PA-1P
(R. 4/92)

COMMONWEALTH OF KENTUCKY
Cabinet for Human Resources
Department for Social Insurance

MEDICAL ASSISTANCE APPLICATION FOR PREGNANT WOMEN AND CHILDREN

AGENCY USE ONLY

1. [ ]Application/Reapplication
[ ]Reinvestigation [ ]Reinstatement

AGENCY USE ONLY

2. Co./Case Number _____ I
Date _____ [ ]Home [ ]Office

COMPLETE THIS APPLICATION ONLY IF A PREGNANT WOMAN OR CHILD LIVES IN THE HOME

SECTION I - APPLICANT INFORMATION

3. Applicant Name _____ (Last) (First) (M.I.) _____ (Phone Number) [ ]Applicant [ ]Other

4. Mailing Address _____ (Street, P.O. Box, etc.) (City) (State) (Zip Code)

5. Residence (if different from mailing address) _____

6. Directions to Residence _____

7. Have you or anyone else in your household previously applied for/received assistance? [ ] Yes [ ] No

If yes, who? _____ When? _____ Case Number _____

Where? _____

8. Other Program Status: [ ]AFDC [ ]MA Case Name(s)/Number(s) _____
[ ]Food Stamps Case Name/Number _____

9. If not currently receiving Food Stamps, have you applied? [ ]Yes Date _____ [ ]No
If no, are you interested in applying? [ ]Yes [ ]No

SECTION II - MEMBER INFORMATION (List all household members.)

10. Name (Last) (First) (M.I.)	11. Race	12. Sex	13. Citizen/ Alien Number	14. Date of Birth	15. Marriage/ Relation	16. Social Security Number	17. Grade Level Completed	18. Health Ins. Yes/No	*19. Pregnant Yes/No

*If yes, Due Date.

20. Has the pregnant woman and/or child(ren) had medical treatment in the past three months? [ ]Yes [ ]No

SECTION III - FINANCIAL INFORMATION

21. List the gross income (before any deductions) of you, your spouse, and children living with you. If you are under age 21 and live with your parent(s), list parental income. EXAMPLES OF INCOME: wages, salaries, tips, child support, unemployment compensation, Social Security, Veterans benefits, contributions from friends or relatives, interest, etc.

Member	Source	Amount	How Often Received?	Member	Source	Amount	How Often Received?
		$				$	
		$				$	
		$				$	

22. If you are working, amount paid for child care $_____ wk./mo.

23. If you or your spouse are not currently employed, complete the following:

Name	Date of Last Employment	Name of Employer	Type of Employment

I understand that during my interview, my worker will assist me in applying for a Social Security Number for anyone whom I request assistance who does not already have a Social Security card. The Social Security Act requires that all recipients of assistance be identified by such a number. Under that law and federal regulations, the Department cannot make a payment or provide medical assistance for any individual who refused to apply for a number.

I understand that Social Security Numbers will be used for various state and federal matches through the Income and Eligibility Verification System (IEVS). These matches include, but are not limited to, Social Security, IRS, SSI, wage records, unemployment insurance, and other matches as provided for under the authority of IEVS. This information may be verified through collateral contacts when discrepancies are found. Information provided under IEVS, after verification, may affect eligibility and result in termination of benefits. This information will be disclosed to other agencies only as permitted by law.

I understand that in accepting Medical Assistance, I assign my rights to third party payments from any source, including hospital or health insurance policies, to the Cabinet for Human Resources, Department for Social Insurance. I further understand that if I refuse to assign my rights to third party payments to the Cabinet for Human Resources, Department for Social Insurance, I will be ineligible to receive a medical card; however, the other members of my family will remain eligible provided that all other eligibility requirements are met.

I understand that when I obtain medical services with a Medical Assistance card issued to me I am responsible for notifying the medical provider of any hospital or health insurance policies covering me or any members of my case.

I agree to reimburse the Medical Assistance Program for services received which are later covered by insurance settlements or payments.

I certify that the information provided by me in this statement is correct and true to the best of my knowledge and give my consent to the Department for Social Insurance to make any necessary contacts to verify statements.

I declare under penalty of perjury that all persons for whom application is made are U.S. citizens or are admitted under an approved alien status.

I understand that if I give false information, withhold information, or fail to report changes within ten (10) days, I may be subject to prosecution for fraud.

