PENNSYLVANIA

Application for Medical Assistance for Workers with Disabilities

Medical Assistance for Workers with Disabilities (MAWD) offers health care coverage for individuals with disabilities who are employed. There may be a nominal fee for this coverage.

If you have a disability and need this form in large print or another format, please call our helpline at 1-800-692-7462. TDD services are available at 1-800-451-5886.

This is an application for Medical Assistance benefits. If you need help translating it, please contact your county assistance office, CAO. Translation services will be provided free of charge.

Esta es una solicitud de beneficious de Asistencia Médica. Si necesita ayuda con la traducción comuníquese con la Oficina de Asistencia del Condado (CAO) que le corresponde. Los servicios de traducción son gratuitos.

Đây là mẫu đơn xin hưởng phúc lợi Bảo Trợ Y Tế. Nếu quí vị cần phiên dịch đơn này, xin liên lạc Văn Phòng Trợ Cấp Quận Hạt nơi quí vị cư ngụ. Dịch vụ phiên dịch sẽ được cung cấp miễn phí.

Настоящий документ является заявлением на получение обслуживания по программе Medical Assistance. Если вам нужна помощь в переводе данного заявления, обращайтесь в Окружное бюро помощи (County Assistance Office). Услуги по переводу предоставляются бесплатно.

នេះជាពាក្យស្នើសុំអត្ថប្រយោជន៍សំរាប្រត្រពេទ្យ។ បើលោកអ្នកត្រូវការជំនួយបកប្រែវា សូមទាក់ទងទៅការិយាល័យជំរឿនប្រៃដែលនៅតាមតំបន់របស់លោកអ្នក។ ការបកប្រែនឹងផ្តល់អោយដោយឥតគិតថ្លៃ។

这是关于医疗协助福利的申请。如果你需要翻译协助，请联络你所在地方的郡县援助办事处。可以免费提供翻译服务。

How Do I Qualify?

1. You must be at least 16 years of age but less than 65 years of age.
2. Your countable resources such as bank accounts, stocks, and bonds may not exceed $10,000.
3. Your countable income, after allowable deductions, must be less than 250% of the Federal Poverty Income Guideline.
4. You must meet the definition of a disability according to the Social Security Administration. To meet the definition of a disability, you must meet one of the following:
   - ☐ You must be currently receiving Social Security Disability Insurance (SSDI).
   - ☐ You must have received Supplemental Security Income, SSI or SSDI, within the past 12 months.
   - ☐ If you do not meet either of the above conditions, the department will review your disability to determine if it meets the qualifying criteria.
5. You must also be employed and receiving compensation to receive coverage as a Worker with a Disability.

How Do I Apply?

1. Complete the enclosed application. (If you need help, call the Helpline at 1-800-842-2020 or TDD 1-800-451-5886 for the hearing impaired.) You can also contact your local county assistance office, or CAO, or check the DPW website at www.dpw.state.pa.us. You can also apply online at www.compass.state.pa.us.
2. Attach proof of your income, impairment-related work expenses, resources, social security number, address, and identification.
3. Read the “Rights and Responsibilities” section and sign the application.
4. Mail the application to your CAO. A staff member from the CAO will contact you if additional information is needed. The CAO will inform you of your eligibility for benefits.

If you need cash assistance or SNAP, you must complete a different application. Please call your county assistance office and they will send you the proper form.

Client Rights and Responsibilities

Right to Non-discrimination
In accordance with Federal law and U.S. Department of Health and Human Services, or HHS, Policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, or disability. To file a complaint of discrimination, contact HHS. Write HHS, Director, Office of Civil Rights, Room 506-F, 200 Independence Avenue, S. W. Washington, D.C. 20201 or call (202) 619-0403 (Voice) or (202) 619-3257 (TTD). HHS is an equal opportunity provider and employer.

Right to Confidentiality
We keep information you give confidential and use it only to administer the programs you apply for and/or may be eligible for.

Right to a Written Notice
We will give you a written notice explaining your benefits. If we deny, change, suspend, or stop benefits, we will explain the reason on the notice. You have 30 days from the date of the notice to ask for a hearing if you disagree with the action taken and/or the reasons given.

Right to Appeal
You have the right to ask for a departmental hearing to appeal a decision of or a failure to act by the department which affects your benefits or that you feel is unfair or incorrect. You may file the appeal at the CAO. At the appeal hearing, you may represent yourself, or someone else, such as a lawyer, friend or relative, may represent you. You may have an agency conference before the hearing.

