State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
P.O. Box 712
Trenton, NJ 08625-0712

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

JENNIFER VELEZ
Commissioner

VALERIE HARR
Director

MEDICAID COMMUNICATION NO. 12-14 **DATE: August 15, 2012**

TO: County Welfare Agency Directors
Institutional Services Section (ISS) Supervisors

SUBJECT: Updated Medicaid Application (PA-1G)

The Division has updated the Medicaid application (PA-1G) to reflect changes in the Medicaid program over the last few years. The major changes include but are not limited to:

- An expanded Resources section (Investments, Property, Trusts, etc.)
- Clarified and updated the Rights and Responsibilities
- Simplified and refined the Income and Resources sections

You may continue to use any unused copies of the previous application before utilizing the attached updated application. We are in the process of having this updated application translated into Spanish, and will distribute that once complete.

If you have any questions regarding this Medicaid Communication, please refer them to the Division's Office of Eligibility Policy field service staff for your agency at 609-588-2556.

Sincerely,

Valerie Harr

Valerie Harr
Director

VH:m
Attachment

c: Jennifer Velez, Commissioner
Department of Human Services

Dawn Apgar, Deputy Commissioner
Division of Developmental Disabilities

Lowell Arye, Deputy Commissioner
Aging and Community Services

Lynn Kovich, Assistant Commissioner
Division of Mental Health and Addiction Services

Joseph Amoroso, Director
Division of Disability Services

Raquel Jeffers, Deputy Director
Division of Mental Health and Addiction Services

Kathleen M. Mason, Director
Division of Aging Services

Jeanette Page-Hawkins, Director
Division of Family Development

Allison Blake, Commissioner
Department of Children and Families

Mary E. O'Dowd, Commissioner
Department of Health

MEDICAID APPLICATION _____ **CASE #** _____

Why do you need help at this time? _____

If disabled, what date did you become disabled? _____

What is the nature of your disability? _____

Do you need special assistance to complete this application? _____

Have you filled out an application before? ☐ Yes ☐ No If yes, where and when? _____

Based on the above information, please check all program(s) / service(s) requested:

- ☐ Home & Community Based Services / Waiver
- ☐ New Jersey Care…Special Medicaid Program
- ☐ Nursing Home / Institutional
- ☐ Assisted Living
- ☐ NJ WorkAbility
- ☐ Medically Needy Program
- ☐ Medicaid Only Program
- ☐ Other: _____

State of New Jersey
Department of Human Services
DMAHS

This is a legal document and subject to verification. Application must be completed truthfully and accurately.

SECTION I Basic Information

Applicant's Name: _____ Phone #: _____
Last Name First M.I. Maiden Name

Applicant's E-mail Address: _____

Birth Date: _____ Birth Place: _____ Social Security #: _____
(or Railroad Retirement #)

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Child

Do you receive Supplemental Security Income Benefits? ☐ Yes ☐ No Date applied for: _____

Have you been denied SSI benefits within the last 12 months? ☐ Yes ☐ No If yes, why? _____

Are you a United States Citizen? ☐ Yes ☐ No If no, explain citizenship status: _____

_____ Alien # _____

Have you, your spouse, or parent (if applying for a child) served in the U.S. Armed Forces? ☐ Yes ☐ No

If yes, Name: _____ VA# (if known): _____

SECTION II Residence

Current Residence: _____
Street City/Town State Zip

Mailing Address (if different): _____

Do you plan to continue living in New Jersey? ☐ Yes ☐ No If no, explain: _____

Previous addresses for the past five years: (if additional space is needed, use separate paper)

From _____ To _____
At: _____
_____

From _____ To _____
At: _____
_____

_____ _____
Signature of Person Initiating Application Date

_____ _____
Relationship to Applicant – Parent, Spouse, Legal Guardian, etc. E-mail Address

_____ _____
Phone # Address

SECTION III Marital Status Information

Name of Spouse:_____ Social Security #:_____ Birth Date:_____

Date of Marriage:_____ City/State where married:_____

Name of former Spouse (if applicable): _____ Social Security #:_____

Address: _____ County:_____

Date of Separation (if applicable):_____

Date of Divorce (if applicable): _____ Where divorced:_____

If Spouse is deceased, list date and city/state of death:_____

If applying for a child, list name of parents:_____

SECTION IV Living Arrangements

In order to calculate your benefit, we need information regarding your living arrangements.

If hospitalized / institutionalized, please complete this based on where you lived prior to entering the hospital or institution.

