pennsylvania
DEPARTMENT OF HUMAN SERVICES

Medical Assistance (Medicaid) Financial Eligibility Application for Long Term Care, Supports and Services

You may also apply online at www.compass.state.pa.us

Check any that you are applying for:

- ☐ Care in a Facility
- ☐ Home and Community Waiver Services Type/Name of Waiver/Service: _____
- ☐ Other _____

** Please read the entire application form*
** Print the requested information in the unshaded sections*
** If you need help, another person can help you or you can get help from your county assistance office*

You or any representative you choose may complete this application. Your representative can be your spouse, a friend, a relative, a person who has your power of attorney, or your medical provider. It should be someone who knows and can provide information about your income and resources. If you are married, information in some sections must be completed for both you and your spouse.

After the form is completed, bring it, have someone else bring it, or mail it to the county assistance office unless you are instructed otherwise. The county assistance office will tell you if a face to face interview is needed. You will need proof of identity and verification for other information on the form unless we already have the information in our records. If you need help to obtain any information ask the county assistance office for help. You should attach verification to this form.

Persons who have given away assets (income or resources) within the past 60 months, or set up or transferred assets to a trust within the past 60 months prior to applying for Medical Assistance for long term care, supports and services may be ineligible for benefits. Because of this requirement, you may need to provide verification of assets owned during the past 60 months even though you may no longer own them. We will use your Social Security Number to get information about your assets for the 60 months prior to your application.

If the information is complete and you have provided the necessary verification (with this form, if possible), the county assistance office will notify you within 30 days of receiving your application if you are eligible, ineligible or if additional information is needed.

PROVIDER USE

NAME		NUMBER
ADDRESS		NUMBER
DATE OF ADMISSION	DATE OF OPTIONS ASSESSMENT	REQUESTED EFFECTIVE DATE
CONTACT NAME/TELEPHONE NUMBER/ADDRESS		

CAO USE

CO.	DIST	RECORD NUMBER	FILE CLEARED BY	APPL. REG. NO.
WORKER I.D.			CASELOAD	
☐ AUTHORIZED REASON				CATEGORY
☐ NOT AUTHORIZED REASON				DATE

PA 600 L (SG) 5/18

PLEASE COMPLETE THE FOLLOWING INFORMATION FOR THE PERSON REQUESTING MEDICAL ASSISTANCE BENEFITS

LAST NAME	FIRST NAME	MIDDLE INITIAL	(JR., SR., I, ETC.)

CURRENT ADDRESS (IF IN A FACILITY, USE FACILITY ADDRESS)	CITY	STATE	ZIP CODE + 4	ADMISSION DATE

DATE MOVED TO THIS ADDRESS	TOWNSHIP	SCHOOL DISTRICT	AREA CODE AND TELEPHONE NUMBER

PREVIOUS ADDRESS (IF IN A FACILITY, GIVE YOUR HOME ADDRESS. IF YOU ARE MARRIED, GIVE YOUR SPOUSE'S ADDRESS.)	AREA CODE AND TELEPHONE NUMBER

Do you want an interpreter? ☐ Yes ☐ No

If yes, what language? _____

Do you need your notices in Spanish? ¿Necessita sus avisos en Español? ☐ Yes ☐ No

Have you ever applied for or received cash or medical benefits or participated in the Supplemental Nutrition Assistance Program (SNAP), formerly known as food stamps, in another county in Pennsylvania or in another state?

☐ Yes ☐ No

If yes, what State? _____

What county? _____

How long? _____

Record Number _____

Have you ever applied for or received benefits using a different Social Security Number? ☐ Yes ☐ No

If yes, what is the number? _____

Have you previously lived in a nursing facility? ☐ Yes ☐ No

If yes, provide name: _____

Address: _____

Dates: _____

1 Complete all information in this section for yourself, your spouse if you are married, and any dependent children or siblings.

*Attach an additional sheet of paper if you have more dependents.

