north dakota department of human services

SFN 958 (12-2009)

HEALTH CARE APPLICATION FOR THE ELDERLY AND DISABLED

AGENCY USE ONLY	
Case Number:	Date Requested:
Date Received:	Interview Date:
Case Number:	

Instructions For Application For Health Care Coverage

This application may be used to apply for Health Care Coverage, the Medicare Savings Programs, Aid to the Blind, or Basic Care. See the Guidebook for more information.

What Do I Need to Do to Get Health Care Coverage?

Follow these steps to apply for Health Care:

Step 1: **Check the assistance for which you are applying** (Check ALL that apply). If you would like more information on these programs, see the Application for Assistance Guidebook. If you did not receive the Guidebook, contact your local social service office.

☐ **Health Care Coverage –** Medicaid coverage for the elderly and disabled.

☐ **Aid to the Blind –** Assists with treatment for people who are not eligible for Medicaid and are in danger of losing their vision or require restorative eye services.

☐ **Medicare Savings Programs –** Assists with Medicare Part B premium, coinsurance and deductibles.

☐ **Basic Care Assistance –** Helps pay for room and board and personal care in licensed basic care facilities.

Step 2: **Answer as many questions as you can.** If you need help applying for assistance, you may have a friend, relative, or someone else help you apply. Your local county social service office can also help you apply for assistance. If you need additional space, attach a separate sheet of paper.

Step 3: **Sign and Return the completed application** to your local county social service office.

To speed up the processing of your application, turn in verifications of the following items with your application. Your county social service office may be able to help you obtain these things if needed.

☐ **Verification of Alien or Citizenship Status such as** (original documents required):

- Resident Alien Card (Form I-551)
- Employment Authorization Card (Form I-688A)
- Birth Certificate
- Temporary Resident Card (Form I-688)
- Arrival-Departure Record (Form I-94)
- U. S. Passport

You will be asked to provide information about the citizenship or immigration status for all persons for whom you want to receive assistance. If any of these persons do not want to give information about their citizenship or immigration status, they will not be eligible for benefits. Other household members may still get benefits if they are otherwise eligible. We will not share alien or citizenship information with the United States Citizenship and Immigration Service (USCIS).

☐ **Verification of the value of current assets such as:**

- Annuities
- Business Accounts
- Certificates of Deposit
- Checking/Savings/Credit Union Accounts
- IRA/401K/KEOGH plans
- Life Insurance
- Real Property (Land, Rental Property, etc.)
- Savings Bonds
- Stocks/Bonds/Mutual Funds
- Trusts

☐ **Verification of expenses such as:**

- Court Ordered Payments (Child/Spousal Support, Medical Support)
- Health Insurance Premiums

☐ **Verification of income such as:**

- Bonuses
- Commissions
- Lease Income
- Money from Friends, Relatives, or Others
- Pay (Pay Stubs or Employer Statement)
- Pension/Retirement Benefits
- Rental Income
- Self-employment Income
- Social Security Benefits
- Spousal Support
- SSI (Supplemental Security Income)
- Unemployment Benefits
- Veteran's/Military Benefits
- Workers Compensation

☐ **Verification of Identity such as (original documents required):**

- Driver's License
- Picture identification card issued by employer

To learn when you may get assistance, go to the General Information section of the Guidebook. If you have questions, contact your local county social service office.

Tell Us About You

First Name	Middle Initial	Last Name
Address Where You Live		
City	State	ZIP Code
Mailing Address (if different)		
Home Telephone Number	Work or Message Number	Cell Phone Number
Directions to Home (if rural)		

Power of Attorney or Family Contact Person

First Name	Last Name	Relationship
Mailing Address Where You Want Notices Sent		
Home Telephone Number	Work or Message Number	Cell Phone Number

Tell Us About The People In Your Home

Fill in the boxes below for yourself, spouse, if any, and anyone else in your home, including those temporarily out of the home for work, the military or medical reasons:

If you need additional space, continue on a separate sheet of paper.

Refer to the General Information section of the Application for Assistance Guidebook to determine what information is optional for you to provide.

Household Members (Enter Legal Name) First	Middle Initial	Last	Relation To You	Social Security Number	Date of Birth	Age	Sex	U. S. Citizen (Yes or No)	Hispanic or Latino (Yes or No)	Race Use Codes Below	Marital Status Use Codes Below
			Self								

Race Codes: **AI** - American Indian/Alaska Native **AP** - Asian **BL** - Black/African American **HP** - Native Hawaiian/Pacific Islander **WH** - White

Marital Status Codes: **DI** - Divorced **MA** - Married **NM** - Never Married **SE** - Separated **WI** - Widowed

Tell Us About Your Household

I/We have lived in North Dakota since (month, day, and year): _____

Do you intend to remain in North Dakota? ☐ Yes ☐ No

List other names that have been used by household members (maiden name, prior married name or nickname): _____

_____

List household members temporarily out of the home: _____

Why are they out of the home? _____ Date Expected to Return: _____

Household continued on next page

Tell Us About Your Household (cont)

List household members who are disabled: _____

If you have recently applied for disability and the decision by the Social Security Administration is still pending please provide proof of your pending status along with this application.