Right to Certificate of Creditable Coverage
You have a right to a certificate of coverage to verify your medical coverage. Federal law limits when health care coverage may be denied or limited for a pre-existing condition. If you enroll in a health plan that allows for a pre-existing condition, exclusion or limitation, you may get credit for the time you received Medical Assistance.

Responsibility to provide Social Security Numbers
You must provide a Social Security number, or SSN for each person for whom you are applying. If you do not have a SSN, we will help you apply for one. Refusal or failure to provide an SSN may result in ineligiblity. We will also ask you to supply a SSN to verify identity and administer our programs. We will use your SSN to prevent duplication in state and federal programs and to get information about income to determine eligibility for benefits.

Responsibility to Provide Information
You must give true, correct and complete information. You must cooperate in documenting or proving the information you give. If you cannot provide proof, you should ask the CAO to help. You must cooperate fully with persons or investigators of Department of Public Welfare, DPW, or Office of Inspector General conducting investigations.

Responsibility to Report Changes
You must report changes in the number of people in your household, address, new unearned income, real property or other resources (such as bank accounts or life insurance). You must report any plans to leave the state, even temporarily. You must report if your gross monthly earned income increases by more than $100. If you have unearned income, you must report if your gross monthly unearned income increases by more than $50. You can report changes to the CAO in person, by telephone, by fax or by mail. **Changes must be reported within the first 10 days of the month following the month of the change.**

Responsibility to use the PA ACCESS Card Lawfully
You may use the PA ACCESS card for the services only during the period you are eligible. You must use the card only for the person who is eligible and you may get only the services that are needed and reasonable.

Responsibility to Pay Monthly Premium
You are responsible for the payment of your monthly premium. If you do not pay your premium timely, you may lose your health coverage.

If You Cannot Pay Your Premium
Your monthly premium can be waived for reasons such as ongoing health problems, layoff or loss of employment, discrimination, or other factors beyond your control. You must also intend to return to the former position or be making a bona fide effort to seek other employment.

Responsibility to Contact Providers for Refunds
If you pay for any medical bills between the date of application and the determination of your eligibility, you are responsible for contacting the provider for a refund.

COUNTY ASSISTANCE OFFICE USE ONLY				AUTHORIZED	UNAUTHORIZED
☐ MAIL ☐ WALK IN		FILE CLEAR BY/DATE	SCREEN BY/DATE	DATE	
COUNTY	DISTRICT	APPLICATION REG. NUMBER	DATE STAMP	BY	
WORKER ID	CASE LOAD	RECORD NUMBER	CAT	CAT	
NAME		APPOINTMENT DATE/TIME ☐ AM ☐ PM		REASON CODE	

TELL US ABOUT YOU, THE PERSON APPLYING

YOUR NAME (Last, First, Middle Initial)		SOCIAL SECURITY NUMBER	
ADDRESS	STATE	ZIP CODE	PLUS 4
TELEPHONE NUMBER	SCHOOL DISTRICT	TOWNSHIP (CIVIL SUBDIVISION)	

Are you receiving Social Security Disability Insurance (SSDI) benefits? ☐ Yes ☐ No ☐ Don't Know

If no, tell us about your disability and provide documentation.

When filling out this application, please attach separate sheets if additional space is needed.

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 BOX BASED ON YOUR RESPONSE ABOVE

☐ Given to Client __/__/__ ☐ Sent to voter registration __/__/__ ☐ Mailed to Client __/__/__
☐ Declined, not interested __/__/__ ☐ Not a U.S. citizen __/__/__ ☐ Declined, already registered __/__/__

1. HOUSEHOLD, CITIZENSHIP, AND IDENTITY INFORMATION

Please list the people who live with you, starting with yourself. Make sure you look below for the application Race Code (the race code is optional and for statistical purposes only, and has no affect on your eligibility for benefits) and Citizenship Code. Attach additional sheets if needed.

Do you understand English? ☐ Yes ☐ No If no, what language(s) do you understand?

____

____

CITIZENSHIP: Use one of the following codes: **1.** US Citizen **2.** Permanent Alien **3.** Temporary Alien **4.** Refugee **5.** Undocumented Alien **6.** Refugee Unaccompanied Minor

FOR RACE (Optional): Use any of the following codes that apply. Your benefits will not be affected if you do not answer. Individuals may fit more than one group.
1. Black **2.** Hispanic **3.** North American Indian or Alaskan Native **4.** Asian **5.** White (Not Hispanic) **6.** Other **7.** Native Hawaiian or Pacific Islander

