pennsylvania
DEPARTMENT OF HUMAN SERVICES

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

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 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.
- Please review any information printed on this form. If any already printed information is incorrect or has changed, strike out the printed information and provide updated information. Please review all questions that do not have a printed response and provide a response unless the instructions tell you that you can choose not to answer.

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 an 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 last 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.

This is an application for Medical Assistance benefits. If you need help translating it, please contact your county assistance office, CAO. Translation services will be provided free of charge.

Esta es una solicitud de beneficios de Asistencia Médica. Si necesita ayuda con la traducción comuníquese con la Oficina de Asistencia del Condado (CAO) que le corresponde. Los servicios de traducción son gratuitos.

នេះជាពាក្យដាក់សុំអត្ថប្រយោជន៍សំរាប្រគ្រពេទ្យ។
បើលោកអ្នកត្រូវការជំនួយបកប្រែវា
សូមទាក់ទងទៅការិយាល័យរដ្ឋបាលប្រៀបដែលនៅតាមតំបន់របស់លោកអ្នក។
ការបកប្រែនឹងផ្តល់អោយដោយឥតគិតថ្លៃ។

这是关于医疗协助福利的申请。
如果你需要翻译协助，请联络你所在
地方的郡县援助办事处。可以免费提供翻译服务。

هذا طلب للحصول على منافع المساعدة الطبية. إذا كنت بحاجة إلى مساعدة في ترجمته، يرجى الاتصال بمكتب معونة مقاطعتك CAO.
ستقدم خدمات الترجمة مجانًا.

Настоящий документ является заявлением на получение обслуживания по программе Medical Assistance.
Если вам нужна помощь в переводе данного заявления, обращайтесь в Окружное бюро помощи (County Assistance Office).
Услуги по переводу предоставляются бесплатно.

Đây là mẫu đơn xin hưởng phúc lợi Bảo Trợ Y Tế.
Nếu quí vị cần phiên dịch đơn này, xin liên lạc
Văn Phòng Trợ Cấp Quận Hạt nơi quí vị cư ngụ.
Dịch vụ phiên dịch sẽ được cung cấp miễn phí.

COMPASS
CLICK. APPLY. BENEFIT.

You can also apply online at: **www.compass.state.pa.us**.

DO NOT COMPLETE – PROVIDER USE ONLY		
PROVIDER NAME	NUMBER	
ADDRESS	CONTACT NAME/TELEPHONE NUMBER	
DATE OF ADMISSION	DATE OF LEVEL OF CARE DETERMINATION	REQUESTED EFFECTIVE DATE

DO NOT COMPLETE - COUNTY ASSISTANCE OFFICE USE ONLY						
CO.	DIST	RECORD NUMBER	FILE CLEARED BY	APPL. REG. NO.	WORKER I.D.	CASELOAD
☐ AUTHORIZED REASON					CATEGORY	
☐ NOT AUTHORIZED REASON					DATE	

Getting Started

What language do you prefer? ¿Qué idioma prefiere usted? ☐ English/Inglés ☐ Spanish/Español ☐ Other/Otro (specify/especifique) _____

Do you need an interpreter? ¿Necesita un intérprete? ☐ Yes/Sí ☐ No If yes, what language? En caso afirmativo, ¿de qué idioma? _____

Complete all information in this section for you, the applicant. Tell us about yourself. Please review any information printed below. If this information is incorrect, please strike it out and write in the correct information.

NAME (INCLUDE FIRST, MIDDLE INITIAL, LAST, SUFFIX-JR./SR./ETC.):	SOCIAL SECURITY NUMBER:	BIRTH DATE (MM/DD/YYYY):	SEX: ☐ MALE ☐ FEMALE

MARITAL STATUS: ☐ SINGLE ☐ SEPARATED ☐ MARRIED ☐ DIVORCED ☐ WIDOWED IF SEPARATED, PLEASE COMPLETE RELATIONSHIP SECTION FOR SEPARATED SPOUSE.	IF YOU CHECKED SEPARATED, WHAT WAS THE DATE OF SEPARATION?
IF YOU CHECKED WIDOWED, WHAT WAS THE DATE OF YOUR SPOUSE'S DEATH?	SPOUSE'S NAME?