RELATIONSHIP	LAST NAME	FIRST NAME	MI	JR/SR	ALIAS/MAIDEN NAME	BIRTH DATE	SEX	*RACE	SSN
SELF									
SPOUSE									
DEPENDENT									

*For Race: Your benefits will not be affected if you do not wish to answer. Please use one of the following codes:
1. Black 2. Hispanic 3. North American Indian or Alaskan Native 4. Asian or Pacific Islander 5. White (Not Hispanic) 6. Other

2 Please answer and sign:

Are you a U.S. Citizen? ☐ Yes ☐ No If No, check one: ☐ Permanent Resident ☐ Temporary Resident ☐ Refugee ☐ Illegal Alien

Alien #:_____Country of Origin: _____Date of Entry:_____

Sign to declare your citizenship or alien status as marked above:

_____ _____
Signature Date

Name and address of sponsor if you have one: _____

_____

3 Marital Status

Please check one: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

If you checked widowed, what was the date of your spouse's death?_____ Name:_____

If you checked separated, what was the date of separation?_____ Please complete item #1 above for spouse.

4 Military Status

Veteran's Name_____

Please check one: ☐ Veteran ☐ Active Military ☐ National Guard ☐ Reserves ☐ Widow/Spouse or Dependent Child of a Veteran

Branch of Service_____ Date Entered_____Date Left_____Claim No._____

5 Voter Registration (Optional)

If you are not registered to vote where you live now, would you like to apply to register to vote here today? ☐ Yes ☐ No

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

To register, you must: 1) Be at least 18 on the day of the next election; 2) Be a citizen of the United States for at least one month PRIOR TO THE NEXT ELECTION; 3) Reside in Pennsylvania and the voting district at least 30 days prior to the next election.

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private. Please contact the county assistance office if you would like help. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Secretary of the Commonwealth, PA Department of State, Harrisburg, PA 17120. (Toll-free telephone number 1-877-VOTESPA.)

COUNTY ASSISTANCE OFFICE STAFF WILL COMPLETE THIS BOX BASED UPON YOUR RESPONSE ABOVE

☐ Given to Client __/__/__ ☐ Sent to voter registration __/__/__ ☐ Mailed to Client __/__/__

☐ Declined, not interested __/__/__ ☐ Not a U.S. citizen __/__/__ ☐ Declined, already registered __/__/__

6 If you are receiving or have received long term care, supports and services, how were your expenses being paid?

7 Do you have unpaid medical bills? ☐ Yes ☐ No If you are requesting Medical Assistance for these bills, attach copies.

8 MEDICAL INSURANCE INFORMATION (Including Long Term Care Insurance)

INSURANCE COMPANY/MEDICARE	INSURANCE COMPANY ADDRESS	AGREEMENT/ POLICY NUMBER	GROUP NAME NUMBER	EFFECTIVE DATE OF COVERAGE	PREMIUM AMOUNT	PAID HOW OFTEN	POLICY HOLDER NAME AND ADDRESS

Add an additional sheet of paper if more space is needed. Please label what question number you are answering on any additional pages.

9 Complete the following resource information for you and your spouse (if you are married):

A. Real Estate None ☐

LOCATION	OWNER	VALUE $	INCOME PRODUCING ☐ YES ☐ NO	RESIDENT ☐ YES ☐ NO
WHO LIVES IN THE PROPERTY?		IS THE PROPERTY LISTED FOR SALE? ☐ YES ☐ NO	IF YES - DATE LISTED	
IF FOR SALE GIVE ▶ REALTOR'S NAME AND TELEPHONE NUMBER * REMEMBER TO REPORT THE PROPERTY SALE TO US.				
ARE YOU PLANNING TO RETURN TO THE PROPERTY? ☐ YES ☐ NO		DO YOU OWN ANY OTHER REAL ESTATE? ☐ YES ☐ NO		

B. Mobile Home None ☐

LOCATION	OWNER	VALUE $	INCOME PRODUCING ☐ YES ☐ NO	RESIDENT ☐ YES ☐ NO
YEAR AND MODEL	WHO LIVES IN THE MOBILE HOME?			
IS THE MOBILE HOME LISTED FOR SALE? ☐ YES ☐ NO IF YES GIVE ▶ REALTOR'S NAME AND TELEPHONE NUMBER				

C. Burial Arrangements None ☐

BANK/INSURANCE COMPANY NAME AND ADDRESS	ACCOUNT NUMBERS	
FUNERAL HOME	VALUE OF ACCOUNT $	DATE ESTABLISHED
CAN MONEY BE WITHDRAWN BEFORE DEATH OF INDIVIDUAL? ☐ YES ☐ NO	CAN INTEREST BE WITHDRAWN? ☐ YES ☐ NO	
DO YOU OWN ANY BURIAL SPACES? ☐ YES ☐ NO IF YES GIVE LOCATION ▶	NUMBER OF SPACES	

D. Life Insurance None ☐

COMPANY NAME	POLICY NUMBER	FACE VALUE	CURRENT CASH VALUE	WHO OWNS THE POLICY?

E. Automobiles, Recreational Vehicles, Trucks, Motorcycles None ☐

NAME OF OWNER(S)	YEAR	MAKE	MODEL	LICENSED?	PLATE NUMBER	ACCOUNT

F. Bank Accounts (Checking, Savings, IRA, etc.) List all accounts that include applicant's and/or spouse's name and money. None ☐

BANK NAME/BRANCH	ACCOUNT TYPE	ACCOUNT NUMBER	CURRENT BALANCE	NAME(S) ON ACCOUNT/OWNER

G. Stocks, Bonds (including U.S. Savings Bonds), Trusts, Mutual Funds, cash on hand, etc. None ☐

NAME ON INVESTMENT	TYPE ACCOUNT	ACCOUNT NUMBER	CURRENT ACCOUNT VALUE	NAME(S) ON ACCOUNT/OWNER

10 **Within the past 60 months, have you or your spouse closed, given away, sold or transferred any assets such as: a home, land, personal property, life insurance policies, annuities, bank accounts, certificates of deposit, stocks, IRA, bonds or a right to income?** ☐ Yes ☐ No

Within the past 60 months, have you or your spouse transferred any assets into a trust? ☐ Yes ☐ No

If yes to either question, explain circumstances (attach extra paper if needed)_____

_____

_____

_____

TYPE OF RESOURCE(S)	MARKET VALUE AT TIME OF TRANSFER ▶	$	DATE OF TRANSFER OR CLOSING

11 If you closed or depleted any accounts because you paid for nursing services, list these accounts.

TYPE OF RESOURCE	LOCATION	ACCOUNT NUMBER	OWNER(S)	DATE OF CLOSING

12 Have you or your spouse received or does either of you expect to receive any income/asset/settlement/lump sum/inheritance? ☐ Yes ☐ No

If yes, describe: _____ AMOUNT $ _____

_____ DATE EXPECTED _____

13 Income information for the applicant:

	INCOME SOURCES	IDENTIFY INVESTMENT TYPE/NAME	GROSS INCOME AMOUNT	HOW OFTEN PAID
☐	SOCIAL SECURITY			
☐	VETERANS BENEFIT AID AND ATTENDANCE			
☐	PENSIONS			
☐	WORKER'S COMPENSATION			
☐	RAILROAD RETIREMENT			
☐	BLACK LUNG			
☐	ANNUITY (COMPANY)			
☐	PAYMENTS FROM A TRUST			
☐	INTEREST/DIVIDEND (SOURCE)			
☐	OTHER INCOME			

TO WHOM ARE THE CHECKS SENT? (GUARDIAN, REPRESENTATIVE PAYEE) ▶	ADDRESS

Complete this section if you have a spouse or dependent. Skip this section if you are not married or do not have a dependent.

