DELAWARE HEALTH AND SOCIAL SERVICES
APPLICATION FOR LONG TERM CARE MEDICAID

Welcome to the State of Delaware Health and Social Services (DHSS)

Apply faster Online ➡	Apply faster online at www.assist.dhss.delaware.gov
Use this application to see if you qualify for Long Term Care Medicaid	• Nursing Facility Services • Long Term Care Community Services (with or without Food Benefits) • Lifespan Waiver • 30-day Hospitalization
Who can use this application?	• Anyone in need of assistance with paying for Long Term Care Services (Nursing Home, Long Term Care Community, Assisted Living, 30 days or more of hospitalization) **NOTE: You can choose an authorized representative to assist you with completing this application. Must complete Appendix C in order to do this.**
What you may need to apply	• Your Social Security Number (or document number if you're a legal immigrant) • Your income and resource information • Information on your spouse will also be needed if you are married. • Policy numbers for any current health insurance
Why do we ask for this information?	We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. **We'll keep all the information you provide private, as required by law.**
What happens next?	Please contact the Central Intake Unit at 1-866-940-8963.
Get help with this application	• If you need someone to help you fill out this application, please call 1-866-940-8963. • If you need help with translation call 1-866-843-7212. • For TTY call 711 or 1-800-232-5460. • En Español: Llame a nuestro centro de ayuda gratis al 1-866-843-7212.

DELAWARE HEALTH AND SOCIAL SERVICES
LONG TERM CARE MEDICAID

CLIENT RIGHTS

RIGHT TO NONDISCRIMINATION

In accordance with Federal law and U.S. Department of Agriculture (USDA) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, religious creed, age, disability, political beliefs, or retaliation.

If you require this information in alternative format (Braille, large print, audiotape, etc.), contact the USDA's TARGET Center at (202) 720-2600 (Voice or TDD).
If you require information about this program, activity or facility in a language other than English, contact the USDA agency responsible for the program or activity, or any USDA office.

To file a complaint alleging discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue SW, Washington, DC 20250-9410 or call, toll free, (866) 632-9992 (Voice). TDD users can contact USDA through local relay or the Federal Relay at (800) 877-8339 (TDD) or (866) 377-8642 (relay voice users). USDA is an equal opportunity provider and employer.

__________**(please initial)**

RIGHT TO A WRITTEN NOTICE

We will make a decision on your application within 30 days of receiving your application for food benefits, 45 days for QMB/SLMB, and within 90 days for Long Term Care Medicaid. If we change, suspend, or stop benefits, we will explain the reason on the notice within 10 days of taking the action. You have 90 days from the date of the notice to ask for a hearing if you disagree with the action taken and/or the reasons given.

__________**(please initial)**

RIGHT TO APPEAL

You have the right to ask for a hearing over a decision or failure to act which affects your benefits or that you feel is unfair or incorrect. You may file a written request at any Division office. At the hearing, you may represent yourself or have someone else, such as a lawyer, friend or relative represent you. If you have a spouse in the community, we may divert a portion of the institutionalized spouse's income to the community spouse. If that protected income is insufficient to meet the community spouse's needs, he or she may ask for a portion of their resources to be protected. To do this, you must request a fair hearing in writing.

__________**(please initial)**

RIGHT TO AN AGENCY CONFERENCE

If you ask for a hearing, you may have an agency conference before the hearing. If you ask for a hearing because we decided that you are not eligible for expedited food benefit service, you have a right to an agency conference with a supervisor within 2 working days.

__________**(please initial)**

RIGHT TO CONFIDENTIALITY

We keep information you give confidential and use it only to administer the programs you apply for and/or may be eligible. Any person knowingly violating any of the rules and regulations of this Department made in accordance with this article shall be guilty of a misdemeanor, and, upon conviction thereof, shall be sentenced to pay a fine, not exceeding one hundred dollars ($100), or undergo imprisonment, not exceeding six months, or both.

_________**(please initial)**

CLIENT RESPONSIBILITIES

RESPONSIBILITY TO ACKNOWLEDGE LIABILITY OF REAL OR PERSONAL PROPERTY

If you are age 55 or older and receive Medicaid to pay for nursing home care, home and community-based services and any related hospital and prescription drug services, you will be required to repay the cost of these services from your probate estate.

