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MARYLAND DEPARTMENT of HUMAN RESOURCES

MARYLAND DEPARTMENT of HEALTH and MENTAL HYGIENE

LONG-TERM CARE/WAIVER MEDICAL ASSISTANCE APPLICATION

Date Signed Application Received in Local Department MUST BE DATE STAMPED

FOR WORKER USE ONLY *This part is for our staff. Please continue to Section A.*	LDSS Office Worker's Name Application Date	Programs Applied For or Receiving	Assistance Unit IDs Client ID
	Program Medical Coverage Group _____ AU ID _____		

SECTION A – BENEFIT SELECTION: *Please tell us about which benefits you want and which benefits you already have.*

I am applying for:
- ☐ Long-Term Care
- ☐ Waiver

Do you need Medical Assistance for medical bills incurred in the past 3 months?
If yes, you will need to provide copies of the bills to your case manager.

☐ YES ☐ NO

Tell us if you are currently receiving other assistance. I currently receive:
- ☐ Medical Assistance ID # _____
  If you already receive Medical Assistance, please provide your ID number.
- ☐ Cash Assistance
- ☐ Food Stamps
- ☐ Other, list: _____
  If you receive any other benefits, please list all the benefits here.

SECTION B – APPLICANT INFORMATION: *Please tell us about yourself.*

Last Name	First Name	Middle Name	Suffix	Maiden Name or Other Name
_____	_____	_____	_____ *(Jr., Sr., etc.)*	_____

Social Security Number:
If you have a Social Security Number, enter it here.

_____

Additional Social Security Number:
If you have an additional Social Security Number, enter it here.

_____

Date of Birth: (Month,Day,Year)

_____

Gender: ☐ Male ☐ Female

SECTION B – APPLICANT INFORMATION (continued)

Ethnicity
Optional

☐ 1 – Hispanic or Latino

☐ 2 – Not Hispanic or Latino

Race
Optional – Please choose all race codes that apply to you.

☐ 1 – American Indian/Alaskan Native
☐ 2 – Asian
☐ 3 – Black/African American
☐ 4 – Native Hawaiian/Pacific Islander
☐ 5 – White

You do not have to give information about your race or ethnicity. If you do, it will help show how we obey the Federal Civil Rights Law. We will not use this information to decide if you are eligible. If you do not give us your race, it will not affect your application. The case manager will enter a race code for statistical purposes only. Title VI of the Civil Rights Act of 1964 allows us to ask for this information.

Are you a resident of Maryland? ☐ YES ☐ NO

Marital Status
☐ Single
☐ Married
☐ Divorced
☐ Separated
☐ Widowed

Are you receiving Medical Assistance (Medicaid) benefits from another state? ☐ YES ☐ NO

If yes, please list the state: _____

Are you a U.S. Citizen? ☐ YES ☐ NO

If you answered NO, please complete SECTION C – IMMIGRATION STATUS, below.

What is your primary language? _____

Do you need an interpreter? ☐ YES ☐ NO

If you are not registered to vote, would you like to receive a voter registration form? ☐ YES ☐ NO ☐ Already registered to vote

SECTION C – IMMIGRATION STATUS (FOR NON-CITIZENS ONLY)

SEND PROOF *Please send a photocopy of the front and back of your INS card.*

What is your current INS Status?	On what date did you receive your INS Status?	Are you a Sponsored Immigrant?	What is your Country of Origin?
_____	_____/_____/_____	☐ YES ☐ NO	_____

When did you enter the U.S.?	What is your INS Number?	If you are a refugee, please list your Refugee Resettlement Agency:
_____/_____/_____	_____	_____

SECTION D – CURRENT ADDRESS of HOME or INSTITUTION/LONG-TERM CARE FACILITY: *Please tell us about your Long-Term Care Facility, if you live in one.*

If you live in a facility, what is the name of the facility?

_____

On what date did you enter the facility?

_____/_____/_____

What is your home address or the address of your facility?

Street _____

City _____ State _____ ZIP _____

Telephone # _____ Cellular Telephone # _____

Is this your mailing address? ☐ YES ☐ NO If you checked NO, please provide your mailing address information in Section V.

