

COMBINED APPLICATION FOR STATE AND COUNTY MEDICAL ASSISTANCE

| | |
|---|--|
| Date Application Received: _____ | Lien Instrument #: _____ Filing Date: _____ UCC Filing Date: _____ |
| Mark the Type of Application: <input type="checkbox"/> Emergency 31-Day <input type="checkbox"/> Additional Request <input type="checkbox"/> Non-Emergency 10-Day Prior <input type="checkbox"/> 180-Day Delayed (Justification Must be Attached) | |

By signing below, I acknowledge that by completing this application form, it will be used to determine my eligibility for BOTH County Indigent Medical Assistance and Idaho Health and Welfare Medicaid program. I also accept and acknowledge that I have read, understand, and will comply with rules promulgated by the Department of Health & Welfare and the Board of the Catastrophic Health Care Cost Program, pursuant to Title 31, Chapter 35, Idaho Code.

Applicant's Signature _____

Co-Applicant's Signature _____

IMPORTANT NOTICE: If you need any of the following assistance, please ask. These services are free:

- Language Interpreter. (Nosotros proveemos los servicios de un interprete, sin costo alguno.) Call 2-1-1 or 1-800-926-2588 or TDD 208-332-7205.
- Help filling out this form.
- Accommodation for a disability.

INSTRUCTIONS: Read all questions and instructions carefully. Answer each question as completely as possible. If you need to provide more information than space allows, attach extra sheets.

What is your preferred language? Spoken _____ Written _____

Do you want an interpreter if you are interviewed? One will be provided at no cost to you. No Yes

¿Usted necesita a intérprete si usted tiene una entrevista? Uno estará disponible en ningún costo para usted. No Sí

List an alternate contact person in the event we are unable to reach someone listed on this application.

| | | | |
|------------|-----------|--------------|-------------------------|
| First Name | Last Name | Phone number | Relationship to patient |
| | | | |

Tell Us What Medical Services You are Requesting

DIAGNOSIS / REQUEST:

| PROVIDER NAME, ADDRESS, & PHONE | DATES OF SERVICE | TYPE OF SERVICE | AMOUNT |
|---------------------------------|------------------|-----------------|--------|
| | FROM: | | |
| | TO: | | |
| | FROM: | | |
| | TO: | | |
| | FROM: | | |
| | TO: | | |
| | FROM: | | |
| | TO: | | |
| | FROM: | | |
| | TO: | | |
| | FROM: | | |
| | TO: | | |

Tell Us Who You Are

* If you need to provide more information, please attach extra sheets.

| | | |
|---|--|--|
| <p>ATTENTION: This combined application will be used to determine your program eligibility. Complete the application in its entirety and <u>attach extra sheets if more space is needed.</u></p> <p>List every person living in your home.</p> <p>Add an additional sheet if you need to include more household members. Social Security numbers and citizenship status are required for those applying for services. Use the code key to indicate your Marital Status and Race. NOTE: Your responses to Race are optional.</p> <p>Mark the appropriate box for the patient and anyone applying for Medicaid.</p> | <p>Race Codes: White Black Asian American Indian/Alaska Native Native Hawaiian/Pacific Island Hispanic/Latino</p> | <p>WH BL AS AL HP HL</p> |
| | <p>Marital Status Codes: Married Never Married Divorced Separated Widowed</p> | <p>MA NM DI SE WI</p> |

