Application for Mississippi Medicaid Aged, Blind and Disabled Medicaid Programs

- This application is used to apply for Medicaid due to age, blindness or disability. An individual or couple may use this form to apply. This form & other program information is available on the MS Division of Medicaid's website www.medicaid.ms.gov
- Please read each question carefully before answering. The answers given will determine whether or not the person(s) applying will be eligible for Medicaid. A friend or relative may help the applicant complete this form. A Medicaid worker is also available if any help is needed.
- Contact your worker if you want to register to vote or update your voter registration information.

What is the language most spoken in your home _____. If not English and you need assistance, contact your Regional Office or call 1-800-421-2408. An interpreter service will be provided free of charge.

If any person(s) applying for Medicaid using this form is blind or hearing impaired, enter the name(s) in this space so that any special needs can be evaluated:

_____

Are there any other special needs?

_____

WHEN THIS FORM IS COMPLETED AND SIGNED, YOU CAN EITHER MAIL, FAX OR BRING IT TO YOUR MEDICAID REGIONAL OFFICE AT THE FOLLOWING ADDRESS:

For Regional Office Use Only:

❑ LTC Facility _____ ❑ HCBS Waiver Type _____

❑ Healthier MS Waiver ❑ Medicare Cost Sharing ❑ DCLH ❑ Working Disabled ❑ SSI Retro ❑ Deemed SSI

❑ Other _____

Worker: _____ Date & Place of Interview _____

Case Name _____ Case Number _____

Spouse Case Name _____Case Number _____

Rights & Responsibilities explained at time of interview? ❑ Yes ❑ No

Programmatic Pamphlet(s) provided? ❑ Yes ❑ No

1. **USE OF MEDICAID PLANNER –** Has anyone paid (or is paying) for the services of a Medicaid Planner in completing this application? ❑ Yes ❑ No If yes, provide the following information:

   Name of Medicaid Planner _____

   Contact Information for Planner _____

   Name Applicant(s) Using Medicaid Planner Service_____

2. **APPLICANT INFORMATION – Enter all information about the 1st applicant:**

   Applicant's Full Name: _____
   (First) (Middle) (Maiden) (Last)

   Social Security Number: _____ - _____ - _____ **Date of Birth:** (Mo) _____ (Day) _____ (Year) _____

   Marital Status: ❑Single ❑Married ❑Separated ❑Widowed ❑Divorced **Gender:** ❑ Male ❑ Female

   Race: (optional) check all that apply: ☐ White ☐ Black ☐ American Indian or Alaska Native ☐ Chinese ☐ Asian Indian ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian ☐ Samoan ☐ Guamanian or Chamorro ☐ Other Pacific Islander ☐ Other _____

   If Hispanic/Latino, check all that apply (optional) ☐ Mexican ☐ Mexican-American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

   This applicant is applying on the basis of: ❑age (65 or over) ❑ blindness ❑ disability (describe the disability): _____

   Applicant lives: ❑ in own home ❑ rental home or apt. ❑ with someone in their home – please list whose home _____ ❑ nursing facility ❑ other _____

   Telephone (Home) _____ (Cell) _____ (Other) _____

   Does applicant plan to enter a nursing facility? ❑ Yes ❑ No If yes, when? _____

   Enter name & location of nursing facility _____

   If in a nursing facility, did applicant enter directly from ❑ a hospital ❑ home ❑ other _____

   Home Address: _____ **Apt. or Lot #** _____

   City: _____**County:** _____**State:** _____ **Zip:** _____

   Who lives at this address now? _____

   _____

   Mailing Address (if different) _____

   City: _____**County:** _____**State:** _____**Zip:** _____

Name of Applicant(s) _____SSN(s)_____

Is applicant a U.S. citizen? ❑ Yes ❑ No **If no, when did applicant enter the U.S.? _____**

If not a U.S. citizen, is applicant in a satisfactory immigration status? ❑ Yes ❑ No (Not required for immigrants seeking Emergency Medicaid services.) A list of satisfactory immigration statuses for Medicaid purposes is available from a Medicaid Regional Office.

