/or federal review. If his/her case is selected, the applicant's full cooperation is required.

  - *The following certifications must be made as a condition of Medicaid eligibility:*
    - I certify that to my knowledge the financial information I have provided above is true and correct.
    - *In addition, I further hereby authorize any financial institution to disclose information, including the amount of my deposits and any other information described in or solicited from the financial institution in this application or in the DOM330 form (Account History Request)concerning my financial accounts held by that institution to the Mississippi Division of Medicaid, or its designated agent or contractor, for the purpose of identifying and verifying my assets relevant to determination or redetermination of my eligibility for publicly funded medical assistance.*

- I understand that I may revoke this authorization at any time by notifying DOM in writing of my desire to revoke my authorization, but that the authorization for disclosure by financial institutions will otherwise be effective until (1) a final, adverse decision is rendered on my application for medical assistance, (2) my eligibility for medical assistance ends, or (3) I revoke my authorization, whichever occurs earlier.
- *I understand that my eligibility for medical assistance cannot be determined or redetermined, absent my authorization or my spouse's authorization of financial disclosures by financial institutions, and that revocation of such authorization would prevent me from being determined or redetermined to be eligible for such medical assistance.*
- I further understand that this authorization of information disclosure by me does not alter or waive my right under the Right to Financial Privacy Act, 12 U.S.C. 3401 et seq., except to the extent that certain such rights may be modified by the asset verification provisions of Section 1940 of the Social Security Act, 42 USC 1396w.

12. SIGNATURE(S)

I certify that the information I have provided above is true to the best of my knowledge, and I give permission for the State of Mississippi to make any necessary contact to check my statements. I have read the list of my rights, responsibilities, and certifications that is printed above. If I knowingly give false statements or leave out information asked for on this application, such as income or household members, I commit a crime that is punishable under federal and/or state law.

Do you accept these responsibilities and agree to notify the Medicaid Regional Office of any and all changes listed above? ❑ Yes ❑No

_____

Signature of 1st Applicant or designated representative *Date*

_____

Signature of 2nd Applicant (if appropriate) *Date*

_____

Signature of Non-Applicant Spouse or Parent (if appropriate) *Date*

_____

Signature of Witness (if anyone signs with a mark) *Date*

The Division of Medicaid complies with all state and federal policies which prohibits discrimination on the basis of race, age, sex, national origin, handicap or disability as defined through The Americans with Disabilities Act of 1990, the Rehabilitation Act of 1973 and the Civil Rights Act of 1964.