| YOURSELF / APPLICANT | | <input type="checkbox"/> Mark here if this is the Patient | <input type="checkbox"/> Mark here if you are applying for Medicaid for this person. | | | |
|---|--|---|---|-------------------|--|--|
| First Name | Middle Initial | Last Name | Date of Birth | Social Security # | Relationship SELF | |
| Former Names, if any | Sex <input type="checkbox"/> M <input type="checkbox"/> F | Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No Due Date | Race | Marital Status | U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No Alien ID # | |
| Student? <input type="checkbox"/> Yes <input type="checkbox"/> No Grade: <input type="checkbox"/> Full Time Name of School: <input type="checkbox"/> Part Time | Primary Doctor / Clinic (first & last name) | | Phone Number | | Sponsor Name | |
| Birth Country | | Birth State (if U.S.) | Enrolled Native American Tribe member? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Tribe: | | | |
| Are you a Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No | VA ID#: _____ Type of Discharge: _____ | Registered to Vote? <input type="checkbox"/> Yes <input type="checkbox"/> No State/County? | Licensed to Drive? <input type="checkbox"/> Yes <input type="checkbox"/> No State? | | | |
| Do you person plan to file a federal tax return for the CURRENT YEAR? <input type="checkbox"/> Yes. Complete questions a, b, and c. <input type="checkbox"/> No. Skip to question c. | | | | | | |
| a. Filing jointly with a spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of spouse: _____ | | | | | | |
| b. Claiming dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of dependents: _____ | | | | | | |
| c. Claimed as a dependent on someone's tax return who does not live at the address(es) listed on page 2 of this application? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | |
| Daytime Phone Number | Type: (work, home, cell) | Message Phone Number | Type: (work, home, cell) | Email Address | | |
| Physical Address | City | State | Zip Code | County | From (date): To: Present | |
| Mailing Address, if different | City | State | Zip Code | County | From (date): To: Present | |
| CO-APPLICANT / SPOUSE / SIGNIFICANT OTHER | | <input type="checkbox"/> Mark here if this is the Patient | <input type="checkbox"/> Mark here if you are applying for Medicaid for this person. | | | |
| First Name | Middle Initial | Last Name | Date of Birth | Social Security # | Relationship | |
| Former Names, if any | Sex <input type="checkbox"/> M <input type="checkbox"/> F | Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No Due Date | Race | Marital Status | U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No Alien ID # | |
| Student? <input type="checkbox"/> Yes <input type="checkbox"/> No Grade: <input type="checkbox"/> Full Time Name of School: <input type="checkbox"/> Part Time | Primary Doctor / Clinic (first & last name) | | Phone Number | | Sponsor Name | |
| Birth Country | | Birth State (if U.S.) | Enrolled Native American Tribe member? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Tribe: | | | |
| Does this person plan to file a federal tax return for the CURRENT YEAR? <input type="checkbox"/> Yes. Complete questions a, b, and c. <input type="checkbox"/> No. Skip to question c. | | | | | | |
| a. Filing jointly with a spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of spouse: _____ | | | | | | |
| b. Claiming dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of dependents: _____ | | | | | | |
| c. Claimed as a dependent on someone's tax return who does not live at the address(es) listed on page 2 of this application? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | |
| Daytime Phone Number | Type: (work, home, cell) | Message Phone Number | Type: (work, home, cell) | Email Address | | |
| Physical Address | City | State | Zip Code | County | From (date): To: Present | |
| Mailing Address, if different | City | State | Zip Code | County | From (date): To: Present | |

Tell Us About the People Who Live With You

* If you need to provide more information, please attach extra sheets.

| | | | | | | |
|---|--|--|------|---|--|--------------|
| OTHER (child, roommate, parent, etc.) | | <input type="checkbox"/> Mark here if this is the Patient | | <input type="checkbox"/> Mark here if you are applying for Medicaid for this person. | | |
| First Name | Middle Initial | Last Name | | Date of Birth | Social Security # | Relationship |
| Former Names, if any | Sex <input type="checkbox"/> M <input type="checkbox"/> F | Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No Due Date | Race | Marital Status | U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No Alien ID # | |
| Student? <input type="checkbox"/> Yes <input type="checkbox"/> No Grade: <input type="checkbox"/> Full Time Name of School: <input type="checkbox"/> Part Time | Primary Doctor / Clinic (first & last name) | | | Phone Number | Sponsor Name | |
| | Birth Country | Birth State (if U.S.) | | Enrolled Native American Tribe member? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Tribe: | | |
| Does this person plan to file a federal tax return for the CURRENT YEAR? <input type="checkbox"/> Yes. Complete questions a, b, and c. <input type="checkbox"/> No. Skip to question c. | | | | | | |
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| b. Claiming dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of dependents: | | | | | | |
| c. Claimed as a dependent on someone's tax return who does not live at the address(es) listed on page 2 of this application? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | |
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| Student? <input type="checkbox"/> Yes <input type="checkbox"/> No Grade: <input type="checkbox"/> Full Time Name of School: <input type="checkbox"/> Part Time | Primary Doctor / Clinic (first & last name) | | | Phone Number | Sponsor Name | |
| | Birth Country | Birth State (if U.S.) | | Enrolled Native American Tribe member? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Tribe: | | |
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| b. Claiming dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of dependents: | | | | | | |
| c. Claimed as a dependent on someone's tax return who does not live at the address(es) listed on page 2 of this application? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | |
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| First Name | Middle Initial | Last Name | | Date of Birth | Social Security # | Relationship |
| Former Names, if any | Sex <input type="checkbox"/> M <input type="checkbox"/> F | Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No Due Date | Race | Marital Status | U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No Alien ID # | |
| Student? <input type="checkbox"/> Yes <input type="checkbox"/> No Grade: <input type="checkbox"/> Full Time Name of School: <input type="checkbox"/> Part Time | Primary Doctor / Clinic (first & last name) | | | Phone Number | Sponsor Name | |
| | Birth Country | Birth State (if U.S.) | | Enrolled Native American Tribe member? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Tribe: | | |
| Does this person plan to file a federal tax return for the CURRENT YEAR? <input type="checkbox"/> Yes. Complete questions a, b, and c. <input type="checkbox"/> No. Skip to question c. | | | | | | |
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| | Birth Country | Birth State (if U.S.) | | Enrolled Native American Tribe member? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Tribe: | | |
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| | | <input type="checkbox"/> Mark here if this is the Patient | | <input type="checkbox"/> Mark here if you are applying for Medicaid for this person. | | |
| First Name | Middle Initial | Last Name | | Date of Birth | Social Security # | Relationship |
| Former Names, if any | Sex <input type="checkbox"/> M <input type="checkbox"/> F | Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No Due Date | Race | Marital Status | U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No Alien ID # | |
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| b. Claiming dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of dependents: | | | | | | |
| c. Claimed as a dependent on someone's tax return who does not live at the address(es) listed on page 2 of this application? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | |

Tell Us About Residency for the Patient * If you need to provide more information, please attach extra sheets

Start with the current Address and work backward for five (5) years.

| | | | | | | |
|--|-----------------|-------|----------|-------------------------|--------------|-----|
| Physical Address | City | State | Zip Code | County | From (date): | To: |
| <input type="checkbox"/> Own? <input type="checkbox"/> Rent? | Landlord's Name | | | Landlord's Phone Number | | |
| Physical Address | City | State | Zip Code | County | From (date): | To: |
| <input type="checkbox"/> Own? <input type="checkbox"/> Rent? | Landlord's Name | | | Landlord's Phone Number | | |
| Physical Address | City | State | Zip Code | County | From (date): | To: |
| <input type="checkbox"/> Own? <input type="checkbox"/> Rent? | Landlord's Name | | | Landlord's Phone Number | | |
| Physical Address | City | State | Zip Code | County | From (date): | To: |
| <input type="checkbox"/> Own? <input type="checkbox"/> Rent? | Landlord's Name | | | Landlord's Phone Number | | |

Current Services and Health Coverage * If you need to provide more information, please attach extra sheets.

Please check any Programs from the list below that you are currently receiving assistance from. Your answer to this question will not affect your eligibility for benefits.

- Other State's Assistance Programs
 Children's or Adult Developmental Disabilities
 Infant and Toddler
 Children's or Adult Mental Health
 Foster Care or Adoption Assistance

Has anyone in your home ever received assistance from another state? Yes No
 If yes, from where? City _____ State _____ County _____ When? _____

List anyone in your home that:

| | NAME OF HOUSEHOLD MEMBER | DATE APPLICATION FILED | CURRENT STATUS OF APPLICATION |
|---|--------------------------|------------------------|-------------------------------|
| Has a disability | | | |
| Receives or has applied for Social Security | | | |
| Receives or has applied for Medicare | | | |
| Has applied for Medicaid in the past Year | | | |
| Has applied for Crime Victims in the past Year | | | |
| Needs medical assistance at home | | | |
| Lives with a relative who provides medical care | | | |
| Lives in a medical care facility | Name of Facility: _____ | | |

Are you a dependant of a full-time State employee? Yes No

Does anyone applying for **State Department of Health and Welfare** health coverage need help paying medical bills from the last three months? Yes No
 If Yes, who? _____

List gross income amount (before taxes) received by your family in each of the last three months.

| | | |
|------------|----------------|------------------|
| \$ | \$ | \$ |
| _____ | _____ | _____ |
| Last Month | Two Months Ago | Three Months Ago |

Would you like Healthy Connections to choose a doctor for you? Yes No

Do you have health insurance that covers inpatient/outpatient hospital, physician's medical and surgical, lab, and x-ray services? Yes No

List everyone in your household who has had health insurance in the past six (6) months.

| NAME OF PERSON(S) INSURED | DATE INSURANCE ENDED | REASON INSURANCE ENDED | NAME OF INSURANCE COMPANY | TYPE OF COVERAGE & POLICY NUMBER |
|---------------------------|----------------------|------------------------|---------------------------|----------------------------------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

If insurance ended due to loss of employment, have you received notification of COBRA? Yes No
 Does anyone in your household have access to any health insurance coverage not listed above? Yes No

Legal Information

* If you need to provide more information, please attach extra sheets.