Do you (applicant/recipient) intend to return home? ☐ YES ☐ NO

Do you (applicant/recipient) intend to return home within 6 months? ☐ YES ☐ NO

SECTION E – PREVIOUS ADDRESSES: *Please tell us where you have lived for the past five years.*

Street _____

City _____ State _____ ZIP _____

Did you or your spouse own this home? ☐ YES ☐ NO

Street _____

City _____ State _____ ZIP _____

Did you or your spouse own this home? ☐ YES ☐ NO

Street _____

City _____ State _____ ZIP _____

Did you or your spouse own this home? ☐ YES ☐ NO

Street _____

City _____ State _____ ZIP _____

Did you or your spouse own this home? ☐ YES ☐ NO

SECTION F – AUTHORIZED REPRESENTATIVE: Do you authorize someone to represent you in this application? If so, please tell us about your authorized representative.

First Name	Middle Name	Last Name	Suffix
_____	_____	_____	_____ *(Jr., Sr., III, etc.)*

Address _____

City_____State_____ZIP_____

SECTION F – AUTHORIZED REPRESENTATIVE (continued)

☐ Home Telephone #_____

☐ Cellular Telephone #_____

☐ Work Telephone #_____

What is the authorized representative's relationship to you?

_____

If answer is spouse, please complete the next question:

Do you or your spouse own this home? ☐ YES ☐ NO

If Authorized Representative is your spouse,
please provide spouse's Social Security Number: _____

SECTION G – SPOUSAL INFORMATION: *Please tell us about your spouse. Leave this section blank if your spouse is listed as your Authorized Representative in Section F.*

Last Name	First Name	Middle Name	Suffix	Maiden Name or Other Name
_____	_____	_____	_____ *(Jr., Sr., etc.)*	_____

Spouse's Social Security Number _____

Street _____

City _____ State _____ ZIP _____

Telephone # _____

Do you or your spouse own this home?
☐ YES ☐ NO

SECTION H – DISABILITY: *Please tell us about your disability, if you have one.*

Are you disabled? ☐ YES ☐ NO

If yes, when did the disability begin?

_____/_____/_____

What is your disability?

_____

_____

Premium Amount

Do you receive Medicare Part A? ☐ YES ☐ NO $ _____

Do you receive Medicare Part B? ☐ YES ☐ NO $ _____

Do you receive Medicare Part C? ☐ YES ☐ NO $ _____

Do you receive Medicare Part D? ☐ YES ☐ NO $ _____

SEND PROOF *Please send verification of the premium amounts you pay*

If yes, please provide your Medicare Claim Number: _____

SECTION I – VETERAN INFORMATION: *If you are a veteran, a disabled widow(er), or a disabled child of a deceased veteran, fill in this section:*

SEND PROOF *Please send a photocopy of the front and back of your military service card.*

Veteran's Name	Relationship to Veteran	Veteran's Status	Military Service Number
_____	_____	_____	_____

SECTION J – MEDICAL INSURANCE: *If the applicant/recipient is insured, fill in this section: If you have more than one policy, place additional information in Section V.*

SEND PROOF *Please send a photocopy of the front and back of your insurance card(s) and verification of the premium amounts you pay.*

Policy Number	Group Number	Policy Holder Name
_____	_____	_____

Relationship to Policy Holder	Policy Effective Dates
	From: _____ To: _____

Policy Holder Address

Street_____

City_____ State _____ ZIP_____ Telephone _____

Insurance Company

Insurance Company Name _____

Street _____

City _____ State _____ ZIP_____ Telephone _____

Union

Union Name _____ Union Local Number _____

Street _____

City _____ State _____ ZIP_____ Telephone _____

SECTION K – INCOME FROM WORKING: *Please tell us about any income you or your spouse are currently receiving from working, including any sick leave payments.*

SEND PROOF *Please send copies of any proof of pay, such as a paystub. If you need additional space to complete this section, please use Section V or attach additional sheets.*

