



Medical Assistance (Medicaid) Financial Eligibility Application for Long Term Care, Supports and Services

You may also apply online at www.compass.state.pa.us

Check any that you are applying for:

- Care in a Facility
- Home and Community Waiver Services Type/Name of Waiver/Service: _____
- Other _____

- * Please read the entire application form
- * Print the requested information in the unshaded sections
- * If you need help, another person can help you or you can get help from your county assistance office

You or any representative you choose may 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 are married, information in some sections must be completed for both you and your spouse.

After the form is completed, bring it, have someone else bring it, or mail it to the county assistance office unless you are instructed otherwise. The county assistance office will tell you if a face to face interview is needed. You will need proof of identity and verification for other information on the form unless we already have

the information in our records. If you need help to obtain any information ask the county assistance office for help. You should attach verification to this form.

Persons who have given away assets (income or resources) within the past 60 months, or set up or transferred assets to a trust within the past 60 months prior to applying for Medical Assistance for long term care, supports and services may be ineligible for benefits. Because of this requirement, you may need to provide verification of assets owned during the past 60 months even though you may no longer own them. We will use your Social Security Number to get information about your assets for the 60 months prior to your application.

If the information is complete and you have provided the necessary verification (with this form, if possible), the county assistance office will notify you within 30 days of receiving your application if you are eligible, ineligible or if additional information is needed.

PROVIDER USE			
NAME		NUMBER	
ADDRESS		NUMBER	
DATE OF ADMISSION	DATE OF OPTIONS ASSESSMENT	REQUESTED EFFECTIVE DATE	
CONTACT NAME/TELEPHONE NUMBER/ADDRESS			

CAO USE				
CO.	DIST	RECORD NUMBER	FILE CLEARED BY	APPL. REG. NO.
WORKER I.D.			CASELOAD	
<input type="checkbox"/> AUTHORIZED REASON				CATEGORY
<input type="checkbox"/> NOT AUTHORIZED REASON				DATE

**PLEASE COMPLETE THE FOLLOWING INFORMATION FOR THE
PERSON REQUESTING MEDICAL ASSISTANCE BENEFITS**

LAST NAME		FIRST NAME		MIDDLE INITIAL	(JR., SR., I, ETC.)
CURRENT ADDRESS (IF IN A FACILITY, USE FACILITY ADDRESS)			CITY	STATE	ZIP CODE + 4
ADMISSION DATE	DATE MOVED TO THIS ADDRESS	TOWNSHIP	SCHOOL DISTRICT		AREA CODE AND TELEPHONE NUMBER
PREVIOUS ADDRESS (IF IN A FACILITY, GIVE YOUR HOME ADDRESS. IF YOU ARE MARRIED, GIVE YOUR SPOUSE'S ADDRESS.)				AREA CODE AND TELEPHONE NUMBER	

Do you want an interpreter? Yes No
 If yes, what language? _____

Do you need your notices in Spanish? ¿Necessita sus avisos en Español? Yes No

Have you ever applied for or received cash or medical benefits or participated in the Supplemental Nutrition Assistance Program (SNAP), formerly known as food stamps, in another county in Pennsylvania or in another state?
 Yes No

If yes, what State? _____
 What county? _____
 How long? _____
 Record Number _____

Have you ever applied for or received benefits using a different Social Security Number? Yes No
 If yes, what is the number? _____

Have you previously lived in a nursing facility? Yes No

If yes, provide name: _____
 Address: _____
 Dates: _____

1 Complete all information in this section for yourself, your spouse if you are married, and any dependent children or siblings.

*Attach an additional sheet of paper if you have more dependents.

RELATIONSHIP	LAST NAME	FIRST NAME	MI	JR/SR	ALIAS/MAIDEN NAME	BIRTH DATE	SEX	*RACE	SSN
SELF									
SPOUSE									
DEPENDENT									

*For Race: Your benefits will not be affected if you do not wish to answer. Please use one of the following codes:

1. Black 2. Hispanic 3. North American Indian or Alaskan Native 4. Asian or Pacific Islander 5. White (Not Hispanic) 6. Other

2 Please answer and sign:Are you a U.S. Citizen? Yes No If No, check one: Permanent Resident Temporary Resident Refugee Illegal Alien

Alien #: _____ Country of Origin: _____ Date of Entry: _____

Sign to declare your citizenship or alien status as marked above:

Signature Date

Name and address of sponsor if you have one: _____

3 Marital StatusPlease check one: Married Single Widowed Divorced Separated

If you checked widowed, what was the date of your spouse's death? _____ Name: _____

If you checked separated, what was the date of separation? _____ Please complete item #1 above for spouse.