Has anyone in your household been convicted of a felony involving drugs? Yes No
 If Yes, who: _____ Year: _____
 Is anyone fleeing to avoid felony prosecution or jail time? Yes No If Yes, who: _____
 Is anyone currently violating conditions of probation or parole? Yes No If Yes, who: _____
 Has anyone been disqualified from public assistance due to an intentional program violation? Yes No
 If Yes, who: _____ Year: _____ Where: _____

List any pending actions (such as lawsuits, inheritance, accident claim, insurance settlement, etc.) that may result in the receipt of money by anyone in your household.

| NAME OF HOUSEHOLD MEMBER | TYPE OF ACTION | BEGINNING DATE OF ACTION | CURRENT STATUS OF ACTION | CLAIM NUMBER |
|--------------------------|----------------|--------------------------|--------------------------|--------------|
| | | | | |
| | | | | |
| | | | | |

List the name, address, and phone number of your attorney. _____

List anyone in your household who has ever been disqualified from an assistance program.

| NAME OF HOUSEHOLD MEMBER | NAME OF PROGRAM | DATE DISQUALIFIED | REASON |
|--------------------------|-----------------|-------------------|--------|
| | | | |
| | | | |
| | | | |

General Information

* If you need to provide more information, please attach extra sheets.

Do you have any children in your home? Yes No
 If YES, do any of them have a parent NOT living with them? Yes No

** If you answered "yes" you will be required to give information about the absent parent(s) to Child Support Services and open a Child Support case unless you fear harm to yourself or your children. If you have questions about Child Support Cooperation, please call 1-800-356-9868 for more information.

| CHILD'S NAME | ABSENT PARENT'S NAME | ABSENT PARENT'S SSN | ABSENT PARENT'S DOB |
|--------------|----------------------|---------------------|---------------------|
| | | | |
| | | | |
| | | | |

Please list each person in your household that pays or receives child support.

| NAME | PAYS/RECEIVES | AMOUNT |
|------|---------------|--------|
| | | |
| | | |

List everyone in your home who PAYS child or adult care expenses due to work or school.

| | | | |
|---------------------------------|--|-------------------------------------|-------------------------------|
| Name: | Reason for Care: <input type="checkbox"/> Work <input type="checkbox"/> Work Search <input type="checkbox"/> School | Name of Child/Adult in Care: | Amount Paid: \$ How Often? |
| Name of Care Provider: | Do you get help paying for care? <input type="checkbox"/> No <input type="checkbox"/> Yes | If yes, how much do you receive? \$ | |
| Name of Person / Agency paying: | | | |
| Name: | Reason for Care: <input type="checkbox"/> Work <input type="checkbox"/> Work Search <input type="checkbox"/> School | Name of Child/Adult in Care: | Amount Paid: \$ How Often? |
| Name of Care Provider: | Do you get help paying for care? <input type="checkbox"/> No <input type="checkbox"/> Yes | If yes, how much do you receive? \$ | |
| Name of Person / Agency paying: | | | |

Tell Us About Your Income and Resources * If you need to provide more information, please attach extra sheets.

Earned Income: List all employment information for each person in your household.

| Patient/Applicant | | | Spouse/Significant Other/Co-Applicant | | |
|--|--------------|----------------|--|--------------|----------------|
| Current Employer Name: | | Phone No: | Current Employer Name: | | Phone No: |
| Address (street, city, state, zip) | | | Address (street, city, state, zip) | | |
| Hours per Week: | Hourly Rate: | Monthly Gross: | Hours per Week: | Hourly Rate: | Monthly Gross: |
| List Dates of Employment: From: _____ To: _____ | | | List Dates of Employment: From: _____ To: _____ | | |
| Previous Employer Name: | | Phone No: | Previous Employer Name: | | Phone No: |
| Address (street, city, state, zip) | | | Address (street, city, state, zip) | | |
| Hours per Week: | Hourly Rate: | Monthly Gross: | Hours per Week: | Hourly Rate: | Monthly Gross: |
| List Dates of Employment: From: _____ To: _____ | | | List Dates of Employment: From: _____ To: _____ | | |
| Other Household Member | | | Other Household Member | | |
| Current Employer Name: | | Phone No: | Current Employer Name: | | Phone No: |
| Address (street, city, state, zip) | | | Address (street, city, state, zip) | | |
| Hours per Week: | Hourly Rate: | Monthly Gross: | Hours per Week: | Hourly Rate: | Monthly Gross: |
| List Dates of Employment: From: _____ To: _____ | | | List Dates of Employment: From: _____ To: _____ | | |
| Other Household Member | | | Other Household Member | | |
| Current Employer Name: | | Phone No: | Current Employer Name: | | Phone No: |
| Address (street, city, state, zip) | | | Address (street, city, state, zip) | | |
| Hours per Week: | Hourly Rate: | Monthly Gross: | Hours per Week: | Hourly Rate: | Monthly Gross: |
| List Dates of Employment: From: _____ To: _____ | | | List Dates of Employment: From: _____ To: _____ | | |

Is the income provided above reflective of what you expect to earn for the entire calendar year (Jan. through Dec. of the current year)? Yes No If **No**, provide us with your anticipated annual gross income (weekly amount before taxes x 4.3 x 12= annual gross income): \$ _____

Is anyone in the household self-employed? Yes No Who? _____
Name of Business _____ Years in Business _____

Unearned Income Is anyone receiving income from the following sources? Check all that apply.

