Medicaid Additional Information:

This form is a supplement to the KHBE I-10 and I-11 Medicaid application forms. This document adds supplemental questions asked on benefind that are not included on the Medicaid hard copy.

First Name:_____ **Last Name:** _____ **Application/Case #** _____

Managed Care Organization (MCO) Preference:

- ❑ Aetna Better Health of KY
- ❑ Anthem
- ❑ Humana CareSource
- ❑ Passport
- ❑ WellCare
- ❑ Other

Disability Information:

Do you have end stage renal disease? ❑ YES ❑ NO

Are you receiving any of the following benefits?

- ❑ Black Lung
- ❑ Lifetime Worker's Compensation
- ❑ Railroad Retirement
- ❑ Social Security
- ❑ VA – Veteran Affairs
- ❑ Worker's Compensation

Living Arrangement:

Where do you currently live?

- ❑ Attending School
- ❑ Chronically Homeless
- ❑ Dormitories/On-Campus Housing
- ❑ Drug Addiction and Alcohol Treatment Centers
- ❑ Emergency Custody Situation
- ❑ Family Home Care
- ❑ Group Living Arrangement
- ❑ Halfway House
- ❑ Homeless or Homeless Shelter
- ❑ Hospitalization
- ❑ Incarcerated
- ❑ In Home
- ❑ Job Corps
- ❑ Long Term Care Facility
- ❑ Military Base
- ❑ Personal Care Home
- ❑ PRTF – Psychiatric Residential Treatment Centers
- ❑ Rehab Facility
- ❑ Shelter for Battered Women and Children
- ❑ Someone Else's Home
- ❑ Staying Somewhere Else for Employment Reasons

If In-Home Care, what type of In-Home Care do you receive?

❑ MFP – Money Follows Person ❑ Non-institutionalized Hospice ❑ Not Applicable ❑ Waiver

Incarceration Release Date: _____ Institution Name: _____

Education and School Attendance:

What is the Highest Level of Education completed?

- ❑ Kindergarten
- ❑ 1st Grade
- ❑ 2nd Grade
- ❑ 3rd Grade
- ❑ 4th Grade
- ❑ 5th Grade
- ❑ 6th Grade
- ❑ 7th Grade
- ❑ 8th Grade
- ❑ 9th Grade
- ❑ 10th Grade
- ❑ 11th Grade
- ❑ High School Diploma
- ❑ GED- General Educational Development
- ❑ Awarded Associates' s Degree
- ❑ Awarded Bachelor's Degree
- ❑ Awarded Graduate Degree (Master's or Higher)
- ❑ Other Credentials (Degree, Certificate, Non-Proprietary School Diploma
- ❑ No Formal Education (Below School Age, Head Start, Preschool)

Medicaid Additional Information:

What date did you graduate (allowed to estimate)? _____
Are you currently enrolled in school? ❑ YES ❑ NO
School Name: _____

Benefits Information:

Have you applied for SSI Benefits? ❑ YES ❑ NO
Status of the application?
❑ Denied ❑ Pending Appeal ❑ Pending Application
When did you apply for SSI Benefits? _____
Please select the benefits you have applied for?

❑ Black Lung	❑ Railroad Retirement	❑ Veteran Affairs Compensation
❑ IRA at 59 and ½ Years	❑ RSDI - Retirement, Survivors, and Disability Insurance	❑ Veteran Affairs Pension
❑ Medicare Part A	❑ UMWA - United Mine Workers of America	❑ Wilson Fish
❑ Medicare Part B	❑ Unemployment Insurance	❑ Worker's Compensation

Accident or Injury Settlement:

Are you or anyone in the household expecting a settlement from an accident or injury? ❑ YES ❑ NO

Medicare Details:

Is anyone in the household currently receiving or has received Medicare Benefits in the past 3 months? ❑ YES ❑ NO

Resource Questions:

Liquid Resource – Does anyone in the household have liquid resources? ❑ YES ❑ NO

Vehicle – Does anyone in the household have a vehicle? ❑ YES ❑ NO

Life Insurance – Does anyone in the household have life insurance? ❑ YES ❑ NO

Real Estate Property – Does anyone in the household have any property other than their home? ❑ YES ❑ NO