RACE (OPTIONAL) (CHECK ALL THAT APPLY):

☐ BLACK OR AFRICAN AMERICAN ☐ ASIAN ☐ NATIVE HAWAIIAN OR PACIFIC ISLANDER ☐ AMERICAN INDIAN OR ALASKA NATIVE

☐ WHITE ☐ OTHER _____

CURRENT ADDRESS (IF IN A FACILITY, USE FACILITY ADDRESS):	PHONE NUMBER:	DATE MOVED TO THIS ADDRESS:

TOWNSHIP:	SCHOOL DISTRICT:	PREVIOUS ADDRESS (IF IN A FACILITY, GIVE YOUR HOME ADDRESS. IF YOU ARE MARRIED, GIVE YOUR SPOUSE'S ADDRESS):

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?	HOW LONG?
	WHAT COUNTY?	RECORD NUMBER:

HAVE YOU PREVIOUSLY LIVED IN A NURSING FACILITY? ☐ YES ☐ NO	IF YES, PROVIDE NAME:	ADDRESS:	DATES:

ARE YOU A U.S. CITIZEN OR NATIONAL? ☐ YES ☐ NO ▶ **If you are not a U.S. citizen or national,** answer the following questions:

DO YOU HAVE ELIGIBLE IMMIGRATION STATUS? ☐ YES ☐ NO	IF YES, FILL IN YOUR DOCUMENT TYPE AND ID NUMBER:	DOCUMENT TYPE:	DOCUMENT ID NUMBER:	ALIEN NUMBER:
WERE YOU LIVING IN THE U.S. BEFORE 1996? ☐ YES ☐ NO		COUNTRY OF ORIGIN:		
IF YOU HAVE A SPONSOR, NAME AND ADDRESS OF YOUR SPONSOR:				

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

_____ SIGNATURE

_____ DATE

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

Please review any information printed below. If this information is incorrect, please strike it out and write in the correct information.

RELATIONSHIP:	NAME (INCLUDE FIRST, MIDDLE INITIAL, LAST, SUFFIX-JR./SR./ETC.):		ALIAS/MAIDEN NAME:
BIRTH DATE (MM/DD/YYYY):	SEX:	*RACE:	SSN

RELATIONSHIP:	NAME (INCLUDE FIRST, MIDDLE INITIAL, LAST, SUFFIX-JR./SR./ETC.):		ALIAS/MAIDEN NAME:
BIRTH DATE (MM/DD/YYYY):	SEX:	*RACE:	SSN

RELATIONSHIP:	NAME (INCLUDE FIRST, MIDDLE INITIAL, LAST, SUFFIX-JR./SR./ETC.):		ALIAS/MAIDEN NAME:
BIRTH DATE (MM/DD/YYYY):	SEX:	*RACE:	SSN

RELATIONSHIP:	NAME (INCLUDE FIRST, MIDDLE INITIAL, LAST, SUFFIX-JR./SR./ETC.):		ALIAS/MAIDEN NAME:
BIRTH DATE (MM/DD/YYYY):	SEX:	*RACE:	SSN

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

Military Status

Please review any information printed below. If this information is incorrect, please strike it out and write in the correct information.

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.:

Voter Registration (Optional)

If you are not registered to vote where you live now, would you like 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 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 ON YOUR RESPONSE ABOVE

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

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

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

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

Medical Insurance Information (including long term care insurance)
Please review any information printed below. If this information is incorrect, please strike it out and write in the correct information.

Who is covered?	Insurance Company	Policy Number	Premium	How Often?

Resource Information for Applicant and Spouse:
Please review any information printed below. If this information is incorrect, please strike it out and write in the correct information. Add an additional sheet of paper if more space is needed. Please label what question you are answering on any additional pages.

A. Real Estate **None** ☐

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

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

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 PROPERTY LISTED FOR SALE? ☐ YES ☐ NO	IF FOR SALE, REALTOR'S NAME AND TELEPHONE NUMBER: (REMEMBER TO REPORT THE PROPERTY SALE TO US)			IF YES, DATE LISTED:

C. Burial Arrangements **None** ☐

OWNER:	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, LOCATION:	NUMBER OF SPACES:

OWNER:	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, LOCATION:	NUMBER OF SPACES:

D. Life Insurance **None** ☐

Please review any information printed below. If this information is incorrect, please strike it out and write in the correct information.

Policy Owner	Company Name	Policy Number	Face Value	Current Cash Value	Beneficiary

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

Please review any information printed below. If this information is incorrect, please strike it out and write in the correct information.