4 Military Status

Veteran's Name _____

Please check one: Veteran Active Military National Guard Reserves Widow/Spouse or Dependent Child of a Veteran

Branch of Service _____ Date Entered _____ Date Left _____ Claim No. _____

5 Opportunity for Voter Registration

Are you (and your spouse, if you are married) interested in registering to vote?

YES	NO	ALREADY REGISTERED	LAST NAME	FIRST NAME

If you do not check any box, we will assume you have decided not to register to vote at this time. Applying to register or declining to register to vote will not affect the amount of assistance that you may be eligible for from this agency. All information will be used only for voter registration purposes. If you register to vote, the name of the office at which you submit this registration application will remain confidential. If you decline or do not wish to register to vote, the fact that you have declined to register will remain confidential. 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.

CAO USE ONLY

Given to Client

Date ___/___/___

Hand carried to County Voter Registration

Date ___/___/___

Mailed to County Voter Registration

Date ___/___/___

6 If you are receiving or have received long term care, supports and services, how were your expenses being paid?

7 Do you have unpaid medical bills? Yes No If you are requesting Medical Assistance for these bills, attach copies.

8 MEDICAL INSURANCE INFORMATION (Including Long Term Care Insurance)

INSURANCE COMPANY/MEDICARE	INSURANCE COMPANY ADDRESS	AGREEMENT/ POLICY NUMBER	GROUP NAME NUMBER	EFFECTIVE DATE OF COVERAGE	PREMIUM AMOUNT	PAID HOW OFTEN	POLICY HOLDER NAME AND ADDRESS

Add an additional sheet of paper if more space is needed. Please label what question number you are answering on any additional pages.

9 Complete the following resource information for you and your spouse (if you are married):

A. Real Estate None

LOCATION	OWNER	VALUE \$	INCOME PRODUCING <input type="checkbox"/> YES <input type="checkbox"/> NO	RESIDENT <input type="checkbox"/> YES <input type="checkbox"/> NO
WHO LIVES IN THE PROPERTY?		IS THE PROPERTY LISTED FOR SALE? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES - DATE LISTED
REALTOR'S NAME AND TELEPHONE NUMBER * REMEMBER TO REPORT THE PROPERTY SALE TO US.				
IF FOR SALE GIVE				
ARE YOU PLANNING TO RETURN TO THE PROPERTY? <input type="checkbox"/> YES <input type="checkbox"/> NO			DO YOU OWN ANY OTHER REAL ESTATE? <input type="checkbox"/> YES <input type="checkbox"/> NO	

B. Mobile Home None

LOCATION	OWNER	VALUE \$	INCOME PRODUCING <input type="checkbox"/> YES <input type="checkbox"/> NO	RESIDENT <input type="checkbox"/> YES <input type="checkbox"/> NO
YEAR AND MODEL	WHO LIVES IN THE MOBILE HOME?			
REALTOR'S NAME AND TELEPHONE NUMBER				
IS THE MOBILE HOME LISTED FOR SALE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES GIVE				

C. Burial Arrangements None

BANK/INSURANCE COMPANY NAME AND ADDRESS		ACCOUNT NUMBERS		
FUNERAL HOME	VALUE OF ACCOUNT \$		DATE ESTABLISHED	
CAN MONEY BE WITHDRAWN BEFORE DEATH OF INDIVIDUAL? <input type="checkbox"/> YES <input type="checkbox"/> NO		CAN INTEREST BE WITHDRAWN? <input type="checkbox"/> YES <input type="checkbox"/> NO		
DO YOU OWN ANY BURIAL SPACES? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES GIVE LOCATION		NUMBER OF SPACES

D. Life Insurance None

COMPANY NAME	POLICY NUMBER	FACE VALUE	CURRENT CASH VALUE	WHO OWNS THE POLICY?

E. Automobiles, Recreational Vehicles, Trucks, Motorcycles None

NAME OF OWNER(S)	YEAR	MAKE	MODEL	LICENSED?	PLATE NUMBER	ACCOUNT

F. Bank Accounts (Checking, Savings, IRA, etc.) List all accounts that include applicant's and/or spouse's name and money. None

BANK NAME/BRANCH	ACCOUNT TYPE	ACCOUNT NUMBER	CURRENT BALANCE	NAME(S) ON ACCOUNT/OWNER


G. Stocks, Bonds (including U.S. Savings Bonds), Trusts, Mutual Funds, cash on hand, etc. None

NAME ON INVESTMENT	TYPE ACCOUNT	ACCOUNT NUMBER	CURRENT ACCOUNT VALUE	NAME(S) ON ACCOUNT/OWNER

10 Within the past 60 months, have you or your spouse closed, 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? Yes No

Within the past 60 months, have you or your spouse transferred any assets into a trust? Yes No

If yes to either question, explain circumstances (attach extra paper if needed) _____

TYPE OF RESOURCE(S)	MARKET VALUE AT TIME OF TRANSFER 	\$	DATE OF TRANSFER OR CLOSING
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11 If you closed or depleted any accounts because you paid for nursing services, list these accounts.