Annuity – Does anyone in the household have one or more annuities? ❑ YES ❑ NO

Trust – Does anyone in the household have a trust? ❑ YES ❑ NO

Pre-Arranged Funeral Contact – Does anyone in the household have a pre-arranged funeral contract? ❑ YES ❑ NO

Burial Funds – Does anyone in the household have Burial Funds? ❑ YES ❑ NO

Promissory Note or Land Contracts – Does anyone in the household have a Promissory Note or Land Contract? ❑ YES ❑ NO

Other Resources – Does anyone in the household have any other resources such as Oil or Mineral Rights, Home Equity Line of Credit, Reverse Mortgage, or other investments? ❑ YES ❑ NO

Medicaid Additional Information:

Life Estate – Does anyone in the household have Life Estate interest in a property or has transferred a Life Estate agreement? ❑ YES ❑ NO

Lifetime Care Agreements – Does anyone in the household have a Lifetime Care Agreement? ❑ YES ❑ NO

Partnership Qualified LTC Policy – Does anyone in the household have a Partnership Qualified LTC Policy? ❑ YES ❑ NO

Burial Plots – Does anyone in the household have burial plots? ❑ YES ❑ NO

Life Settlement Contract – Does anyone in the household have a life settlement contract? ❑ YES ❑ NO

Expense Information:

Does anyone in the household have medical expenses or pay for Medicare Part D? ❑ YES ❑ NO

Does an elderly, blind, or disabled individual in the household have medical expenses? ❑ YES ❑ NO

Does the household have expenses for tax deductions? ❑ YES ❑ NO

Employer Information:

Employer: _____

Address: _____

Street Address

_____

City State Zip Code Employer Phone Number

Healthcare Coverage and Benefits Information:

Does anyone in your household have coverage or access to health insurance, including dental or vision coverage that is not Medicaid, KCHIP, or Medicare. ❑ YES ❑ NO

Note: *Providing Healthcare coverage will not affect your Medicaid Eligibility.*

What is the source of healthcare coverage?

❑ Cancer Only
❑ CHAMPVA - Civilian Health and Medical Program of the Veterans Administration
❑ COBRA - Consolidated Omnibus Budget Reconciliation Act
❑ Dental Only
❑ Indian Health Services
❑ Insurance from a Non-Custodial Parent
❑ Insurance through an Employer, including the Parent's Employer
❑ Kentucky Access
❑ Long Term Care Insurance
❑ Medical Supplemental
❑ Other
❑ Peace Corps
❑ Pharmacy Only
❑ Private Medical Insurance
❑ Retiree Health Plan
❑ TRICARE
❑ United Mine Workers
❑ VA - Veteran Affairs (Veteran's Health benefit)
❑ Vision Only

Medicaid Additional Information:

What type of coverage is this?

❑ Dental ❑ Hospital ❑ Medical ❑ Vision

Is the insurance policy holder a member of the case? ❑ YES ❑ NO

Who is the policy holder? _____

Loss of Medical Coverage Information:

Has anyone in your household lost healthcare coverage in the last 90 days? Please include the loss of Medicaid or KCHIP in your answer. Note: Please indicate loss of health coverage in the last 90 days even if the person currently has health coverage. ❑ YES ❑ NO

Date coverage was lost? _____

Type of coverage lost?

❑ Cancer Only
❑ CHAMPVA - Civilian Health and Medical Program of the Veterans Administration
❑ COBRA - Consolidated Omnibus Budget Reconciliation Act
❑ Dental Only
❑ Indian Health Services
❑ Insurance from a Non-Custodial Parent
❑ Insurance through an Employer, including the Parent's Employer
❑ Kentucky Access
❑ Long Term Care Insurance
❑ Medicaid/KCHIP
❑ Medical Supplemental
❑ Other
❑ Peace Corps
❑ Pharmacy Only
❑ Private Medical Insurance
❑ Retiree Health Plan
❑ TRICARE
❑ United Mine Workers
❑ VA - Veteran Affairs (Veteran's Health benefit)
❑ Vision Only

Reason Coverage Lost?