__________**(please initial)**

RESPONSIBILITY TO PROVIDE INFORMATION

You must give true, correct and complete information to the best of your ability. You are responsible for any fraudulent statements made on this application even if the application is submitted by someone acting on your behalf. Your benefits may be reduced or you can be penalized for giving false information. You must cooperate in documenting or proving the information you give. If you cannot provide proof, you should ask the Medicaid office to help. You must cooperate fully with persons or investigators of the Department or the Attorney General's Office conducting investigations.

_________**(please initial)**

RESPONSIBILITY TO REPORT CHANGES

You must report changes in the number of people in your household, address (mailing and/or physical location), income, real property, or other assets (such as bank accounts or life insurance). You must report new employment or changes in your employment. You also must report plans to leave the state, even temporarily. IF YOU ARE NOT SURE IF YOU MUST REPORT A PARTICULAR CHANGE, YOU SHOULD REPORT THE CHANGE. You can report to a member of the DMMA office staff in person, by telephone, or by mail. If you receive food benefits and/or medical assistance benefits, you must report changes by the 10th day of the month after the month the change occurred.

For food benefits, you must report any change in your residence and the resulting change, if any, in shelter costs. **Your benefits may be reduced or you can be penalized for not reporting changes that would affect your benefits. A person with earned income is a simplified reporter and will follow those rules which can be found in the program information booklet.** If you are proven to have failed to report earned income in a timely manner, you will not receive any earned income deduction on the unreported income which will increase the amount of the overpayment claim.

__________**(please initial)**

RESPONSIBILITY TO CONTRIBUTE TO YOUR COST OF LONG TERM CARE SERVICES

Some Medicaid recipients are required to contribute towards the cost of their care in a nursing home or assisted living facility. This is called a "patient pay". A "patient pay" is the amount of the recipient's monthly income that the recipient must pay to the nursing home or assisted living facility each month. Recipients who have a "patient pay" must make that payment promptly to the facility each month. If not paid promptly, the facility may act to discharge or evict the recipient. In addition, if the "patient pay" is not paid timely, the recipient's resources could accumulate and exceed the $2,000 resource limit. The recipient would lose Medicaid eligibility if resources exceed the program's limit.

Home and community-based services recipients in a residential placement through the DDDS Lifespan Waiver may also be required to make a "patient pay" to a Waiver service provider.

__________**(please initial)**

RESPONSIBILITY TO PROVIDE SOCIAL SECURITY NUMBERS

For medical and/or food benefits, you must provide a Social Security number (SSN) for each person for whom you are applying. If you do not have a SSN you must apply for one. Refusal or failure to provide a SSN may result in disqualification. For medical benefits, we will also ask you to supply a SSN for anyone else whose income and/or resources affect your eligibility or amount of benefits. We use the SSN to verify identity, administer our programs, prevent duplication in state and federal programs, for computer matches with other programs and to get information about income and resources to determine eligibility for and/or the amount of our benefits.

_________**(please initial)**

RESPONSIBILITY TO APPLY FOR OTHER BENEFITS

I understand that I must apply for and accept other benefits that I may be eligible to get such as Unemployment Compensation, Social Security, or Medicare.

__________**(please initial)**

RESPONSIBILITY TO REPORT LOTTERY and GAMBLING CHANGES

For Food Benefits, you must report any lottery and gambling winnings within 10 days. If the amount of the winnings exceeds the substantial lottery and gaming amount your food benefit case will close.

_________**(please initial)**

RESPONSIBILITY TO COMPLETE AND SIGN THE COMPLIANCE ATTESTATION

For Food Benefits, you must complete and sign the Compliance Attestation found in Appendix __of this application. _________ **(please initial)**

GENERAL INFORMATION

MEDICAID ELIGIBILITY

An applicant qualifies for Medicaid if he/she is financially and technically eligible. Some Medicaid programs also have medical eligibility criteria, i.e. the Nursing Home (NH) program, Long Term Care Community Services (LTCCS) programs and Lifespan Waiver program. Medical eligibility for the NH and LTCCS programs is determined by the Medicaid Pre-Admission Screening Unit based on information from the applicant's/recipient's physician(s). Some Medicaid programs have a resource limit. If an applicant's/recipient's countable resources exceed the resource limit, the applicant/recipient is not eligible for Medicaid. A complete redetermination of Medicaid eligibility is done annually. _________**(please initial)**

PROTECTION OF INCOME FOR MEDICAID NURSING HOME RECIPIENTS

Medicaid will protect $50 of monthly income for personal needs for Nursing Home recipients. This $50 is for personal care expenses like a hairdresser, cosmetics, etc. The remainder of the Nursing Home recipient's monthly income must be paid to the nursing home for the recipient's care. Medicaid may allow the recipient to retain additional monthly income to pay for health insurance premiums and medical items not covered by Medicaid such as eyeglasses, dentures, and hearing aids. The Medicaid Social Worker can give you more information.