List household members who have ever served in the military or who was a spouse of someone that served:

_____

Have household members received medical assistance in another state? ☐ Yes ☐ No

If Yes, When? _____ Which City, County, and State: _____

Does anyone in your household require nursing care services? ☐ Yes ☐ No

If yes, when did/will they start receiving nursing care services? _____

If receiving nursing care services in a facility, which facility? _____

Tell Us About Your Medical Bills

Medicaid may be able to help pay medical bills, including prescription costs, for up to three months prior to the month of your application. Would you like help paying any of these bills? ☐ Yes ☐ No

If yes, list each month: _____

Medicaid can allow unpaid medical bills older than three months to reduce your out-of-pocket costs. Do household members have unpaid medical bills older than three months? ☐ Yes ☐ No

If yes, explain: _____

Tell Us About Your Household Assets

Assets

Check yes by the assets owned, jointly owned, or being purchased by household members. Check no, if none.

☐ Yes ☐ No Annuities
☐ Yes ☐ No Assets Owned with Another Person
☐ Yes ☐ No Burial Plots
☐ Yes ☐ No Burial Space Items (Casket, Vault, Marker, etc.)
☐ Yes ☐ No Business Accounts
☐ Yes ☐ No Business Inventory/Equipment
☐ Yes ☐ No Cash on Hand
☐ Yes ☐ No Certificates of Deposit
☐ Yes ☐ No Checking/Credit Union Accounts
☐ Yes ☐ No Farm Equipment, Livestock, Stored Grain
☐ Yes ☐ No Home/Mobile Home (Not Owner Occupied)
☐ Yes ☐ No Home/Mobile Home (Owner Occupied)
☐ Yes ☐ No Income Producing Tools/Equipment
☐ Yes ☐ No Individual Indian Monies Accounts
☐ Yes ☐ No Life Estate/Life Lease
☐ Yes ☐ No Mineral Rights (Oil, Gas, Gravel, Coal, etc.)
☐ Yes ☐ No Notes or Contract for Deed
☐ Yes ☐ No Prepaid Funeral Plans
☐ Yes ☐ No Real Property (Land, Rental Property, Buildings, etc.)
☐ Yes ☐ No Retirement Funds (IRA/KEOGH/401K)
☐ Yes ☐ No Safety Deposit Box
☐ Yes ☐ No Savings Bonds
☐ Yes ☐ No Savings/Credit Union Accounts
☐ Yes ☐ No Stocks/Bonds/Mutual Funds
☐ Yes ☐ No Trusts
Other, specify: _____

For all items checked yes, fill in the boxes below:

Type of Asset	Location/Description	Total Value	Amount Owed	Owners

Continue on next page

For all items checked yes, fill in the boxes below (continued):

Type of Asset	Location/Description	Total Value	Amount Owed	Owners

List household members who have made arrangements for funeral expenses or gave money, property, or insurance to someone else to pay for funeral expenses: _____

_____

_____

Explain: _____

_____

Do you expect changes in assets next month? ☐ Yes ☐ No If yes, explain: _____

_____

Transfer of Assets

Have household members sold, given away or transferred anything of value within the past 5 years? ☐ Yes ☐ No

If yes, list the items: _____

_____ Date: _____

Life Insurance

Does any household member have life insurance? ☐ Yes ☐ No If yes, fill in the boxes below:

Name of Insured Person	Name and Address of Company	Policy Number	Face Value	Cash Surrender Value	Owners

Vehicles

List vehicles (car, truck, motor home, snowmobile, motorcycle, 3 wheeler/4 wheeler, boat or other watercraft, camper, trailer, etc.) owned, jointly owned or being purchased for all household members, even if the vehicle is not running or not in your possession. Include vehicles licensed through North Dakota, tribal motor vehicle or another state.

Make/Model	Year	Value	Amount Owed	Owners

Tell Us About the Income/Money Your Household Receives

Have household members sold, given away or transferred any income or stream of income within the past 5 years? (Example: annuity payments, VA improved pension) ☐ Yes ☐ No

If yes, explain: _____

Self-Employment

Are any household members self-employed? ☐ Yes ☐ No If yes, complete the following:

Household Member: _____

Name and Type of Business: _____ Date Business Started: _____

Employment

Are any household members employed? ☐ Yes ☐ No

If Yes, list information about pay from employment such as wages, commissions, bonuses, and incentives for all household members.

Household Member	Employer	Hours Worked Per Week	Hourly Pay	This Month's Pay Before Taxes (Gross)	Next Month's Pay Before Taxes (Gross)	Amount of Tips	Date of Next Check	How Often Paid (Use Codes Below)	Day or Dates Paid (Use Codes Below)

How Often Paid Codes:
M - Monthly **2X** - Twice a Month **W** - Weekly **EX** - Every Two Weeks Other, specify: _____

Day Paid Codes:
M - Monday **T** - Tuesday **W** - Wednesday **TH** - Thursday **F** - Friday **S** - Saturday **SU** - Sunday

Have any household members received commissions, bonuses or incentives other than those included above within the last year? ☐ Yes ☐ No If yes, complete the following:

Household Member: _____

Date Received: _____ Amount: _____

Unearned Income or Other Money Received

The following is a list of different kinds of unearned income. Check yes for each unearned income or other money received by household members. Check no, if not received.