Previous Marriages: Has applicant ever been widowed or divorced? ❑ Yes ❑ No If yes, enter information for all previous marriages:

Former Spouse's Name (First) (Middle) (Maiden) (Last)	How Long Married	How Marriage Ended (Death or Divorce)

Does applicant have Medicare Part A? ❑ Yes ❑ No **Medicare Part B?** ❑ Yes ❑ No If yes, enter the Health Insurance Claim # as shown on the Medicare card: _____

Does applicant have other health insurance? ❑ Yes ❑ No If yes, enter the following information:

_____

Insurance Company Group or Policy # Begin Date End Date (if ending)

Does applicant receive Medicaid from another state? ❑ Yes ❑ No If yes, complete the following:
Name of State _____ Date Medicaid will close _____

Legal Representative: Does this applicant have a court appointed guardian or conservator? ❑ Yes ❑ No
Has this applicant appointed Power of Attorney to anyone? ❑ Yes ❑ No
If yes, give the name, address & phone # of the person legally appointed to act for this applicant:
Verification of guardianship, conservatorship or power of attorney will be required.

Name/Address _____

Phone #s _____Relationship to Applicant _____

Authorized Representative: If there is no legal representative, would this applicant like to name a person to act as their representative? ❑ Yes ❑ No. A representative acts in the applicant's behalf on matters relating to this application, including providing needed information. Enter the name, address & phone number of the person representing this applicant:

Name/Address _____

Phone #s _____Relationship to Applicant _____

3. **SPOUSE OR PARENT INFORMATION - Provide the following information for the spouse of the applicant or information on the parent applying for a minor disabled child. The spouse of Applicant #1 may also apply by completing this entire section.**

Full Name of Spouse or Parent _____

Social Security Number*: _____ - ____ - _____ **Date of Birth:** (Mo) _____ (Day) _____ (Year) _____
(*not required unless spouse is applying)

Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Widowed ❑ Divorced **Gender:** ❑Male ❑ Female

Race: (optional) check all that apply: ☐ White ☐ Black ☐ American Indian or Alaska Native ☐ Chinese ☐ Asian Indian ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian ☐ Samoan ☐ Guamanian or Chamorro ☐ Other Pacific Islander ☐ Other _____

If Hispanic/Latino, check all that apply (optional) ☐ Mexican ☐ Mexican-American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

Telephone (Home) _____(Cell) _____(Other) _____

Home Address (if different from Applicant #1) _____**Apt .or Lot#** _____

City: _____C**ounty:** _____**State:** _____**Zip:** _____

Mailing Address (if different from above) _____

City: _____ **County:** _____**State:** _____ **Zip:** _____

Who lives at this address now?

_____

<u>Is spouse applying for Medicaid on this application?</u> ❑ **Yes** ❑ **No** **If yes, answer all of the following questions as Applicant #2.**
If spouse is not applying, skip to Question #4. If parent is applying for a minor disabled child, skip to Question #4.

Applicant #2 is applying on the basis of: ❑ age (65 or over) ❑ blindness ❑ disability (describe the disability): _____

Applicant #2 lives: ❑ in own home ❑ rental home or apt. ❑ with someone in their home – please list whose home _____ ❑ nursing facility ❑ other _____

Does Applicant #2 plan to enter a nursing facility? ❑ Yes ❑ No If yes, when? _____

Enter name & location of nursing facility _____

If in a nursing facility, did Applicant #2 enter directly from ❑ a hospital ❑ home ❑ other _____

Name of Applicant(s) _____SSN(s)_____

Is Applicant #2 a U.S. citizen? ❑ Yes ❑ No **If no, when did spouse enter the U.S.? _____**

If not a U.S. citizen, is Applicant #2 in a satisfactory immigration status? ❑ Yes ❑ No (Not required for immigrants seeking Emergency Medicaid services.) A list of satisfactory immigration statuses for Medicaid purposes is available from a Medicaid Regional Office.)

