

COMMONWEALTH OF KENTUCKY
Cabinet for Human Resources
Department for Social Insurance

APPLICATION/REINVESTIGATION FOR "U" AND "P" MEDICAL ASSISTANCE

Date _____
Place: Home Office Facility

Case No. _____
(Co.) (Prg.) (Case No.)
 Investigation New Application
 Reinvestigation Reinstatement within
10 Days of Disc.
 Previously Received

- Foster Care
- Subsidized Adoption
- Child in Psychiatric Facility

1. Name _____
(Last) (First) (M.I.)

Alias _____
(Last) (First) (M.I.)

2. Social Security Number _____ Verified: Yes No
If No, Date SS-5 Sent _____

3. Sex: 1-Male 2-Female

4. Birthdate _____ Age _____ 5. Race: 4-White 6-Asian, Asian American, Pac. Islander 8-American Indian, Alaskan Native
 5-Black 7-Hispanic

6. U.S. Citizen: Yes No If No, Alien Status _____ INS Document _____

7. Home/Facility _____ Approved Not Approved

Psy. Facility _____ Licensed Unlicensed

Admission Date _____ Physician Statement Yes No Projected Length of Stay _____
Date

Address _____
(Street) (City) (County) (State) (Zip Code) (Phone Number)

8. Ky. Resident: Yes No

9. Previous Placement _____

10. Responsible Agency _____ Type of Commitment _____

11. DSS Case Number _____ 12. Date of Removal _____ Placement _____

ALL CASES

ALL CASES

13. Resources: Type Amount

Verification _____

Within Limits? []Yes []No, Reason _____

14. Unearned Income: Type Monthly Gross

Verification _____

Total Countable Unearned _____

15. Earned Income: Type Monthly Gross

Verification _____

Total Countable Gross Earned _____

Work Expense Standard _____

Total Countable Earned _____

16. Medical Expenses

a. List all health insurance policies, policy numbers, type of coverage and premium(s) of child. Indicate how often premium(s) is paid and who pays the premium(s).

b. List other recognized medical expenses.

17. I certify all entries are correct and true to the best of my knowledge and belief. I understand this information will be used to determine eligibility for benefits from the Department for Social Insurance. I understand if I give false information or withhold information in order to receive assistance, I may be subject to prosecution for fraud. I understand I have the right to request a Fair Hearing before an impartial hearing officer if I am dissatisfied with any agency action. 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. The information may be verified through collateral contacts when discrepancies are found. Information provided under IEVS, after verification, may affect eligibility for and amount 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, and am willing to cooperate with 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, the case member will be ineligible to receive a medical card. I understand that when I obtain medical services with a Medical Assistance card issued to the case member, I am responsible for notifying the medical provider of any hospital or health insurance policies covering the case member. I agree to reimburse the Medical Assistance Program for services received which are later covered by insurance settlements or payments. I further give my consent to the Department for Social Insurance to make any necessary contacts to verify my statements or gain additional pertinent information.

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.

Signature _____ Date Signed _____ Ph. No. _____

Address _____

18. CHILD IN FOSTER CARE/SUBSIDIZED ADOPTION

Total Countable Unearned... \$ _____ [] Deficit, Eligible
 Total Countable Earned..... \$+ _____
 Total Countable..... \$ _____ [] Excess, Spend Down Determined
 MA Scale for One..... \$ - _____
 Deficit/Excess..... \$ _____ Quarter(s) Considered _____ to _____ to _____
 x 3
 Quarterly Excess..... \$ _____

19. CHILD IN PSYCHIATRIC FACILITY Psy. Facility Contacted _____ Current Patient Status [] Yes [] No
Date _____

Step I

1. Child's Countable Income \$ _____
 2. Parent's Countable Income, If Appropriate.....\$ _____
 3. Less MA Scale for Appropriate Family Size...\$ - _____
 \$ _____
 4. Less Recognized Medical Expenses..... \$- _____
 \$ _____
 5. Less Mo. Private Pay.... \$- _____
 6. No Excess. Complete Step II..... \$ _____

Step II

1. Child's Gross Income..... \$ _____
 2. Plus Excess Income of Parent(s), If Appropriate (Gross Income/Net Profit Less MA Scale For Appropriate Family Size)..... \$ _____
 3. Less Personal Needs Allowance.. \$ -40 _____
 \$ _____
 4. Less Increased Personal Needs.. \$- _____ Allowance, If Appropriate..... \$ _____
 5. Less Recognized Medical Expenses..... \$- _____
 6. Plus Third Party Payment Paid Directly To Facility For Cost of Care.....\$ _____
 7. Child's Liability..... \$ _____

20. DECISION: [] Approved Effective _____ If less than 3 months retroactive MA coverage, explain

[] Continued Eligible

[] Denied [] Discontinued Effective _____ Reason for negative action _____

21. FORMS CHECKLIST:

[] PAFS-2 [] PAFS-628 [] PA-40 [] DSS-114 [] L01 [] SS-10
 [] MA-105 [] PA-3 [] PA-62 [] DSS-125 [] MAP-552 [] SSA-5028
 [] PAFS-116 [] PA-8 [] DSS-111A [] Commitment Documents/ [] SS-5
 [] PA-13 Adoption Agreement
 [] PA-31
 [] PA-31A

2. COMMENTS:

Standard of Promptness Met: [] Yes [] No, Reason _____

Worker Signature _____ Date _____

Supervisor Signature _____