__________**(please initial)**

NURSING HOME RESPONSIBILITIES

Each nursing home must protect and promote the rights of each resident. Residents must be informed verbally and in writing what their rights are at the time of admission to the nursing home. State law requires that any abuse, neglect or mistreatment of a nursing home resident be reported. For more information contact the Division of Health Care Quality's Incident and Complaint Referral Center (IRC) @ 1-877-453-0012.

Federal law prohibits nursing homes from charging Medicaid recipients or their families for items and services covered by Medicaid. Nursing homes must provide a list of what items and services are included in the basic Medicaid rate and what items or services will be billed directly to the recipient. Federal laws prohibit nursing homes that accept Medicaid from requiring Medicaid eligible recipients to supplement Medicaid coverage as a condition of admission. A Medicaid enrolled nursing home cannot refuse to continue to care for a resident when the resident converts to Medicaid coverage if the home has an available Medicaid-certified bed.

__________ **(please initial)**

CLIENT ACKNOWLEDGMENT

1. I certify, under penalty of fraud, that the information I give on this application is true, correct, and complete to the best of my knowledge.
2. I am giving the State the right to seek, with or without legal action, payment from private or public health insurance or a liable third party.
3. I agree to allow Delaware Health and Social Services, or its representatives, to act as my agent in recovering money spent by the Medicaid program when other money from insurance, estates, etc., becomes available to pay my medical bills.
4. I understand that the State operates a fraud control program under which local, state, and federal officials may verify the information I give on this application.
5. I understand that the State may obtain information about my circumstances from other persons or organizations, including computer matches and U.S. Citizenship and Immigration Services.

Signature of Applicant or Representative ____ Date ______________________

DELAWARE HEALTH AND SOCIAL SERVICES
APPLICATION FOR LONG TERM CARE MEDICAID

Date Stamp

SECTION I: BASIC INFORMATION

A. Application for:

1) ____ Medicaid Nursing Facility Care
2) ____ Long Term Care Community Services
3) ____ Long Term Care Community Services and Food Benefits
5) ____ Lifespan Waiver
6) ____ 30-Day Hospitalization

B. Date of admission to hospital or nursing home (if applicable): ______________________ Name of facility ________________________________

Are you requesting retroactive Medicaid assistance for the last three months? (Not available for all Medicaid programs) YES____ NO____

First Name, Middle Name, Last Name, & Suffix of Applicant					
Home Address			Mailing Address (if different from Home address)		
City	State	Zip	City	State	Zip
Primary Telephone		Secondary Telephone		Email address	
Preferred Method of Contact I want to receive information about this application and future communication by: _____Email _____U.S. Mail			Preferred spoken or written language (if other than English)		
Has anyone been appointed as applicant's Legal Guardian/Power of Attorney? YES ____ NO _____ Name ________________________________ **You will need to provide copies of Guardianship and/or Power of Attorney papers.**					
For Food Benefits, the day we get this page of the application with your name, address, and signature sets the date food benefits may start if the completed and signed application is returned to DHSS within 30 days. Applicant's Signature (Required) Date Authorized Representative Signature Date					
If you wish to have someone else manage your case and act as your representative, please complete Appendix C.					

SECTION II FOOD BENEFITS If you are NOT applying for Food Benefits please begin with Section III.

COMPLETE THIS SECTION IF YOU ARE APPLYING FOR FOOD BENEFITS

Your Food Benefit application date is the day we receive page 1 of the application.

If your household has little or no income right now, you may be able to receive food benefits within seven (7) days from the date we receive your application: (Before you get benefits you must complete and sign the application, be interviewed, and provide proof of identity.)

- If your household has $100 or less in cash and bank accounts and expects to receive less than $150 in income this month; or
- If you are a migrant or seasonal farm worker with less than $100.00 in liquid resources: or
- If your household's monthly gross income and cash on hand is less than your rent/mortgage and utility costs (including entitlements to a Standard Utility Allowance) for this month.