14 Income information for the spouse and/or dependent:

INCOME SOURCES	IDENTIFY INVESTMENT TYPE/NAME	GROSS INCOME AMOUNT	HOW OFTEN PAID
☐ SOCIAL SECURITY			
☐ VETERANS BENEFIT AID AND ATTENDANCE			
☐ PENSIONS			
☐ WORKER'S COMPENSATION			
☐ RAILROAD RETIREMENT			
☐ BLACK LUNG			
☐ ANNUITY (COMPANY)			
☐ PAYMENTS FROM A TRUST			
☐ INTEREST/DIVIDEND (SOURCE)			
☐ OTHER INCOME			

15 Shelter expense:

MONTHLY RENT/MORTGAGE ..... $ _____

SALES OR LEASE PURCHASE AGREEMENT ..... $ _____

PERSONAL CARE OR DOMICILIARY CARE RENTAL CHARGE ..... $ _____

MAINTENANCE CHARGES FOR CONDO OR CO-OP RESIDENCE..... $ _____

LOT RENT FOR MOBILE HOME ..... $ _____

PROPERTY TAXES - ANNUAL AMOUNT ..... $ _____

HOMEOWNERS INSURANCE - ANNUAL AMOUNT..... $ _____

BASIC TELEPHONE ..... $ _____

GAS ..... $ _____

ELECTRIC ..... $ _____

HEATING FUEL..... $ _____

WATER..... $ _____

SEWER..... $ _____

GARBAGE ..... $ _____

Do you pay for heating and/or air conditioning separate from your rent? ☐ Yes ☐ No

RIGHT TO NONDISCRIMINATION
We may not discriminate on the basis of age, sex, race, color, ancestry, disability, religious creed, national origin, sexual preference, life-style, union membership, political belief, or because you applied for and/or received assistance before. If you feel you have been discriminated against by the department or anyone providing services for the department, you may file a verbal or written complaint with the department or the county assistance office. The Department or county assistance office will then forward the complaint to the appropriate Federal or State agency.

RIGHT TO APPEAL
You have the right to ask for a Departmental hearing to appeal a decision of or failure to act by the department which affects your benefits or that you feel is unfair or incorrect. You may file the appeal at the county assistance office. At the appeal hearing, you may represent yourself or someone else, such as a lawyer, friend, or a relative may represent you.

RIGHT TO AN AGENCY CONFERENCE
If you appeal, you may have an agency conference before the hearing.

RIGHT TO A WRITTEN NOTICE
We will give you a written notice explaining your benefits. If we deny, change, suspend, or stop benefits, we will explain the reason on the notice. You have 30 days from the date of the notice to ask for a hearing if you disagree with the action taken and/or the reasons given.

RIGHT TO CONFIDENTIALITY
We keep information you give confidential and use it only to administer the programs you apply for and may be eligible for. Any person knowingly violating any of the rules and regulations of this Department made in accordance with this article shall be guilty of a misdemeanor, and upon conviction thereof, shall be sentenced to pay a fine, not exceeding one hundred dollars ($100), or to undergo imprisonment, not exceeding six months, or both (62 P.S. Section 483).

ESTATE RECOVERY
If you are age 55 or older and receive medical assistance to pay for nursing facility services, home and community-based waiver services and any related hospital and prescription drug service, you will be required to repay the cost of these services from your probate estate. You may call the MA Estate Recovery Program at 800-528-3708.

CHANGES
If you are not sure if you must report a particular change, you should report the change. You can report to a member of the county assistance office staff in person, by telephone, or by mail.

USE OF THE PA ACCESS CARD
You may use the PA ACCESS card for services only during the period you are eligible. You must use the card only for the person who is eligible and you may get only services that are needed and reasonable.

RESPONSIBILITY TO PROVIDE SSNs
You must provide a Social Security Number (SSN). If you do not have an SSN, you must apply for one. Refusal or failure to provide an SSN may result in disqualification. If you have a community spouse, he or she must also supply an SSN. We use the SSN to verify identity, administer our programs, prevent duplication in state and federal programs, for computer matches with other programs, and to get information about income and resources to determine eligibility for and/or the amount of your benefits (42 U.S.C. Section 1320b-7).

PENALTIES
If you do not report changes as required, your benefits may be reduced or stopped. If you purposely fail to give correct information or report changes, you may be fined and/or put in jail. Improper use of the PA Access Card for services may result in a fine, imprisonment or both.

