

**APPLICATION/REDETERMINATION FOR MEDICAID FOR
SSI RECIPIENTS**

AGENCY USE ONLY		
CASE NAME		LOCALITY
CASE NUMBER	WORKER	DATE RECEIVED

A. IDENTIFYING INFORMATION

NAME: _____ SOCIAL SECURITY #: _____ DATE OF BIRTH: _____
 ADDRESS: _____ TELEPHONE NUMBER: _____
 MARITAL STATUS: NEVER MARRIED _____ MARRIED _____ SEPARATED _____ WIDOWED _____ DIVORCED _____
 SEX: _____ COUNTRY OF ORIGIN: _____ CITIZEN/ALIEN STATUS: _____
 LANGUAGE (Enter Code): _____ 1 - English 2 - Spanish 3 - Cambodian 4 - Vietnamese 5 - Farsi 6 - Haitian-Creole 7 - Laotian 8 - Chinese
 9 - Korean A - Somali B - Kurdish C - Arabic F - French G - German J - Japanese O - Other
 RACE (Enter Code): _____ 1 - White 2 - Black/African-American 3 - American Indian/Alaskan Native 4 - Asian 5 - Native Hawaiian/OtherPacific Islander
 6 - American India/Alaskan Native and White 7 - Asian and White 8 - Black/African-American and White
 9 - American Indian/Alaskan Native and Black/African-American A - Asian and Black B - Other
 ETHNICITY (Enter Code): _____ 1 - Hispanic or Latino 2 - Not Hispanic or Latino

B. ADDITIONAL INFORMATION

	CIRCLE ONE
1. I AM A RESIDENT OF VIRGINIA.	YES NO
2. I RECEIVE A SUPPLEMENTAL SECURITY INCOME (SSI) CHECK.	YES NO
3. I OWN, HAVE AN INTEREST IN, OR HAVE INHERITED REAL PROPERTY (LAND OR BUILDINGS).	YES NO
TYPE OF PROPERTY: _____ ACREAGE: _____	
VALUE: \$ _____ LOCATION: _____	
4. I HAVE OTHER RESOURCES SUCH AS LIVESTOCK, CAR, TRUCK, CAMPER, MOBILE HOME, RETIREMENT ACCCOUNT, LIFE INSURANCE, BANK ACCOUNT, STOCKS, BONDS, SAVINGS CERTIFICATES, PATIENT FUND ACCOUNT, TRUST FUNDS, CASH, BURIAL PLOTS, OR BURIAL ARRANGEMENTS.	YES NO
RESOURCE: _____ VALUE: _____	
RESOURCE: _____ VALUE: _____	
RESOURCE: _____ VALUE: _____	
5. I HAVE SOLD, TRADED, OR GIVEN AWAY ASSETS (LAND, BUILDINGS, BANK ACCOUNTS, MONEY, CARS, STOCKS, TRUST FUNDS, INCOME, ETC.) DURING THE PREVIOUS 60 MONTHS.	YES NO
WHEN: _____ TO WHOM: _____	
WHAT: _____ AMOUNT RECEIVED: \$ _____	
6. I HAVE MEDICARE.	YES NO
MEDICARE #: _____	
PART A EFFECTIVE DATE: _____ PART B EFFECTIVE DATE: _____	
7. I HAVE OTHER HEALTH INSURANCE.	YES NO
COMPANY NAME: _____ POLICY #: _____	
TYPE OF COVERAGE: _____ EFFECTIVE DATE: _____	
8. I LIVE IN A NURSING FACILITY OR STATE INSTITUTION.	YES NO
IF YOU STILL OWN YOUR HOME, WHO LIVES IN IT. _____ (NAME AND RELATIONSHIP)	
10. I RECEIVED MEDICAL CARE DURING THE THREE MONTHS BEFORE THIS APPLICATION.	YES NO
FROM: _____ DATE: _____	

