

COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES
Department for Social Insurance

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

2. SSI Status:

- Receiving
- Denied/Disc. _____
- Reason _____
- Pending _____
- Never Applied

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

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

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 _____

TECHNICAL ELIGIBILITY

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

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)

a. Real Property	Assessed	Debt	Equity	Type, Location, Verification, Computation	Amount Considered
Disposal of Real Property <input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$	\$		
Home Property <input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$	\$		
Non-home Property Income Producing <input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$	\$		
Non-Income Producing <input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$	\$		
b. Motor Vehicle(s) <input type="checkbox"/> Yes <input type="checkbox"/> No	NADA/FMV \$	\$	\$		

Verification Attached

ALL CASES

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

c. Burial/Life Ins. Life Insurance [] Yes [] No Other Burial Reserves [] Yes [] No	Ins. Co./Policy No. and FV/CSV and/or Funeral Home/Address/Amount	Amount Considered	
Verification Attached []			
d. Liquid Assets 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	Amount \$ \$ \$ \$ \$ \$ \$	Location, Account Number, Verification	Countable Resources 9a.....\$ _____ 9b.....\$ _____ 9c.....\$ _____ 9d.....\$ _____ TOTAL...\$ _____ Within Limits? [] Yes [] No
Verification Attached []			

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ALL CASES

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

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..... \$= _____

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) _____
- 15. Standard of Promptness Met? Yes No If No, Reason _____

16. Spot Check Alert? Yes No Reason _____ Date _____

17. *If Less Than 3 Months Retroactive Coverage, Explain _____

18. Worker's Signature _____ Date _____

Concurred by _____ Title _____ Date _____

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ALL CASES