NAME (Last, First, Middle Initial)	Jr./Sr., etc.	Date of Birth	Sex ☐ Male ☐ Female	Social Security Number	Medicare Claim Number
NAME ON BIRTH CERTIFICATE (Last, First, M.I.)	State of Birth	County of Birth	City of Birth	Alien Registration Number	Are You Applying for this Person? ☐ Yes ☐ No
MOTHER'S MAIDEN NAME (First, Last)	Race Code	Citizenship Code	Does This Person Have A Pa Access Card? ☐ Yes ☐ No	Driver's License (State & Number) or State ID No.	Relationship of Applicant to You

NAME (Last, First, Middle Initial)	Jr./Sr., etc.	Date of Birth	Sex ☐ Male ☐ Female	Social Security Number	Medicare Claim Number
NAME ON BIRTH CERTIFICATE (Last, First, M.I.)	State of Birth	County of Birth	City of Birth	Alien Registration Number	Are You Applying for this Person? ☐ Yes ☐ No
MOTHER'S MAIDEN NAME (First, Last)	Race Code	Citizenship Code	Does This Person Have A Pa Access Card? ☐ Yes ☐ No	Driver's License (State & Number) or State ID No.	Relationship of Applicant to You

NAME (Last, First, Middle Initial)	Jr./Sr., etc.	Date of Birth	Sex ☐ Male ☐ Female	Social Security Number	Medicare Claim Number
NAME ON BIRTH CERTIFICATE (Last, First, M. I.)	State of Birth	County of Birth	City of Birth	Alien Registration Number	Are You Applying for this Person? ☐ Yes ☐ No
MOTHER'S MAIDEN NAME (First, Last)	Race Code	Citizenship Code	Does This Person Have A Pa Access Card? ☐ Yes ☐ No	Driver's License (State & Number) or State ID No.	Relationship of Applicant to You

NAME (Last, First, Middle Initial)	Jr./Sr., etc.	Date of Birth	Sex ☐ Male ☐ Female	Social Security Number	Medicare Claim Number
NAME ON BIRTH CERTIFICATE (Last, First, M. I.)	State of Birth	County of Birth	City of Birth	Alien Registration Number	Are You Applying for this Person? ☐ Yes ☐ No
MOTHER'S MAIDEN NAME (First, Last)	Race Code	Citizenship Code	Does This Person Have A Pa Access Card? ☐ Yes ☐ No	Driver's License (State & Number) or State ID No.	Relationship of Applicant to You

NAME (Last, First, Middle Initial)	Jr./Sr., etc.	Date of Birth	Sex ☐ Male ☐ Female	Social Security Number	Medicare Claim Number
NAME ON BIRTH CERTIFICATE (Last, First, M. I.)	State of Birth	County of Birth	City of Birth	Alien Registration Number	Are You Applying for this Person? ☐ Yes ☐ No
MOTHER'S MAIDEN NAME (First, Last)	Race Code	Citizenship Code	Does This Person Have A Pa Access Card? ☐ Yes ☐ No	Driver's License (State & Number) or State ID No.	Relationship of Applicant to You

2. INCOME

Please tell us if anyone listed on this application has, or is expecting any type of income. List the income amount before deductions (such as taxes or insurance) are taken out. Income includes but is not limited to:

☐ Wages ☐ Baby Sitting ☐ Rent ☐ Veterans Benefits ☐ Sick Benefits ☐ Dividends or Interest
☐ Self-Employment ☐ Room and Board ☐ Social Security/SSI ☐ Support or Alimony ☐ Unemployment or Worker's Compensation
☐ Pensions ☐ Commissions ☐ Money for College or Training

NAME	EMPLOYER OR SOURCE OF INCOME	EMPLOYER'S ADDRESS	TELEPHONE

HOURS WORKED PER WEEK	HOURLY WAGE	HOW OFTEN IS INCOME RECIEVED? (CIRCLE ONE)	GROSS AMOUNT BEFORE DEDUCTIONS
		Weekly / Bi-weekly / Monthly / Other (explain)	
		Weekly / Bi-weekly / Monthly / Other (explain)	
		Weekly / Bi-weekly / Monthly / Other (explain)	
		Weekly / Bi-weekly / Monthly / Other (explain)	
		Weekly / Bi-weekly / Monthly / Other (explain)	

3. EXPENSES

You may have spent money in order to receive income. If you did, please list the expense(s) below:

☐ Court Costs or Attorney Fees ☐ Transportation ☐ Impairment related work expenses (such as medical devices, or attendant care)

NAME	TYPE OF EXPENSE	AMOUNT	HOW OFTEN PAID

4. RESOURCES

Does anyone listed on this application have any of the following resources?

