PA-1A
(R. 3/91)

COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES
Department for Social Insurance

Medical Assistance/Supplementation
Application/Eligibility Determination
Aged, Blind, and Disabled

1. Date _____
Place: [ ]Home [ ]Office [ ]Facility
Case No. _____ (Co.) (Prg.) (SSN)

[ ]New Application [ ]Investigation
[ ]Reinvestigation [ ]Previously Received
[ ]Reinstate within 10 days of Disc.

2. SSI Status:
[ ]Receiving
[ ]Denied/Disc. _____
[ ]Reason _____
[ ]Pending _____
[ ]Never Applied

3. Name _____ (Last) (First) (MI) ___/___/___ (Birth Date)
[ ]Home
[ ]Facility Address: _____ (Street or RFD) (City) (State) (Zip Code) (Telephone)
Race: [ ]White [ ]Black [ ]Other _____ Sex: [ ]Male [ ]Female
SSN _____ [ ]Verification Attached Claim No. _____ [ ]Verification Attached

4. Marital Status: [ ]Single; Never Married [ ]Divorced; Date _____ [ ]Widowed; Date _____
[ ] Married; Living Together [ ]Married; Living Apart Since Date _____

Citizenship/Alien Status - Citizen or national of the United States [ ]Yes [ ]No
If no: In satisfactory immigration status? [ ]Yes [ ]No Immigration and Naturalization Service (INS) Status _____
Name of Spouse or Parent of Disabled Child _____ (Last) (First) (MI) ___/___/___ (Birth Date)
SSN _____ Claim No. _____
[ ]Home [ ]Facility Address if living apart: _____
Spouse is: [ ]SSI [ ]MA Only [ ]SSP [ ]AFDC [ ]Ineligible Dependents _____
Parent of Disabled Child is: [ ]SSI [ ]MA Only [ ]SSP [ ]AFDC [ ]Ineligible Dependents of Parent _____

ALL CASES

TECHNICAL ELIGIBILITY

		Requirement Met
5. Basis of Eligibility [ ]Age [ ]Blind [ ]Disabled [ ]SSI-ABD	Age verified by: _____ Basis for Field Determination: _____ Blind or Disabled (PA-610) Onset Date: _____	[ ] Yes [ ] No
6. In LTC, PSY/MH, HCBS, AIS/MR, Hospice, PCH, FCH, [ ]Yes [ ] No	Name of Facility: _____ [ ]Public [ ]Private; [ ]LTC [ ]PSY/MH [ ]HCBS [ ]AIS/MR [ ]Hospice [ ]PCH [ ]FCH; [ ]Licensed [ ]Unlicensed	[ ] Yes [ ] No
7. Residence	Residence Verification	[ ] Yes [ ] No

P5, 6 or 7

8. Caretaker:
Name, Address, Telephone No. _____
Name, Address, Telephone No. _____
Services Provided to: [ ]Client [ ]1 of an Elig. Couple [ ]Elig. Couple Services Provided Prevent Institutionalization? [ ]Yes [ ]No
Services Purchased: _____
Purchase Verified By: _____

FINANCIAL ELIGIBILITY

9. Resources [ ]Client [ ]Client and Spouse [ ]Client and Dependent(s) [ ]Client and Parent(s)

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a. Real Property	Assessed	Debt	Equity	Type, Location, Verification, Computation	Amount Considered
Disposal of Real Property [ ]Yes [ ]No	$	$	$		
Home Property [ ]Yes [ ]No	$	$	$		
Non-home Property Income Producing [ ]Yes [ ]No	$	$	$		
Non-Income Producing [ ]Yes [ ]No	$	$	$		
b. Motor Vehicle(s) [ ]Yes [ ]No	NADA/FMV $	$	$	Verification Attached [ ]	

FINANCIAL ELIGIBILITY (cont'd)

9. Resources (cont'd) [ ]Client [ ]Client and Spouse [ ]Client and Dependent(s) [ ]Client and Parent(s)

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c. Burial/Life Ins.	Ins. Co./Policy No. and FV/CSV and/or Funeral Home/Address/Amount	Amount Considered
Life Insurance [ ]Yes [ ]No Other Burial Reserves [ ]Yes [ ]No	Verification Attached [ ]	

d. Liquid Assets	Amount	Location, Account Number, Verification
Transfer of Liquid Assets [ ]Yes [ ]No	$	
Cash [ ]Yes [ ]No	$	
Checking Acct. [ ]Yes [ ]No	$	
Savings Acct. [ ]Yes [ ]No	$	
Stocks/Bonds [ ]Yes [ ]No	$	
Trusts [ ]Yes [ ]No	$	
Cert. of Dep. [ ]Yes [ ]No	$	
Other [ ]Yes [ ]No	$	Verification Attached [ ]

Countable Resources
9a.....$
9b.....$
9c.....$
9d.....$
TOTAL..$

Within Limits? [ ]Yes [ ]No

ALL CASES

10. Income — Computation/Verification/Amount Considered

	Amount Received By: Client	Spouse	Parent	Dependents
Earned				
Wages.....	$	$	$	$
Farm/ Business....	$	$	$	$
Rental.....	$	$	$	$
Other Self-Employment..	$	$	$	$
Other.....	$	$	$	$
Unearned				
Farm/ Business....	$	$	$	$
Rental.....	$	$	$	$
SSI.....	$	$	$	$
RSDI.....	$	$	$	$
Black Lung..	$	$	$	$
RR.....	$	$	$	$
VA.....	$	$	$	$
Pension.....	$	$	$	$
Other.....	$	$	$	$

Verification Attached [ ]

11. Medical Expenses Use item 13 for listing recognized medical expense(s) considered.

a. Health Insurance [ ]SMI $_____ [ ] HIB (Client) List all other health insurance of client and
[ ]SMI $_____ [ ] HIB (Spouse) spouse and dependent children, if applicable.

List all other health insurance policies, coverage and premiums of client and spouse/dependent children. Indicate individual(s) covered, how often premiums are paid and who pays the premium.

b. List Other Medical Expenses.

ALL CASES

12. I certify all entries have been read by me or to me and are correct and true to the best of my knowledge and belief I declare, under penalty of perjury, that I am a U.S. citizen or admitted under an approved alien status. I understand information on this application is used to determine if I am eligible for benefits from the Department for Social Insurance. I understand if I receive Medical Assistance I assign the rights to third party payments and am willing to cooperate with the Cabinet for Human Resources, Department for Social Insurance. I understand if I give false information or withhold information in accepting assistance, I may be subject to prosecution for fraud. I have also read, or had read to me, the explanation of my rights and obligations as a Social Insurance client and understand I have the right to request a Fair Hearing before an impartial hearing officer if I am dissatisfied with any agency action. I further give my consent to the Department for Social Insurance to make any necessary contacts to verify my statement or gain additional information pertinent to my eligibility.

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 for and amount of benefits. This information will be disclosed to other agencies only as permitted by law.

(Signature of Committee, Representative, Client or Witness if Signed by mark) (Date Signed) (Phone No. - Com./Rep.)

Address

13. INCOME ELIGIBILITY COMPUTATIONS

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a. Spend Down/Regular MA

1. Quarters Considered.. ____ to ____ ____ to ____
2. Family Size..... _____ _____
3. Countable Income.... $_____ $_____
4. Less MA Scale..... $-_____ $-_____
5. Monthly Excess..... $_____ $_____
   X3 X3
6. Quarterly Excess.... $_____ $_____
7. Less Recognized Medical Expenses.... $-_____ $-_____
8. Excess or "0"..... $_____ $_____

Recognized Medical Expenses

Date of Service	Type of Bill and Verification	Amt. of Recognized Medical Expense

TOTAL Recognized Medical Expenses Considered..... $_____

b. State Supplementation Payment (SSP)

1. Standard..... $_____
2. Less Countable Income..... $-_____
3. Payment-Single Individual or Elig. Individual with Inelig. Spouse OR Eligible Couple One Requiring Care.. $_____
4. 1/2 of #3 for Eligible Couple Both Requiring Care (Caretaker Services Only)..... $_____

BD-FGH

Pass Through [ ]Yes [ ]No If yes, complete form PA-1A, Supplememnt A.