1. Do you: (Please check ALL boxes that apply.)

☐ Own your own home?

☐ Rent a ☐ House? ☐ Room? ☐ Apartment?

Is your name on the lease? ☐ Yes ☐ No

☐ Live in a residential health care facility?

☐ Live in a licensed boarding home?

☐ Live alone, or with your spouse? (If you live with children, please list them in #2 below.)

☐ Live with a relative or friend?

☐ Have other living arrangements not described above? Please explain:_____

☐ Purchase and prepare your own meals?

☐ Share your meals with others?

2. List other people living with you. Include name, age, and relationship._____

_____

3. How much is your household's rent or mortgage? _____ What portion do you pay?_____

Name and address of Mortgage Company or landlord:_____

_____

SECTION V Earned and Unearned Income Information

Do you have income direct deposited to an account? ☐ Yes ☐ No

Employment: List income for you, your spouse, or parent(s) (if applying for a child).

Please complete the following (including self-employment): **If not employed, check here** ☐

Person Employed	**Name & Address of Employer**	**Gross Pay Amounts**	**How Often Paid** (Weekly, Monthly, etc)

SECTION VI Benefits or Other Income

If you/your spouse/parent(s) with whom the applicant child lives, received, or have applied for income from any sources listed below, please complete all information that applies:

Other Income	**Gross Income Received**	**How Often** (Weekly/ Monthly)	**Applied For/Have Potential To Receive** (Yes/No)	**If Benefit is Pending: Date of Application**	**Name of Recipient or Potential Recipient**	**Claim # or Account # (if applicable)**
Social Security Benefits – Including Retirement, Disability or Survivor Benefits						
Railroad Retirement						
Supplemental Security Income (SSI)						
Pensions, including Private, Government, Foreign						
Annuities						
Dividends, Royalties, Interest						
Reparation Payments including German, Austrian, Other						
Veterans Benefits / Military Allotment or Pay						
Unemployment Benefits / Workers Compensation						
Cash Public Assistance (TANF/GA)						
Sick or Disability Payments						
Payment from Boarders, Rent						
Cash Support including Child Support, Alimony						
If anyone is helping to support you such as giving or loaning you money, list amount.						
In Kind Support, including help with food, bills or shelter						
Other Income (Non-Wages) including Strike or Black Lung Benefits						

If you have no income or potential entitlement, check here ☐

Lump Sum Income

If you received a Lump Sum Payment (including but not limited to winnings, gifts, inheritance, retroactive wages or benefits, etc.), indicate source, gross amount, and date received: _____

_____

SECTION VII Resources

Using the following list, please check any resource owned by you, your spouse, and/or parent(s) (living with applicant child). These may be owned individually or jointly with others.

- ☐ Cash on Hand
- ☐ Cash that someone is holding for you
- ☐ Savings or checking accounts, or Certificate of Deposits
- ☐ Retirement savings plans – 401K, 403B, IRA, KEOGH
- ☐ Annuities, settlements, lottery winnings
- ☐ Stocks, bonds, or savings bonds
- ☐ Trust funds, including Special Needs Trusts
- ☐ Credit Union or mutual fund shares
- ☐ Ownership of mortgages, notes, or contracts of value
- ☐ Christmas / Vacation / Other Club savings accounts
- ☐ Mineral / Natural Resource Interests
- ☐ Real Estate, including but not limited to:
  - ☐ Home (principal residence)
  - ☐ Home (other than principal residence)
  - ☐ Investment property
  - ☐ Land
- ☐ Other, including but not limited to jewelry, furs, coins, money or other valuables in safe deposit box. Please indicate below:

_____

_____

_____

☐ None of the above

A. If you checked any resource above, please complete the following (if you need more room, use separate paper)**:**

Bank Accounts owned or closed within the last 60 months

Bank Name	Bank Address	Name(s) on Account	Account or Certificate #	Current Value	If Closed, Date & Value at Closing

Investments (Stocks, Bonds, etc) owned within the last 60 months

Type of Investment	Company	Account #	Current Value	If Closed, Date & Value at Closing

Property owned or sold within the last 60 months

Real Estate (Include Type of Property)	Address	Liens, Mortgages, or Encumbrances	Fair Market Value	Owner(s)	If Sold, Date & Value at Sale

Is there a Plan of Liquidation on any of the above property? ☐ Yes ☐ No (If yes, attach related form.)

