MEDICAID APPLICATION FOR THE ELDERLY AND DISABLED

DEPARTMENT OF HEALTH AND HUMAN SERVICES
SFN 958 (5-2026)

Click Here to Clear Field Data

Agency Use Only

Case Number	Date Requested	Date Received	Date Interviewed
Individual Interviewed			

If you are not elderly or disabled and wish to apply for Medicaid, complete the Application for Health Care Coverage, SFN 1909 or the Application for Assistance, SFN 405.

Instructions For Application For Medicaid

This application may be used to apply for Medicaid, the Medicare Savings Programs, or Basic Care. See the Guidebook for more information.

What Do I Need to Do to Get Medicaid?

Follow these steps to apply for Medicaid:

Step 1:

Select the assistance for which you are applying: Select ALL that apply
If you would like more information on these programs, see the Application for Assistance Guidebook. If you did not receive the Guidebook, contact your local Human Service Zone office.

- ☐ **Medicaid -** Medicaid coverage for the elderly and disabled.
  - ☐ **Workers With Disabilities -** Disabled gainfully employed individuals ages 16 to less than age 65 can buy into Medicaid.
  - ☐ **Children With Disabilities** - Disabled children under age 19 can buy into Medicaid.
- ☐ **Medicare Savings Programs –** Assists with Medicare premiums.
- ☐ **Basic Care Assistance Program (BCAP): A program for residents of Basic Care Facilities Only -** Apply for this program **IF** you live in a licensed Basic Care Facility to meet your health and living needs **AND** you are age 18 or older, blind, disabled or aged. This program helps pay for room and board costs.

Step 2:

Answer as many questions as you can. For assistance completing the application, contact or visit your local Human Service Zone office. You may have a friend, relative, or someone else help you apply.
If you need additional space, attach a separate sheet of paper.

Step 3:

Return your signed and dated form to your local Human Service Zone office
OR
Submit by mail to:
Department of Health and Human Services
Customer Support Center
PO Box 5562
Bismarck ND, 58506
OR FAX: (701)-328-1006
OR Email: **applyforhelp@nd.gov**

For questions call Customer Support Center at: 1-866-614-6005
Human Service Zone office locations can be found here: https://www.hhs.nd.gov/human-service/zones

To speed up the processing of your application, turn in proof of the following items with your application. Your local Human Service Zone office may be able to help you obtain these things if needed.

☐ **Proof of Alien or Citizenship Status such as:** Original documents required if applying for Medicaid

- Permanent Resident Card - Form I-551
- Employment Authorization Document - Form I-766
- American Indian or Alaskan Native Tribal Document
- Birth Certificate - if born in the United States
- Arrival-Departure Record - Form I-94
- Passport

You will be asked to provide information about the citizenship or immigration status for all persons for whom you want to receive assistance. This information may be subject to verification by the United States Citizenship and Immigration Service (USCIS), and that the submitted information received from USCIS may affect the household's eligibility and level of benefits. **For Medicaid, verification will be required if not available through electronic notifications.** If any of these persons do not want to give information about their citizenship or immigration status, they will not be eligible for benefits. These persons must provide their financial information to determine eligibility for other household members. Other household members may still get benefits if they are otherwise eligible. We will not share alien or citizenship information about non-applicants with the United States Citizenship and Immigration Service (USCIS).

☐ **Proof of the value of current assets such as:**

- Annuities
- Business Accounts
- Certificates of Deposit
- Checking/Savings/Credit Union Accounts
- IRA/401K/KEOGH Plans
- Life Insurance
- Real Property - Land, Rental Property, etc.
- Savings Bonds
- Stocks/Bonds/Mutual Funds
- Trusts

☐ **Proof of expenses such as:**

- Court Ordered Payments - Child/Spousal Support, Medical Support)
- Health Insurance Premiums

☐ **Proof of income such as:**

- Bonuses
- Child Support
- Commissions
- Lease Income
- Money from Friends, Relatives, or Others
- Pay - Pay Stubs or Employer Statement
- Pension or Retirement Benefits
- Rental Income
- Self - employment Income - most recent copy of Federal Income Tax Form
- Social Security Benefits
- Spousal Support
- SSI - Supplemental Security Income
- Unemployment Benefits
- Veteran's/Military Benefits
- Workers Compensation

☐ **Proof of other information such as:**

- Identity - Birth Certificate, Driver's License, Work or School ID, American Indian or Alaskan Native Tribal Document, Passport - original documents required if applying for Medicaid
- Age - Birth Certificate, Driver's License
- Social Security Numbers - card or proof of application for SSN

To learn when you may get assistance, go to the General Information section of the Guidebook. If you have questions, contact the Customer Support Center.

Tell Us About You

Name - First, Middle, Last, Suffix		
Address Where You Live		
City	State	ZIP Code
Mailing Address - If different from address where you live		
Home Telephone Number	Work or Message Number	Cell Phone Number
Directions to Home, If Rural Address		
If you do not speak English, what is your preferred spoken or written language?		