RIGHTS AND RESPONSIBILITIES

I UNDERSTAND THAT I MUST REPORT ANY CHANGES THAT OCCUR IN MY SITUATION TO THE DEPARTMENT OF SOCIAL SERVICES WITHIN TEN DAYS. I AGREE TO ASSIGN MY RIGHTS TO MEDICAL SUPPORT AND OTHER THIRD-PARTY PAYMENTS TO THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES, EFFECTIVE WITH MY COVERAGE UNDER MEDICAID. ALL MONEY I RECEIVE FOR (1) DIAGNOSIS OR TREATMENT OF ANY INJURY, DISEASE OR DISABILITY OR (2) MEDICAL CARE SUPPORT MUST BE SENT TO THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES, THIRD PARTY LIABILITY SECTION. I UNDERSTAND REFUSAL TO ASSIGN MY RIGHTS WILL MAKE ME INELIGIBLE FOR MEDICAID.

I UNDERSTAND THAT I HAVE THE RIGHT TO FILE A COMPLAINT IF I FEEL I HAVE BEEN DISCRIMINATED AGAINST BECAUSE OF RACE, COLOR, NATIONAL ORIGIN, SEX, AGE, HANDICAP, OR RELIGIOUS BELIEF. I UNDERSTAND THAT I HAVE THE RIGHT TO APPEAL AND HAVE A FAIR HEARING IF I AM (1) NOT NOTIFIED IN WRITING OF THE DECISION REGARDING MY APPLICATION WITHIN 45 DAYS; (2) DENIED MEDICAID; OR (3) DISSATISFIED WITH ANY OTHER DECISION THAT AFFECTS MY RECEIPT OF MEDICAID. I UNDERSTAND THAT REFUSAL TO COOPERATE WITH A REVIEW OF MY MEDICAID ELIGIBILITY BY QUALITY CONTROL WILL MAKE ME INELIGIBLE FOR MEDICAID UNTIL I COOPERATE WITH THE REVIEW.

I AUTHORIZE THE DEPARTMENT OF SOCIAL SERVICES AND THE DEPARTMENT OF MEDICAL ASSISTANCE TO OBTAIN ANY VERIFICATIONS NECESSARY TO ESTABLISH MY ELIGIBILITY FOR ASSISTANCE. I AUTHORIZE RELEASE TO THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES ANY INFORMATION IN ANY MEDICAL RECORDS PERTAINING TO ANY SERVICES RECEIVED BY ME AS A BENEFIT UNDER MY MEDICAL ASSISTANCE (MEDICAID) ELIGIBILITY.

I RECEIVED THE BOOKLETS: MEDICAID HANDBOOK [] YES [] NO BENEFIT PROGRAMS [] YES [] NO
 I FILLED IN THIS FORM MYSELF. [] YES [] NO IF NO, IT WAS READ BACK TO ME WHEN COMPLETED. [] YES [] NO

I DECLARE THAT ALL INFORMATION I HAVE GIVEN ON THIS APPLICATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND THAT IF I GIVE FALSE INFORMATION, WITHHOLD INFORMATION, OR FAIL TO REPORT A CHANGE PROMPTLY OR ON PURPOSE, I MAY BE BREAKING THE LAW AND COULD BE PROSECUTED FOR PERJURY, LARCENY, AND/OR WELFARE FRAUD. I UNDERSTAND THAT MY SIGNATURE ON THIS APPLICATION CERTIFIES, UNDER PENALTY OF PERJURY, THAT I AM A U.S. CITIZEN OR ALIEN IN LAWFUL IMMIGRATION STATUS.

SIGNATURE OR MARK: _____ DATE: _____

WITNESS/AUTHORIZED REPRESENTATIVE: _____ DATE: _____

I COMPLETED THIS APPLICATION/REDETERMINATION FOR _____ I UNDERSTAND THAT IF I AIDED OR ABETTED THIS INDIVIDUAL IN OBTAINING ASSISTANCE FOR WHICH HE IS NOT ELIGIBLE, THAT I MAY BE BREAKING THE LAW AND COULD BE PROSECUTED.