Previous Marriages: Has Applicant #2 ever been widowed or divorced? ❑ Yes ❑ No If yes, enter information for all previous marriages:

Former Spouse's Name (First) (Middle) (Maiden) (Last)	How Long Married	How Marriage Ended (Death or Divorce)

Does Applicant #2 have Medicare Part A? ❑ Yes ❑ No **Medicare Part B?** ❑ Yes ❑ No If yes, enter the Health Insurance Claim # as shown on the Medicare card: _____

Does Applicant #2 have other health insurance? ❑ Yes ❑ No If yes, enter the following information:

_____

Insurance Company Group or Policy # Begin Date End Date (if ending)

Does Applicant #2 receive Medicaid from another state? ❑ Yes ❑ No If yes, complete the following:
Name of State _____ Date Medicaid will close _____

Legal Representative: Does Applicant #2 have a court appointed guardian or conservator? ❑ Yes ❑ No
Has Applicant #2 appointed Power of Attorney to anyone? ❑ Yes ❑ No
If yes, give the name, address & phone # of the person legally appointed to act for Applicant #2:
Verification of guardianship, conservatorship or power of attorney will be required.
Name/Address _____

Phone #s _____Relationship to Applicant _____

Authorized Representative: If there is no legal representative, would Applicant #2 like to name a person to act as their representative? ❑ Yes ❑ No. A representative acts in the applicant's behalf on matters relating to this application, including providing needed information. Enter the name, address & phone number of the person representing Applicant #2:

Name/Address _____

Phone #s _____Relationship to Applicant _____

4. **RETROACTIVE MEDICAID –** Medicaid may be able to cover Applicant #1 and Applicant #2 (if applicable) for the 3 months prior to the date of this Medicaid application or the date an application was filed for SSI. Each applicant must be determined eligible for each requested month and have received services covered by Medicaid during the retroactive period. ***The month of application is the month Medicaid receives this signed form.***

Does Applicant #1 want to apply for retroactive Medicaid? ❑ Yes ❑ No If yes, enter month(s) needed

_____

Does Applicant #2 want to apply for retroactive Medicaid? ❑ Yes ❑ No If yes, enter month(s) needed

_____

5. **VETERAN STATUS**

Is Applicant #1 a veteran? ❑ Yes ❑ No Has Applicant #1 ever been married to a veteran (living or not)? ❑ Yes ❑ No

Is Applicant #2 a veteran? ❑ Yes ❑ No Has Applicant #2 ever been married to a veteran (living or not)? ❑ Yes ❑ No

Is Applicant a dependent of a veteran? ❑ Yes ❑ No If yes to any of these questions, complete the following:

Name of Veteran _____Relationship to Applicant _____

Dates of Service _____Branch of Service _____

Has Applicant #1 ever applied for VA benefits? ❑ Yes ❑ No

Has Applicant #2 ever applied for VA benefits? ❑ Yes ❑ No

If yes for Applicant #1 or #2, please provide proof of the VA decision to grant or deny benefits.

6. **INCOME AND WORK HISTORY – The Division of Medicaid is required to verify all income received and resources owned by each applicant, each applicant's spouse (applying or not applying) and the parent(s) of a minor disabled child. If this application is for a <u>minor disabled child</u>, please check one of the following:**

❑ I will provide parental financial information so that my child can be considered under any and all categories of eligibility for Medicaid and/or CHIP. Enter information for parent(s) and child applicant below.

❑ I elect to have my child's eligibility considered **<u>only</u>** under the Disabled Child Living At-Home (DCLH) category and will not provide any parental income or resource information to use for evaluation under any other category of eligibility. The DCLH category requires the income/resources of the disabled child to be verified. Enter income and resource information for the child applicant below.

Name of Applicant(s) _____SSN(s)_____

Does applicant, spouse (applying or not) or parent(s) of a minor disabled child work? ❑ Yes ❑ No

If yes, name person(s) working: _____

Name of Employer(s): _____

Total wages (before deductions) $ _____How often paid? _____

If paid weekly or biweekly, what is day of week paid? _____ ***Wages must be verified for the last 3 months. Copies of check stubs or wage printouts are examples of verification that can be provided.***

Is applicant, spouse (applying or not) or parent(s) of a minor child currently self-employed or self-employed during the last 12 months? ❑ Yes ❑ No If yes, name person(s) currently or previously self-employed:_____

Type of business _____End Date (if not active) _____
Self-employment must be verified. A copy of the last federal tax return verifying net earnings is required. If a tax return is not available, another form of verification will be required.