PLEASE ANSWER THE FOLLOWING QUESTIONS: Write Answer and (Circle One) YES or NO

- What is the total gross income your household received or will receive this month? $__________
- Did your household's income recently stop or change? YES NO
- How many people live in your home and eat with you? (include yourself) __________
- How much do the members of your household have in cash and savings? (Give your best estimate of the total.) $__________
- What is your total rent/mortgage and utility expenses this month? $__________
- Is anyone in your household a migrant or seasonal farm worker? If yes, who? YES NO
  ____
- Has your household been approved for a postponement of verification requirements? YES NO
  If yes, when and where? ________________________

REPORTING AND VERIFYING EXPENSES

Failure to report or verify any of the following expenses will be seen as a statement by your household that you do not want to receive a deduction for the unreported expenses.

- Shelter (rent/mortgage/lot expenses);
- Real Estate taxes;
- Water and Sewage expenses;
- Phone Expenses;
- Dependent care expenses;
- Homeowner's Insurance;
- Utility expenses (gas/electric/oil);
- Garbage expenses;
- Medical expenses;
- Child support expenses paid to children who do not live in your home

ANSWER THE FOLLOWING QUESTIONS IF YOU ARE APPLYING FOR FOOD BENEFITS (Circle YES or NO)

Yes No 1. Is anyone on strike? If yes, who? ________________________________ When did the strike start? ______________

Yes No 2. Did anyone in your household quit a job in the last 60 days?

Yes No 3. Do you or anyone in your household pay child support to children who do not live in your home?
If yes, do you have a court order? YES NO How much do you pay each month? $________________

Yes No 4. Does anyone in your household pay someone to care for a child or disabled adult?
If yes, list the amount and how often paid ___________________________________

Yes No 5. Are you a boarder? (Do you pay someone for meals?) If yes, how much? $_________ How many meals daily? ________

Yes No 6. Does anyone in your household pay or help you pay for any shelter, utility, medical, dependent care or child support expense?

Yes No 7. Are you or any person in your household, a convicted felon fleeing to avoid prosecution or going to jail for a crime, or attempt to commit a crime? If yes, please list the name(s): ____

Yes No 8. Are you or any person in your household, violating a condition of probation or parole? If YES, please list the name(s):
____

Yes No 9. Is anyone who is age 16 or older a student in high school, college, training, or vocational school? If YES, complete below.

NAME	NAME OF SCHOOL	TYPE OF SCHOOL	PART TIME OR FULL TIME	EXPECTED GRAD. DATE MONTH DAY YEAR
			☐ Part time ☐ Full time	
			☐ Part time ☐ Full time	

Yes No 10. Does the student have a meal plan for two or more meals per day?

Yes No 11. Do you expect any changes in your rent/shelter costs?

Yes No 12. Do you live in subsidized housing?

Yes No 13. Do you share rent/shelter costs with anyone?

Yes No 14. Do you share utility costs with anyone?

Yes No 15. Do you receive a separate bill for heating/cooling your home?

Yes No 16. Do you pay for excess utilities?

Yes No 17. Do you receive a HUD/WHA utility allowance?

IMPORTANT NOTICE ABOUT DEDUCTIONS

Once Food Benefit eligibility can be determined, benefits will be issued even if all the deductions you have reported have not been verified before the 30th day after the date of application. Supplemental benefits may be issued if the deductions are verified before the 30th day after the application date.

If you or anyone in your household is 60 years or older and/or receiving disability payments, such as SSI, Social Security Disability, or Veterans Benefits, please list all regular medical expenses, the amount paid and how often:

NAME	MEDICAL EXPENSE	AMOUNT PAID	HOW OFTEN	COVERED BY MEDICAL INSURANCE? (Circle Yes or No)
				Yes No
				Yes No
				Yes No
Do you anticipate any other medical expenses this year? YES NO				

FOOD BENEFIT PENALTIES AND WARNINGS

You must not:

- give false, incorrect, or incomplete information to get food benefits;
- trade or sell your food benefits or any authorization document;
- use other people's food benefits or authorization documents;
- use your food benefits to buy ineligible items, such as alcoholic drinks or tobacco;
- alter authorization documents to get food benefits you are not entitled to receive.

Any member of your household who is found guilty by court or an Administrative Disqualification hearing for breaking any of the above rules will be barred from getting food benefits for:

- 12 months for the first violation;
- 24 months for the second violation; and
- permanently for the third violation.

