pennsylvania
DEPARTMENT OF PUBLIC WELFARE

Application for SERVICES IN YOUR HOME

This is an application for Medical Assistance benefits for services in your home. If you need this application in another language or someone to interpret, please contact your local county assistance office. Language assistance will be provided free of charge.

Esta es una solicitud de beneficios de Asistencia Médica para recibir servicios en su hogar. Si necesita esta solicitud en otro idioma o si necesita a un intérprete, por favor comuníquese con la oficina de asistencia del condado (CAO) de su zona. La asistencia bilingüe se proporcionará de manera gratuita.

នេះជាសំបុត្រដាក់ពាក្យសុំជំនួយប្រយោជន៍សំបុត្រពេទ្យដើម្បីសេវាការនៅផ្ទះរបស់លោកអ្នក។ ប្រសិនបើលោកអ្នកត្រូវការសំបុត្រដាក់ពាក្យសុំនេះជាភាសាផ្សេងទៀតឬអ្នកណាម្នាក់អោយជួយបកប្រែ សូមទាក់ទងការិយាល័យជំនួយរបស់លោកអ្នក។ ជំនួយលើការបកប្រែត្រូវផ្តល់អោយដោយឥតគិតថ្លៃ។

这是关于在您住家获得医疗补助福利服务的申请表。如果您需要其他语言的申请表或需要请人翻译，请联系您所在地区的郡县协助办事处（County Assistance Office）。可提供免费的语言协助服务。

Настоящий документ является заявлением на вступление в программу медицинской помощи (Medical Assistance). Если вам нужно данное заявление на каком-либо другом языке или переводческое обслуживание, обращайтесь в Бюро помощи графства (County Assistance Office). Помощь переводчика предоставляется бесплатно.

Đây là mẫu đơn xin hưởng những dịch vụ về phúc lợi Trợ Cấp Y Tế tại nhà. Nếu quí vị cần có mẫu đơn này bằng một thứ tiếng khác hay cần người phiên dịch, xin liên lạc với Văn Phòng Trợ Cấp Phúc Lợi Quận Hạt thuộc địa phương của quí vị. Trợ giúp về phiên dịch sẽ được cung cấp miễn phí.

QUESTIONS YOU MIGHT HAVE

1. I have a Medicare supplemental health insurance policy. Must I stop it to qualify for benefits?

   NO, your insurance is primary coverage after Medicare. Medical Assistance will cover those health care services not covered by your insurance.

2. I have some unpaid medical bills that are past due. Will Medical Assistance pay for those bills?

   YES, if you are eligible for Medical Assistance and if certain conditions are met. Coverage under Medical Assistance can cover three months prior to the month of application for Medical Assistance.

3. Must I live in Pennsylvania a certain amount of time before I can apply for health care coverage under Medical Assistance?

   NO, you can be eligible for services in your home from the day you establish residency in Pennsylvania.

4. What is the Medical Assistance Estate Recovery Program?

   If you are age 55 or older and receive long-term care services in a facility or in the community, Medical Assistance will seek reimbursement by recovering the cost of those services from the assets of your estate. This includes hospital and prescription services received while you are in a facility or while you are receiving home and community-based services. All monies collected by the Medical Assistance Estate Recovery Program are returned to the Department of Public Welfare's long-term care programs to assist others in need of long-term care services.

5. When does Medical Assistance Estate Recovery occur?

   Medical Assistance Estate Recovery happens **only** after the death of the Medical Assistance recipient.

6. Is a lien placed against my home if I receive health care services under Medical Assistance?

   NO, a lien is not placed against your home if you receive health care services under Medical Assistance. However, your home may be subject to a recovery by the Medical Assistance Estate Recovery Program as described in question 4 above.

7. Must the income of both spouses be reported when completing the application for services in your home?

   YES, the income of both spouses must be reported.

8. Must the resources of both spouses be reported when completing the application for services in your home?

   YES, the resources of both spouses must be reported.