If not currently employed, what is the last date of employment (for the applicant, spouse or parent(s) of a minor disabled child)? Provide employer(s) name and ending date of employment:

_____

Did applicant, spouse or parent(s) file a federal tax return last year? ❑ Yes ❑ No

Are there children under the age of 18 in the home that have income? ❑ Yes ❑ No If so, name the child and the source/amount of income

_____

Income of a child (not applying for Medicaid) is used to determine how much of a non-applying spouse's or parent's income is counted.

Complete the next 2 questions <u>only if</u> applicant #1 or #2 is in a nursing facility:

- If applicant has a spouse living at-home, does applicant wish to make his or her income available to the community spouse? ❑ Yes ❑ No

- Does applicant in the nursing facility receive sheltered workshop earnings or any income from work therapy? ❑ Yes ❑ No If yes, what are the monthly earnings? $_____

All other income received by the **applicant, spouse** (applying or not) or **parent(s)** of a minor disabled child must be verified for eligibility purposes. If an electronic verification source is available to us, we will verify the income for you. Otherwise, verification needs to come from the source of the payment. You will be asked to provide a check stub or other official document. Enter the gross amount (before any deductions) of income received from any source in the space below:

Source of Income	How Often Received	Applicant #1	Applicant #2 or Spouse	Parent of Minor Disabled Child	Parent of Minor Disabled Child
Social Security		$	$	$	$
SSI		$	$	$	$
Railroad Retirement		$	$	$	$
VA Pension		$	$	$	$
VA Compensation		$	$	$	$
Other VA Benefits		$	$	$	$
Military Retirement		$	$	$	$
State Retirement		$	$	$	$
Federal Civil Service		$	$	$	$
Municipal Retirement		$	$	$	$
Private Pension		$	$	$	$
Unemployment Compensation		$	$	$	$
Rental Income		$	$	$	$
Workers' Comp.		$	$	$	$
IRA Income		$	$	$	$
Annuity Income		$	$	$	$
Interest Income		$	$	$	$
Trust Income		$	$	$	$
Dividends		$	$	$	$
Promissory Note Income		$	$	$	$
Oil, Gas or Mineral or Timber Leases		$	$	$	$
Government Payments on Land		$	$	$	$
Royalties		$	$	$	$
Child Support		$	$	$	$
Alimony		$	$	$	$
Cash Contributions		$	$	$	$
Public Assistance (TANF or other)		$	$	$	$
Other (specify)		$	$	$	$
Other (specify)		$	$	$	$

If applying for long term care in a nursing facility or Home & Community Based waiver services, has the applicant or spouse given away any income or the rights to income or the right to receive income within 5 years of this application? ❑ Yes ❑ No ***If yes, verification will be required for all transfers of income.***

Name of Applicant(s) _____SSN(s)_____

7. **RESOURCES –Report real or personal property owned or being purchased in part or in whole by the applicant, spouse (applying or not) or parent(s) of a minor disabled child. Not all resources count for eligibility purposes but you must tell us about all resources. Enter requested information below:**

Home Property: ❑ Yes ❑ No If yes, enter State/County of Home _____

Address/City _____

If ownership is shared, who else is on the deed _____

Does anyone live in the home? ❑ Yes ❑ No If yes, who? _____

Is the home being rented or does it produce income? ❑ Yes ❑ No Is yes, explain _____

_____ Amount of rental income $ _____

Does applicant owe money on the property? ❑ Yes ❑ No If yes, what is owed? $_____

Does applicant have a reverse mortgage? ❑ Yes ❑ No If yes, what are payments? $ _____
The most recent deed & tax receipt may be required to verify home property.

Other Real Property ❑ Yes ❑ No If yes, number of other properties: _____
If yes, list each property below: ***Copies of deeds and tax receipts will be required to verify other real property.***

Location of Each Property (City, County, State)	Type of Ownership Name on Deed	Who Lives on Property?	Income Produced by Property
			$
			$
			$
			$
			$

Does applicant own a mobile home? ❑ Yes ❑ No If yes, who owns the land where the mobile home is located?

_____

Has applicant or spouse sold or given away home or non-home property within 5 years of this application? ❑ Yes ❑ No If yes, give date(s) and describe the property that was sold or transferred:

_____

Copies of deeds showing current ownership or ownership at the time property was sold or transferred will be needed on all property owned or owned within the last 5 years in order to determine eligibility for long term care and Home and Community Based Services (HCBS) applicant(s).