Employer Name _____	Type of Job _____

Employer Address _____

City_____ State_____ ZIP_____

Telephone # _____

Date Job Began_____	Date Job Ended_____	Gross Wages per Pay Period, including tips and commissions. $_____ per _____
Hours per Pay Period _____	How often do you get paid? ☐ Weekly ☐ Biweekly ☐ Monthly	If the job has ended, what is your last expected pay date? _____

SECTION L – YOUR BENEFITS AND OTHER INCOME: *Please tell us about any income or benefits that you are receiving, have applied for, or have been denied.*

SEND PROOF *Please send current copies of statements that verify the gross amount of income you receive.*

TYPE OF BENEFIT OR INCOME	RECEIVING INCOME OR BENEFITS?	AMOUNT	APPLICATION STATUS	APPLICATION DATE OR DENIAL DATE
Social Security Please write your claim number:	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Black Lung Benefits	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
SSI (Supplemental Security Income) Please write your claim number:	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Veteran's Pension/Benefits	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Pension or Retirement	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Civil Service Annuity	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Railroad Retirement Benefits Please write your claim number:	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Alimony	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	

SECTION L – YOUR BENEFITS AND OTHER INCOME (continued)

TYPE OF BENEFIT OR INCOME	RECEIVING INCOME OR BENEFITS?	AMOUNT	APPLICATION STATUS	APPLICATION DATE OR DENIAL DATE
Worker's Compensation	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Disability/Sick Benefits	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Union Benefits	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Unemployment Benefits	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Lump Sum Cash Amounts	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Interest/Dividends from Stocks, Bonds, Savings, or other investments	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Business Income	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Other (e.g., ☐ Rental Income, or ☐ Compensation from a Legal Settlement)	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Other Please describe:	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	

SECTION M – ASSETS: *Please tell us about your assets as of the first day of this month. Check YES or NO for each ASSET TYPE. If you check YES, fill in the other boxes. List all assets owned by you or your spouse individually, jointly, or with other persons. If you have more than one asset of the same type, use the "Other" boxes at the bottom of the list.*

SEND PROOF *Please send copies of current statements that verify the value of the assets.*

ASSET TYPE	CHECK ONE	OWNER	AMOUNT	ACCOUNT NUMBER	INSTITUTION NAME
Cash on Hand	☐ YES ☐ NO		$		
Checking Account	☐ YES ☐ NO		$		
Savings Account	☐ YES ☐ NO		$		
Credit Union Account	☐ YES ☐ NO		$		
Trust Fund	☐ YES ☐ NO		$		
IRA or Keogh Account	☐ YES ☐ NO		$		
Other Retirement Accounts	☐ YES ☐ NO		$		
Stocks and Bonds	☐ YES ☐ NO		$		

SECTION M – ASSETS (continued)

ASSET TYPE	CHECK ONE	OWNER	AMOUNT	ACCOUNT NUMBER	INSTITUTION NAME
Treasury or Other Notes	☐ YES ☐ NO		$		
Annuity	☐ YES ☐ NO		$		
Ownership in a Company	☐ YES ☐ NO		$		
Patient Fund Account	☐ YES ☐ NO		$		
Other _____	☐ YES ☐ NO		$		
Other _____	☐ YES ☐ NO		$		
Other _____	☐ YES ☐ NO		$		
Other _____	☐ YES ☐ NO		$		

SECTION N – OTHER ASSETS: *Please tell us about any other assets you own and assets jointly owned with other individuals. This could include livestock, recreational vehicles, or any other property of value such as collections of antiques, coins, jewelry, or stamps.*

SEND PROOF *Please send copies of current statements or documents that establish the fair market value of the asset(s) as well as the amount owed.*

ASSET TYPE	CURRENT FAIR MARKET VALUE	CURRENT AMOUNT OWED	OWNER(S)
	$	$	
	$	$	

SECTION O – POTENTIAL ASSET OR INCOME: *Please tell us about any accident settlement, trust fund, inheritance, or any other money, property, real property, or assistance you expect to receive.*

SEND PROOF *Please send copies of current statements or documents that describe the nature, amount, and payment schedule of the asset.*

Asset Type	Lawyer Name
_____	_____

SECTION O – POTENTIAL ASSET OR INCOME (continued)

Explanation ______________________________	Lawyer Telephone # ______________________
Anticipated Date of Receipt ______________________________	

SECTION P – REAL PROPERTY: *Please tell us about any real property that you own in or out of the state of Maryland.*

SEND PROOF *Please send a copy of the deed to each property. Please also send copies of current documents that verify the equity value of each property.*

Do you and/or your spouse own or have a legal interest in any other real property? ☐ YES ☐ NO
If yes, please answer the following questions:

ADDRESS OF PROPERTY	TYPE OF OWNERSHIP (CHECK ONE)	CURRENT FAIR MARKET VALUE	CURRENT AMOUNT OWED
	☐ Rental Property ☐ Vacation Property ☐ Time Share ☐ Vacant Land ☐ Other Property Rights ☐ Burial Plot	$	$
	☐ Rental Property ☐ Vacation Property ☐ Time Share ☐ Vacant Land ☐ Other Property Rights ☐ Burial Plot	$	$
	☐ Rental Property ☐ Vacation Property ☐ Time Share ☐ Vacant Land ☐ Other Property Rights ☐ Burial Plot	$	$
	☐ Rental Property ☐ Vacation Property ☐ Time Share ☐ Vacant Land ☐ Other Property Rights ☐ Burial Plot	$	$

SECTION Q – LIFE INSURANCE AND FUNERAL PLANS: *Please tell us about any life insurance or pre-paid burial plans or funds that you own. Please list all policies and funds, no matter who pays for them.*

SEND PROOF *Please send a copy of the declaration page of each policy. Please also send copies of current statements to verify the cash value of each policy, if applicable.*

ORIGINAL FACE VALUE OR VALUE OF PLAN	CASH VALUE	TYPE OF PLAN	POLICY NUMBER OR ACCOUNT NUMBER	POLICY OWNER	COMPANY, FUNERAL HOME, OR BANK NAME
$	$	☐ Life Insurance ☐ Burial Plan			
$	$	☐ Life Insurance ☐ Burial Plan			
$	$	☐ Life Insurance ☐ Burial Plan			

SECTION R – TRANSFER OF ASSETS: *Please tell us about any assets that you sold, traded, gifted, or disposed of in the past five years. This could include personal and real property, motor vehicles, stocks, bonds, cash, or other assets.*

SEND PROOF *Please send copies of current statements or documents that verify the date the asset was transferred, the value of the asset at the time of the transfer, and the amount you received for the transferred asset. If you need additional space to complete this section, please use Section V or attach additional sheets.*

TRANSFER DATE	TYPE OF ASSET	VALUE OF THE ASSET AT THE TIME OF THE TRANSFER	WHO RECEIVED THE ASSET AND THE REASON FOR THE TRANSFER	AMOUNT RECEIVED
				$
				$
				$

SECTION S – SPOUSAL BENEFITS AND OTHER INCOME: *Please tell us about any income or benefits that your spouse is receiving, has applied for, or has been denied.*

SEND PROOF *Please send current copies of statements that verify the gross amount of income your spouse receives.*

TYPE OF BENEFIT	RECEIVING BENEFITS?	AMOUNT	APPLICATION STATUS	APPLICATION DATE OR DENIAL DATE
Social Security Please write your claim number:	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Black Lung Benefits	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
SSI (Supplemental Security Income Please write your claim number:	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	

SECTION S – SPOUSAL BENEFITS AND OTHER INCOME (continued)

TYPE OF BENEFIT	RECEIVING BENEFITS?	AMOUNT	APPLICATION STATUS	APPLICATION DATE OR DENIAL DATE
Veteran's Pension/Benefits	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Pension or Retirement	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Civil Service Annuity	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Railroad Retirement Benefits Please write your claim number:	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Alimony	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Worker's Compensation	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Disability/Sick Benefits	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Union Benefits	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Unemployment Benefits	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Lump Sum Cash Amounts	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Interest/Dividends from Stocks, Bonds, Savings, or other investments	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Other Please describe:	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Other Please describe:	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Other Please describe:	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	