Name of Owner(s)	Year, Make, Model	Licensed?	Plate Number	Amount Owed	% Owned	Comments
		☐ YES ☐ NO				
		☐ YES ☐ NO				
		☐ YES ☐ NO				
		☐ YES ☐ NO				
		☐ YES ☐ NO				
		☐ YES ☐ NO				

F. Other Resources **None** ☐

Please review any information printed below. If this information is incorrect, please strike it out and write in the correct information.

Resources include bank accounts (including checking, savings, vacation accounts); Certificates of Deposits (CD); retirement accounts (including IRA, KEOGH); stocks; bonds (including U.S. Savings Bonds); annuities; trust funds; mutual funds and cash-on-hand.

Name of Owner(s)	Resource	Current Value	Bank Name/Account Number	Percentage Owned	Comments
		$			
		$			
		$			
		$			
		$			
		$			
		$			
		$			
		$			

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 polices, annuities, bank accounts, certificates of deposit, stocks, IRA, bonds, trust 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 RESOURCES:	MARKET VALUE AT TIME OF TRANSFER:	DATE OF TRANSFER OR CLOSING:
	$	

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

Account Owner(s)	Type of Resource	Location	Account Number	Date of Closing

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

If yes, explain circumstances (attach extra paper if needed): _____

_____

_____

AMOUNT:	DATE EXPECTED:
$	

Income Information for the Applicant, Spouse, and/or Dependent(s)

Please review any information printed below. If this information is incorrect, please strike it out and write in the correct information. Add an additional sheet of paper if more space is needed. Please label what question you are answering on any additional pages.

List all household income including but not limited to: earned income (wages, self-employment, rental income, room and board, commissions, etc.) and unearned income (pensions, Veterans benefits, Social Security benefits, Unemployment Compensation, Workers' Compensation, Railroad Retirement, Black Lung payments, sick benefits, payments from trusts or annuities, support or alimony, dividends or interest, etc.)

Whose income is this?	Income Type	Income Source	Frequency (weekly, biweekly, monthly, yearly)	Average Hours Worked Each Week	Gross Amount (amount of income before taxes and deductions)	Comments

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

Shelter Expenses

$	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

Your Rights and Responsibilities Read about your rights and responsibilities:

RIGHT TO NONDISCRIMINATION

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and in some cases religion or political beliefs.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (TTY).

This institution is an equal opportunity provider.

RIGHT TO CONFIDENTIALITY

We will keep your information private. It will only be used to decide which programs you may be eligible for. The county assistance office (CAO), when requested, must provide federal, state and local law enforcement officials with the address, Social Security number (SSN) and photograph (if available) of an individual who is fleeing to avoid prosecution, custody or confinement for a felony or violating probation or parole. Any person knowingly violating any of the rules and regulations of this department shall be guilty of a misdemeanor and, upon conviction shall be sentenced to pay a fine, not exceeding one hundred ($100) dollars, or to undergo imprisonment, not exceeding six months, or both (62 P.S. section 483).

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 give you a written explanation of why. You have 30 days from the mailing date of the notice to ask for a hearing.

RIGHT TO APPEAL

You have the right to ask for a Department of Human Services (DHS) hearing to appeal a decision if you believe it is unfair or incorrect, or if DHS fails to act on your application for benefits. You may file the appeal at the CAO. If you appeal, you may also request an agency conference before the hearing. At the hearing you may represent yourself, or someone else, such as a lawyer, friend or relative may represent you.

RIGHT TO CLAIM GOOD CAUSE

If you apply for cash or Medical Assistance benefits, the law requires you to cooperate with establishing paternity and seeking support. You may be excused from these requirements if you prove it may be dangerous for you and/or your children. This is known as good cause. Unless a good cause exemption is established, you will be required to meet employment and training requirements. You will also be required to meet semi-annual reporting requirements unless good cause is granted.

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 Medical Assistance Estate Recovery Program at 1-800-528-3708.

RIGHT TO CERTIFICATE OF CREDITABLE COVERAGE

Federal law limits when health coverage may be denied or limited for a pre-existing condition. If you enroll in a group health plan that excludes treatment for a condition you already had, you can be credited for the time you received Medical Assistance coverage. This may help you obtain coverage. Contact your caseworker to request this certificate.