(Case Name) (Case Number)

d. Companion Case [ ]Yes [ ]No If yes, complete form PA-1B.

(Case Name) (Case Number)

13. INCOME ELIGIBILITY COMPUTATIONS (continued)

e. Long Term Care

Step I

Complete if Client Has Been in LTC 30 Full Consecutive Days.

1. Client's Gross Income..... $_____
2. Special Income Standard (3 x SSI Rate)..... $-_____
3. No Excess, Complete Step III. Excess, Complete Step II ..... $=_____

Step II

Complete if Client Has Been in LTC Less than 30 Full Consecutive Days.

1. Client's Countable Income (Gross Income/Net Profit Less $20 General Exclusion).. $_____
2. Plus Spouse's Gross Income/ Net Profit if Spouse's Income Exceeds the Special Income Standard for an Individual, if appropriate..... $+_____
   $=_____
3. Less MA Scale for 1 (or 2 if Spouse's Income is Considered)..... $-_____
   $=_____
4. Less Client's Recognized Medical Expenses..... $-_____
   $=_____
5. Less Spouse's Recognized Medical Expenses (if spouse's income is considered)..... $-_____
   $=_____
6. Less Mo. LTC Private Pay or Hospice Institutional Rate or Enter Cost of HCBS (Form MAP-9) or AIS/MR (Standard).. $-_____
7. No Excess, Complete Step III. $=_____

Step III

1. Client's Gross Income/Net Profit. $_____
2. Plus Spouse's Excess Income When Appropriate (Gross Income/ Net Profit Less MA Scale for 1).. $+_____
   $=_____
3. Less Personal Needs Allowance.... $-_____
   $=_____
4. Less Increased Personal Needs Allowance..... $-_____
   $=_____
5. Conserved for Spouse and/ or Dependent(s) up to MA Scale for Family Size..... $-_____
   $=_____
6. Less LTC Client's Recognized Medical Expenses..... $-_____
   $=_____
7. Less Spouse's Recognized Medical Expenses..... $-_____
   $=_____
8. Plus VA Aid and Attendance Allowance..... $+_____
   $=_____
9. Client's Liability..... $=_____

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14. CASE DECISION

a. State Supplementation (SSP)

1. [ ]Approved [ ]Continued Eligible
2. MA Eff. Date _____*
   Grant $ _____ Eff. Date _____

b. Medical Assistance (MA)

1. [ ]Approved, Code 1, Eff. MA Date _____*
   [ ]Approved, Code 7, Eff. MA Date _____*
2. [ ]Approved, Code 2, From _____ To _____
   From _____ To _____
3. [ ]Approved, Code 3, Eff. MA Date _____*
4. [ ]Approved, Code 5, Eff. MA Date _____*
5. [ ]Continued Eligible

c. Denied/Discontinued

1. [ ]Denied/WD (Reason) _____
2. [ ]Denied, Code 2, Excess Inc., Qtr. $ _____
3. [ ]Discontinued (Reason) _____

ALL CASES

15. Standard of Promptness Met? [ ]Yes [ ]No If No, Reason _____
16. Spot Check Alert? [ ]Yes [ ]No Reason _____
17. *If Less Than 3 Months Retroactive Coverage, Explain _____ Date _____
18. Worker's Signature _____ Date _____

Concurred by _____ Title _____ Date _____