If any member of your household is found guilty of misrepresenting their identity or place of residence in order to get multiple food benefits for the same month, the individual will not be able to get food benefits for a 10 year period.

If any member of your household is fleeing to avoid prosecution or custody or confinement after a conviction, under the law of any state, for a crime, or attempt to commit a crime, or violating a condition of probation or parole imposed under a Federal or State law, the individual will not be able to get food benefits.

Any household member found guilty by a court of having used food benefits to buy controlled substances will be disqualified for:

- 24 months for the first violation; and
- permanently for the second violation.

Any household member found guilty by a court of having used food benefits to buy firearms, ammunition, or explosives will be disqualified permanently for the first violation.

If you are found guilty of violating these rules, or committing fraud, you may also be:

- fined up to $250,000 for food benefits;
- jailed up to 20 years for food benefits; and/or
- required to repay the benefits you received.

SECTION III HOUSEHOLD COMPOSITION

COMPLETE THIS PAGE FOR EVERYONE IN THE HOUSEHOLD AND FOR THE APPLICANT'S SPOUSE

PLEASE PRINT ALL INFORMATION

APPLICANT'S NAME FIRST		M.I.	Jr/Sr. I, II	Are you applying for this person?	Alias, Maiden Name, Former Maiden Name	Birth Date Mo/Day/Yr	Birth State	Sex M/F	Social Security Number	Marital Status	How is this person related to the applicant?
LAST NAME	FIRST NAME										
											APPLICANT

We *may* need to request verification of birth, marital status and social security number. We will let you know if we need you to provide this information.

SPOUSAL INFORMATION:

1. If spouse is deceased: Name ______________________________ Date of Death ______________________

   Was he/she ever in the military? YES NO

   If yes, have you ever applied for a VA pension for the applicant? YES NO Give date of application for pension ________________

2. If separated: Spouse's Name ________________________ How long have you been separated? __________________

   Spouse's Address ____

TAX DEPENDENCY

1. Does the applicant, plan on filing taxes for the current year? YES NO

   If so, will the applicant be the primary filer? YES NO

If you answered yes, please fill in the table below and answer questions in A. If you answered no, please skip to B.

Name of Tax Filer	Who will be claimed as a Tax Dependent

A. Will anyone file jointly with a spouse? ☐ Yes ☐ No

- If yes, name of spouse: ________________________

B. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

- If yes, please list the name of the tax filer and how you are related to the tax filer: ____

FOR RACE/ETHNICITY: USE ONE OF THE FOLLOWING CODES. YOUR BENEFITS WILL NOT BE AFFECTED IF YOU DO NOT ANSWER.

Race Codes: 1. White 2. Black or African American 3. Asian 4. American Indian or Alaska Native 5. Native Hawaiian or Other Pacific Islander
Ethnicity Codes: 6. Hispanic/Latino 7. Non-Hispanic/Latino

Race/ Ethnicity Code		VETERAN STATUS	CHECK STATUS OF EACH PERSON				SIGN BELOW				SPONSOR
See Codes Above (Optional) Race 1-5	Ethnic 6-7	Non-Veteran, Veteran, Active Military, National Guard/Reserves	1 Citizen	2 Lawful Alien	3 Refugee	4 Illegal Alien	I certify, under penalty of perjury, by signing my name below, that the applicant and all household members under 18 years of age for whom I am signing are US citizens or aliens in lawful immigration status	For non-citizens, give date entered the USA	Non-citizen entered USA from what country?	For non-citizens, give alien registration #	For non-citizen, give sponsor's name, and address, if applicable

We will attempt to verify your citizenship, identity and/or alien status electronically. If we are unable to verify your status electronically, we will need to request verification from you to complete your case.

ANSWER ALL QUESTIONS - CIRCLE YES OR NO – IF YES, PROVIDE EMPLOYMENT INFORMATION BELOW

1. Is the applicant, his/her spouse, or anyone for whom you are applying currently employed? YES NO
2. Has the applicant, his/her spouse, or anyone for whom you are applying ever been employed for more than five (5) years by the same employer? YES NO

NAME	EMPLOYER'S NAME	EMPLOYER'S ADDRESS (Street, City, Zip)	PHONE	# OF YRS EMPLOYED

3. Is the applicant and/or spouse expecting money from any type of property such as an accident settlement, settlement from a lawsuit, inheritance, trust fund, pension or any other source? YES NO

   If yes, type of settlement/property/pension___________________________ Value _________________ When to be received, date ____________________

SECTION IV INCOME

PLEASE ENTER ALL **GROSS** INCOME (INCOME BEFORE DEDUCTIONS) including any **JOINT** income received.