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Social Security / SSI / SSD | <input type="checkbox"/> Veteran's Benefits | <input type="checkbox"/> Food Stamps | <input type="checkbox"/> Cash Assistance / TAFI |
| <input type="checkbox"/> Worker's Compensation | <input type="checkbox"/> Child Support | <input type="checkbox"/> Alimony | <input type="checkbox"/> Employer Disability |
| <input type="checkbox"/> Crime Victims | <input type="checkbox"/> Unemployment | <input type="checkbox"/> Energy Assistance | <input type="checkbox"/> School Financial Aid |
| <input type="checkbox"/> Retirement | <input type="checkbox"/> Tribal/BIA Assistance | <input type="checkbox"/> Commodities | <input type="checkbox"/> Rental / Escrow |
| <input type="checkbox"/> Inheritance / Trust | <input type="checkbox"/> Loans / Gifts | <input type="checkbox"/> Insurance Settlements | <input type="checkbox"/> Church |
| <input type="checkbox"/> Income Tax Refunds/Earned Income Credit | | <input type="checkbox"/> Interest/Dividends | <input type="checkbox"/> Other |

Please provide details for any unearned income marked above.

| SOURCE OF UNEARNED INCOME | PERSON RECEIVING INCOME | AMOUNT | HOW OFTEN RECEIVED? |
|---------------------------|-------------------------|--------|---------------------|
| | | | |
| | | | |
| | | | |

ASSETS

* If you need to provide more information, please attach extra sheets.

sheets.

List all assets for anyone in your household. Include anything you have or your name appears on, even as a co-signer.

| ITEM | HAVE IT? (CHECK) | ITEM DESCRIPTION / ACCOUNT NUMBERS | OWNER(S) / NAME(S) ON ACCOUNT | BANK NAME / ITEM OR ACCOUNT LOCATION | VALUE / AMOUNT | AMOUNT OWED |
|---|------------------|------------------------------------|-------------------------------|--------------------------------------|----------------|-------------|
| Cash | | | | | | |
| Checking Acct. | | | | | | |
| Savings Acct. | | | | | | |
| Line of Credit | | | | | | |
| CDs / Mutual Funds | | | | | | |
| Stocks / Bonds | | | | | | |
| Trusts / Annuities | | | | | | |
| Retirement (IRA, 401K, etc.) | | | | | | |
| Credit Cards | | | | | | |
| Credit Cards | | | | | | |
| Other Financial | | | | | | |
| Home / Residence | | | | | | |
| Land | | | | | | |
| Rental Property | | | | | | |
| Vehicle(s) | | | | | | |
| Vehicle(s) | | | | | | |
| Recreational Vehicles (Camper, Trailer, ATVs, etc.) | | | | | | |
| Livestock / Tools of Trade | | | | | | |
| Mining Claims | | | | | | |
| Burial Plots / Burial Funds | | | | | | |
| Life Insurance | | | | | | |
| Other | | | | | | |

List anyone in your household who has sold, transferred or given away any cash, property, or assets in the past 5 years.

| NAME OF PERSON(S) | DATE OF TRANSACTION | WHAT ASSETS | \$\$ RECEIVED | FAIR MARKET VALUE |
|-------------------|---------------------|-------------|---------------|-------------------|
| | | | | |
| | | | | |
| | | | | |

Tell Us About Your Expenses

* If you need to provide more information, please attach extra sheets.

List all expenses for anyone in your household. Include anything you have or your name appears on, even as a co-signer.

| ITEM | MONTHLY AMOUNT | BALANCE OWED | NAME(S) ON ACCOUNT | PAID TO: | OFFICE USE ONLY |
|---|----------------|--------------|--------------------|----------|-----------------|
| Rent or Mortgage <small>Subsidized? <input type="checkbox"/> Yes <input type="checkbox"/> No</small> | | | | | |
| 2 nd Mortgage | | | | | |
| Space Rent | | | | | |
| Food | | | | | |
| Non-Food | | | | | |
| Electricity | | | | | |
| Heat – <small>(Source?)</small> | | | | | |
| Water / Sewer / Trash | | | | | |
| Telephone <small>(Base Rate)</small> | | | | | |
| Health / Accident Insurance | | | | | |
| Home Owners / Renters Insurance | | | | | |
| Life Insurance | | | | | |
| Auto Insurance | | | | | |
| Car Payment | | | | | |
| Fuel | | | | | |
| Alternate Transportation <small>(Bus, Taxi, etc.)</small> | | | | | |
| Hospitals | | | | | |
| Doctors | | | | | |
| Medications | | | | | |
| Dental | | | | | |
| Property Taxes | | | | | |
| Payroll Taxes <small>(for business owners or self-employed)</small> | | | | | |
| Education Expenses | | | | | |
| Child Care <small>Subsidized? <input type="checkbox"/> Yes <input type="checkbox"/> No</small> | | | | | |
| Dues and Tithing | | | | | |
| Child Support | | | | | |
| Garnishment | | | | | |
| Fines | | | | | |
| Other | | | | | |
| Other | | | | | |
| TOTAL EXPENSES | | | | | |

