



MEDICAID/MEDICARE BUY-IN APPLICATION

	nic Informatio all information for y		spouse. If no	spouse,	indicate	e "None"			
Your Name (A				- N 41	1				
V	First			MI	Last		o.		
Your S	Social Security Number	er:					Sex: Male	e Female	•
Name of	f Spouse: First			MI	Last				
0							Sex:	Male Fe	male
	oouse live together?						_		
Your Medicar	re claim number:								
Spouse's Medicare	e # (if applying):								
Living Address: _	Niversia	Chroat		A t. 44		Cit.		7:- 0-4-	
Mailing Address: _	Number	Street		Apt #		City		Zip Code	
Walling Address	Number	Street		Apt #		City		Zip Code	
Telephone Number	r: Telephone #								
Contact Person: _(Other than Yourself)	First	l	.ast			MI			
_	Number	Street		Apt #		City		Zip Code	
_	Telephone #						Date Stamp:	(Official DCF	use only
Relationship of Cor	ntact Person to you:								
	lity determined for the e the month of applicantion:		s No						
Please complete a	all information for yo	ou and your sp	oouse.						
Date of Birth: _	You	Spo	use						
Are you a U.S. C	itizen? You: Yes	No	Spouse:	Yes	No				
If not a citizen, prov	vide alien number and	status:	You			;	Spouse	(if applying)	
Do you intend t	o remain in the State	of Florida?	You: Yes	No		Spouse:			
	use have any other ins ne following informatio		han Medicare?	You:	Yes	No	Spous	e:	No No
Name of Other Insura	ance Company						Othe	r Insurance Pol	icy Number

Asset Information: Please list all assets owned by you and/or spouse (even if your spouse is not applying).

TYPE	NAME OF BANK/ FINANCIAL INSTITUTIO	N ADDRESS	ACCOUNT NUMBER	VALUE OF ASSET	IN WHOSE NAME IS IT HELD		
CASH							
SAVINGS ACCOUNT							
CHECKING ACCOUNT							
CAR Make/Model/Year:							
HOMESTEAD							
OTHER PROPERTY							
TRUST FUND							
STOCKS/BONDS							
TAX SHELTERED ACCOUNTS							
LIFE INSURANCE							
KEOGH PLAN							
Other: Please Specify							
Income Inform	nation' Plassa com	nlote all information for	you and your spouse (e	yon if enouse is	not anniving)		
Are you or your spouse		piete ali illiorillation loi	you and your spouse (e	ven n spouse is	посаррупіду.		
Applicant			Spouse				
Yes		ross Amount rned Monthly	Yes	No Gross Amount Earned Monthly			
Do you or your spouse	work for someone else?	-			-		
Applicant			Spouse				
Yes		ross Amount rned Monthly	Yes	No	Gross Amount Earned Monthly		
Do you or your spouse	receive income from any	of the following?		Gross Amount Received Each Month (Before Any Deductions)			
Туре		Benefit No.	Applicant	Spouse			
Veterans Benefits							
Pension							
Interest/Dividends							
Civil Service Annuity							
Income from another person							
Black Lung							
Social Security							
Other (e.g. SSI, Annuit	ies): (specify)						

Date:

YOUR RIGHTS AND RESPONSIBILITIES: Read this sheet before you sign your name.

YOU HAVE THE RIGHT TO:

- Apply for assistance and have a determination of your eligibility made without regard to race, color, sex, age, handicap, religion, national origin, marital status or political belief.
- Have a representative help you fill out the eligibility forms.
- Have action taken on your application promptly and be notified of such action.
- Be informed of other available services of the Department of Children and Families.
- Request a fair hearing when you disagree with a decision of the Department of Children and Families.
- Have the information about you and/or your spouse that is collected by the department treated confidentially in accordance with federal and state laws.

YOU HAVE THE RESPONSIBILITY TO (things you must do):

- Assist in determining your eligibility by giving complete and correct information and provide written proof of information, as requested, within the time limits given.
- Declare the citizenship or alien status for you and your spouse by signing the Medicaid/Medicare Buy-In Application.
- File for any payments or benefits from other sources if this application, or other information, indicates that you or your spouse may be eligible for such payments or benefits.
- Assign your rights to third party benefits and cooperate in reporting any insurance or other health plan that covers medical costs
 for you (and/or your spouse, if applying) unless good cause can be shown not to do so.
- Report changes in your situation (e.g., income, assets) within 10 days of the change.

Signature of Individual Who Assisted Applicant in Completing Buy-In Application Form

 Report your (and your spouse's, if applying) Social Security numbers. Without accurate numbers, we will be unable to provide Medicaid/Medicare buy-in benefits if you are determined eliqible for any benefits.

IMPORTANT INFORMATION ABOUT MEDICAID:

Any person (including the designated representative) who knowingly withholds information or knowingly misrepresents the truth may be punished under federal or state law or both. If you get medical assistance for which you do not qualify, you may have to repay the cash value of that assistance.

Certification of Citizenship/Alien Status: I certify, under the penalty of perjury, by signing my name on this application, that I and my spouse (if applicable) are U.S. citizens or nationals of the United States or qualified aliens.				
Certification: In signing this application, I swear and affirm, under penalty of perjury, that the information I have given on this application is correct and complete to the best of my knowledge. I have read and understand the above rights and responsibilities and important information about Medicaid.				
Applicant Signature:	Date:			
Spouse Signature:	Date:			
Designated Representative Signature:	Date:			
HELPING PERSON: (Official use only)				

In accordance with Federal law and our policy, the Department of Children and Families is prohibited from discriminating on the basis of race, color, national origin, sex, age, disability, religion, political belief, or marital status.