HEALTH CARE APPLICATION FOR THE ELDERLY AND DISABLED

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
SFN 958 (11-2019)

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

If you are not elderly or disabled and wish to apply for Health Care Coverage, complete the Application for Health Care Coverage (SFN 1909) or the Application for Assistance (SFN 405).

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 premiums.

☐ **Basic Care Assistance Program (BCAP) (a program for residents of Basic Care Facilities Only)** - Apply for this program **IF** you live in a licensed Basic Care Facility to meet your health and living needs **AND** you are age 18 or older, blind, disabled or aged. This program helps pay for room and board costs.

Step 2: **Answer as many questions as you can.** For assistance completing the application, contact or visit your local county social services office. You may have a friend, relative, or someone else help you apply. 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 proof of the following items with your application. Your county social service office may be able to help you obtain these things if needed.

☐ **Proof of Alien or Citizenship Status such as** (original documents required if applying for Health Care Coverage):

- Resident Alien Card (Form I-551)
- Employment Authorization Card (Form I-688A)
- American Indian/Alaskan Native Tribal Document
- Birth Certificate (if born in the United States)
- Temporary Resident Card (Form I-688)
- Arrival-Departure Record (Form I-94)
- Passport

You will be asked to provide information about the citizenship or immigration status for all persons for whom you want to receive assistance. This information may be subject to verification by the United States Citizenship and Immigration Service (USCIS), and that the submitted information received from USCIS may affect the household's eligibility and level of benefits. **For HCC, verification will be required if not available through electronic notifications.** If any of these persons do not want to give information about their citizenship or immigration status, they will not be eligible for benefits. These persons must provide their financial information to determine eligibility for other household members. Other household members may still get benefits if they are otherwise eligible. We will not share alien or citizenship information about non-applicants with the United States Citizenship and Immigration Service (USCIS).

☐ **Proof 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

☐ **Proof of expenses such as:**

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

☐ **Proof of income such as:**

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

☐ **Proof of Other Information such as:**

- Identity (Birth Certificate, Driver's License, Work or School ID, American Indian/Alaskan Native Tribal Document, Passport - original documents required if applying for Health Care Coverage)
- Age (Birth Certificate, Driver's License)
- Social Security Numbers (card or proof of applicant for SSN)

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	Suffix
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)			
If you do not speak English, what is your preferred spoken or written language?			

** If you are applying for Health Care Coverage (Medicaid) and you have entered your residential and mailing address as 'General Delivery', or 'Homeless', or have left it blank, your mail will be sent to the local county social service office. You will need to arrange to pick up your mail at the local county social service office on a weekly basis. If you do not pick up your mail for three (3) weeks, your case may be closed due to lack of contact.

Sign and Date Your Application Here

Signature of Applicant	Date
Other Signature (Spouse, Guardian, or Other Adult)	Date

Help with HCC?

If you are applying for HCC, you can give a trusted person permission to talk about this application with us and see your information. This individual can act on your behalf on matters related to this application, including giving and getting information, signing your application and acting for you on all future matters. This person is called an “authorized representative.” If you ever need to change your authorized representative, contact your county social services office.

If the person you give this permission is a **legally appointed representative** for someone on this application, submit proof with application.

If you choose to have someone help you, fill in the boxes below with their information:

First Name	Middle Initial	Last Name	Suffix
Street Address			Apartment of Suite Number
City	State	ZIP Code	Telephone Number

By signing, you authorize this person to serve as your “authorized representative.”

Signature of Applicant	Date

Power of Attorney, Family Contact Person or Guardian Section

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

☐ Power of Attorney ☐ Family Contact Person ☐ Guardian

Would You Like to Receive Text and E-mail Notification

By opting to receive text message or e-mail notifications, you agree to the following:

A text message or e-mail notification will be sent to the cell phone number or e-mail address you entered when a review or full application is needed to determine eligibility or continued eligibility for the program(s) you are enrolled in.

Cell phone carrier text message rates may apply and DHS will not be liable for any text message charges.

You are responsible for notifying your case worker of any changes to your e-mail address, cell phone carrier or cell phone number, or if your cell phone is lost or stolen.

Note that unencrypted e-mail and text messaging is NOT a secure form of communication. There is some risk that any Protected Health Information (PHI) and other confidential information that may be contained in such e-mail or text messages may be misdirected, disclosed to, or intercepted by, unauthorized third parties. I consent and accept the risk in transmitting PHI and other confidential information via unencrypted e-mail or text messaging.

Would you like to receive text message notifications? ☐ Yes ☐ No	If yes, list name of cell phone provider:
Would you like to receive e-mail notifications? ☐ Yes ☐ No	If yes, list e-mail address:

Tell Us About The People In Your Home

Check the boxes below for all the people who live in your home, including members temporarily out of your home (working away from home, attending school or boarding school, in the military, etc.)

☐ Yourself ☐ Your husband or wife ☐ Your children ☐ Other adults or children living in your home

For each person checked, fill in the boxes below. These people make up your household.

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

You are asked to provide information about the race and the ethnic background for all persons for whom you want assistance. This information is voluntary and is used to make sure that benefits are provided without regard to race, color, or national origin. Providing this information will not affect your eligibility or benefit amount.

You are also asked to provide information about the sex, last grade completed and marital status of all persons for whom you want assistance. This information is voluntary.