Cash on Hand – Does applicant, spouse or parent(s) keep cash on hand (greater than $200 spending money)? ❑ Yes ❑ No If yes, how much? $ _____

Funds Held in a Bank or Credit Union – Check all of the following types of accounts individually or jointly owned or used by the applicant, spouse or parent(s) to hold funds belonging to the applicant, spouse or parent. ***Verification of balances will be needed from the bank/credit union.***

❑ Checking Account(s) ❑ Direct Deposit Debit Card Account ❑ Savings Account(s) ❑ CD(s)
❑ Conservatorship Account ❑ Funds Held in a Bank Account Owned by Another
❑ Fund Raiser Account ❑ IRA ❑ Annuity ❑ Safety Deposit Box ❑College Savings Fund

Enter information for each account below:

Name of Bank	Type of Account	Account Number	Name(s) on Account	Current Balance

If applicant is in a nursing facility, is there a patient account at the facility? ❑ Yes ❑ No

Have any accounts been closed, names changed or funds transferred from any account(s) in the last 5 years? ❑ Yes ❑ No If yes, explain:

_____

Verification of changes in accounts may be required for long term care and HCBS waiver applicant(s).

Retirement Funds – Does applicant, spouse or parent(s) have retirement funds on deposit from a pension plan, IRA, annuity, or other type of fund? ❑ Yes ❑ No Has periodic payment from this fund or funds been requested? ❑ Yes ❑ No Is the owner of these fund(s) still employed & working? ❑ Yes ❑ No

Owner of Retirement Fund(s) _____***Verification of funds will be required.***

Name of Applicant(s) _____SSN(s)_____

Annuities – Does applicant, spouse or parent(s) own, individually or jointly, an annuity? ❑ Yes ❑ No

If yes, name owner(s) _____

Initial investment $ _____ Date purchased _____ Name annuitant _____

Does annuity produce fixed monthly payments? ❑Yes ❑ No Are payments based on entire investment? ❑Yes❑ No

Each annuity must be verified by providing the annuity contract. Other information may also be required.

Trust Funds – Is the applicant, spouse or parent(s) the beneficiary of a trust? ❑ Yes ❑ No If yes, enter Trustee's name/address/telephone _____

Has a trust been set up using assets belonging to the applicant, spouse or parent(s)? ❑ Yes ❑ No

A copy of any/all trusts created by the applicant, spouse or parent(s) in full or in part must be provided.

Promissory Notes, Loans or Property Agreements – Does applicant, spouse or parent(s) own an agreement for repayment of money loaned or property sold? ❑ Yes ❑ No If yes, enter the following:

Balance of Loan $_____ Income Received $_____ How Often? _____

A copy of the note or agreement will be required in order to determine eligibility for the applicant(s).

Stocks, Bonds or Similar Investments– Check all of the following types of investments owned by the applicant, spouse or parent(s): ❑ Stocks ❑ Mutual Fund Shares ❑ Corporate Bonds ❑ Municipal Bonds ❑ Government Bonds/U.S. Securities ❑ U.S. Savings Bonds ❑ Foreign Investments ❑ Other _____. Enter information for each investment owned:

Type of Investment	Owner(s)	Current Value
		$
		$

All investments owned must be verified by an official document confirming value.

Automobiles (Cars, Trucks, Motorcycles, Boats) – List any vehicle used for transportation owned by the applicant, spouse, parent(s)

Type of Vehicle	Owner(s)	Model/Year	Amount Owed

Verification of ownership of vehicles may be required.

Personal Property – Includes recreational vehicles, campers, and boats used for recreation only, antiques or other collectables of substantial value. Does applicant, spouse or parent(s) own any personal property of this type? ❑ Yes ❑ No If yes, what is owned?

_____

Describe and give value: _____

Verification may be required to confirm the value.

Life Insurance – Does applicant, spouse or parent(s) own life insurance? ❑Yes ❑ No If yes, specify:

Owner	Insured	Face Value	Insurance Co.	❑ Whole Life ❑ Term
				❑ Whole Life ❑ Term
				❑ Whole Life ❑ Term
				❑ Whole Life ❑ Term

A copy of the face value page is needed for verification.