RESPONSIBILITY TO PROVIDE INFORMATION
You must give true, correct and complete information to the best of your ability. You must cooperate in documenting or verifying the information. If you cannot provide proof, you should ask the county assistance office to help. You must cooperate fully with quality control and with persons from the department or the Inspector General's Office who are conducting investigations.

I UNDERSTAND:
My benefits may be reduced or I can be penalized for giving incomplete or false information or for not reporting changes that would affect my benefits.

Any person enriched as a result of a transfer of assets or income, which would have affected my eligibility, will be liable for repayment of those benefits issued incorrectly.

I am giving the state the right to seek, with or without legal action, payment from private or public health insurance or liable third party. The amount recovered will not exceed the amount paid by Medical Assistance.

The state has the right to review all records of medical service paid for by Medical Assistance.

Payment for medical services will be made directly to the provider, not to me. This includes payments from Medicare.

I received a copy of my rights and responsibilities, have read them or someone has read them to me, and I understand them.

I agree to provide or cooperate in getting any information needed to prove my statements.

I must report any changes in my circumstances within 10 days of the change.

I am responsible for any fraudulent statements made on this application even if the application is submitted by someone acting on my behalf.

The state operates a fraud control program under which local, state, and federal officials may verify the information I have given.

I understand that Pennsylvania receives information from the Income Eligibility Verification System (IEVS), financial institutions, consumer reporting, and state and federal agencies to verify the information I give them. Information available through IEVS and other entities will be requested, used and may be verified through collateral contact when conflicting details are found by the state agency, and such information may affect my household's eligibility and level of benefits.

I understand that by signing this application, I am authorizing any financial institution to disclose, through electronic or any other means, any and all financial information held by that institution, to the Department of Human Services or its designated agent or contractor for the purpose of identifying and verifying assets when needed to determine and re-determine eligibility for Medical Assistance. I understand that financial information includes deposits, withdrawals, account closures and other relevant information requested or received from the financial institution, including other transactions undertaken by the financial institution with respect to the account or asset. I understand that this authorization is effective until Medical Assistance eligibility is denied or ends, or if I decide to revoke it by written notification to the department, whichever happens first. I understand that if I revoke this authorization, that may make me or my household ineligible for Medical Assistance.

I understand that if I misrepresent, hide or withhold facts that may affect my eligibility for benefits, I may be required to repay my benefits and I may be prosecuted and disqualified from receiving certain future benefits.

AFFIDAVIT

I certify, subject to penalties provided by law, that the information I gave is true and correct and complete to the best of my knowledge. I have read this application in full or someone has read it to me and I understand the questions asked. I have received a copy of and read my rights and responsibilities, or someone has read them to me, and I understand them.

APPLICANT OR AUTHORIZED REPRESENTATIVE SIGNATURE | DATE | I.D. VERIFIED | RELATIONSHIP TO APPLICANT

ADDRESS OF REPRESENTATIVE | CITY | STATE | ZIP CODE + 4 | ( ) TELEPHONE NUMBER

WITNESS (IF SIGNED WITH AN X ABOVE) | DATE

ADDRESS OF WITNESS | CITY | STATE | ZIP CODE + 4 | ( ) TELEPHONE NUMBER

PROVIDER SIGNATURE (IF SUBMITTED BY PROVIDER) | DATE

CAO OR OPTIONS | DATE

- ☐ Face to Face Interview With _____
- ☐ Telephone Interview With _____
- ☐ Interview Waived

Who is your representative or power of attorney?

Copies of notices will be sent to the person named.

LAST NAME, FIRST NAME, MIDDLE INITIAL			RELATIONSHIP TO APPLICANT	☐ REPRESENTATIVE ☐ POWER OF ATTORNEY
ADDRESS	CITY	STATE	ZIP CODE + 4	TELEPHONE NUMBER ( )

I WISH TO WITHDRAW MY APPLICATION

SIGNATURE | / / DATE

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