INSTRUCTIONS FOR THE COMPLETION OF THE PA 600WP APPLICATION FOR SERVICES IN THE HOME

	APPLICANT INFORMATION
NAME	Enter your full name (First Name, Middle Initial, Last Name).
SOCIAL SECURITY NUMBER	If you do not have a Social Security Number, a number can be applied for through the CAO.
DATE OF BIRTH	Enter your date of birth. Provide a copy of your birth certificate.
MOTHER'S MAIDEN NAME, DRIVER'S LICENSE INFO, BIRTH CERTIFICATE NAME AND STATE, COUNTY, CITY OF BIRTH	Enter this information **only** if you do not have Medicare A and/or B health care coverage.
MEDICARE CLAIM NUMBER	Enter your Medicare number, if applicable.
CITIZENSHIP	Enter whether you are a U.S. citizen/legal alien (an individual who is an undocumented alien is only eligible for emergency services under Medical Assistance. Immediate services in the home may not be considered an emergency situation).
ADDRESS AND TELEPHONE NUMBER(S)	Enter your complete street address, city, state, zip code and telephone number(s).
RACE/ETHNICITY	Completion of these sections is optional.
MARITAL STATUS	Enter your current marital status.
SPOUSE'S NAME	Enter your spouse's full name (First Name, Middle Initial, Last Name).
SOCIAL SECURITY NUMBER	Enter your spouse's Social Security Number. If your spouse does not have a Social Security Number, a number can be applied for through the CAO.
DATE OF BIRTH	Enter your spouse's date of birth.
REPRESENTATIVE INFORMATION	Enter this information if someone is completing the application on your behalf.
RESOURCES (Acceptable Proof) **For all resources listed on Page 6 of the application, please enter the owner's name, the corresponding resource code, the total value, the amount owed (if any), the net value and whether documentation of the resource is provided.**	
CASH ON HAND	A written statement showing the total amount of money not in the bank or otherwise invested. **NOTE:** This would include money in a safe deposit box.
SAVINGS ACCOUNT(S) CHRISTMAS/VACATION CLUB	Photocopies of bank statements, bank books or a written statement from the financial institution that shows the account number and current account value.
CHECKING ACCOUNT(S)	Photocopies of bank statements or a written statement from the financial institution that shows the account number and current account value.
STOCKS AND/OR BONDS	A written statement from the brokerage firm, issuing agent or authority or institution where the stocks, bonds, etc. were purchased or held; or a copy of the stock certificate or bond and a statement of the value. Identify any serial numbers of bonds.
TRUST FUND	Photocopy of the trust agreement showing the terms of the trust and inventory of the trust assets; or other documentation of value.
PREPAID FUNERAL CONTRACT/IRREVOCABLE BURIAL RESERVE / REVOCABLE BURIAL RESERVE	Photocopy of the burial reserve agreement(s) or prepaid funeral contract(s).
CERTIFICATE OF DEPOSIT	Photocopy of the deposit statement from the financial institution or a written statement from the financial institution that shows the account number and current value.
ANNUITIES	Photocopy of the document that explains the terms, date of purchase and value of the annuity.
NOTES	Photocopy of any note agreements that you have and the current value of the note.
OTHER RESOURCES	Photocopy of any agreement(s) or statement(s) regarding any money or other resources not already listed.
LIFE INSURANCE	Enter the name of the insured, the name of the insurance company, the policy number, the name of the beneficiary (the name of the person who will receive the insurance payment upon your death), the face value of the policy(ies) (the amount that will be paid to your beneficiary), the cash value of the policy(ies) (if known). **Verification:** A photocopy of a document identifying ownership for each insurance policy and a written statement of current cash value from the insurance company.