You will be asked to provide Social Security Numbers (SSNs) for all persons whom you want assistance. If someone wants help getting an SSN, call 1-800-772-1213 or visit ssa.gov. TTY users should call 1-800-325-0778. If you are applying only for emergency Medicaid because of your citizenship or immigration status, you do not need to give us information about your SSN. **(See the 'General Information Section' of the Application for Assistance Guidebook for additional information regarding use of Social Security Numbers.)**

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

If you do not want Health Care Coverage for all members of the household listed above, please list members you DO NOT want Health Care Coverage for:

If any household members are enrolled member in a federally-recognized Indian tribe, list enrolled members, the name of the tribe and their tribal enrollment numbers:

If you are applying for Health Care Coverage you may be eligible for no enrollment fees or premium payments under certain Health Care Coverage.

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:
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 are a a veteran, a spouse, parent, or dependent of a veteran, or are an active-duty member in the US Military:	
Have household members received, or are they currently receiving, 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, provide the name and address of the facility

Name of Facility			
Address	City	State	ZIP Code

Tell Us About Your Medical Bills

Medicaid can 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 which months and provide verification of income, assets and expenses for those months:	
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 Debit Card Account (Not Checking/Savings)
- ☐ 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 Irrevocable Burial Fund
- ☐ Yes ☐ No Inheritance
- ☐ Yes ☐ No Life Estate/Life Lease
- ☐ Yes ☐ No Mineral Rights (Oil, Gas, Gravel, Coal, etc.)
- ☐ Yes ☐ No Money Market Account
- ☐ 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 Safe Deposit Box
- ☐ Yes ☐ No Savings Bonds
- ☐ Yes ☐ No Savings/Credit Union Accounts
- ☐ Yes ☐ No Stocks/Bonds/Mutual Funds
- ☐ Yes ☐ No Trusts
- ☐ Yes ☐ No Individual Indian Monies (IIM) Accounts*

Other, specify: _____

*IIM information is required if applying for Basic Care ONLY.

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

Type of Asset	Location/Description	Total Value	Amount Owed	Owners

Are <u>any</u> assets subject to a "Transfer at Death"? ☐ Yes ☐ No

If yes, describe the property and approximate value.

Tell Us About Your Household Assets

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

Tell Us About the Income/Money Your Household Receives

Self-Employment

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

Name of Household Member(s):

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. If employment stopped last month or this month, also list income received this month here.

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	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:

Name of Household Member:	Date Received:	Amount Received:

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 Benefits while on Strike
- ☐ 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 CRP
- ☐ 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 Deposited into a Bank Account from an Individual Outside of Your Household
- ☐ Yes ☐ No Money from Friends, Relatives or Others
- ☐ Yes ☐ No Money from Inheritance
- ☐ Yes ☐ No Oil/Mineral Rights/Royalties
- ☐ Yes ☐ No Pension/Retirement Benefits
- ☐ Yes ☐ No Railroad Retirement Benefits
- ☐ Yes ☐ No Refugee Assistance
- ☐ 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: _____

**IIM information is required if applying for Basic Care ONLY.

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:

Does anyone outside of the household deposit money into a household members bank acoount? ☐ Yes ☐ No If yes, explain:

Transfer of Income

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:

Life Insurance

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

Does the life insurance policy include irrevocable itemized burial fund? ☐ Yes ☐ No If yes, provide copy of life insurance policy

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 Court Ordered Expenses

Is any household member court ordered to pay child support, spousal support, other support or health insurance? ☐ 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: (provide copy, front and back, of all insurance cards)

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/Advantage
N -Prescription Drug Insurance
P - Workers Compensation or Accident
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:

Long Term Care Insurance

Does any household member have a long-term care insurance policy? ☐ Yes ☐ No

This information may allow you to protect additional assets.

Has the policy paid any benefits? ☐ Yes - if yes, provide documentation ☐ No

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, complete below:

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

Application for Health Care Coverage-Notice of Rights

Read The Following Information

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

I understand that additional information on privacy practices and civil rights protections are further explained in the 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. The alien status of applicant household members may be subject to verification by USCIS through the submission of information from the application to USCIS. 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, which may include electronic verification. 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 provide proof of.

Estate Recovery

State and Federal law requires the Department of Human Services to make claims against the estate of some Medicaid recipients. A claim will be made against the estate of: (1) any recipient who was age 55 or older when the Medicaid benefits were provided; (2) any recipient who has been permanently institutionalized and received services regardless of age; or (3) against the estate of a spouse of any Medicaid recipient who was age 55 or older or permanently institutionalized when the Medicaid benefits were paid. The claim is for the amount of Medicaid benefits issued to a person age 55 or older or if permanently institutionalized. Effective August 1, 2015, the department CANNOT file a claim against the estate to recover payments made on behalf of recipients who received coverage through a private carrier. Individuals eligible under the Medicaid Expansion coverage receive their coverage through a private carrier.

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 90 days past case closure or until revoked in writing. I/We authorize Child Support to release any records of child support payments that I/we have made or received. A copy of this authorization is as valid as the original.

Sign And Date The Application Here

By signing my name, I attest that I have read and agree to the information contained in this Notice of Rights.

Signature of Applicant:	Date:
Other Signature (Spouse, Guardian or Other Adult):	Date: