

2. Spouse (If ever married, please answer the questions below)		B. Birthdate Month ____ Day ____ Year ____
A. Full Name of Spouse _____ Address of Spouse _____ _____ _____		C. If deceased, date of death Month ____ Day ____ Year ____
D. Social Security Number	E. Medicare Claim Number	F. Civil Service Annuity Number
G. Railroad Retirement Number	H. Is/was your spouse a Veteran Yes () No ()	I. Veterans Benefit Number

3. Dependents

A. If you have dependent children living in your home, complete the questions below.

Child's Name	Date of Birth	Social Security Number

B. Dependent's Gross Income:

Source _____	Source _____
Amount _____	Amount _____
Frequency _____	Frequency _____

4. Living Arrangements

A. Do you or your spouse have shelter costs? (House payments, rent, utilities, etc.) Yes () No ()
 If yes, specify type and amount of expenses below. All shelter costs must be verified.

Type of Expense	Amount of Payment	Other
Mortgage	\$ _____	Balance due:
Taxes	\$ _____	How often paid?
Insurance	\$ _____	How often paid?
Rent	\$ _____	How often paid?
Utilities		
[] Heating	\$ _____	
[] Electricity	\$ _____	
[] Air Conditioning	\$ _____	

B. Does anyone pay food or shelter costs for you or give you money to pay these costs? Yes () No ()
 If yes, specify type of expenses and amount paid below.

Type of Expense	Amount of Payment	Who Pays
	\$ _____	
	\$ _____	

5. Medical

A. Name and address of your primary physician.

B. Have you visited your doctor or have you been hospitalized during the last three months?

Yes () No ()

Name & address of hospital

C. Are you requesting retroactive assistance for any of the last three months? Yes () No ()

If yes, for what months?

6. Authorized Representative

A. If you are completing this form for another person give:

Your Full Name (Print) _____

Address _____

Telephone (_____) _____

Your Title or Relationship to Applicant _____

B. Name & address of applicant's relative or friend who may be contacted for information:

Telephone (_____) _____

7. Legal Guardian/Power of Attorney

Do you have a legal (court-appointed) guardian? Yes () No ()

Do you have a Power of Attorney? Yes () No ()

Name and address of this person _____

Their telephone number _____

Date of guardianship or Power of Attorney (Month & Year) _____

Please provide a copy of document unless previously provided.

8. Resources/Assets

Complete questions below for yourself and your spouse.

(Include all your resources/assets, and those owned by your spouse or owned jointly with anyone.)

(NOTE: YOU ARE REQUIRED TO VERIFY ALL OF THE FOLLOWING INFORMATION)

A. Cash on hand, savings at home, or money held by friends/relatives Yes () No ()

Description:	Owner(s):	Value: \$
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B. Do you have money in a nursing home account? Yes () No ()

Current Balance:

C. Do you or your spouse have checking accounts or money market accounts? Yes () No ()

Bank Name & Address:	Owner(s):	Current Balance: \$ \$ \$ \$	Account Number: 1. 2. 3. 4. Does checking acct. pay interest? Yes () No ()
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NOTE: You are required to attach copies of your most recent bank statements

D. Do you or your spouse have savings accounts? Yes () No ()

Bank Name & Address:	Owner(s):	Balance: \$ \$ \$ \$	Account Number: 1. 2. 3. 4.
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E. Do you or your spouse have certificates of deposit? Yes () No ()

Bank Name & Address:	Owner(s):	Current Value: \$ \$ \$ \$	Certificate #: 1. 2. 3. When is interest Paid? ◆ Monthly ◆ Quarterly ◆ Semi-Annually ◆ Annually
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F. Do you or your spouse own U.S. bonds? Yes () No ()

Description:	Owner(s):	Total Value:	Series# Purch. Date: _____ _____ _____ _____
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G. Do you or your spouse have funds such as Keogh, or IRA's? Yes () No ()			
Describe:	Owner(s):	Total Value: \$ \$ \$	Name & Address of Institution
H. Do you or your spouse have funds in an annuity or any similar plan or legal instrument? Yes () No () (Please read annuity disclosure information and information concerning when the State shall be named beneficiary of an annuity provided on page 11.)			
Describe:	Owner(s):	Total Value: \$	Date of Purchase:
I. Are you or your spouse named in any trust? Yes () No ()			
Describe:	Owner(s):	Total Value: \$	Name of Trustee:
J. Do you or your spouse have municipal/corporate/government bonds? Yes () No ()			
Describe:	Owner(s):	Total Value: \$	Name & Address of Institution
K. Do you or your spouse have stocks or mutual funds? Yes () No ()			
Describe:	Owner(s):	Total Value: \$	Name & Address of Institution
L. Do you or your spouse have a safety deposit box? Yes () No ()			
Location:	Owner(s):	List Contents:	
M. Do you or your spouse own a home? Yes () No ()			
Location:	Owner(s):	Who lives in the home Amount owned on home? \$ _____	
N. Do you or your spouse own real property (land, city lots, etc.)? Yes () No ()			
Is this property rented? Yes () No ()	Owner(s):	Value: \$	County Located:
O. Do you or your spouse own any buildings or property rights (including mineral or timber rights)? Yes () No ()			
Where? (County & State)	Owner(s):	Value: \$	Description:

P. Do you or your spouse retain a life estate in any property? Yes () No ()			
Owner(s) of property	County Location:	Property Value: \$	Legal Description:
Q. Do you or your spouse have real property held in trust by the U.S. Government (ie: lease land)? Yes () No ()			
Tribe of Enrollment: County:	Enrollment Number:	Yearly Lease Income: \$	IIM Account No.:
R. Do you or your spouse own business equipment, machinery, livestock, antiques, or collections other than household furnishings? Yes () No ()			
Please List _____ _____ _____ _____ _____			Value: \$ \$ \$ \$ \$ \$
S. Have you or your spouse sold property on a contract for deed? Yes () No ()			
Balance Due on Contract: \$ _____	Owner(s) of property:	Description of Property:	
T. Do you or your spouse have ownership in licensed or unlicensed cars, trucks, motorcycles, boats, recreational vehicles (camper, snowmobile), or any other vehicle? Yes () No () If yes complete below.			
Owner's First and Last Name:	Co-owner's First and Last Name:	Amount Owed:	
Year, Type, Make and Model of Vehicle:	Primary Use of Vehicle:	Value: \$	
Owner's First and Last Name:	Co-owner's First and Last Name:	Amount Owed:	
Year, Type, Make and Model of Vehicle:	Primary Use of Vehicle:	Value: \$	

U. Do you or your spouse have life insurance policies? Yes () No ()
 If yes, list all policies:

Policy No.	Name of Company	Address	Policy Owner	Face Value	Cash Value

V. Do you or your spouse have any financial arrangements such as contracts, insurance, or accounts designated for burial? Yes () No () **If yes, list below.**

<u>Applicant</u>	<u>Spouse</u>
Where? _____ _____	Where? _____ _____
Face Value _____	Face Value _____
Does the interest stay in this account? Yes () No () If no, is the interest paid to you? Yes () No ()	Does the interest stay in this account? Yes () No () If no, is the interest paid to you? Yes () No ()

9. Property/Assets In Trust Or Transferred (See statement regarding transfers on page 11)

A. In the last thirty-six months have you, your spouse, or anyone on behalf of you or your spouse, transferred, given away, gifted, loaned, or deeded sole or joint ownership in anything of value, such as money, land buildings, etc.?
 Yes () No () If yes, complete below.

1. Item transferred, given away, gifted, loaned, or deeded: _____
 Date of transactions(s): Month _____ Year _____
 Cash Value at time of transfer: \$ _____
 What did you receive in return: _____

2. Item transferred, given away, gifted, loaned, or deeded: _____
 Date of transactions(s): Month _____ Year _____
 Cash Value at time of transfer: \$ _____
 What did you receive in return: _____

3. Item transferred, given away, gifted, loaned, or deeded: _____
 Date of transactions(s): Month _____ Year _____
 Cash Value at time of transfer: \$ _____
 What did you receive in return: _____

<p>B. In the last 36 months have you, your spouse, or anyone established a joint ownership in any real property owned by either you or your spouse? Yes () No () If yes, complete below.</p>
<p>1. Date of Joint Ownership: _____ Type of property: _____ Name of Joint Owner: _____ Address of Joint Owner: _____</p> <p>2. Date of Joint Ownership: _____ Type of property: _____ Name of Joint Owner: _____ Address of Joint Owner: _____</p>
<p>C. In the last 36 months has a joint owner taken possession of their share in any of your or your spouse's asset such as money, savings accounts, checking accounts, certificates of deposits, bonds, stocks, or anything else of value?</p>
<p>1. Date joint owner took possession of their share: Month _____ Day _____ Year _____ List the type of asset: _____ Name of joint owner: _____ Address of joint owner: _____</p> <p>2. Date joint owner took possession of their share: Month _____ Day _____ Year _____ List the type of asset: _____ Name of joint owner: _____ Address of joint owner: _____</p>
<p>D. In the last sixty months were any of your, your spouse's funds, or property placed in trust for you, your spouse, or anyone else? Yes () No () If yes, complete following:</p>
<p>1. Date Established: _____ Value: _____ Name of Trustee: _____ Address of Trustee: _____</p> <p>2. Date Established: _____ Value: _____ Name of Trustee: _____ Address of Trustee: _____</p>
<p>E. In the last 36 months has any payment from a trust (either income or principal) become unavailable to you or your spouse? Yes () No () If yes, complete the following:</p>
<p>Date payment stopped or ceased to be available: Month _____ Day _____ Year _____ Name of Trustee: _____ Address of Trustee: _____</p>
<p>F. Is any of your income paid directly into a trust? Yes () No () If yes, complete below:</p>
<p>Date trust was established. Month _____ Day _____ Year _____ Name of Trustee: _____ Address of Trustee: _____</p>

10. Health Insurance/Nursing Home Insurance

A. Do you or your spouse have any health insurance coverage? Yes () No ()
 If yes, complete below for each person insured.