TYPE OF RESOURCE	LOCATION	ACCOUNT NUMBER	OWNER(S)	DATE OF CLOSING

12 Have you or your spouse received or does either of you expect to receive any income/asset/settlement/lump sum/inheritance? Yes No

If yes, describe: _____ AMOUNT \$ _____
 _____ DATE EXPECTED _____

13 Income information for the applicant:

<u>INCOME SOURCES</u>	<u>IDENTIFY INVESTMENT TYPE/NAME</u>	<u>GROSS INCOME AMOUNT</u>	<u>HOW OFTEN PAID</u>
<input type="checkbox"/> SOCIAL SECURITY	_____	_____	_____
<input type="checkbox"/> VETERANS BENEFIT AID AND ATTENDANCE	_____	_____	_____
<input type="checkbox"/> PENSIONS	_____	_____	_____
<input type="checkbox"/> WORKER'S COMPENSATION	_____	_____	_____
<input type="checkbox"/> RAILROAD RETIREMENT	_____	_____	_____
<input type="checkbox"/> BLACK LUNG	_____	_____	_____
<input type="checkbox"/> ANNUITY (COMPANY)	_____	_____	_____
<input type="checkbox"/> PAYMENTS FROM A TRUST	_____	_____	_____
<input type="checkbox"/> INTEREST/DIVIDEND (SOURCE)	_____	_____	_____
<input type="checkbox"/> OTHER INCOME	_____	_____	_____

TO WHOM ARE THE CHECKS SENT? (GUARDIAN, REPRESENTATIVE PAYEE) 	ADDRESS
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Complete this section if you have a spouse or dependent. Skip this section if you are not married or do not have a dependent.

14 Income information for the spouse and/or dependent:

<u>INCOME SOURCES</u>	<u>IDENTIFY INVESTMENT TYPE/NAME</u>	<u>GROSS INCOME AMOUNT</u>	<u>HOW OFTEN PAID</u>
<input type="checkbox"/> SOCIAL SECURITY	_____	_____	_____
<input type="checkbox"/> VETERANS BENEFIT AID AND ATTENDANCE	_____	_____	_____
<input type="checkbox"/> PENSIONS	_____	_____	_____
<input type="checkbox"/> WORKER'S COMPENSATION	_____	_____	_____
<input type="checkbox"/> RAILROAD RETIREMENT	_____	_____	_____
<input type="checkbox"/> BLACK LUNG	_____	_____	_____
<input type="checkbox"/> ANNUITY (COMPANY)	_____	_____	_____
<input type="checkbox"/> PAYMENTS FROM A TRUST	_____	_____	_____
<input type="checkbox"/> INTEREST/DIVIDEND (SOURCE)	_____	_____	_____
<input type="checkbox"/> OTHER INCOME	_____	_____	_____

15 Shelter expense:

MONTHLY RENT/MORTGAGE	\$ _____	BASIC TELEPHONE	\$ _____
SALES OR LEASE PURCHASE AGREEMENT	\$ _____	GAS	\$ _____
PERSONAL CARE OR DOMICILIARY CARE RENTAL CHARGE	\$ _____	ELECTRIC	\$ _____
MAINTENANCE CHARGES FOR CONDO OR CO-OP RESIDENCE.....	\$ _____	HEATING FUEL	\$ _____
LOT RENT FOR MOBILE HOME.....	\$ _____	WATER	\$ _____
PROPERTY TAXES - ANNUAL AMOUNT	\$ _____	SEWER	\$ _____
HOMEOWNERS INSURANCE - ANNUAL AMOUNT	\$ _____	GARBAGE	\$ _____

Do you pay for heating and/or air conditioning separate from your rent? Yes No

RIGHT TO NONDISCRIMINATION

We may not discriminate on the basis of age, sex, race, color, ancestry, disability, religious creed, national origin, sexual preference, life-style, union membership, political belief, or because you applied for and/or received assistance before. If you feel you have been discriminated against by the Department or anyone providing services for the Department, you may file a verbal or written complaint with the Department or the county assistance office. The Department or county assistance office will then forward the complaint to the appropriate Federal or State agency.