RESOURCES CONTINUED	
MOTOR VEHICLES (i.e. car, truck, van, boat, snowmobile, trailer etc.)	Enter the make, model, and year of the vehicle along with the name(s) of the owner(s), amount owed (if any) and the current value. One vehicle is excluded regardless of its value. The market value of all other vehicles is counted. **Verification:** A written statement of fair market value from a dealer or Blue Book value.
RESIDENT PROPERTY	Enter the street address, city, state and zip code of your primary residence. **Verification:** not required
NON-RESIDENT PROPERTY	Enter the street address, city, state and zip code of any additional property owned. **Verification:** Real estate tax bill or a broker's statement of the fair market value of the property.

TRANSFER OF RESOURCES

Eligibility for Waiver Services under Medical Assistance **MAY** be affected if you or your spouse transferred, sold or disposed of income or resources to someone other than each other within the past 60 months. If a transfer to or from a Trust within the past 60 months was made, eligibility **MAY** also be affected for Waiver Services. Enter the appropriate yes or no responses to the questions regarding the transfer of resources and the transfer of resources used to establish a trust. If you respond yes to either question, provide additional information about the date(s) of the transfer(s) and the amount(s) transferred. Depending on the date(s) and amount(s) of the transfer(s), eligibility **MAY** be affected.

INCOME

Check yes or no to indicate the type of income you receive.
Enter any claim, file or other identifying number associated with the type of income you receive.
Enter how often the income is received. Enter **GROSS** income (amount of income before any taxes or deductions).
If the individual is under age 21, only his/her income is counted. Parental income of a child under age 21 is NOT counted.
Income includes but is not limited to: Social Security Retirement or Disability, Veteran's Benefits (VA Pension), Supplemental Security Income (SSI), Railroad Retirement (RR), Black Lung payment, Pension from employer, Wages, Dividends/Interest, and Self-employment. (If you have other types of income, you must specify the source.)
Note: While the Veteran's Benefits (VA Pension) are counted as income in determining eligibility, any portion of the VA Benefits that is allocated for Aid and Attendance or VA Housebound Allowance does not count in determining eligibility.

HEALTH INSURANCE

Enter the appropriate yes or no response regarding any other medical insurance that you have. If you indicate that you have other insurance, enter the name of the insurance company, the policy number, the type of insurance and the amount of the premium.

HELP WITH UNPAID MEDICAL BILLS

Medical Assistance may be able to help you with unpaid medical bills. Answer these questions to help the CAO determine whether you may need help with unpaid medical bills. Your response to these questions is optional.

VOTER REGISTRATION INFORMATION

The voter registration information is OPTIONAL; you can choose to apply to register now.

SIGNATURES

Prior to signing the application, you should review the Rights and Responsibilities section.
If you sign with a mark, a signature of a witness is required. If you are unable to sign, your representative may sign on your behalf.

CERTIFICATION OF CITIZENSHIP OR ALIEN STATUS

A signature is required to certify citizenship or alien status. Proof of citizenship and identity **must** be provided. This section must be signed in order for you to be eligible for Medical Assistance.
If you sign with a mark, a signature of a witness is required.
If you are unable to sign, your representative may sign on your behalf.

FINANCIAL ELIGIBILITY QUESTIONS

INCOME: Is your Total **GROSS** Monthly Income more than **$**_____ ☐ Yes ☐ No

RESOURCES: If single, is the **TOTAL VALUE** of your resources greater than **$8,000.00**? ☐ Yes ☐ No
If married, is the **TOTAL VALUE** of your resources greater than **$**_____**?** ☐ Yes ☐ No

If both total gross income and total value of resources are less than these amounts, the applicant meets the financial eligibility requirements for Medical Assistance and for services in the home.

APPLICATION FOR SERVICES IN YOUR HOME

Si necesita este información en español, llame al teléfono: 1-800-842-2020

Do you understand English? ❑ Yes ❑ No
If no, what language do you understand? _____

1. Fill out the form. Please print.
2. Please provide complete information, if known, on resources.
3. Attach proof of all income, if available.
   - Proof includes pay stubs, award letters or checks.
   - If self-employed, copies of tax returns or receipts or other records count as proof of income.
   - Attach information that shows your income before taxes and deductions.
4. Attach proof of citizenship and identity, if possible.
5. If you are applying for someone who is not a U.S. citizen, please attach proof of alien status.
6. Mail or take this form and any accompanying documents to your local county assistance office. Call 1-800-842-2020 if you do not know where to send your form.
7. If you need help with this application, please call 1-800-842-2020, or if you are hearing impaired call TDD 1-800-451-5886.