RESPONSIBILITY TO PROVIDE INFORMATION

You must give true, correct and complete information. You must help in proving the information you give. Benefits may be denied if you fail to provide certain proof. If you cannot provide proof, you should ask the CAO to help you obtain it. If you are contacted by DHS or the Office of Inspector General, you must fully cooperate with those persons or investigators. 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 may be required to repay the cost of these services from your probate estate. If you are applying for cash assistance, we may require you to sign an agreement to repay benefits that you, your spouse and your children have received.

RESPONSIBILITY TO PROVIDE SOCIAL SECURITY NUMBERS

For Medical Assistance benefits, you must provide a SSN for each person for whom you are applying. If you do not have a SSN, you must apply for one. Not providing a SSN may result in not being able to receive benefits. Your SSN will be used for identity, for computer matches which verify income and resources, and to prevent duplication of state and federal benefits. A non-citizen who is applying for emergency Medical Assistance only is not required to provide a SSN. (42 U.S. C 1320b-7)

RESPONSIBILITY TO USE THE PA ACCESS CARD LAWFULLY

Once you are eligible for benefits, you will be issued a PA ACCESS card. This card may only be used for the person who is eligible and only during the eligibility period. You may only use the card for services that are needed and reasonable.

RESPONSIBILITY TO REPORT CHANGES

If you qualify for benefits, you will be required to report changes in your circumstances to your caseworker or to the Customer Service Center. Types of changes reported would include people leaving or moving into the house, a new address, a new job for someone, if someone loses a job, birth of a child, new sources of income or changes to income. Your caseworker and notices you receive will cover the specifics in detail based on the programs and benefits you are eligible for. Failure to report required changes within the program guidelines could result in a loss of benefits, sanctions, or civil or criminal charges. You may report changes to the CAO in person, by phone, fax, mail or through a My COMPASS account. You may also report changes to the Customer Service Center at 1-877-395-8930, or for Philadelphia, 1-215-560-7226 any time.

Understanding Your Rights and Responsibilities

When I sign this form:

- 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 redetermine 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.
- I understand that I can designate a representative or Power of Attorney by completing the Representative or Power of Attorney section.
- I understand and agree that I am responsible for any fraudulent statements made on this application, even if the application is being submitted by someone acting on my behalf.
- I understand 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 received a copy of my rights and responsibilities, have read them or someone has read them to me, and I understand them.
- I understand that the information entered in this application will be kept confidential and only to administer benefits. I authorize the release of personal, financial and medical information for the purpose of determining eligibility.
- I understand that any changes I am required to report must be reported within 10 days of the change.
- I understand that I will receive a written notice explaining the benefits. If benefits are denied, changed, suspended or stopped, the written notice will explain why.
- I understand that I will have 30 days from the date of the notice to request a hearing if I do not agree with the decision made on this application.
- I understand that my situation is subject to verification from employers, financial sources and other third parties.
- I understand that applicants must provide their Social Security number or apply for one if they do not have one. This number may be used to check the information on this application.
- I understand that I must use the PA ACCESS Card only during the period I am eligible. I must use the PA ACCESS Card only for the person who is eligible and may get only the benefits that are needed and reasonable.
- I understand that I do not have to provide a Social Security number for anyone who is not applying for assistance. If I do provide their Social Security number, it may be used to check the information on this application.
- I certify that all information that has been entered is true under penalty of perjury (criminal).
- I understand that I have the right to a certificate of creditable coverage to verify my medical coverage. Federal law limits when health care coverage may be denied or limited for a pre-existing condition. If I enroll in a group health plan that has a pre-existing condition clause, I can get credit for the time I received Medical Assistance.
- I understand that if I am determined eligible for Medical Assistance, I will be placed in the most comprehensive health care benefit package that is available to me. I understand that I may be required to enroll in a health plan. I understand that enrolling in a health plan may be free or low cost to me, because the Department pays a monthly fee to the health plan for me. I understand that the monthly fee is a capitation fee. I understand that if I receive Medical Assistance that I am not eligible for, due to error, fraud, or any other reason, then I may be required to repay the Department all monthly fees paid on my behalf.
- I understand the state has the right to review all records of medical service paid by Medical Assistance. Payment for service will be made directly to the provider, not me. This includes payments from Medicare.
- 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 recorded will not exceed the amount paid by Medical Assistance.
- I understand that I have the right to ask the county assistance office (CAO) for assistance in getting proof of expenses and that the CAO can contact other people for confirmation if I am having trouble getting proof of anything.
- I understand that if some or all of the individuals applying do not qualify for health care through the Department, that they may be eligible for federal benefits and/or explore private health care options through the Health Insurance Marketplace. If this is the case, I authorize the Department to give my name and information on this application to the Marketplace.
- **Renewal of coverage in future years:** To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Health Insurance Marketplace to use my income data, including information from tax returns. The Marketplace will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next: (Check one):

- ☐ Five years (the maximum number of years allowed)
- ☐ Four years
- ☐ Three years
- ☐ Two years
- ☐ One year
- ☐ Do not use my information from tax returns to renew my coverage.