	APPLICANT				SPOUSE				OTHER HOUSEHOLD INCOME			
SOURCE OF INCOME	**$ AMOUNT**	**HOW OFTEN?**	**DIRECT DEPOSIT?**		**$ AMOUNT**	**HOW OFTEN?**	**DIRECT DEPOSIT?**		**NAME OF RECIPIENT?**	**$ AMOUNT**	**HOW OFTEN?**	**DIRECT DEPOSIT?**
Social Security												
Supplemental Security Income (SSI)												
Veteran's Benefits												
VA Improved Pension												
Railroad Retirement Benefits												
Annuity												
Pension												
Rental Income (house, mobile home, farm, land, etc.)												
Interest/Dividends												
Income from Mortgage Payments												
Employment												
Income from Relatives/Friends												
Unemployment												
Long Term Care Insurance (LTCI)												
Child Support												
Lottery or Gambling Winnings												
Other												

We will attempt to verify income electronically. If we are unable to verify your income electronically, we will need to request verification from you to complete your case.

SECTION V RESOURCES

A. OPEN FINANCIAL ACCOUNTS

Circle YES or NO for all open financial accounts for the applicant and their spouse.

									Other:		
Checking	Yes	No	Savings	Yes	No	Certificates of Deposit	Yes	No			
Money Market	Yes	No	Trust	Yes	No	Savings Bonds	Yes	No		Yes	No
Christmas Club	Yes	No	Vacation Club	Yes	No	Stocks	Yes	No		Yes	No
Bonds	Yes	No	Personal Needs Account (Nursing Home)	Yes	No	Annuities **State of DE must be named as remainder beneficiary**	Yes	No		Yes	No
IRA	Yes	No	401K	Yes	No	Promissory Notes/Loans	Yes	No		Yes	No

List all open accounts by financial institution: If there are no accounts, where do you cash your checks? ______________________________

FINANCIAL INSTITUTION	TYPE OF ACCOUNT	ACCOUNT #	CURRENT BALANCE/DATE	NAMES ON ACCOUNT and/or Co-Owner	NOTES (Does the money in the account belong to someone else? If so, explain)

We may need to ask you to provide copies of at least the 3 most current financial statements for each account listed above. We will let you know if we need you to provide this information.

B. CLOSED FINANCIAL ACCOUNTS

Have any accounts in the applicant's or spouse's name been closed or cashed-in within the last 60 months (such as, bank accounts, stocks, bonds, CDs)? (Circle one) YES NO

If yes, complete the following:

FINANCIAL INSTITUTION	TYPE OF ACCOUNT	ACCOUNT #	NAMES ON ACCOUNT	DATE CLOSED	CLOSING BALANCE	DESCRIBE WHAT HAPPENED TO THE MONEY IN THE CLOSED ACCOUNT(S)

We may need to ask you to provide verification of when these accounts were closed, verification of the closing balance and where the funds went. We will let you know if we need you to provide this information.

Does the applicant's and/or spouse's name appear on any bank account which you consider to belong to someone else? (Circle one) YES NO

If yes, give the person's name, location of account, and account number.

____

____

Does applicant have a Safe Deposit Box? (Circle one) YES NO If yes, give name of bank and list contents:

____

Does applicant have any cash on hand (Greater than $100.00)? (Circle one) YES NO If yes, how much? $__________
Where? ____________________________

Is someone holding any money for the applicant? (Circle one) YES NO If yes, Who? ___________________ How Much? $ __________________

Do you have a security deposit at the nursing home? (Circle one) YES NO If yes, how much? $ ___________________

C. TRANSFERRED ASSETS

Has the applicant and/or spouse given away, sold or transferred ownership of any asset (including cash and income), or property within the last 60 months?

(Circle one) YES NO

If yes, complete the following:

TYPE OF ASSET	LOCATION AND/OR ACCOUNT #	DATE OF SALE OR TRANSFER	REASON SOLD OR GIVEN AWAY	FAIR MARKET VALUE OF ASSET	GROSS AMOUNT OF MONEY RECEIVED	WHAT HAPPENED TO MONEY RECEIVED
1.						
2.						
3.						
4.						
5.						