Burial Funds – Does applicant, spouse or parent(s) have funds set aside for burial? ❑ Yes ❑ No If yes,

How are funds set up? ❑ Burial Insurance ❑ Pre-Need Contract With Funeral Home ❑ Other (specify)

_____Value of fund(s) $_____

Verification of the value of the funds and whether funds are accessible may be required.

Burial Spaces - Does applicant, spouse or parent(s) own burial plots or spaces? ❑ Yes ❑ No If yes,

Number of gravesites owned _____Location of Cemetery _____

Are all gravesites used / intended for use by family members of applicant? ❑ Yes ❑ No

Other – Are there any other resources owned or being bought by the applicant, spouse or parent(s) that are not shown above in the Resource section? ❑ Yes ❑ No If yes, specify type & value of resource:

_____

Resource Activity in the Last 5 Years – Has the applicant or spouse sold or given away any resources within 5 years of this application that have not already been disclosed on this application?

❑ Yes ❑ No If yes, specify:

_____

A 5-year look back period may be imposed for nursing home and Home &Community Based waiver applicant(s). Verification of any/all transfers identified within the last 5 years will be required.

8. **STATEMENT OF RESIDENCY** – Does Applicant #1 plan to remain in Mississippi? ❑ Yes ❑ No

Does Applicant #2 plan to remain in Mississippi? ❑ Yes ❑ No

Name of Applicant(s) _____SSN(s)_____

9. **ESTATE RECOVERY –** The Estate Recovery provision applies to Medicaid recipients age 55 or older and in a nursing facility or enrolled in a Home & Community Based Waiver program at the time of death. If this applies to either Applicant #1 or Applicant #2 or both, please read the following:

   I understand that upon my death the Division of Medicaid has the legal right to seek recovery from my estate for services paid by Medicaid in the absence of a legal surviving spouse or a legal surviving dependent. Consideration will be made for hardship cases. An estate consists of real and personal property. I understand that homestead property is in many cases protected from the claims of creditors and exempt from judicial sale and that, by signing this contract, I voluntarily give up my right to this protection for this property with respect to claims based upon this contract.

10. **PRIVACY ACT AND USE OF SOCIAL SECURITY NUMBERS** – The MS Division of Medicaid is authorized to determine eligibility for Medicaid and is protected by law from disclosure to unauthorized persons. It is possible that this form may be used to determine another person's right to Medicaid benefits. Pursuant to the authority found in federal law at 42 U.S.C. 1320b-7(a) and federal regulations at 42 CFR 435.910, you are required to disclose the Social Security Number (SSN) for each person applying for Medicaid. This is a mandatory requirement in order to be eligible for Medicaid benefits, unless an applicant is a non-qualified alien seeking emergency Medicaid services. If you cannot recall the SSN for each applicant or if the applicant does not have a SSN, the agency can assist you in applying for a SSN for each applicant. If the applicant has a well-established religious objection for not providing his or her SSN, he or she should state the basis for such objection and the agency will review this request. The SSN will be used to verify information such as assets, income and insurance coverage and to help maintain files regarding eligibility pursuant to the authority described in federal regulations 42 CFR 435.940 through 42 CFR 435.960. Consistent with Federal Law, Section 1940 of the Social Security Act (42 USC 1396w), which mandates asset verification services by all state Medicaid agencies, and Mississippi House Bill 1391, the SSN will be used for electronic verification of disclosed and undisclosed assets. The SSN may also be used to match with records within the State Medicaid agency and in other state, federal, and/or local agencies, such as the Social Security Administration, Internal Revenue Services, and Employment Security as well as banks and other financial institutions.

11. **DISCLOSURE OF FINANCIAL INFORMATION -** By signing this application, you are certifying that to your knowledge all financial information provided is true and correct. In addition, you are authorizing any financial institution to disclose information concerning financial accounts held by that institution to the MS Division of Medicaid or its designated agent or contractor for the purpose of identifying and verifying your assets at application and redetermination for Medicaid eligibility. This includes the amount of deposits and any other information described in or solicited from the financial institution, including an account history request. This authorization is effective until Medicaid eligibility is denied or Medicaid eligibility ends or you revoke this authorization, whichever occurs first. You may revoke this authorization at any time by notifying the MS Division of Medicaid in writing of your desire to revoke this authorization; however, such revocation would prevent eligibility from being determined or redetermined. This authorization of information disclosure does not alter or waive your right under the Right to Financial Privacy Act, 12 U.S.C. 3401 et seq., except to the extent that certain such rights may be modified by the asset verification provisions of Section 1940 of the Social Security Act, 42 USC 1396w.