X _____ _____

Signature of Applicant or Authorized Representative — Date

IMPORTANT: If your household is eligible for SNAP/LIHEAP, you may receive a Fast Track consent form in the mail that could allow you and your household members to be automatically enrolled in Medical Assistance.

Name of Authorized Representative	Address of Authorized Representative	Phone Number

COUNTY ASSISTANCE OFFICE ONLY	I have explained to the applicant her or his rights and responsibilities. _____ _____ CAO Signature — Date

BE SURE TO SIGN AND DATE THIS APPLICATION AND INCLUDE REQUIRED DOCUMENTS

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

☐ Face-to-face interview with: _____

☐ Telephone interview with: _____

CAO OR OPTIONS | DATE

☐ Interview waived

Representative or Power of Attorney

Please complete if you have a 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:	TELEPHONE NUMBER:

I wish to withdraw my application:

SIGNATURE | DATE

Your Rights and Responsibilities Read about your rights and responsibilities:

RIGHT TO NONDISCRIMINATION

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and in some cases religion or political beliefs.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (TTY).

This institution is an equal opportunity provider.

RIGHT TO CONFIDENTIALITY

We will keep your information private. It will only be used to decide which programs you may be eligible for. The county assistance office (CAO), when requested, must provide federal, state and local law enforcement officials with the address, Social Security number (SSN) and photograph (if available) of an individual who is fleeing to avoid prosecution, custody or confinement for a felony or violating probation or parole. Any person knowingly violating any of the rules and regulations of this department shall be guilty of a misdemeanor and, upon conviction shall be sentenced to pay a fine, not exceeding one hundred ($100) dollars, or to undergo imprisonment, not exceeding six months, or both (62 P.S. section 483).

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 give you a written explanation of why. You have 30 days from the mailing date of the notice to ask for a hearing.

RIGHT TO APPEAL

You have the right to ask for a Department of Human Services (DHS) hearing to appeal a decision if you believe it is unfair or incorrect, or if DHS fails to act on your application for benefits. You may file the appeal at the CAO. If you appeal, you may also request an agency conference before the hearing. At the hearing you may represent yourself, or someone else, such as a lawyer, friend or relative may represent you.

RIGHT TO CLAIM GOOD CAUSE

If you apply for cash or Medical Assistance benefits, the law requires you to cooperate with establishing paternity and seeking support. You may be excused from these requirements if you prove it may be dangerous for you and/or your children. This is known as good cause. Unless a good cause exemption is established, you will be required to meet employment and training requirements. You will also be required to meet semi-annual reporting requirements unless good cause is granted.

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 Medical Assistance Estate Recovery Program at 1-800-528-3708.

RIGHT TO CERTIFICATE OF CREDITABLE COVERAGE

Federal law limits when health coverage may be denied or limited for a pre-existing condition. If you enroll in a group health plan that excludes treatment for a condition you already had, you can be credited for the time you received Medical Assistance coverage. This may help you obtain coverage. Contact your caseworker to request this certificate.

RESPONSIBILITY TO PROVIDE INFORMATION

You must give true, correct and complete information. You must help in proving the information you give. Benefits may be denied if you fail to provide certain proof. If you cannot provide proof, you should ask the CAO to help you obtain it. If you are contacted by DHS or the Office of Inspector General, you must fully cooperate with those persons or investigators. 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 may be required to repay the cost of these services from your probate estate. If you are applying for cash assistance, we may require you to sign an agreement to repay benefits that you, your spouse and your children have received.