You will need to provide verification of the date of the transfer, the amount of the transfer, and the fair market value of the asset transferred, the amount received (if any), and how the money was used.

D. OTHER ASSETS

Are there any other assets owned by the applicant and/or spouse that have not been identified? (Circle one) YES NO If Yes, please list and describe: ____

____

E. PROPERTY

- **List applicant's and spouse's address/residences for the past 5 years.**

Include # of years at this address

Address	Own	Value	Rent	Life Estate	Other	# of years
1. ______	( ) Own	Value $______	( ) Rent	( ) Life Estate	( ) Other	______
2. ______	( ) Own	Value $______	( ) Rent	( ) Life Estate	( ) Other	______
3. ______	( ) Own	Value $______	( ) Rent	( ) Life Estate	( ) Other	______
4. ______	( ) Own	Value $______	( ) Rent	( ) Life Estate	( ) Other	______
5. ______	( ) Own	Value $______	( ) Rent	( ) Life Estate	( ) Other	______

- Is applicant's and/or spouse's name on any other property such as a house, mobile home, trailer, land? (Circle one) YES NO

If yes, list type of property and address: | List occupant's names and relationship to applicant:

1. ______________________ ______________________

2. ______________________ ______________________

3. ______________________ ______________________

- Is applicant's or spouse's name on any other property which may belong to someone else? (Circle one) YES NO

If yes, please list: ____

____

- Has the applicant ever owned property, or had a life estate interest in property? (Circle one) YES NO

If yes, please indicate what happened to this property and when: ______________________

____

We may need to ask you to provide copies of deeds to properties or other types of verification of ownership, such as a probated will. We may also need to ask you for verification of the equity value of property. We will let you know if we need you to provide this information.

SHELTER AND UTILITY EXPENSES

Please complete if the applicant or spouse's household has any of the following expenses/payments (Circle Yes or No)

Shelter Expenses			MONTHLY AMOUNT	Utility Expenses			MONTHLY AMOUNT
Rent	Yes	No		Electric	Yes	No	
Mobile Home Lot Rent	Yes	No		Gas	Yes	No	
Mortgage	Yes	No		Oil	Yes	No	
Condo Fees	Yes	No		Water	Yes	No	
Homeowner's Insurance	Yes	No		Sewer	Yes	No	
Real Estate Taxes	Yes	No		Garbage	Yes	No	
Room Rent	Yes	No		Phone	Yes	No	
Room And Meals	Yes	No		Other	Yes	No	
Other	Yes	No		Other	Yes	No	

We may need to ask you to provide verification of these expenses (copies of bills, canceled checks…). We will let you know if we need you to provide this information.

F. VEHICLES

Does applicant or spouse have ownership of cars, trucks, motorcycles, boats, trailers, recreational vehicles (mobile home, camper, snow mobile, jet ski, etc.), or any other vehicles? (Circle one) YES NO

If yes, complete the following even for vehicles that are not insured or that do not operate:

Owner's first and last name:	Co-owner's first and last name:	Amount owed:
Year, Type, Make, Model of Vehicle	Vehicle is used for:	Value:
Owner's first and last name:	Co-owner's first and last name:	Amount owed:
Year, Type, Make, Model of Vehicle	Vehicle is used for:	Value:

We may need to ask you to provide copies of vehicle titles and verification of any amount owed on the vehicle. We will let you know if we need you to provide this information.

G. LIFE INSURANCE

Does the applicant and/or spouse own any life insurance policies? (Circle one) YES NO

If yes, complete the following for all policies.

PERSON INSURED	POLICY OWNER	INSURANCE COMPANY	POLICY NUMBER	FACE VALUE	CASH VALUE	ACCUMULATED DIVIDEND
1.						
2.						
3.						
4.						
5.						
6.						

We may need to ask you to provide copies of your life insurance policy and a letter from the insurance company verifying the value of your policy. We will let you know if we need you to provide this information.

H. BURIAL INFORMATION

Does the applicant have a pre-paid funeral arrangement? (Circle one) YES NO

Does the spouse have a pre-paid funeral arrangement? (Circle one) YES NO

APPLICANT	SPOUSE
Name of Owner/Insured:	Name of Owner/Insured:
Type:	Type:
Name and Address of Funeral Home:	Name and Address of Funeral Home:
Total Value:	Total Value:
Paid in Full: (Circle one) YES NO	Paid in Full: (Circle one) YES NO
If no, what amount has been paid?	If no, what amount has been paid?