SECTION T – SPOUSAL NEEDS (SPOUSAL IMPOVERISHMENT): *If you have a living spouse, fill in this section. List all assets owned in the month the applicant was admitted to a long-term care facility. Include all assets owned individually or jointly by the applicant, or owned individually or jointly by your spouse.*

SEND PROOF *Please send copies of statements that verify the value of the assets.*

ASSET TYPE	CHECK ONE	OWNER	AMOUNT	ACCOUNT NUMBER	INSTITUTION NAME
Cash on Hand	☐ YES ☐ NO		$		
Checking Account	☐ YES ☐ NO		$		
Savings Account	☐ YES ☐ NO		$		

SECTION T – SPOUSAL IMPOVERISHMENT (continued)

ASSET TYPE	CHECK ONE	OWNER	AMOUNT	ACCOUNT NUMBER	INSTITUTION NAME
Credit Union Account	☐ YES ☐ NO		$		
Trust Fund	☐ YES ☐ NO		$		
IRA or Keogh Account	☐ YES ☐ NO		$		
Other Retirement Accounts	☐ YES ☐ NO		$		
Stocks and Bonds	☐ YES ☐ NO		$		
Certificates and Money Market Funds	☐ YES ☐ NO		$		
Treasury or Other Notes	☐ YES ☐ NO		$		
Annuity	☐ YES ☐ NO		$		
Ownership in a Company	☐ YES ☐ NO		$		
Other _____	☐ YES ☐ NO		$		
Other _____	☐ YES ☐ NO		$		
Other _____	☐ YES ☐ NO		$		

SECTION U – RESIDENTIAL, SPOUSAL, OR DEPENDENT ALLOWANCE

Have you or your spouse been in an institution/Long-Term Care Facility in the past? ☐ YES ☐ NO

If yes, please provide the following:

Date Entered Institution/
Long-Term Care Facility _____ Name of the Facility _____

Is there a spouse, child under 21, or any other dependent relatives at home? ☐ YES ☐ NO

If YES, fill in the section below. If you need additional space for assets for dependent children and relatives at home, please use Section V or attach additional sheets.

NAME	RELATIONSHIP	AGE	GROSS MONTHLY INCOME SEND PROOF	TYPE OF INCOME	VALUE OF ASSET SEND PROOF	ASSET TYPE
			$		$	

SECTION U – RESIDENTIAL, SPOUSAL, OR DEPENDENT ALLOWANCE (continued)

NAME	RELATIONSHIP	AGE	GROSS MONTHLY INCOME SEND PROOF	TYPE OF INCOME	VALUE OF ASSET SEND PROOF	ASSET TYPE
			$		$	
			$		$	

If applicant/recipient intends to return home within six months and if there is no spouse, child under 21, or other dependent relatives, fill in the section below:

SEND PROOF *Please provide your most recent statements to verify the expenses you listed below:*

Rent/Mortgage $_____	Utilities $_____	Heat (if separate from utilities) $_____	Property Taxes $_____
Home Owner's Insurance $_____	Condo Fees $_____	Other Shelter Costs (Specify) $_____	Other Shelter Costs (Specify) $_____

SECTION V – ADDITIONAL INFORMATION: *Please use this area for any information that would not fit in the spaces provided on this application.*

SECTION W – TAX RETURNS: *Please tell us about any tax returns filed by you and/or your spouse in the last five years.*

Did you or your spouse file Federal income tax returns in the last five years? ☐ YES ☐ NO

SEND PROOF *Please send copies of Federal tax returns for the current year and the preceding four years, including all forms and schedules.*

SECTION X – PRE-ELIGIBILITY MEDICAL EXPENSES (NON-COVERED SERVICES): *Please tell us about any unpaid medical bills that you incurred in the last three months. You may be eligible for deductions from your income.*

Do you have any unpaid medical bills that you incurred in the last three months? ☐ YES ☐ NO

SEND PROOF *If you answered yes, provide a newly dated, itemized, unpaid medical bill(s) that you incurred up to three months prior to this application. The bill must contain a service date, charge, and a detailed description of the service(s) provided. Attach copies of the bill(s) to the form and submit them with your Long-Term Care Medical Assistance application. If you do not have the bills at the time you submit the application, the bills may be submitted at a later date during this application process.*

Please check one of the YES or NO choices below and sign where you have indicated your choice:

☐ YES, I HAVE unpaid medical bills from the last three months.