☐ Yes ☐ No BIA/Tribal General Assistance
☐ Yes ☐ No Bingo/Gambling Winnings
☐ Yes ☐ No Child Support or Spousal Support
☐ Yes ☐ No Contract Sale or Rental Income
☐ Yes ☐ No Income from Tribes
☐ Yes ☐ No Income from Roomer/Boarder
☐ Yes ☐ No Individual Indian Monies (IIM)
☐ Yes ☐ No Insurance/Lawsuit Settlement
☐ Yes ☐ No Interest/Dividend Income
☐ Yes ☐ No Money from Friends, Relatives or Others
☐ Yes ☐ No Oil/Mineral Rights/Royalties
☐ Yes ☐ No Pension/Retirement Benefits
☐ Yes ☐ No Railroad Retirement Benefits
☐ Yes ☐ No Social Security Benefits
☐ Yes ☐ No Supplemental Security Income (SSI)
☐ Yes ☐ No TANF-Temporary Assistance for Needy Families
☐ Yes ☐ No Unemployment Benefits
☐ Yes ☐ No Veteran's/Military Benefits
☐ Yes ☐ No Workers' Compensation
Other, specify: _____

For all items checked yes, fill in the information below:

Type of Unearned Income or Other Money Received	Household Member	How Often Received	Amount This Month	Amount Next Month

Have household members applied for benefits not yet received (Social Security, SSI, Worker's Compensation, Unemployment Compensation, Veterans/Military Benefits?) ☐ Yes ☐ No

If yes, explain: _____

Tell Us About Court Ordered Expenses

Is any household member court ordered to pay child support, health insurance, or other support payments? ☐ Yes ☐ No

If yes, who? _____

Who are the payments for? _____

Amount Court Ordered: _____ Amount Paid: _____

Tell Us About Your Health Insurance Coverage

List household members who have health insurance:

Persons Covered	Policy Holder Name and Address	Health Insurance Name and Address	Effective Date	Policy Number	Group Number	Monthly Premium	Type of Coverage Use Codes Below

List all that apply

A - Hospital
B - Doctor
C - Major Medical/Lab/X-Ray
D - Dental
E - Vision
F - Nursing Home
G - Cancer
H - Champus/Tricare
I - HMO Insurance
J - Court Ordered
K - Medicare Part A
L - Medicare Part B
M - Medicare Supplement
N -Prescription Drug Insurance
P - Workers Compensation or Accident
R - Medicare Advantage
V - Veterans Administration
W - Medicare Part D

Does anyone outside the household pay the premium? ☐ Yes ☐ No If yes, who? _____

Do household members expect changes in health insurance coverage? ☐ Yes ☐ No

If yes explain: _____

Tell Us if Someone Else May Help With Your Medical Costs

Does anyone help pay your medical costs? ☐ Yes ☐ No If yes explain: _____

Do household members have medical problems due to an accident? ☐ Yes ☐ No

If yes, list type of accident: _____ Date of Accident: _____

Do household members have a pending legal action from which they may receive money or medical benefits (including inheritance?) ☐ Yes ☐ No

Basic Care Applicants Only

If you are requesting coverage for the month you enter a Basic Care Facility, list the amount of rent and utilities you will pay this month. This includes rent, mortgage, lot rent, electricity, heating, water, garbage, property taxes, telephone, etc. These expenses may be deducted from your first month's room rate at the basic care facility. Provide hard copy verification for each expense listed.

Type of Expense	Total Amount Paid	Type of Expense	Total Amount Paid

Read The Following Information

I have received, reviewed and understand my rights and responsibilities as explained in the Application for Assistance Guidebook.

I declare under penalty of law, the information on this application is correct. This includes information about identity, citizenship and alien status of the household members applying for assistance.

I understand that alien status information and other information will be verified when discrepancies are found. Verification received may affect eligibility and level of benefits.

I understand the information I provide on or with this application is subject to verification by federal, state and local officials to determine if the information is correct. If any of the information is incorrect, assistance may be denied and I may be subject to criminal prosecution for knowingly providing incorrect information.

I agree to report to the county social service office any changes in income, assets, or living arrangements as required.

I understand I will not receive a deduction for any allowable expenses I do not report and verify.

Authorization To Release Information

I/We authorize any person having custody or knowledge of the information relating to me or other household members to disclose any requested information, including confidential information other than protected health information, to any authorized agent of the North Dakota Department of Human Services. This authorization will remain valid until canceled in writing or until coverage ends. A copy of this authorization is as valid as the original.

Sign And Date The Application Here

Signature of Applicant: _____ Date: _____

Other Signature (Spouse, Guardian or Other Adult): _____ Date: _____