Insurance Company Name & Address	Policy Number	Type of Coverage	Premium Amount
_____ _____ _____	_____	♦ Inpatient Hospital ♦ Outpatient ♦ Dental ♦ Cancer ♦ Medicare Supplement ♦ Other (i.e. prescriptions, Workman's Compensations)	Paid: \$ _____ ♦ Monthly ♦ Quarterly ♦ Semi-Annually ♦ Annually
Name of Insured _____ Policy Holder Name _____	Group Number _____ Policy Began ___/___/___		Employer Name (if have group insurance)
Insurance Company Name & Address	Policy Number	Type of Coverage	Premium Amount
_____ _____ _____	_____	♦ Inpatient Hospital ♦ Outpatient ♦ Dental ♦ Cancer ♦ Medicare Supplement ♦ Other (i.e. prescriptions, Workman's Compensations)	Paid: \$ _____ ♦ Monthly ♦ Quarterly ♦ Semi-Annually ♦ Annually
Name of Insured _____ Policy Holder Name _____	Group Number _____ Policy Began ___/___/___		Employer Name (if have group insurance)

B. Do you or your spouse have any Nursing Home Insurance? Yes () No ()
 If yes, complete below for each person insured.

Company & Address	Policy #	Person Insured	Premium Amount
_____ _____ _____	_____		Paid: \$ _____ ♦ Monthly ♦ Quarterly ♦ Semi-Annually ♦ Annually
_____ _____ _____	_____		Paid: \$ _____ ♦ Monthly ♦ Quarterly ♦ Semi-Annually ♦ Annually
_____ _____ _____	_____		Paid: \$ _____ ♦ Monthly ♦ Quarterly ♦ Semi-Annually ♦ Annually

10. <u>Income</u> (List all income and benefits that you or your spouse receive from any source.)			
Please provide proof of all income received.		List amount of income. If not received monthly, indicate how often.	
		You	Your Spouse
A. Actual amount of your Social Security Check	Yes () No ()		
B. SSI (Supplemental Security Income)	Yes () No ()		
C. Veterans Benefits	Yes () No ()		
D. Veterans Compensation	Yes () No ()		
E. Railroad Retirement	Yes () No ()		
F. Civil Service Annuity	Yes () No ()		
G. Other Pension If yes, list name, address, & acct #.	Yes () No ()		
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<hr/>			
H. Annuities	Yes () No ()		
I. Trusts	Yes () No ()		
J. Insurance Payments	Yes () No ()		
K. IRA/KEOGH Payments	Yes () No ()		
L. Interest Income (on bonds, bank acct's, CD's etc.)	Yes () No ()		
M. Lease Income	Yes () No ()		
N. Rental Income	Yes () No ()		
O. BIA General Assistance	Yes () No ()		
P. Payments on Contract for Deed	Yes () No ()		
Q. Contributions from Relatives or Others	Yes () No ()		
R. Gross Earnings from Employment	Yes () No ()		
S. Child Support Payments	Yes () No ()		
T. Alimony Payments	Yes () No ()		
U. Income from Mineral or Timber Rights	Yes () No ()		
V. Income from Life Estate	Yes () No ()		
W. Any Other Income	Yes () No ()		

12. Certification of Citizenship or Alien Status

Effective July 1, 2006, Public Law No. 109-171 Deficit Reduction Act of 2005 Section 6036 requires individuals to provide satisfactory documentary evidence of citizenship or nationality, and, if not a citizen or national of the United States, that the individual is in a satisfactory immigration status when initially applying for Medicaid or upon a recipient's first Medicaid re-determination.

Any person who refuses or chooses not to provide information about their citizenship or alien status will not be eligible for benefits, however the individual may be required to answer questions and submit verifications about his or her income/resources, etc. The individual's information may affect the eligibility and/or benefit level of the applicant or recipient of medical assistance.

EXCEPTION: Emergency medical assistance may be available to otherwise eligible individuals regardless of their citizenship, immigration status, or having a Social Security Number.

Non-citizens applying for or receiving benefits will need to show documentation of immigration status from the Immigration and Naturalization Service (INS). This proof will be verified by the Department of Social Services through INS. Information received from INS may affect your household's eligibility and level of benefits.