Trusts

Grantor: _____ Trustee: _____ Beneficiary: _____

Trust was funded by: ☐ Own ☐ Inheritance ☐ Will ☐ Other: _____

Tax ID #: _____ Date trust was initially funded: _____

SECTION VII Resources (Continued)

B. Burial Arrangements (if applicable)

Do you own any: (check all that apply)

☐ Prepaid burial contracts/trusts irrevocable/revocable? Value: _____

Funeral Home: _____

☐ Burial plots? Location: _____

☐ Accounts set aside for burial (special bank account, etc.)? Account #: _____ Value: _____

Have you or anyone set up a burial arrangement or contract that is paid through a life insurance policy?

☐ Yes ☐ No Details: _____

C. Life Insurance Policies that you and/or Spouse own or for which you are the named insured:

Owner	Insured	Insurance Company	Policy #	Cash Value

Do you have any knowledge of being named beneficiary on someone else's insurance policy?

☐ Yes ☐ No Details: _____

D. Vehicles owned by you, your spouse, parent(s)/stepparent(s) of applicant child living at home:

Include all types of transportation, such as cars, vans, tractors, pickup trucks, motor homes, motorcycles, boats, etc.

Owner's Name	Year / Make	Model / Style	Use	Amount Owed

E. Transfers

Did you or your spouse trade, give away, or sell resources in which you had an interest, including but not limited to cash, real estate, vehicles, businesses, stocks, bank accounts, etc.?

☐ Yes ☐ No If yes, complete the information below for each transfer. Use additional paper if needed.

What was sold or given away? _____

By whom? _____ To whom? _____

Location (if land or property): _____

Date of sale or gift: _____ Amount received: _____

Did you retain a Life Estate? ☐ Yes ☐ No Date Recorded: _____

SECTION VII Resources (Continued)

F. Legal Issues

Are there any pending claims such as lawsuits, divorce settlements, inheritance, accident claims, sale of property, or other claims? ☐ Yes ☐ No Details: _____

Attorney's Name: _____ Phone #: _____

Address: _____

Does anyone owe you money? ☐ Yes ☐ No Details: _____

If there is a court order in effect to provide medical care or carry medical coverage, please indicate. For example: Is your absent parent or separated / divorced spouse under court order to provide medical care or carry medical coverage for you? _____

Is the disability, illness, or injury accident related? ☐ Yes ☐ No If yes, explain: _____

_____

Will you be filing a lawsuit? ☐ Yes ☐ No Attorney Name: _____

Does anyone help you to pay for medical bills? ☐ Yes ☐ No If yes, give the person's name, amount of payment and frequency. State if this is a loan, and if so, explain the terms of repayment agreement.

_____

SECTION VIII Health Insurance Coverage

Please complete the following if you have coverage in your own name or have coverage under a spouse, parent, disability coverage, etc.

Also include other health care plans such as Medigap, Dental, Optical, and Prescription that may be available to pay for your/applicant health care needs.

Medical Insurance Company Name & Address	Policy Holder	Coverage Type	Policy / Certificate Group or Claim #	Eligibility Date	Premium Amount	Payment Frequency
MEDICARE		☐ Part A ☐ Part B ☐ Part C				

If you have Medicare coverage, are you also covered under Part D? ☐ Yes ☐ No

If you expect a change in insurance coverage, indicate. (Example: You, your parent or spouse recently started / left employment and will receive / drop coverage in a few months.) _____

_____

If a change is expected, please give the carrier name, policy number, and date the insurance will go into effect / expires:

_____

Do you have Long-Term Care (LTC) Insurance? ☐ Yes ☐ No If yes, complete below:

Insurance Company Name: _____ Is it a LTC Partnership Policy? ☐ Yes ☐ No

Amount of benefit: _____ How much of the benefit have you used? _____

Is payment made directly to the Nursing Facility? ☐ Yes ☐ No

Do you have unpaid bills for medical services incurred within the past 3 months? ☐ Yes ☐ No

SECTION IX Rights and Responsibilities

Before signing this document, please read your rights and responsibilities outlined below.

If there is anything you do not understand or have questions about, please ask for clarification.

* The information I gave on this form is true to the best of my knowledge. I realize that if I knowingly give false information that isn't true OR if I knowingly withhold information and I get health benefits for which I am not eligible, I can be criminally punished for fraud and I may have to pay Medicaid for any medical bills which are paid incorrectly.

* If I am a third party applying on behalf of another person, as evidenced by a completed Designation of Authorized Representative form, my signature below indicates that this application has been examined by or read to the applicant and, to the best of my knowledge, the facts are true and complete. I understand as a third party I may be criminally punished for knowingly providing false information.