❑ Because of long term disability
❑ Divorce and other parent stopped coverage
❑ Fraud
❑ Job Loss
❑ Medicaid of KCHIP ended
❑ Moved and no coverage was available
❑ Non-Payment
❑ Too expensive
❑ Other
❑ Parent giving coverage died
❑ Self-employed

Does anyone in your household have any medical bills from the last three months that he/she needs help paying? By medical bills, we mean the amount you have to pay for:

- Doctor or dentist visits
- Hearing aids, eye glasses, or other durable medical supplies
- Medicines prescribed by a doctor
- Hospital visits
- Health insurance premiums, fees, co-payments, deductibles, and other payments
- Transportation to medical appointments

❑ YES ❑ NO

Medicaid Additional Information:

Authorized Representatives:

Note: *Benefits may be pended until documentation is provided and reviewed by DCBS for Authorized Representative. Complete application, run eligibility, and update RFI's as information is provided.*

Would you like to choose one or more Authorized Representatives? ❑ YES ❑ NO

Full Name: _____

First Name M.I. Last Name Suffix

What is the person's relationship to you?

❑ Executor	❑ Nursing Facility Representative	❑ Power of Attorney
❑ Family member (not spouse)	❑ Other	❑ Spouse
❑ Friend	❑ Outside entity	❑ Statutory Benefit Payee
❑ Legal Guardian	❑ Parent of a minor child	❑ Treatment Center Employee

Does your Authorized Representative belong to an organization that helps you? ❑ YES ❑ NO

Please tell us about the permissions you would like to give to your Authorized Representative.

Program	**Level of Permission**
❑ KTAP (Cash Assistance)	❑ Apply, Report Changes, Recertify
❑ Medicaid/KCHIP/Kentucky HEALTH/KI-HIPP	❑ Apply, Report Changes, Recertify and receive checks
❑ SNAP (Food Assistance)	❑ Apply, Report Changes, Recertify and receive checks made out to the client
❑ State Supplementation	❑ Apply, Report Changes, Recertify and receive copy of Notices
	❑ Apply, Report Changes, Recertify and use EBT card
	❑ Statutory Benefit Payee
	❑ Use EBT Card

How do we reach your Authorized Representative?

Address: _____

Street Address

_____

City State Zip Code County

_____

Phone Number Email Address

Assisters:

Is there an Appendix B attached? ❑ YES ❑ NO

Note: *Assisters will still need to fill out the Appendix B or call the Professional Service Line to be associated to the case.*

MA 34 – Declaration of Annuities:

- The Deficit Reduction Act (DRA) of 2005 changed the Medicaid eligibility rules regarding annuities or nursing home and waiver applicants. All annuities owned by an applicant or the applicant's spouse must be disclosed at application/recertification.

Medicaid Additional Information:

- Annuities purchased on or after February 8, 2006, must name the Department for Medicaid Services (DMS) as beneficiary in the appropriate position. The community spouse and/or minor/disabled children shall be named prior to DMS. This includes any annuities belonging to the applicant's spouse. Annuities purchased by a third party, with assets, are not required to name DMS as beneficiary.
- DMS will only recoup an amount equal to the claims paid on the institutionalized individual' any excess will be available to a secondary beneficiary to the estates of the annuitant.
- Failure to comply will result in the annuity being treated as a transfer of resources for less than fair market value and could result in an eligibility period.
- I have disclosed any and all interest that I (applicant) and/or the community spouse may have in an annuity.

❑ YES ❑ NO

❑ YES I have agreed to name DMS as beneficiary, in the appropriate position, on all appropriate annuities.
❑ NO I have refused to name DMS as beneficiary on my annuities and understand that in doing so I may be subject to an ineligibility period.

Military Information:

Has anyone in the household ever served in the military? ❑ YES ❑ NO
If so, who? _____

Additional Notes:

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