☐ I am sending copies of my bills with this application.

☐ I will send copies of my bills at a later date during this application process.

Signature: _____ (Applicant)

Date: _____

Signature: _____ (Authorized Representative)

Date: _____

☐ NO, I DO NOT HAVE unpaid medical bills at this time.

Signature: _____ (Applicant)

Date: _____

Signature: _____ (Authorized Representative)

Date: _____

RIGHTS AND RESPONSIBILITIES

I UNDERSTAND I HAVE THE FOLLOWING RIGHTS:

- **The Department cannot discriminate against me.** Federal and State law prohibit the Department from discriminating against me because of race, color, national origin, sex, age, or disability. If I think the Department has discriminated against me, I may contact the U.S. Department of Health and Human Services at: HHS, Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or by calling 202-619-0403 (voice) or 202-619-3257 (TDD).
- **I have the right to privacy of my personal information.** I am providing personal information (that includes, but is not limited to: name, address, date of birth, Social Security number, income history, employment history, medical history) in this application for Medical Assistance. The purpose of requesting this personal information is to determine my eligibility for Medical Assistance. If I do not provide this information, the Department may deny my application for benefits. I have a right to inspect, amend, or correct this personal information. The Department will not permit inspection of my personal information, or make it available to others, except as permitted by Federal and State law. I understand, however, that the Department may deny my application for Medical Assistance if I do not provide this information.
- **If my case is approved, the Department will provide me with a written notice explaining my benefits.** The Department must give me written notice when it changes my benefits or, determines that I am ineligible for Medical Assistance. I have 90 days from the date of the notice to request a hearing. If I am already receiving benefits and request a hearing within 10 days from the date of the notice, I may continue to receive benefits while I wait for the hearing. Any erroneous benefits I receive from the Department must be repaid to the Department.
- **I have the right to appeal certain actions taken by the Department.** I can request a hearing if: my application for Medical Assistance eligibility is denied; I assert the Department's decision about Medical Assistance services was erroneous; or, there was a delay in the Department's action(s) related to my application. I may call the Department at 1-800-332-6347 for help requesting a hearing. I am responsible for providing the reason for requesting a hearing. At the hearing, I may speak for myself or I may be accompanied by a lawyer, friend, or relative to speak on my behalf.

IF I ACCEPT MEDICAL ASSISTANCE, I UNDERSTAND BY SIGNING THIS APPLICATION:

- **Payment Authorization** - I authorize payment under Medicare Part B to be made directly to health care providers and medical suppliers.
- **Assignment of Health Insurance/Third Party Payments** - I assign all rights, title, and interest of health insurance payments I may have to the Department and give the Department the right to seek payment from private or public health insurance and any liable third party for the costs the Department incurs for the benefits I receive under Medical Assistance. The Department may seek payment without legal action, providing it does not keep more than the amount Medical Assistance paid. I agree to promptly forward, to the Department, any health insurance payments I receive, including payments received as a settlement from an accident.
- **Access to Records** - I give the Department the right to inspect, review, and copy all relevant portions of my medical records for purposes of determining my eligibility for, and for determining the appropriateness of the services received through, the Medical Assistance program.
- **Quality Review Cooperation** - I understand that the Department may select my case for a random check or audit for quality control purposes. I agree to allow any representative from the Department to visit me where I reside. I will fully assist the Department in retrieving all proof needed from any source.
- **Estate Recovery** - I understand that the Department may recover, from the estate of a deceased Medical Assistance recipient, Medical Assistance payments made on his or her behalf on or after the person attained age 55. The Department may recover only if there is no surviving spouse, unmarried child younger than 21, or blind or disabled child (married or unmarried) of any age.
- **Accurate and Confidential Application Information** - I acknowledge that I must provide true, correct, and complete information and provide proof of this information.