APPLICANT INFORMATION

FIRST NAME	MI	LAST NAME	SOCIAL SECURITY NUMBER	
DATE OF BIRTH	MOTHER'S MAIDEN NAME LAST NAME, FIRST NAME	ARE YOU: ❑ MALE OR ❑ FEMALE	MEDICARE CLAIM NUMBER	DRIVERS LICENSE STATE & NUMBER
NAME ON BIRTH CERTIFICATE LAST, FIRST, MIDDLE		STATE OF BIRTH*	COUNTY OF BIRTH	CITY OF BIRTH
U.S. CITIZEN ❑ YES ❑ NO	DATE ENTERED THE U.S.	FROM WHAT COUNTRY	ALIEN REGISTRATION NUMBER	INS SECTION

HOME ADDRESS	CITY	STATE	ZIP CODE
MAILING ADDRESS (if different)	CITY	STATE	ZIP CODE

HOME PHONE NUMBER	WORK PHONE NUMBER	OTHER CONTACT PHONE NUMBER

RACE (check all that apply) This is optional.
❑ African American ❑ Native Alaskan/American Indian ❑ Asian
❑ Caucasian ❑ Native Hawaiian/Pacific Islander ❑ Asian (Indian subcontinent)

ETHNICITY (optional)
❑ Hispanic ❑ Non Hispanic

CURRENT MARITAL STATUS:
❑ NEVER MARRIED ❑ MARRIED ❑ DIVORCED ❑ COMMON-LAW ❑ WIDOWED

EFFECTIVE DATE OF CURRENT MARITAL STATUS:

IF MARRIED, DO YOU AND YOUR SPOUSE LIVE TOGETHER? ❑ YES ❑ NO

IF NO, DATE OF SEPARATION:

SPOUSE INFORMATION

SPOUSE'S LAST NAME FIRST NAME M.I.	SOCIAL SECURITY NO.	DATE OF BIRTH

SPOUSE'S ADDRESS IF DIFFERENT (STREET AND CITY)	STATE	ZIP CODE	SPOUSE'S TELEPHONE NO.

REPRESENTATIVE'S FIRST AND LAST NAME	REPRESENTATIVE'S RELATIONSHIP TO YOU	REPRESENTATIVE'S PHONE NUMBER

REPRESENTATIVE'S MAILING ADDRESS: STREET	CITY	STATE	ZIP CODE

* If born in a territory of the United States, list the territory.

RESOURCES

YOUR INFORMATION IS CONFIDENTIAL FOR USE ONLY BY THE DEPARTMENT OF PUBLIC WELFARE

List all resources owned by you and your spouse (if applicable). **IF THE APPLICATION IS FOR A CHILD UNDER AGE 21, RESOURCES OF THE CHILD AND THE RESOURCES OF THE PARENT(S) OF THE CHILD DO NOT COUNT.**

PLEASE PROVIDE VERIFICATION FOR EACH RESOURCE LISTED BELOW AND ON PAGE 7 WHEN YOU APPLY, IF POSSIBLE. ACCEPTABLE VERIFICATION IS LISTED ON THE INSTRUCTIONS FOR COMPLETION OF THE PA 600WP. YOU WILL BE ***REQUIRED*** TO PROVIDE VERIFICATION OF EACH RESOURCE LISTED ON THIS APPLICATION FORM AT A LATER DATE.