RIGHT TO APPEAL

You have the right to ask for a Departmental hearing to appeal a decision of or 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 county assistance office. At the appeal hearing, you may represent yourself or someone else, such as a lawyer, friend, or a relative may represent you.

RIGHT TO AN AGENCY CONFERENCE

If you appeal, you may have an agency conference before the hearing.

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 CONFIDENTIALITY

We keep information you give confidential and use it only to administer the programs you apply for and may be eligible for. Any person knowingly violating any of the rules and regulations of this Department made in accordance with this article shall be guilty of a misdemeanor, and upon conviction thereof, shall be sentenced to pay a fine, not exceeding one hundred dollars (\$100), or to undergo imprisonment, not exceeding six months, or both (62 P.S. Section 483).

ESTATE RECOVERY

If you are age 55 or older and receive medical assistance to pay for nursing facility services, home and community-based waiver services and any related hospital and prescription drug service, you will be required to repay the cost of these services from your probate estate. You may call the MA Estate Recovery Program at 800-528-3708.

CHANGES

If you are not sure if you must report a particular change, you should report the change. You can report to a member of the county assistance office staff in person, by telephone, or by mail.

USE OF THE PA ACCESS CARD

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 services that are needed and reasonable.

RESPONSIBILITY TO PROVIDE SSNs

You must provide a Social Security Number (SSN). If you do not have an SSN, you must apply for one. Refusal or failure to provide an SSN may result in disqualification. If you have a community spouse, he or she must also supply an SSN. We use the SSN to verify identity, administer our programs, prevent duplication in state and federal programs, for computer matches with other programs, and to get information about income and resources to determine eligibility for and/or the amount of your benefits (42 U.S.C. Section 1320b-7).

PENALTIES

If you do not report changes as required, your benefits may be reduced or stopped. If you purposely fail to give correct information or report changes, you may be fined and/or put in jail. Improper use of the PA Access Card for services may result in a fine, imprisonment or both.

RESPONSIBILITY TO PROVIDE INFORMATION

You must give true, correct and complete information to the best of your ability. You must cooperate in documenting or verifying the information. If you cannot provide proof, you should ask the county assistance office to help. You must cooperate fully with quality control and with persons from the Department or the Inspector General's Office who are conducting investigations.

I Understand:

My benefits may be reduced or I can be penalized for giving incomplete or false information or for not reporting changes that would affect my benefits.

Any person enriched as a result of a transfer of assets or income, which would have affected my eligibility, will be liable for repayment of those benefits issued incorrectly.

I am giving the state the right to seek, with or without legal action, payment from private or public health insurance or liable third party. The amount recovered will not exceed the amount paid by Medical Assistance.

The state has the right to review all records of medical service paid for by Medical Assistance.

Payment for medical services will be made directly to the provider, not to me. This includes payments from Medicare.

I received a copy of my rights and responsibilities, have read them or someone has read them to me, and I understand them.

I agree to provide or cooperate in getting any information needed to prove my statements.

I must report any changes in my circumstances within 10 days 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.

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.

AFFIDAVIT

I certify, subject to penalties provided by law, that the information I gave is true and correct and complete to the best of my knowledge. I have read this application in full or someone has read it to me and I understand the questions asked. I have received a copy of and read my rights and responsibilities, or someone has read them to me, and I understand them.

APPLICANT OR AUTHORIZED REPRESENTATIVE SIGNATURE	DATE	I.D. VERIFIED	RELATIONSHIP TO APPLICANT		
ADDRESS OF REPRESENTATIVE	CITY		STATE	ZIP CODE + 4	() TELEPHONE NUMBER
WITNESS (IF SIGNED WITH AN X ABOVE)	DATE				
ADDRESS OF WITNESS	CITY		STATE	ZIP CODE + 4	() TELEPHONE NUMBER
PROVIDER SIGNATURE (IF SUBMITTED BY PROVIDER)	DATE				
CAO OR OPTIONS	DATE	<input type="checkbox"/> Face to Face Interview With _____ <input type="checkbox"/> Telephone Interview With _____ <input type="checkbox"/> Interview Waived			

Who is your representative or power of attorney?

Copies of notices will be sent to the person named.

LAST NAME, FIRST NAME, MIDDLE INITIAL			RELATIONSHIP TO APPLICANT		<input type="checkbox"/> REPRESENTATIVE <input type="checkbox"/> POWER OF ATTORNEY
ADDRESS	CITY	STATE	ZIP CODE + 4	TELEPHONE NUMBER ()	

I WISH TO WITHDRAW MY APPLICATION

SIGNATURE	/ / DATE
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