- **Social Security Number(s)** - I must provide my (and my spouse's) Social Security number as an applicant for Medical Assistance. The Department will use the Social Security number(s) and other information I provide to verify the information I provide for program reviews. The Department will do this to make sure I am eligible. The Department may also verify my information by contacting my employer, bank, or other parties; and/or, the Department may contact local, State, or Federal agencies to make sure the information I provide is correct. If I do not have a Social Security number, I must apply for one and the Department can provide assistance in applying for a number.
- **Accurate Financial Reporting** - I understand that I am responsible for reporting true, correct, and complete financial information. This includes, but is not limited to information about: all my assets; potential assets; transfer of assets within the last 5 years of my initial application; transfer of assets within the last 12 months of the date of the annual redetermination of my eligibility; income; insurance; real property; annuities; and all other benefits I may be receiving. I understand that Federal law requires that, as a condition of receiving long-term care services, the Department must be named, in my annuity, as the primary remainder beneficiary.
- **Report Changes** - I am responsible for reporting changes in my situation. I must report changes within 10 days. The best way for me to report changes is in writing. Examples of changes in my situation are changes in my income, assets, address, health insurance premiums, or persons living in my home. My representative (person acting on my behalf who may file my application) is responsible for reporting such changes. Changes must be reported to the appropriate Local Department of Social Services or the Bureau of Long-Term Care Eligibility.
- **Medical Assistance Card Misuse** - If I become eligible for Medical Assistance, I must use my Medical Assistance card properly. It is against the law to allow another person to use my card.
- **Medical Assistance Fraud** - If I do not report true, correct, and complete information, or report changes, the Department may deny, stop, or reduce my benefits. A judge may fine me and/or imprison me if I intentionally do not give correct information or report changes.

SIGNATURES:

I swear or affirm that I have read or had read to me this entire application. I also swear or affirm, under penalty or perjury, that all the information I have given is true, correct, and complete to the best of my ability, knowledge and belief. I have received a copy of my rights and responsibilities. I authorize any person, partnership, corporation, association, or governmental agency which knows the facts relevant to determining my eligibility to release that information to the Department. I also authorize the Department to contact any person, partnership, corporation, association, or governmental agency that has provided information relevant to my eligibility for benefits. I certify, under penalty of perjury, by signing my name below, that the person for whom I am applying is a U.S. citizen or lawfully admitted immigrant.

Signature of Applicant/Recipient _____ Date_____

Signature of Witness (If you Signed an X) _____ Date_____

Signature of Spouse (If applicable) _____ Date_____

Signature of Authorized Representative (if applicable)_____ Date_____

☐ I withdraw my application for Medical Assistance

_____ _____

Signature of Applicant, Recipient, or Authorized Representative | Date

Signature of Case Manager	Date

DECLARATION

I swear or affirm, under penalty of perjury, that all information, including financial information, I have provided on this application is true, correct, and complete to the best of my knowledge. The requirement to report true, correct, and complete information includes the requirement to report financial changes that may affect my eligibility for benefits. Federal and State law requires that I disclose all transfers or gifting of assets within the 60 month (5 year) period prior to the month of application.

I understand that if I knowingly do not tell the truth, hide information, pretend to be someone else, or withhold information about myself (and my spouse, if any) or about the person for whom I am applying (and that person's spouse, if any), I may be breaking the law. Information provided on the application may be verified or investigated by Federal, State, and local officials including Federal and State Quality Control staff.

The consequences of not complying with the law are: my benefits may be denied; I may be required to pay back the State for benefits received; my case may be investigated for suspected fraud; and I may be prosecuted for perjury, larceny, and/or Federal health care fraud [not limited to Statute 42 U.S.C. sec. 1320a-7b(a)(ii)], which may involve a fine up to $10,000 per offense and/or federal imprisonment.

_____ _____
Signature of Applicant/Recipient Date

_____ _____
Signature of Witness (If signed with X) Date

_____ _____ _____
Signature of Spouse (If applicable) Date

_____ _____ _____
Signature of Authorized Representative (If applicable) Date