Name on Birth Certificate	Status*	Place of Birth (City and State)

*List status of each person such as: Citizen, Lawful Alien, Student, Visa, etc.

ASSIGNMENT OF MEDICAL SUPPORT, INSURANCE PROCEEDS

An application for and acceptance of medical assistance paid from the Department of Social Services shall operate as an assignment and subrogation of any rights to medical support, insurance proceeds, or both that the applicant or recipient may have. Any rights or amounts so assigned or subrogated shall be applied against the cost of the applicant's or recipient's care

DISCLOSURE OF ANNUITIES AND STATE TO BE NAMED AS REMAINDER BENEFICIARY

Public Law No. 109-171 Deficit Reduction Act of 2005 Section 6012 requires individuals applying for long-term care medical assistance and an individual whose eligibility is being reviewed for purposes of determining whether the individual continues to be eligible for long-term care assistance to disclose the description of any interest the individual or the individual's spouse has in an annuity or similar financial instrument. Failure to disclose this information results in ineligibility for assistance. In addition, by virtue of receipt of long term care assistance, the department shall be named as a preferred remainder beneficiary of any interest the individual or individual's spouse has in an annuity or similar financial instrument purchased and owned after February 7, 2006.

Note: The annuity will also be considered a potential resource.

TRANSFER OF ASSETS FOR LESS THAN FAIR MARKET VALUE

Public Law No. 109-171 Deficit Reduction Act of 2005 Section 6011 requires the department to use the following look back periods when determining whether an asset was transferred for less than fair market value.

If the asset was transferred before February 8, 2006 and was not transferred to a trust or similar legal device, the look back period extends back to 36 months before the first day an individual is institutionalized and applies for long-term care assistance. If the asset was transferred to a trust or similar legal device, the look back period extends back 60 months.

If the asset was transferred after February 7, 2006, the look-back period for all transfers extends back to the date 60 months before the first day an individual is institutionalized and applies for long-term care assistance.

ESTATE RECOVERY AND MEDICAL ASSISTANCE LIENS

Under Federal and State law, the Department of Social Services is authorized to make recovery from the estates of deceased medical assistance recipients, who were permanently institutionalized or who were at least 55 years of age and for whom the Department made

a payment for nursing facility services; intermediate care facility services for the mentally retarded; other medical institutional services, home and community based services; hospital services; and prescription drug services. The Department of Social Services is authorized to recover the debt of a medical assistance recipient from the estate of a surviving spouse. If a surviving spouse wishes to limit the amount of the surviving spouse's estate that will be liable for recovery for the amount of medical assistance paid on behalf of the recipient, the surviving spouse must file a petition within six months of the death of the medical assistance recipient. The petition will determine the amount of the surviving spouse's estate from which recovery may be claimed for Medicaid expended on behalf of the applicant indicated below. The petition must be filed on the Department's form.

Under Federal and State law, the Department of Social Services may impose a medical assistance lien against real property owned by a recipient who has received a benefit from the Department of Social Services for the services of a nursing facility, an intermediate care facility for the mentally retarded, or other medical institution. The Department of Social Services will issue a separate notice when the Department decides to impose a lien. The notice will describe the amount of the lien and the real property to which the lien is to attach.

Under State law, the Department of Social Services is authorized to recover any funds of the resident kept or maintained by the home or other facility if the resident was receiving medical assistance from the Department at the time of death.

Privacy Act Statement

Federal and State Law Regulations limit the use and disclosure of confidential information concerning applicants and recipients of economic and medical assistance programs to purposes directly related to the administration of those programs. When you apply for assistance from the Department of Social Services, you will be asked to provide your Social Security Number on the application form. Title 42 of the Code of Federal Regulations Part 435.910(a), requires the furnishing of Social Security Numbers as a condition of eligibility for Medicaid. The Department uses your number in its computer processing for eligibility determination, welfare fraud investigations and audits. Social Security Numbers are also used to verify income information, through agencies such as Internal Revenue Service, Department of Labor, and Social Security Administration, etc. to prevent a person or family from receiving duplicate benefits under any program, to make mass changes in benefits easier to implement and to determine the accuracy and reliability of information given to the department by applicants for and recipients of assistance.

Verifications

Information you give to answer the questions on this form, and information obtained by the department to verify your answers will be used to determine your eligibility and level of benefits. Your benefits may change from month to month, or be stopped, based on this information.

Federal and state officials will verify information given on this form to determine if it is correct. A department representative may contact you or may contact other people in order to verify your eligibility for assistance. Information given will also be verified by computer cross-matching with other agencies and private sectors. When state and federal personnel verify the information on this application, if what is reported is found to be incorrect your Medical case may be denied or terminated and you may be subject to criminal prosecution for knowingly providing false information.