SIGNATURE: _____ RELATIONSHIP: _____ DATE: _____

ADDRESS: _____ TELEPHONE#: _____

VOTER REGISTRATION

CHECK ONE OF THE FOLLOWING:

- () I AM NOT REGISTERED TO VOTE WHERE I CURRENTLY LIVE NOW, AND I WOULD LIKE TO REGISTER TO VOTE HERE TODAY. I CERTIFY THAT A VOTER REGISTRATION FORM WAS GIVEN TO ME TO COMPLETE. (IF YOU WOULD LIKE HELP IN FILLING OUT THE VOTER REGISTRATION, WE WILL HELP YOU. THE DECISION TO HELP YOU IS YOURS. YOU ALSO HAVE THE RIGHT TO COMPLETE YOUR FORM IN PRIVATE.)
- () I AM REGISTERED TO VOTE AT MY CURRENT ADDRESS. (IF ALREADY REGISTERED AT YOUR CURRENT ADDRESS, YOU ARE NOT ELIGIBLE TO REGISTER TO VOTE.)
- () I DO NOT WANT TO APPLY TO REGISTER TO VOTE.
- () I DO WANT TO APPLY TO REGISTER TO VOTE. PLEASE SEND ME A VOTER REGISTRATION FORM.

APPLYING TO REGISTER OR DECLINING TO REGISTER TO VOTE WILL NOT AFFECT THE ASSISTANCE OR SERVICES THAT YOU WILL BE PROVIDED BY THIS AGENCY. A DECISION NOT TO APPLY TO REGISTER TO VOTE WILL REMAIN CONFIDENTIAL. A DECISION TO APPLY TO REGISTER TO VOTE AND THE OFFICE WHERE YOUR APPLICATION WAS SUBMITTED WILL ALSO REMAIN CONFIDENTIAL AND MAY ONLY BE USED FOR VOTER REGISTRATION PURPOSES. 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 TO VOTE, OR YOUR RIGHT IN APPLYING TO REGISTER TO VOTE, YOU MAY FILE A COMPLAINT WITH: SECRETARY OF VIRGINIA STATE BOARD OF ELECTIONS, NINTH STREET OFFICE BUILDING, 200 NORTH NINTH STREET, RICHMOND, VA 23219-3497. THE PHONE NUMBER IS (804) 786-6551.

*****AGENCY USE ONLY *****

A.	ELEMENTS OF EVALUATION	VERIFICATION/PERTINENT INFORMATION	MEETS ELIGIBILITY REQUIREMENTS
1.	VA RESIDENCY, IF QUESTIONABLE	_____	YES NO
2.	RECEIVES SSI CHECK If no, have the individual complete the Application for Benefits.	SDX _____ SVES _____ OTHER _____	YES NO
3.	SSI CONDITIONAL/PRESUMPTIVE	_____	YES NO
4.	ASSET TRANSFER	_____	YES NO
5.	RESOURCES (IF HAS A TRUST OR OWNS UNDIVIDED HEIR PROPERTY, CONTIGUOUS PROPERTY, FORMER HOME, OR OTHER REAL PROPERTY)	_____	
	VALUE OF COUNTABLE RESOURCES	\$ _____	YES NO

B. RECOMMENDATION

- 1. CURRENT ELIGIBILITY: ELIGIBLE: _____ EFFECTIVE DATE: _____ INELIGIBLE _____
- 2. RETROACTIVE ELIGIBILITY: ELIGIBLE: _____ EFFECTIVE DATE: _____ INELIGIBLE _____

WORKER'S SIGNATURE: _____ DATE: _____

SUPERVISOR'S SIGNATURE: _____ DATE: _____

C. ENROLLMENT

SPEC REVIEW: _____ CTY: _____ CI: _____ BEGIN: _____ END: _____ TYPE: _____

PD: 11 _____ 31 _____ 51 _____ APP DATE: _____ MEDICAL RESOURCE: _____ TYPE COV: _____

INS CO: _____ POLICY NUMBER: _____ BEGIN DATE: _____ END DATE: _____