* I understand that any information I give is subject to verification by the County Welfare Agency (CWA) and/or other agencies or officers of the NJ Department of Human Services, Division of Family Development (DFD) and the Division of Medical Assistance and Health Services (DMAHS). I understand that my medical benefits may be reduced, denied, or stopped because of information received.

* I hereby give permission to the CWA, DFD, and/or the DMAHS to contact any individual or other source who may have knowledge about my circumstances (including, but not limited to, IRS, Social Security Wage and Benefit files, State Wage and Unemployment files, and/or credit reporting services), for the sole purpose of verifying the statements I have made.

* **I understand that Medicaid benefits received after age 55 may be reimbursable to the State of New Jersey from my estate.**

* I agree to tell Medicaid immediately of the following changes:
    1) If anyone receiving health benefits moves out of state;
    2) Changes in where we live or get our mail;
    3) Changes in other health insurance coverage;
    4) Changes in income and/or resources;
    5) Improvement in medical condition, if disabled;
    6) Marriages and/or divorces;
    7) Family members moving in or out of my household;
    8) Sale of my home or other property;
    9) Student status.

  I understand that failure to do so may result in incorrectly paid benefits and I may have to reimburse the State of New Jersey for those benefits.

* I understand, as a condition of eligibility of medical assistance, that I have assigned to the Commissioner of Human Services, any rights to support for the purpose of medical care as determined by a court or administrative order and any rights to payment for medical care from any third party.

* I understand that I may request a fair hearing if I am not satisfied with any action taken regarding my application.

* I may be eligible for retroactive Medicaid coverage for unpaid covered medical services by Medicaid providers during the three (3) months prior to this application. I further understand that these retroactive benefits will only apply to the month(s) that eligibility requirements are met. This may be a separate form that must be completed within six (6) months from the date of this application.

SECTION IX Rights and Responsibilities (Continued)

* I understand that an individual is only permitted to retain $2,000 or $4,000 in applicable program resources in order to be eligible. If I am married and seeking nursing home care or a waiver program, the applicable program resource level will be higher. I understand that if I am seeking nursing home care or a waiver program, Medicaid will examine transfers of resources that occurred within the look back period before, and anytime after, my first date of applying for benefits.

* I give third parties permission to share information about me with authorized State and County staff conducting investigations pertaining to fraud, fraud prevention and misrepresentation. Third parties include, but are not limited to, financial institutions, credit reporting agencies, landlords, public housing agencies, schools, utility companies, insurance agencies, employers, other governmental agencies and others as they apply. I further authorize taxing authorities to release copies of my income tax returns. I also understand that my permission for release is effective for six (6) months after my benefits stop.

* I understand that I will not be discriminated against because of race, color, religion, sex, handicap, national origin, or marital, parental, or birth status. To file a complaint of discrimination, I should contact the U.S. Department of Health and Human Services (HHS) in writing to the HHS Director, Office of Civil Rights, Room 506F, 200 Independence Avenue, SW, Washington, DC 20201 or call 202-619-0403 (voice) or 202-619-3257 (TDD). HHS is an equal opportunity provider and employer.

* I understand that by accepting Medicaid, I give DMAHS the right to any medical support or payments from third parties who would be legally responsible for any medical services paid by Medicaid for me or any member of my household. I agree to release any medical information needed by the Medicaid Program or others for the purpose of paying or receiving payment of medical bills. I understand that this is required to get coverage. I agree to help in obtaining medical support and payments from anyone who is legally responsible.

* I, by signing below, attest that I have read and agree to these statements and fully realize that the CWA and/or DFD and/or DMAHS rely upon the truth and accuracy of my statements.

I, (print name) _____, have read or had read to me the statements on this page. I understand those statements. Upon penalty of perjury, I swear that the answers I have given on this application are complete and correct. I am the person represented by the signature on this document.

Applicant Signature	OR	Authorized Agent Signature	Date
Date		Relationship to Applicant	
		Address	
		Witness	Date

NOTE: The submission of a Social Security number (SSN) is mandatory in accordance with 42 U.S.C. 1320b-7.

Your SSN will be used to check your identity, prevent duplicate participation, and facilitate making mass changes. Your SSN will also be used in computer matching and program reviews or audits and to make sure you are eligible for Medicaid. These procedures are designed to identify persons who fraudulently or wrongfully participate in the Medicaid programs. Such persons may be subjected to criminal action, administrative claims, and/or possible loss of all benefits. Failure to file for a SSN may result in disqualification for Medicaid.