***IMPORTANT* ANSWER ALL QUESTIONS**

SSI REDETERMINATION FORM

1. CLIENT IDENTIFICATION

- Client's Full Name:_____
  (First) (Middle) (Maiden) (Last)
- Client's Medicaid ID# _____
- Social Security Number: _____-_____-_____ If none, have you applied for one?_____
- Date of Birth: (mo) _____(day) _____(year) _____ Sex (check one): ☐ Male ☐ Female
- Race (check one): ☐ White ☐ Black ☐ American Indian ☐ Hispanic ☐ Asian ☐ Indo-Chinese
- Does client have Medicare Part A? ☐ Yes ☐ No; Part B? ☐ Yes ☐ No Medicare Claim #_____

  Does client have any other health insurance? ☐ Yes ☐ No
- Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced
- If someone other than the client is filling out this SSI Redetermination Form, please complete the following:

  Name of Designated Representative:_____
  Address:_____
  Telephone #:_____ Relationship to client:_____
- Has client given written power of attorney to anyone? ☐ Yes ☐ No If you marked "Yes", please answer the following:
  Name/Address:_____
- Does client have a court appointed guardian or conservator? ☐ Yes ☐ No If you marked "Yes", please answer the following:
  Name / Address: _____
- Is the client the beneficiary of a trust? ☐ Yes ☐ No If you marked "Yes", please give the trustee's:
  Name / Address:_____
- If client is under the age of 65, what is disability?_____
- What is client's current living arrangement?_____
- What is client's current mailing address?_____ City_____
  County_____State_____ Zip _____ Telephone Number _____
- List members of client's household. If client is in a nursing facility, list the people living in the house prior to client entering the nursing facility:

Name of Household Member	*Age*	*Relationship to Client*

2. SPOUSE OR PARENT IDENTIFICATION - Complete even if spouse is deceased.

If client is a child 18 years or under, give parent(s) information.

- Full Name of Spouse/Parent(s) _____
- Social Security No. _____-_____-_____ Date of Birth _____ /_____ /_____ Death Date_____/_____/_____
- Current Address_____
- City _____ State _____ Zip_____ Telephone #_____-_____
- Is spouse or parent applying for Medicaid? ❑ Yes ❑ No
- Has spouse or parent ever received Medicaid? ❑ Yes ❑ No
- If client has ever been widowed or divorced, give the following information for **all** previous marriages:

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

3. VETERAN STATUS

- Is client a veteran? ❑ Yes ❑ No
- Has client ever been married to a veteran? ❑ Yes ❑ No
- Is client a dependent of a veteran? ❑ Yes ❑ No

If you answered "Yes" to any of the above questions, please complete the following:

Name of Veteran_____

Client's Relationship to Veteran_____

Veteran's Service Number or Claim Number_____
Branch of Service_____ Date(s) of Service_____
Has client ever applied for VA benefits under the new Veterans and Survivors Improvement Act? ❑ Yes ❑ No

If client is in a nursing home, has client ever applied for VA Aid & Attendance? ❑ Yes ❑ No

4. RETROACTIVE MEDICAID

Medicaid may be able to cover the client in the 3 months prior to the date of this SSI Redetermination (if needed) or the date the application was filed for SSI if the client is eligible & received services covered by Medicaid during the 3 month retroactive period.

- Does client want to apply for retroactive Medicaid? ❑ Yes ❑ No

5. RESOURCES - This is real or personal property owned or being bought by the client, spouse or parent(s) of a child.

Does client or spouse / parent(s) **own** or is client / spouse / parent(s) **buying** any of the following types of resources:

- **RETIREMENT FUNDS** (IRA, Keough Plan, state, federal or municipal retirement or private pension funds)

  ☐ Yes ☐ No If yes, has client applied for income from retirement funds? ☐ Yes ☐ No

- **SAFE DEPOSIT BOX** ☐ Yes ☐ No If yes, at what bank?_____

- **BANK ACCOUNTS** (checking, savings, CDs, Christmas Club, Patient Accounts, etc.) ☐ Yes ☐ No

  If yes, complete the following:

  Name of Bank_____

Type of Account /Account Number	*Balance*	*Type of Ownership*	*Interest Paid How Often*
_____	_____	☐ Joint ☐ Individual	_____
_____	_____	☐ Joint ☐ Individual	_____
_____	_____	☐ Joint ☐ Individual	_____

- **PROMISSORY NOTES, LOANS OR PROPERTY AGREEMENTS** ☐ Yes ☐ No If yes,

  Principal balance_____ Does note produce income? ☐ Yes ☐ No

  Amount of income $_____ How often_____

- **STOCKS, BONDS & SAVINGS BONDS** ☐ Yes ☐ No If yes, describe the type and number owned_____

  _____ value _____

- **HOME PROPERTY** ☐ Yes ☐ No If yes, what state_____ county_____

  Address / location_____

  Type of ownership: ☐ Sole ☐ Shared ☐ Life Estate ☐ Other (describe)_____

- **OTHER REAL PROPERTY** ☐ Yes ☐ No If yes, number of other properties _____

  Address/location_____

  County _____ State_____ Type of ownership: ☐ Sole ☐ Shared ☐ Life Estate ☐ Heir Interest ☐ Other

  Explain how property is used: _____

  Does property produce income? ☐ Yes ☐ No

  If yes, include amount of income $_____. How often _____

- **HOUSEHOLD GOODS / PERSONAL PROPERTY** (Includes boats, campers, recreational vehicles, or any other personal effects of substantial value.) ☐ Yes ☐ No If yes, what is owned?_____

  Describe: make_____ model_____ year_____ value_____

- **AUTOMOBILE (S)** - (This includes any cars, trucks, motorcycles or farm machinery). ☐ Yes ☐ No If yes,

Type of Vehicle	*Model / Year*	*Amount Owed*	*Use of Vehicle*
_____			☐ Employment ☐ Medical ☐ Other
_____			☐ Employment ☐ Medical ☐ Other
_____			☐ Employment ☐ Medical ☐ Other

- **LIFE INSURANCE** ☐ Yes ☐ No If yes,

Insured	*Owner*	*Face Value*	*Insurance Company*	*Type of Policy*
				☐ Whole Life ☐ Term
				☐ Whole Life ☐ Term
				☐ Whole Life ☐ Term

- **BURIAL SPACES** (Includes burial plots or spaces) ☐ Yes ☐ No

  Number of gravesites owned_____ Location of cemetery_____

  Are these gravesites used / intended for use by client's family? ☐ Yes ☐ No

- **BURIAL FUNDS** Are there funds set aside for burial? ☐ Yes ☐ No

  How are the funds set up? ☐ Cash ☐ Burial Insurance or Contract ☐ Other

  Value of funds $_____ Can funds be cashed in? ☐ Yes ☐ No

- **OTHER** Are there any other resources owned or being bought that are not shown above? ☐ Yes ☐ No
- If yes, specify _____
- Has client or spouse sold or given as a gift any resource (including cash) to **anyone** in the last 36 months?

  ☐ Yes ☐ No If yes, specify:_____

Type of Resource Transferred	*Date*	*Person to Whom Transferred*	*Amount of Compensation*

6. INCOME AND WORK HISTORY

- Does client, spouse or parent(s) work? ☐ Yes ☐ No
- If yes, name of person who works_____

  Employer_____

  Total wages (before deductions) $_____ Paid how often_____If paid weekly or biweekly, what is day of week check is received? _____ Was client, spouse or parent(s) self-employed at any time this or last year? ☐ Yes ☐ No

  If yes, type of business_____

  Amount earned $_____ Paid how often_____
- If client, spouse or parent(s) do not currently work, what is date last employed?_____

  Employer_____
- Did client / spouse file state or federal income tax last year? ☐ Yes ☐ No
- Complete the next two questions only if client is in a nursing facility or facility for the mentally retarded.

  - -If client has a spouse living at home, does client wish to make income available to the community spouse?

    ☐ Yes ☐ No

  - -Does client receive sheltered workshop earnings or any income from work therapy? ☐ Yes ☐ No

    If yes, what are the monthly earnings? $_____

List below all other types of money received by the client, his/her spouse, or any dependent child. If this is an SSI Redetermination for a child, each parent must account for his/her income.

		Source of Income	*Client*	*Parent(s) or Spouse*	*Children (Under 18)*	*Claim Numbers*
☐ Yes	☐ No	Social Security	$_____	$_____	$_____	_____
☐ Yes	☐ No	SSI	$_____	$_____	$_____	_____
☐ Yes	☐ No	VA Pension/Compensation	$_____	$_____	$_____	_____
☐ Yes	☐ No	VA Insurance	$_____	$_____	$_____	_____
☐ Yes	☐ No	Military Retirement	$_____	$_____	$_____	_____
☐ Yes	☐ No	Railroad Retirement	$_____	$_____	$_____	_____
☐ Yes	☐ No	State Retirement	$_____	$_____	$_____	_____
☐ Yes	☐ No	Municipal Retirement	$_____	$_____	$_____	_____
☐ Yes	☐ No	Civil Service Retirement	$_____	$_____	$_____	_____
☐ Yes	☐ No	Private Retirement	$_____	$_____	$_____	_____
☐ Yes	☐ No	Unemployment Compensation	$_____	$_____	$_____	_____
☐ Yes	☐ No	Rental Income	$_____	$_____	$_____	_____
☐ Yes	☐ No	Workers' Compensation	$_____	$_____	$_____	_____
☐ Yes	☐ No	Interest Income	$_____	$_____	$_____	_____
☐ Yes	☐ No	Trust Income	$_____	$_____	$_____	_____
☐ Yes	☐ No	Dividends	$_____	$_____	$_____	_____
☐ Yes	☐ No	Income from Promissory Note or Loan	$_____	$_____	$_____	_____
☐ Yes	☐ No	Oil, Gas, Mineral Royalties	$_____	$_____	$_____	_____
☐ Yes	☐ No	Child Support/Alimony	$_____	$_____	$_____	_____
☐ Yes	☐ No	Cash Contributions	$_____	$_____	$_____	_____
☐ Yes	☐ No	Other	$_____	$_____	$_____	_____

7. STATEMENT OF CITIZENSHIP OR ALIENAGE - In order to receive Medicaid, each client must certify, under penalty of perjury, whether he/she is a citizen or national of the United States or is in a satisfactory immigration status. Satisfactory immigration status means that the person is living in the U.S. legally.

Is client a United States citizen by birth or naturalization? ☐ Yes ☐ No

If no, is client lawfully admitted for permanent residence in the U.S.? ☐ Yes ☐ No

If not lawfully admitted, when did client first enter the U.S.? _____

Is the Immigration & Naturalization Service (INS) aware of client's presence? ☐ Yes ☐ No

Does client plan to remain in Mississippi? ☐ Yes ☐ No

BY SIGNING THIS REDETERMINATION, THE CLIENT IS STATING THAT THIS STATEMENT OF CITIZENSHIP IS TRUE

8. ASSIGNMENT OF RIGHTS TO THIRD PARTY PAYMENT, COOPERATION REQUIREMENT & ESTATE RECOVERY REQUIREMENT

- Medicaid does not pay medical expenses that a third party, such as a private health insurance company, is supposed to pay. All persons applying for Medicaid benefits are required to assign the Division of Medicaid any rights they may have to medical support or other third party payments for medical care. When you sign this SSI Redetermination for Medicaid benefits, you are assigning the Division of Medicaid all rights to collect or receive any such payments for the time you are (were) on Medicaid.
- *I understand that by applying for Medicaid benefits I agree to cooperate with the Division of Medicaid in identifying and providing information to help pursue any third party who may be responsible for providing medical support for me. If I am signing this SSI Redetermination on behalf of another person, I agree to cooperate in identifying and obtaining information to pursue any third party who may be responsible for providing medical support for them.*
- I understand that if I am eligible to enroll in any insurance or benefit plan offered by my employer or my spouse's employer, I am required to enroll in that plan.
- *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 & personal property. Estate recovery applies to nursing home clients age 55 and older.*

9. PRIVACY ACT AND COMPUTER MATCHING NOTICE - The Division of Medicaid is authorized to request the information on this form. The primary use of this information is 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. Also, to comply with federal law, the client's Social Security Number(s) will be computer matched with other agencies, such as the Social Security Administration and the Internal Revenue Service, to obtain information about income and resources available to the client. These matches may also be done on an individual basis.

10. CLIENT RESPONSIBILITIES

- I know that anyone who makes or causes to be made a false statement or misrepresentation of material in this form or for use in determining eligibility for Medicaid commits a crime, punishable by federal and/or state law. I affirm that all information given this document or in support of it is true.
- *If this SSI redetermination or other information shows that the client may be eligible for any payments or benefits from other sources, the client is required to file for other benefits when notified by the Division of Medicaid.*
- The Medicaid regional office must be notified immediately if there is a change in the client's address, living arrangement, family size, income or resources. Also, the regional office must be notified if the client is discharged from a hospital or nursing home or if the client moves from one medical facility to another.
- *If this SSI redetermination is for someone who is blind or disabled, the regional office must be notified of any improvement in the client's medical condition or if the client returns to work.*
- The client's case may be selected for quality control purposes in a state and/or federal review. If his/her case is selected, the client's full cooperation is required.

Does the client and/or designated representative accept these responsibilities and agree to notify the Medicaid regional office of any and all changes listed above? ☐ Yes ☐ No

_____ _____

Signature of client or designated representative *Date*

_____ _____

Signature and address of witness (if client signs with a mark) *Date*

The Division of Medicaid complies with all state and federal policies which prohibit discrimination on the basis of race, age, sex, national origin, handicap or disability - as defined through The Americans with Disabilities Act of 1990.

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-300B - SSI REDETERMINATION FORM

PURPOSE & USE

Form DOM-300B, SSI Redetermination Form, is used to determine continuing Medicaid eligibility for individuals terminated from SSI due to excess income and/or resources. The form is computer generated by the fiscal agent and issued along with the SSI Notice of Termination. Refer to Section C for policy governing the SSI Redetermination process.

INSTRUCTIONS

The completed DOM-300B will be filed in the case record upon receipt of the completed/signed form. The form must be signed by the client or designated representative before the redetermination process is completed.