12. RIGHTS AND RESPONSIBILITIES OF APPLICANTS

- I understand that if this application shows that I may be eligible for payments or benefits from other sources, I am required to apply for them.
- I understand that as a condition of receiving Medicaid, the MS Division of Medicaid may become a remainder beneficiary on any annuity that I or my spouse purchased or on which we performed certain transactions on or after February 8, 2006.
- I understand that if I am awarded Medicaid in a nursing facility that part or all of my income must be applied toward the cost of my care in the facility, as directed by the MS Division of Medicaid.
- I understand that my case is subject to review by state or federal auditors or for quality control purposes and I must cooperate with reviewers. No additional permission is needed to get verification or other information.
- I assign all insurance and medical support benefits to Medicaid if I am approved for Medicaid. If Medicaid pays my bills, then my insurance or other benefits (such as lawsuit settlements) must be used to reimburse Medicaid. By accepting Medicaid, I agree to give up my rights to any third party payments to the MS Division of Medicaid. I agree to help and cooperate with the MS Division of Medicaid in identifying and collecting this money, or I may lose my Medicaid.
- I agree to notify the MS Division of Medicaid within ten (10) days if there is a change in my address, living arrangement, family size, income or resources. I also agree to notify the MS Division of Medicaid if I return to work, am discharged from a nursing facility or hospital or move from one facility to another. I will report any improvement in my medical condition if I am receiving Medicaid due to disability or blindness.
- In-person interviews are required for new applications and may be required for annual reviews.
- An annual review is required for all Medicaid recipients. Adults may be reviewed more than once per year depending on the types of changes reported during the year.
- Information you share is confidential. Your medical information can only be released if needed to administer the Medicaid program. If you receive care or treatment under Medicaid, you authorize the health care provider to release to Medicaid your medical records and information relating to your diagnosis, examination and treatment.
- You may ask for a hearing if you are not satisfied with any action taken by the MS Division of Medicaid in connection with this application.
- Your application will be considered without regard to race, color, age, handicap, religion, national origin, political belief or limited English proficiency. The MS Division of Medicaid complies with all state and federal policies which prohibit discrimination as defined through The Americans with Disabilities Act of 1990, the Rehabilitation Act of 1973 and the Civil Rights Act of 1964.
- Adults eligible for Medicaid should get a yearly health screening (health exam) from your doctor or clinic. This exam will not count against your annual doctor visit limit under Medicaid. Children under age 21 who are eligible for Medicaid are eligible for a free health care prevention program that provides a way for children to get medical exams, check-ups, follow up treatment and special care to make sure they maintain good health.

Name of Applicant(s) _____SSN(s)_____

13. RELEASE OF INFORMATION – I hereby authorize and give my consent for the MS Division of Medicaid to obtain information from any source for the purpose of determining my eligibility for Medicaid benefits. I authorize this release form to be in effect for as long as I am on Medicaid regardless of the date that it is signed. I further authorize copies of this document to be used in place of the original. I give my consent for the release of information for those purposes directly related to the administration of the Medicaid program. These purposes include, but are not limited to, establishing eligibility for benefits, determination of the amount of medical assistance received, the provision of service and the investigation of program violations.

SIGNATURE(S)

I certify that the information I have provided above is true to the best of my knowledge, and I give permission for the State of Mississippi to make any necessary contact to check my statements. I have read the list of my rights and responsibilities that is printed above. If I knowingly give false statements or leave out information asked for on this application, such as income or household members, I commit a crime that is punishable under federal and/or state law.

Do you accept these responsibilities and agree to notify the Medicaid Regional Office of any and all changes listed above? ❑ Yes ❑ No

_____

Signature of 1st Applicant or Legal or Authorized Representative **Date**

_____

Signature of 2nd Applicant or Legal or Authorized Representative **Date**

_____

Signature of Non-Applicant Spouse or Parent (if appropriate) **Date**

_____

Signature of Witness if anyone signs with a mark **Date**