RESPONSIBILITY TO PROVIDE SOCIAL SECURITY NUMBERS

For Medical Assistance benefits, you must provide a SSN for each person for whom you are applying. If you do not have a SSN, you must apply for one. Not providing a SSN may result in not being able to receive benefits. Your SSN will be used for identity, for computer matches which verify income and resources, and to prevent duplication of state and federal benefits. A non-citizen who is applying for emergency Medical Assistance only is not required to provide a SSN. (42 U.S. C 1320b-7)

RESPONSIBILITY TO USE THE PA ACCESS CARD LAWFULLY

Once you are eligible for benefits, you will be issued a PA ACCESS card. This card may only be used for the person who is eligible and only during the eligibility period. You may only use the card for services that are needed and reasonable.

RESPONSIBILITY TO REPORT CHANGES

If you qualify for benefits, you will be required to report changes in your circumstances to your caseworker or to the Customer Service Center. Types of changes reported would include people leaving or moving into the house, a new address, a new job for someone, if someone loses a job, birth of a child, new sources of income or changes to income. Your caseworker and notices you receive will cover the specifics in detail based on the programs and benefits you are eligible for. Failure to report required changes within the program guidelines could result in a loss of benefits, sanctions, or civil or criminal charges. You may report changes to the CAO in person, by phone, fax, mail or through a My COMPASS account. You may also report changes to the Customer Service Center at 1-877-395-8930, or for Philadelphia, 1-215-560-7226 any time.

Understanding Your Rights and Responsibilities

When I sign this form:

- 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 redetermine 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.
- I understand that I can designate a representative or Power of Attorney by completing the Representative or Power of Attorney section.
- I understand and agree that I am responsible for any fraudulent statements made on this application, even if the application is being submitted by someone acting on my behalf.
- I understand 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 received a copy of my rights and responsibilities, have read them or someone has read them to me, and I understand them.
- I understand that the information entered in this application will be kept confidential and only to administer benefits. I authorize the release of personal, financial and medical information for the purpose of determining eligibility.
- I understand that any changes I am required to report must be reported within 10 days of the change.
- I understand that I will receive a written notice explaining the benefits. If benefits are denied, changed, suspended or stopped, the written notice will explain why.
- I understand that I will have 30 days from the date of the notice to request a hearing if I do not agree with the decision made on this application.
- I understand that my situation is subject to verification from employers, financial sources and other third parties.
- I understand that applicants must provide their Social Security number or apply for one if they do not have one. This number may be used to check the information on this application.
- I understand that I must use the PA ACCESS Card only during the period I am eligible. I must use the PA ACCESS Card only for the person who is eligible and may get only the benefits that are needed and reasonable.
- I understand that I do not have to provide a Social Security number for anyone who is not applying for assistance. If I do provide their Social Security number, it may be used to check the information on this application.
- I certify that all information that has been entered is true under penalty of perjury (criminal).
- I understand that I have the right to a certificate of creditable coverage to verify my medical coverage. Federal law limits when health care coverage may be denied or limited for a pre-existing condition. If I enroll in a group health plan that has a pre-existing condition clause, I can get credit for the time I received Medical Assistance.
- I understand that if I am determined eligible for Medical Assistance, I will be placed in the most comprehensive health care benefit package that is available to me. I understand that I may be required to enroll in a health plan. I understand that enrolling in a health plan may be free or low cost to me, because the Department pays a monthly fee to the health plan for me. I understand that the monthly fee is a capitation fee. I understand that if I receive Medical Assistance that I am not eligible for, due to error, fraud, or any other reason, then I may be required to repay the Department all monthly fees paid on my behalf.
- I understand the state has the right to review all records of medical service paid by Medical Assistance. Payment for service will be made directly to the provider, not me. This includes payments from Medicare.
- 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 recorded will not exceed the amount paid by Medical Assistance.
- I understand that I have the right to ask the county assistance office (CAO) for assistance in getting proof of expenses and that the CAO can contact other people for confirmation if I am having trouble getting proof of anything.
- I understand that if some or all of the individuals applying do not qualify for health care through the Department, that they may be eligible for federal benefits and/or explore private health care options through the Health Insurance Marketplace. If this is the case, I authorize the Department to give my name and information on this application to the Marketplace.
- **Renewal of coverage in future years:** To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Health Insurance Marketplace to use my income data, including information from tax returns. The Marketplace will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next: (Check one):

- ☐ Five years (the maximum number of years allowed)
- ☐ Four years
- ☐ Three years
- ☐ Two years
- ☐ One year
- ☐ Do not use my information from tax returns to renew my coverage.