OWNER(S) OF RESOURCE LAST NAME FIRST NAME M.I.	RESOURCE CODE	TOTAL VALUE	AMOUNT OWED	NET VALUE	DOCUMENTED	
					YES	NO

IF YOU NEED ADDITIONAL SPACE, USE NOTES/ADDITIONAL INFORMATION SECTION OF THE FORM

ENTER THE TWO DIGIT CODE IN THE "RESOURCE CODE" COLUMN THAT BEST DESCRIBES THE RESOURCE THAT YOU ARE IDENTIFYING

01 CASH ON HAND
02 SAVINGS ACCOUNT(S)
03 CHECKING ACCOUNT(S)
04 CHRISTMAS/VACATION CLUB
05 STOCKS OR BONDS
06 TRUST FUND
07 IRREVOCABLE BURIAL RESERVE
26 SAVINGS CERTIFICATE
27 IRA OR KEOGH
30 PENSION FUNDS (INCLUDING 401K)
31 REVOCABLE BURIAL RESERVE
99 OTHER (INCLUDING ANNUITIES)

LIFE INSURANCE - COMPLETE THE INFORMATION BELOW FOR EACH LIFE INSURANCE POLICY								
NAME OF INSURED	INSURANCE COMPANY	POLICY NUMBER	NAME OF BENEFICIARY	FACE VALUE	CASH VALUE	DATE ACQUIRED	DOCUMENTED	
							YES	NO

VEHICLES (car, truck, van, motorcycle, other vehicle, etc.)

TYPE OF VEHICLE	MAKE	MODEL	YEAR	LICENSED		LICENSE #	STATE	OWNER/JOINT OWNERS	AMOUNT OWED	CURRENT VALUE
				YES	NO					

Has documentation of any vehicle(s) been provided? ❑ Yes ❑ No

Do you own any property including a home, mobile home, land or other buildings? ❑ Yes ❑ No
If yes, complete the following:

ADDRESS/LOCATION OF RESIDENT PROPERTY:			ADDRESS/LOCATION OF NON-RESIDENT PROPERTY:		
STREET ADDRESS			STREET ADDRESS		
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE
OWNER(s):			OWNER(s):		
Is this your home? ❑ Yes ❑ No			Is the property listed for sale? ❑ Yes ❑ No		
Is the property listed for sale? ❑ Yes ❑ No					
Do you get income from the property? ❑ Yes ❑ No					

TRANSFER OF RESOURCES

1. Within the past 60 months, have you or your spouse closed, given away, sold, transferred, converted or disposed of any assets such as, but not limited to, the following: a home, land, personal property, life insurance policies, annuities, bank accounts, certificates of deposit, stocks, IRAs, bonds or a right to income?

   ❑ Yes ❑ No

2. Within the past 60 months, have you or your spouse transferred any resources into a trust?

   ❑ Yes ❑ No

If yes to either question, explain below. Provide verification of the dates of the transfers and the values of the resources that were transferred.

NOTES / ADDITIONAL INFORMATION SECTION

INCOME

List all sources of income.

IF THE APPLICATION IS FOR A CHILD UNDER AGE 21, ONLY THE INCOME OF THE CHILD IS COUNTED. PARENTAL INCOME OF A CHILD UNDER AGE 21 IS NOT COUNTED.

DO YOU HAVE INCOME FROM: *(Please check YES or NO.)*	YES	NO	SOURCE	HOW OFTEN IS THE INCOME RECEIVED *(weekly, bi-weekly, monthly, quarterly, etc.)*	AMOUNT OF INCOME BEFORE TAXES AND DEDUCTIONS
SOCIAL SECURITY			Claim #		$
PENSION					$
VA PENSION			VA file #		$
VA Aid and Attendance/ Housebound Allowance			(This benefit does not count.)		$
SUPPLEMENTAL SECURITY INCOME (SSI)					$
RR RETIREMENT					$
BLACK LUNG					$
ANNUITY/TRUST					$
WAGES					$
DIVIDENDS/INTEREST					$
SELF EMPLOYMENT					$
OTHER INCOME (specify)					$

HEALTH INSURANCE

Are you covered by any other medical insurance, including Medicare or coverage purchased by someone else?