☐Yes ☐ No Cash-on-hand (01)
☐Yes ☐ No Savings Account (02)
☐Yes ☐ No Checking Account (03)
☐Yes ☐ No Christmas or Vacation Club (04)
☐Yes ☐ No Stocks or Bonds (05)
☐Yes ☐ No U.S. Savings Bonds (05)
☐Yes ☐ No Trust Fund (06)
☐Yes ☐ No Certificate of Deposit (26)
☐Yes ☐ No IRA, KEOGH, or other retirement plan (27)
☐Yes ☐ No Burial Reserves or Trusts (97)
☐Yes ☐ No Non-resident Property (98)

NAME	DESCRIBE TYPE/ACCOUNT NUMBER/LOCATION OF THE RESOURCE	CURRENT VALUE

☐ Yes ☐ No Is anyone listed on this application expecting money or any type of resource such as, but not limited to, an accident settlement, inheritance, trust fund or other resource? If yes, type of resource: _____ Value: _____ Date expected: _____

☐ Yes ☐ No Since February 8, 2006 have you or anyone listed on the application given away, sold or transferred any assets such as: a home, land, personal property, life insurance policies, annuities, bank accounts, certificates of deposit, stocks, IRA, bonds or a right to income? If yes, describe the type of property: _____ Value: _____ Date sold, transferred, or given away: _____

Does anyone listed on this application own or are they making payments on a vehicle (car, truck, motorcycle)? ☐ Yes ☐ No

NAME	YEAR	MAKE	MODEL	LICENSED	AMOUNT OWED
				☐ Yes ☐ No	
				☐ Yes ☐ No	

Does anyone listed on this application have a life insurance policy? ☐ Yes ☐ No

POLICY OWNER	NAME OF INSURANCE COMPANY/POLICY NUMBER	FACE VALUE	CASH VALUE	WHO IS COVERED?

Does anyone listed on this application have health insurance besides Medical Assistance? ☐ Yes ☐ No

POLICY OWNER	NAME OF INSURANCE COMPANY/POLICY NUMBER	WHO IS COVERED?

5. BENEFITS FOR PREGNANT WOMEN

There are additional benefits which may be available to pregnant women. Complete this section if you want to make a referral for someone in your household who is pregnant.

NAME	ADDRESS	PREGNANCY DUE DATE

6. U.S. MILITARY SERVICE

Is anyone in the U.S. military, or has been in the U.S. military? ☐ Yes ☐ No

Is anyone a widow, spouse, or child (under age 18) of anyone in the U.S. military, or anyone who has been in the U.S. military? ☐ Yes ☐ No

PERSON WHO SERVED	BRANCH (ARMY, NAVY, MARINE CORP, AIR FORCE, COAST GUARD)	DATES OF SERVICE

7. IF YOU HAVE UNPAID MEDICAL BILLS

If you have unpaid medical bills for up to three months before the application date, those bills could be covered. This is called retroactive coverage. If you are determined eligible for retroactive coverage, you may be responsible for premium payments for each retroactive month. Please note that your retroactive bills will not be covered until these premium payments are received. If you think your bills might be less than the premium payment, you may not want to apply for retroactive coverage. Complete the section below if you wish to be considered for retroactive coverage. Please list any additional bills on a separate sheet of paper.

Please Note: You must submit verification of your income and resources for all months in which retroactive coverage is requested.

DATE OF SERVICE	HOSPITAL / DOCTOR / PRESCRIPTION	AMOUNT OF BILL

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8. ATTACH PROOF

We will need proof of the information you have provided to process your application. If you are unable to obtain proof of the information, your CAO will help you.

☐ Check here if you need help getting proof of your address, income and/or resources.

Do you have copies of the information you provided? ☐ Yes ☐ No

PLEASE SEND COPIES - NOT ORIGINALS	
Identification (only one source)	driver's license, passport, photo ID
Citizenship	birth certificate or passport
Alien status (only if non-U.S. citizen)	Most current immigration documents
Address (only one source)	rent receipt, utility bill, driver's license (with current address), mortgage bill or receipt, post office records, tax records, etc.
Income	One month's current pay stub, proof of pension, Financial Eligibility Notice for Unemployment Compensation, tax forms or other records of self-employment income, copies of check stubs or statements from the source of income.
Resources	bank statements, insurance policies, Tax Assessment Notices

If you are unable to obtain proof of the information you have provided, the county assistance office will help you. Please attach a note explaining why you are unable to provide the proof.

9. WHEN WILL BENEFITS BEGIN?

You may choose the month you want Medical Assistance to start. Check (✓)one of the boxes below:

☐ Check (✓) here and your eligibility will begin the month of application. You will have to pay the premium starting the month of application.