You will need to provide a copy of the itemization, a copy of the pre-paid burial arrangement (such as, copy of burial trust, irrevocable page of the life insurance policy, copy of the certificate of deposit designated for burial purposes…).

SECTION VI HEALTH INSURANCE

INSURANCE COVERAGE Applicant	POLICY OWNER	POLICY NUMBER	PREMIUM AMOUNT	HOW OFTEN PAID	EFFECTIVE DATE OF COVERAGE	DESCRIBE HOW THESE PREMIUMS ARE PAID
Blue Cross/Blue Shield						
Blood Bank						
Medicare						
Medicare Prescription						
AARP						
Long Term Care Insurance						
Other Insurance						

INSURANCE COVERAGE Spouse	POLICY OWNER	POLICY NUMBER	PREMIUM AMOUNT	HOW OFTEN PAID	EFFECTIVE DATE OF COVERAGE	DESCRIBE HOW THESE PREMIUMS ARE PAID
Blue Cross/Blue Shield						
Blood Bank						
Medicare						
Medicare Prescription						
AARP						
Long Term Care Insurance						
Other Insurance						

We may need to ask you to provide a copy of your health insurance card and verification of paid premiums. We will let you know if we need you to provide this information.

SECTION VII: SIGNATURES

The applicant should sign the application unless incapacitated or represented by Legal (Court Appointed) Guardian. An authorized representative may sign the application on behalf of the incapacitated or deceased applicant. The applicant's mark should be witnessed by a person familiar with the applicant.

AUTHORIZATION FOR RECEIPT OF PREGNANCY PREVENTION INFORMATION

You are authorized to receive pregnancy prevention information. If you wish to receive this information you can call Planned Parenthood at 1-800-230-PLAN (7526). If you wish to get teen pregnancy prevention information, you may also call the Alliance for Adolescent Pregnancy Prevention at 1-800-499-WAIT (9248). You can also call the Delaware Helpline at 1-800-464-4357 for the Public Health Family Planning clinic in your area.

AUTHORIZATION TO DISCLOSE INFORMATION

I authorize and request disclosure of the information listed below to Delaware Health and Social Services and/or its Managed Care Organization (MCO) representatives for determining my eligibility for medical assistance and/or food benefits. This release may be used to ask for, receive and/or release information that is pertinent to my eligibility determination:

- All records and other information regarding treatment, hospitalizations, and outpatient care for my impairment(s).
- Information about how my impairment(s) affect my ability to complete tasks, activities of daily living, and specific functions in the work environment.
- All records from financial institutions, including information of any accounts closed within the last 60 months.
- Information from all sources of income (Social Security Administration, current and past employers, Annuity companies, etc.)
- All life insurance companies.

This authorization ends when the requested information is received, or twelve (12) months from the date this application is signed or until revoked by me in writing, whichever comes first.

I understand that I have the choice of either Long Term Care Community Services or Long Term Care Facility Placement.

I choose to apply for (check only one):

______ Assisted Living

______ Long Term Care Community

______ Nursing Facility

______ PACE

____

Signature of Applicant or Recipient Date

Authorization to disclose information ends 12 months from this date or upon my written statement.

CERTIFICATION OF UNDERSTANDING AND ACCURACY OF APPLICATION ANSWERS

I understand the questions on this application form and the penalty for hiding or giving false information or breaking any of the rules listed in the penalty warning. I certify, under penalty of perjury, that all my answers are correct and complete to the best of my knowledge, including information about the citizenship or alien status of each household member. I understand and agree to provide documents to prove what I have said. I understand and agree that DHSS may contact other persons or organizations to obtain the necessary proof of my eligibility and level of benefits.

CERTIFICATION OF HEAD OF HOUSEHOLD SELECTION: I have read and have had explained to me the provisions about selecting a head of household. I have selected the following person to be head of household and certify that all adult members in my household agree to this selection.

Signature of Applicant or Recipient	Date	Signature of Spouse	Date
Witness to Applicant's Mark	Date	Signature of Authorized Representative	Date
Signature of DMMA Worker	Date	Signature of Authorized Representative	Date

SIGNATURE FOR WITHDRAWAL OF THIS APPLICATION

I am no longer interested in applying for Assistance at this time. Therefore, I am requesting that this application be withdrawn.
I fully understand that I may reapply at any time.

Signature of Applicant or Representative Date

Signature of DMMA Worker Date