❑ Yes ❑ No

If yes, complete the following and provide a copy of the card, policy and/or premium notice.

NAME OF COMPANY	POLICY NUMBER	TYPE OF POLICY	PREMIUM

HELP WITH UNPAID MEDICAL BILLS

You may be able to get help from Medical Assistance for unpaid medical bills that were incurred within the last three months.

Did you have unpaid medical bills during this time? ❑ Yes ❑ No

When did you incur these medical bills? _____

Do you wish to apply for medical assistance for this time period? ❑ Yes ❑ No

By signing below, you are agreeing to the following statements:

I understand that the information on this form will be kept confidential.

I authorize the release of personal, financial and medical information for the purpose of determining eligibility for Medical Assistance.

I understand that I must report all changes in my household or financial situation to the county assistance office within 10 calendar days of the date of the change.

I understand that I can request a hearing if I do not agree with a decision made on this application.

I understand that my eligibility is subject to verification from financial sources and other third parties.

I understand that Medical Assistance applicants must provide their Social Security Number. This number may be used to check the information on this application. Exception: An alien who is applying for emergency Medical Assistance is not required to provide a SSN (42 U.S.C. §1320b-7 (1)).

I understand that I have a right to a certificate of creditable coverage to verify my medical coverage. Federal law limits when health coverage may be denied or limited for a pre-existing condition. If I enroll in a group health plan that has a pre-existing condition limit, I can get credit for the time I received Medical Assistance.

I certify to the best of my knowledge that I understand my rights and responsibilities.

I understand that the Department of Public Welfare will seek recovery from my estate for certain health care coverage paid for under Medical Assistance. These services include nursing facility services, home and community-based services and hospital and prescription drug services while I was in a nursing facility or while I was receiving home and community-based services for the period of time when I was 55 years of age or older.

I certify that all information on this application is true under penalty of perjury.

I understand that if the information that I provided is not accurate, I can be held liable for repayment of the services received and may be subject to criminal prosecution.

SIGNATURE OF APPLICANT	DATE
SIGNATURE OF WITNESS (if applicant signed with a mark)	DATE
SIGNATURE OF REPRESENTATIVE	DATE

CERTIFICATION OF CITIZENSHIP OR ALIEN STATUS

By signing my name below, I certify that, subject to penalties provided by law, I am a U.S. citizen or alien in lawful immigration status. I may still be required to provide proof that I am a U.S. citizen or an alien in lawful immigration status.

SIGNATURE OF APPLICANT	DATE	SIGNATURE OF WITNESS, IF SIGNED WITH A MARK	DATE

Voter Registration (Optional)

If you are not registered to vote where you live now, would you like to apply to register to vote here today? ☐ Yes ☐ No

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

To register, you must: 1) Be at least 18 on the day of the next election; 2) Be a citizen of the United States for at least one month PRIOR TO THE NEXT ELECTION; 3) Reside in Pennsylvania and the voting district at least 30 days prior to the next election.

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency. If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private. Please contact the county assistance office if you would like help. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Secretary of the Commonwealth, PA Department of State, Harrisburg, PA 17120. (Toll-free telephone number 1-877-VOTESPA.)

COUNTY ASSISTANCE OFFICE STAFF WILL COMPLETE THIS SECTION BASED UPON YOUR RESPONSE ABOVE

☐ Given to Client __/__/__ ☐ Sent to voter registration __/__/__ ☐ Mailed to Client __/__/__

☐ Declined, not interested __/__/__ ☐ Not a U.S. citizen __/__/__ ☐ Declined, already registered __/__/__

INFORMATION ABOUT HEALTH CARE COVERAGE

ELIGIBILITY FOR SERVICES IN YOUR HOME UNDER MEDICAL ASSISTANCE INCLUDES HEALTH CARE COVERAGE

HEALTH CARE COVERAGE MAY INCLUDE:

- Checkups
- Immunizations
- Sick visits and prescriptions
- Emergency room care
- Lab tests and x-rays
- Hearing testing and hearing aids
- Mental health and substance abuse treatment
- Care in your home (or services)
- Inpatient care

You or any representative you choose may help you complete this application. Your representative can be your spouse, a friend, a relative, a person who has your power of attorney or your medical provider. It should be someone who knows and can provide information about your income and resources. If you need help with this application, please call

1-800-842-2020,

or if you are hearing impaired call

TDD 1-800-451-5886.