☐ Check (✓) here and your eligibility will begin the month after application. You will have to pay the premium starting the month after application.

10. HOW TO PAY THE PREMIUM

To participate in this program, you must pay a monthly premium. The preferred method of payment is payroll deduction. With payroll deduction, your employer will deduct the monthly premium amount directly from your paycheck. Please check the box below if you want payroll deduction.

☐ YES, I want payroll deduction
If you are self-employed, do not want payroll deduction, or your employer doesn't offer payroll deduction, you will be sent a monthly statement. You will be responsible for mailing that statement each month with your payment. Please check the box below if you want a monthly statement, and do not want payroll deduction

☐ NO, I do not want payroll deduction.

NOTE: In some cases, you may not be required to pay a premium.

11. YOUR RIGHTS AND RESPONSIBILITIES

RIGHT TO NON-DISCRIMINATION

In accordance with Federal law and U.S. Department of Health and Human Services, or HHS, Policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, or disability. To file a complaint of discrimination, contact HHS. Write HHS, Director, Office of Civil Rights, Room 506-F, 200 Independence Avenue, S. W. Washington, D.C. 20201 or call (202) 619-0403 (Voice) or (202) 619-3257 (TTD). HHS is an equal opportunity provider and employer.

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We keep information you give confidential and use it only to administer the programs you apply for and/or may be eligible for.

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RIGHT TO APPEAL

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RIGHT TO CERTIFICATE OF CREDITABLE COVERAGE

You have a right to a certificate of coverage to verify your medical coverage. Federal law limits when health care coverage may be denied or limited for a pre-existing condition. If you enroll in a health plan that allows for a pre-existing condition, exclusion or limitation, you may get credit for the time you received Medical Assistance.

RESPONSIBILITY TO PROVIDE SOCIAL SECURITY NUMBERS

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You must report changes in the number of people in your household, address, new unearned income, real property or other resources (such as bank accounts or life insurance). You must report any plans to leave the state, even temporarily. You must report if your gross monthly earned income increases by more than $100. If you have unearned income, you must report if your gross monthly unearned income increases by more than $50. You can report changes to the CAO in person, by telephone, by fax or by mail. **Changes must be reported within the first 10 days of the month following the month of the change.**

RESPONSIBILITY TO USE THE PA ACCESS CARD LAWFULLY

You may use the PA ACCESS card for services only during the period you are eligible. You must use the card only for the person who is eligible and you may get only the services that are needed and reasonable.

RESPONSIBILITY TO PAY MONTHLY PREMIUM

You are responsible for the payment of your monthly premium. If you do not pay your premium timely, you may lose your health coverage.

IF YOU CANNOT PAY MONTHLY PREMIUM

Your monthly premium can be waived for reasons such as ongoing health problems, layoff or loss of employment, discrimination, or other factors beyond your control. You must also intend to return to the former position or be making a bona fide effort to seek other employment.

RESPONSIBILITY TO CONTACT PROVIDERS FOR REFUNDS

If you pay for any medical bills between the date of application and the determination of your eligibility, you are responsible for contacting the provider for a refund.

12. AGREEMENT AND UNDERSTANDING

WHEN I SIGN THIS FORM I AGREE THAT:

- ☐ I have read this application in full or someone has read it to me and I understand the questions asked.
- ☐ I received a copy of my rights and responsibilities, have read them or someone has read them to me, and I understand them.
- ☐ I will provide or cooperate in getting any information needed to prove my statements.
- ☐ I must report any changes in my circumstances within the first 10 days of the month following the month of the change.
- ☐ I am responsible for any fraudulent statements made on this application even if the application is submitted by someone acting on my behalf.
- ☐ I certify that, subject to penalties provided by law, the information I gave is true, correct, and complete to the best of my knowledge.

WHEN I SIGN THIS FORM I UNDERSTAND THAT:

- ☐ If I do not report changes as required, my benefits may be reduced or stopped. If I purposely fail to give correct information or report changes, I may be fined and/or put in jail.
- ☐ The state operates a fraud control program under which local, state, and federal officials may verify the information I have given.
- ☐ The state may obtain information about my circumstances from other persons or organizations, including computer matches and Immigration and Naturalization.
- ☐ My Social Security number will be used to obtain information to verify my circumstances and eligibility.
- ☐ I understand, that by signing below, I am certifying that the persons I am applying for are U.S. citizens or aliens in lawful immigration status.

CLIENT OR REPRESENTATIVE SIGNATURE

Signature of Client/Representative

Address of Client/Representative

Telephone

Date

Signature of Witness (if “x” used above)

Address of Witness

Telephone

Date