Patient Rights and Responsibilities for State and County Assistance

The Applicant must read, or have read to them, and initial each of the following statements acknowledging they understand and accept these rights and responsibilities.

For State Assistance:

- _____ I could be sanctioned and required to return any Medicaid benefits I receive if my information is not true. Sanctions may include administrative, civil or criminal actions against me, including prosecution.
- _____ I consent to the gathering, use and disclosure of my information by the Idaho Department of Health and Welfare. I understand the information is needed for the purpose of providing benefits or services, obtaining payment for my benefits or services, and for normal business operations of the Department.
- _____ I have the right to revoke this consent, in writing at any time except to the extent the Department has already used and disclosed my information in reliance on this consent. If I revoke this consent, the Department may not provide me further benefits or services.
- _____ I understand that I will be notified of the right to appeal Department decision and I can contact the Department for information on the appeal process.
- _____ My signature indicates I have received a copy of the Department Privacy Practices.
- _____ By applying for benefits for a minor child, a medical support case must be opened, when applicable. If I am receiving benefits for myself, failure to cooperate with Child Support Services may result in loss or decrease of my benefits.
- _____ I consent to the gathering and use of income data, including information from tax returns for determining eligibility for help paying for health coverage in future years (up to 5 years). I will receive notice when this occurs, be able to make changes, and may opt out at any time.

- _____ If a third party is responsible for my disease or injury, I give to Medicaid any rights I may have, or may acquire in the future to be compensated by that responsible party for any Medicaid benefits I receive.
- _____ My signature or the signature of my representative authorizes State offices to communicate with insurance companies related to my medical assistance.
- _____ I have the right to choose my Healthy Connections Primary Care Doctor, to request referrals for services, and to change my doctor/clinic if my circumstances change. I understand that if I do not request a Primary Care Doctor, one will be assigned to me.
- _____ If I receive Medicaid after age 55, my estate may be subject to recovery of medical expenses paid on my behalf, and that any transfer of assets may be set aside by a court if I do not receive adequate value.
- _____ If I receive Medicaid/Cash Assistance, I am required to report changes in my circumstances including income, assets and living situations within ten (10) days of the change.
- _____ If I am determined eligible for Medicaid, I choose the plan that is based on my health needs, unless I tell my Self-Reliance worker otherwise.
- _____ If I receive a Child Support payment in error, Child Support Services will withhold future payments to recover the amount unless I submit written instructions to the contrary.
- _____ My signature certifies that the listed citizenship / immigration status is correct for each person applying.
- _____ I have read and understand the plan choices and that I might be responsible for paying part of the cost of my health plan.

For County Assistance:

- _____ An automatic lien will attach to my real and personal property, insurance benefits, and any additional resources or assets I own.
- _____ I must complete the entire application within the timelines allowed by Law.
- _____ I must cooperate with the investigation of my application by providing documentation and submitting to an interview.
- _____ I am obligated to reimburse the County for any assistance requested and provided on my behalf.
- _____ I must notify the County if I receive resources after filing an application with the County.
- _____ To assist in determining my eligibility, I consent to the gathering, use, and disclosure of my personal and financial information by the County.
- _____ A provider may file an application on my behalf as a third party applicant.
- _____ I will be notified of the County's decisions and that I may appeal an adverse decision of the Board of County Commissioners within 28 days of the date of determination.

- _____ I may seek judicial review of the County's final determination denying my application.
- _____ If I fail to cooperate with the County, make a material misstatement or material omission, my application will be denied and I will be ineligible for non-emergency services for up to two (2) years.
- _____ If I do not provide required material information or if I divest myself of resources within one (1) year prior to filing an application in order to become eligible for County assistance, my application will be denied.
- _____ If I am sanctioned by federal or state authorities and lose medical benefits, I will be ineligible for County Assistance for the period of the sanction.
- _____ If I give false or misleading information to a hospital, county, to its agent, or to any person in order to receive County assistance, or fail to disclose resources or benefits available to me as payment or reimbursement, I will be guilty of a misdemeanor and punishable under the law.