It is important that you answer each question. Please enter **"no"** or **"none"** to questions that do not apply to you, and be sure that the application is signed and dated.

CURRENT ELIGIBILITY LIMITATIONS:

The Total GROSS Monthly Income added together on page 9 cannot exceed 300 percent of current federal benefit rate ($_____ effective ___/___/_____).

The Total Countable Resources added together on pages 6 and 7 cannot exceed $8,000 if you are single (unmarried) or $_____ if you are married.

YOU HAVE CERTAIN RIGHTS AND RESPONSIBILITIES

THEY ARE:

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I understand that I can request a hearing if I do not agree with a decision made on this application.

I understand that my eligibility is subject to verification from financial sources and other third parties.

I understand that Medical Assistance applicants must provide their Social Security Number. This number may be used to check the information on this application. Exception: An alien who is applying for emergency medical assistance is not required to provide a SSN (42 U.S.C. §1320b-7 (1)).

I understand that I have a right to a certificate of creditable coverage. Federal law limits when health coverage may be denied or limited for a pre-existing condition limit. If I enroll in a group health plan that has a pre-existing condition, I can get credit for the time I received Medical Assistance.

I certify to the best of my knowledge that I understand my rights and responsibilities.

I understand that the Department of Public Welfare will seek recovery from my estate for certain health care coverage paid for under Medical Assistance. These services include nursing facility services, home and community-based services and hospital and prescription drug services while I was in a nursing facility or while I was receiving home and community-based services for the period of time when I was age 55 or older.

I certify that all information on this application is true under penalty of perjury.

I understand that if the information that I provided is not accurate, I can be held liable for repayment of the services received and may be subject to criminal prosecution.

KEEP THIS PAGE FOR YOUR RECORDS

ADDITIONAL PROGRAMS

There are other programs that can provide additional assistance for you:

SUPPLEMENTAL NUTRITIONAL ASSISTANCE PROGRAM (SNAP)

- This program helps low-income individuals and families buy food for a healthy diet.
- If you are eligible for this program, benefits for food purchases will be deposited in an account for you.
- You will be given an electronic benefit (EBT) card for the account, which you can use just like a bank card to purchase food at grocery stores.
- If you wish to apply for SNAP, please let the enrolling agency know or contact your local county assistance office.

LIHEAP

- LIHEAP stands for Low Income Home Energy Assistance Program.
- This program helps low-income individuals and families pay their heating bills.
- If you are eligible for this program, payments will be made to your utility company or your fuel provider.
- This program also provides emergency assistance if you are in danger of being without heat in your home.
- LIHEAP is a seasonal program, so it is available only during certain months—usually November through March.
- If you wish to apply for LIHEAP, please let your enrolling agency know or contact your local county assistance office.

CHECKLIST

1. DID YOU COMPLETE THE INFORMATION FOR THE APPLICANT?
2. DID YOU COMPLETE THE INFORMATION FOR THE SPOUSE WHO IS NOT APPLYING FOR SERVICES?
3. DID YOU LIST ALL RESOURCES OWNED INDIVIDUALLY OR JOINTLY?
4. DID YOU COMPLETE THE LIFE INSURANCE SECTION?
5. DID YOU READ THE STATEMENT REGARDING THE INFORMATION YOU PROVIDED?
6. DID YOU SIGN THE FORM AND INDICATE YOUR RELATIONSHIP TO THE APPLICANT?
7. DID YOU ATTACH PHOTOCOPIES OF THE DOCUMENTATION TO VERIFY ALL RESOURCES?