If signed by a mark (X):

(Signature) _____ (Date) _____ (Signature of Witness) _____ (Date) _____

AGENCY USE ONLY

DETERMINATION/REDETERMINATION OF ELIGIBILITY FOR PREGNANT WOMEN AND CHILDREN

Other Payee _____ [ ]Committee [ ]Pr[illegible]ve
(Name) (Address)

Other Case(s) in Home _____ _____
(C, MA, FS) (Name) (Number) (Name) (Number)

Check of IMS Programs: Concurrent Receipt? [ ]Yes [ ]No If yes, explain _____

Inactive case pulled
and old case number used? [ ]Yes [ ]No If no, explain _____

I. **TECHNICAL ELIGIBILITY**: To determine technical eligibility, evaluate responses to questions 1 thru 19 by completing the following:

Name of Pregnant Women and Children	A. Pregnancy Verified			B. Enumeration Requirement		C. Residence/ Alien Status		REMARKS
	Yes	No	N/A	Yes	No	Yes	No	

IF APPLICATION IS BEING MADE FOR CHILD(REN) DEPRIVED OF PARENTAL SUPPORT DUE TO VOLUNTARY ABSENCE, COMPLETE ITEM D.

D. Medical Support	Yes	No	REMARKS
1. Medical Support Enforcement Required? (If no, skip to item 7 ; if yes, complete PA-125 series)			
2. If yes, client cooperating? (If yes to both 1 and 2, skip to section II.)			
3. If not cooperating, "good cause" claim filed? (Enter date filed in REMARKS.)			
4. Determination made? (If yes, enter date in REMARKS; if no, explain.)			
5. "Good Cause" exists?			
6. Claim Reviewed: No change.....			
"Good Cause" no longer exists.....			

7. Nonassistance child support services requested?

I. TECHNICAL ELIGIBILITY (continued)

E. Health Insurance Reported?	Yes	No	REMARKS
1. Client questioned?			
2. Statements in doubt or inconsistent?			

(If health insurance initially reported or changed, complete form PA-40)

II. INCOME ELIGIBILITY - To determine income eligibility, evaluate responses to question 20 and 21 by completing the following:

A. UNEARNED INCOME reported?	Yes	No	REMARKS/COMPUTATIONS

If unearned income, complete the following:

Type	Member(s)	Verification	Amount
			$
			$
			$
			$

B. EARNED INCOME reported?	Yes	No

If earned income, complete the following:

Type	Member(s)	Verification	Amount
			$
			$
			$
			$

C. DEPENDENT CARE requested as work expense?	Yes	No

If yes, enter name/address of provider _____

_____

Phone No. _____ Verified Amount $_____

D. INCOME DEDUCTIONS appropriate?	Yes	No
1. Parent(s)/Child(ren) standard deduction	$	
2. Stepparent standard deduction	$	
3. Self employment/farm income allowable costs	$	

E. INCOME ELIGIBILITY SUMMARY	Yes	No
1. Pending income reported?		
2. Client questioned?		
3. Statements in doubt or inconsistent?		
4. Spot checks required? (If yes, enter factor(s) and date(s) in Section III.)		

III. ELIGIBILITY DETERMINATION

	YES	NO	REMARKS
A. Technical Eligibility Met? (If no, explain in REMARKS)			

B. Financial Eligibility Met?
YES. [ ]

Countable Income ..... _____

Appropriate Poverty Level MA Scale - _____

Result ..... _____

If excess exists, explore eligibility in prior 3 months.

IV. SPOT CHECK ALERT

Member _____ Factor _____ Month _____

Member _____ Factor _____ Month _____

V. CASE DECISION AND ACTION CHECKLIST

[ ]Approval, *MA effective date _____
[ ]Continued eligible
[ ]Denial
[ ]Discontinuance, Effective date _____

Explain _____

*If less than 3 months retroactive coverage, explain.

_____

_____

Standard of Promptness Met? [ ]Yes [ ]No
If no, reason and method used to update application:

_____

_____

[ ]PAFS-116	[ ]PA-125.1	[ ]PA-3
[ ]PAFS-116, Sup. A	[ ]CS-333	[ ]MA-105
[ ]PA-13	[ ]CS-333.1	[ ]PAFS-2
[ ]PA-62	[ ]PA-121	[ ]SS-5
[ ]PA-30A	[ ]PA-121.1	[ ]PAFS-35
[ ]PA-31	[ ]PA-127	[ ]PA-40
[ ]PA-31A	[ ]PA-321	[ ]PA-66
[ ]PA-125 Series	[ ]PAFS-628	[ ]PAF[illegible]

Explained:

[ ]MA eligibility coverage/KenPAC
[ ]Retroactive MA coverage
[ ]Medicaid is payor of last resort
[ ]Third Party Liability
[ ]Clients rights/obligations

Worker's Signature _____ Date _____

Concurred by _____ Title _____ Date _____