Applicant's Name: _____

Co-Applicant's Name: _____

Applicant's Signature: _____

Co-Applicant's Signature: _____

***** IF BY A THIRD PARTY APPLICANT ON BEHALF OF THE APPLICANT:**

Printed Name of Third Party Applicant _____

Date _____

Name of Facility _____

Signature of Third Party Applicant _____

Phone _____

Address of Facility _____

RELEASE OF INFORMATION

Patient's Name: _____

County: _____

Applicant's Name: _____

Co-Applicant's Name: _____

I/we authorize and request any hospital, doctor, or other person that has provided care to the above named patient ("Providers") to release medical records to representatives of the State or the County as the records are pertinent to the investigation and eligibility determination of medical indigency pursuant to Chapter 35, Title 31 Idaho Code. I acknowledge that some records pertaining to treatment I have received for which I am seeking payment from the State or the County may include information that is protected under the Federal Law. Specific authorization is given to release information concerning a federal-assisted drug or alcohol abuse program, drug-alcohol abuse information, mental health information, HIV information, or any other information that may be protected by law. I understand that I am waiving the confidentiality of such records for the limited purpose of this application for medical indigency and any supplements or amendments thereto. I acknowledge that the State or the County may disclose any information received to my providers participating in the medical indigency process and to representatives of the State Catastrophic Health Care Cost Program. I acknowledge that the purpose of the release is to determine whether or not I meet the statutory requirements for medical indigency assistance from the State or the County.

Federally protected records obtained as authorized by this release will be maintained in accordance with federal confidentiality regulations (Title 42CFR) which prohibits re-disclosure.

I/we also request my/our relatives, banker(s), credit union(s), financial or investment institution(s), physician(s), hospital(s), creditor(s), credit reporting agencies, and any other persons or organizations including the State Department of Health and Welfare, Social Security Administration, Public Health Districts, Veterans Administration, Crime Victims Compensation Program, Idaho Industrial Commission, utility companies or departments, law enforcement agencies, courts, Idaho Department of Labor, or employer(s), having any information concerning me/us or my/our circumstances to provide the information to such representative of the State or the County, inasmuch as it is pertinent to this application.

I/we hereby authorize the State or the County and its representatives to release pertinent information regarding this application, the contents thereof and action taken thereon to all parties of interest as provided by Chapter 35, Title 31, Idaho Code. I/we acknowledge that my/our medical indigency application waives any confidentiality granted by state law to the extent necessary to carry out the intent of Idaho Code 31-3504 regarding such applications. I/we hereby authorize a copy of this agreement to be used when necessary and give it full force as the original.

I/we understand that I/we may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that unless consent is sooner revoked; this release is valid as long as it is pertinent to this application, post-application reimbursement, or collection activity.

Signature of Patient

Date

Signature of Applicant

Date

Signature of Co-Applicant

Date

STATE OF IDAHO)
) :SS.
County of _____)

On this _____ day of _____, 20____, _____ personally appeared before me and proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to this instrument and acknowledged to me that he/she/they executed the same.

Subscribed and sworn before me:

(SEAL)

Notary Public for the State of Idaho

Residing In: _____

My Commission Expires On: _____

This authorization conforms to the regulations promulgated under Section 333 of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, and Section 408 of the Drug Abuse Offense and Treatment Act of 1972 and the Health Insurance Portability and Accountability Act of 1996.

REQUIRED INFORMATION

The following information is required when applying for assistance. **You must provide proof of ALL income, resources, assets, benefits, and expenses of ALL household members. Failure to provide verification of all items listed may result in denial of your application. Bring your verifications with you to your scheduled interview.** (The documentation should include your name, your monthly payment amount, and the balance owing. If you get a monthly billing statement for the expense, bring in the statement for the most recent month. Otherwise, bring in the applicable lease or contract agreement.)

IDENTIFICATION:

- **Picture ID** (Driver's license, school I.D., etc.) for All members of the household.
- **Social Security cards** for All members of the household.
- **Citizenship and Residency Documentation** for All members of the household. (VISA, Resident Alien Card, etc.)
- **Veteran's Status** (DD214, military discharge papers)

INCOME / ASSETS / BENEFITS:

- **Verification of all household income for the past six (6) months including but is not limited to:**

| | | |
|--|--------------------------------------|---|
| Wage Stubs/ Employer Earning Statements | Health Insurance or Life Insurance | Rental Income/ Escrow Income |
| Self Employment Records (i.e. Year-to-date Profit and Loss Statement) | Survivor Benefits | Land-Trust Payments/ Per-Capita Payments |
| Unemployment Benefits | Food Stamps Benefits | Garnishment Income |
| Retirement Pension | TAFI Benefits | Investment Income |
| IRA or other Retirement Income | ICCP Benefits | Cash Settlement Payments |
| Worker's Compensation | SSI/ SSD/ Social Security Retirement | School Financial Aid/ Scholarships/ Loans |
| Crime Victims Compensation | Alimony | Family Financial Assistance |
| Veteran Disability/ Pension | Child Support | Other |

- **Federal and State tax returns** for the most recent year filed.
- **Bank / Credit Union / Investment Income statements** for all checking, savings, money market accounts, IRAs, certificates of deposit, stocks, bonds, mutual funds, real estate, retirement investments etc. (If you don't have these, please get a print-out from your bank/credit union, brokerage firm / investment house)
- **Verification of any assistance received from other agencies or assistance programs including, but not limited to:**

| | | |
|--------------------|-------------------|--------------------|
| Energy Assistance | SEICCA | Aid for Friends |
| Subsidized Housing | Project Share | Salvation Army |
| Phone Assistance | Church Assistance | St. Vincent DePaul |

EXPENSES:

- **Provide all medical bills (immediately, upon receipt) to the county for which assistance is requested.**
- **Proof of *all* monthly household expenses and *all* outstanding debts including, but not limited to:**

| | | | |
|-----------------|---------------------|-------------------|---------------------|
| Rental Lease | Water/sewer/garbage | Child Support | Transportation |
| Lot Space Lease | Telephone | Child Care | Taxes |
| Mortgage | Food | Medications | Court-Ordered Fines |
| Heating | Non-Food Grocery | Insurance | Loan Payments |
| Electricity | Car payment | Doctor / Hospital | Other |

ALSO: Any and all other information requested by the Idaho Department of Health and Welfare and/or the County Indigent Program.

DO I HAVE TO BE A CITIZEN?

According to the U.S. Citizenship and Immigration Services, if you do NOT have a green card, members of your family who are eligible can use non-cash benefits, including Medicaid, Food Stamps, WIC, housing assistance, energy benefits, job training, child care, disaster relief, public health assistance, etc., without hurting your chances of getting a green card, becoming a U.S. citizen, or sponsoring relatives in the future.

DO I HAVE TO RELEASE MY SOCIAL SECURITY NUMBER (SSN) AND CITIZENSHIP STATUS?

Some family members of applicants may choose not to apply for Health and Welfare services. In that case, they do not have to provide a SSN or citizenship or immigration status. Benefits to applicants will not be delayed or denied because some family members do not apply.

Anyone who applies for services, except child care, must have a SSN or apply for one. If you want Emergency Medicaid only or you are a victim of domestic violence, you may not have to give a SSN or immigration status. You only have to give us citizenship or immigration status information for persons who want help, except when applying for child care.

We can help you apply for a SSN, and benefits will not be denied or delayed while the application is being processed. We need the SSN to help you establish paternity, get Child Support, and change or enforce Child Support orders, including medical insurance coverage for a child. SSN's will not be given to the U.S. Citizen and Immigration Services.

IS THERE EQUAL OPPORTUNITY FOR APPLICANTS?

In accordance with federal law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy, the Department of Health and Welfare is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. Under the Food Stamp Act and USDA policy, discrimination is prohibited also on the basis of religion or political beliefs.

To file a complaint of discrimination, contact USDA or HHS:

| | |
|--|--|
| <p>USDA, Director, Office of Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410</p> <p>(800) 795-3272 (Voice) (202) 720-6382 (TTY)</p> <p>USDA & HHS are equal opportunity providers and employers.</p> | <p>U.S. Department of Health & Human Services Room 506 F, 200 Independence Avenue, SW Washington, D.C. 20201</p> <p>ocrcomplain@hhs.gov (202) 619-0403 (Voice) (202) 619-3257 (TTY)</p> |
|--|--|

IDAHO MEDICAID PLAN CHOICE

If you are eligible for Medicaid, you have the right to choose the plan that is based on your health needs. Idaho Medicaid offers the Medicaid Basic Plan and the Medicaid Enhanced Plan to meet different health needs.

- **The Medicaid Basic Plan** is for low-income children and working-age adults with average health needs. This plan provides complete health, prevention, and wellness benefits for children and adults who don't have special health needs.
- **The Medicaid Enhanced Plan** is for individuals with disabilities or special health needs. This plan includes all benefits in the Basic Plan, plus additional benefits.

You may choose NOT to enroll in the plan that meets your health needs. You may choose to enroll in Standard Medicaid instead. Standard Medicaid does not include prescription drugs, certain prevention and wellness benefits, therapies, dental services, vision services, and other services. If you do not want to enroll in the benefit plan that meets your health needs, you must inform your Self-Reliance worker.