If you are applying for Medicaid and you have entered your residential and mailing address as General Delivery, or Homeless, or have left it blank, your mail will be sent to the local Human Service Zone office. You will need to arrange to pick up your mail at the local Human Service Zone office on a weekly basis. If you do not pick up your mail for three weeks, your case may be closed due to loss of contact.

Sign and Date Your Application Here

Signature of Applicant	Date
Other Signature - Spouse, Guardian, or Other Adult	Date

Help with Medicaid?

If you are applying for Medicaid, you can give a trusted person permission to talk about this application with us and see your information. This individual can act on your behalf on matters related to this application, including giving and getting information, signing your application and acting for you on all future matters. This person is called an “authorized representative.” If you ever need to change your authorized representative, contact the Customer Support Center.

If the person you give this permission is a **legally appointed representative** for someone on this application, submit proof with application.

If you choose to have someone help you, fill in these boxes with their information:

Name - First, Middle, Last, Suffix			
Address			Apartment or Unit Number
City	State	ZIP Code	Telephone Number

By signing, you authorize this person to serve as your "authorized representative."

Signature of Applicant	Date

Power of Attorney, Family Contact Person or Guardian Section

Specify Type: Select one

◯ Power of Attorney ◯ Family Contact Person ◯ Guardian

First and Last Name	Relationship		
Mailing Address Where You Want Notices Sent	City	State	ZIP Code
Home Telephone Number	Work or Message Number	Cell Phone Number	

Would You Like to Receive Text and E-mail Notification

All email and text messages that contain Protected Health Information (PHI) or other confidential information are transmitted encrypted or secure unless you request and consent to receive unencrypted or unsecure email and text messages.

The privacy and security of email and text messages cannot be guaranteed. There is some risk that any PHI or other confidential information contained in an email or text message may be misdirected, disclosed to, or intercepted by an unauthorized third party. You should not agree to email and text messages unless you are willing to accept these risks.

The Department of Health and Human Services is not responsible for any fees imposed by your email and text message service providers, email or text messages that are not received due to technical failure, or the improper disclosure of PHI or other confidential information that is not a result of our negligence.

You are responsible for notifying your case worker of any changes to your contact information and if you wish to terminate this request.

I request the following communications: Select all that apply:

☐ Notice of review for continued eligibility in enrolled programs, or need for full application to determine program eligibility. ☐ Email ☐ Text Message

☐ Regular and ongoing communications regarding application, eligibility, enrollment, and participation in enrolled programs. ☐ Email ☐ Text Message

I accept the associated risks and consent to receive:

☐ Encrypted or secure email and text messages as previously indicated.

☐ Unencrypted or unsecure email and text messages as indicated above. I understand that unencrypted or unsecure means the added security protections that safeguard the contents of emails and text messages are removed.

Email Address	Text Message Number
Signature	Date

Tell Us About The People In Your Home

Select the boxes below for all the people who live in your home, including members temporarily out of your home. Example: working away from home, attending school or boarding school, or in the military.

☐ Yourself ☐ Your husband or wife ☐ Your children ☐ Other adults or children living in your home

For each person selected, complete household member 1 through 3. These people make up your household.

If you need additional space,continue on a separate sheet of paper.

You are asked to provide information about the race and the ethnic background for all persons for whom you want assistance. This information is voluntary and is used to make sure that benefits are provided without regard to race, color, or national origin. Providing this information will not affect your eligibility or benefit amount.

You are also asked to provide information about the sex, last grade completed and marital status of all persons for whom you want assistance. This information is voluntary.

You will be asked to provide Social Security Numbers (SSNs) for all persons whom you want assistance. If someone wants help getting an SSN, call 1-800-772-1213 or visit SSA.gov. TTY users should call 1-800-325-0778. If you are applying only for emergency Medicaid because of your citizenship or immigration status, you do not need to give us information about your SSN. **See the General Information Section of the Application for Assistance Guidebook for additional information regarding use of Social Security Numbers.**

Household Member 1

Legal Name: First, Middle Initial, Last			Relationship to You	Social Security Number
Date of Birth	Age	Sex	U.S. Citizen ◯ Yes ◯ No	Hispanic or Latino ◯ Yes ◯ No
Marital Status: Select One ◯ Divorced ◯ Married ◯ Never Married ◯ Separated ◯ Widowed				
Race: Select One ◯ American Indian or Alaska Native ◯ Asian ◯ Black or African American ◯ White or Caucasian ◯ Native Hawaiian or Pacific Islander				

Household Member 2

Legal Name: First, Middle Initial, Last			Relationship to You	Social Security Number
Date of Birth	Age	Sex	U.S. Citizen ◯ Yes ◯ No	Hispanic or Latino ◯ Yes ◯ No
Marital Status: Select One ◯ Divorced ◯ Married ◯ Never Married ◯ Separated ◯ Widowed				
Race: Select One ◯ American Indian or Alaska Native ◯ Asian ◯ Black or African American ◯ White or Caucasian ◯ Native Hawaiian or Pacific Islander				

Household Member 3

Legal Name: First, Middle Initial, Last			Relationship to You	Social Security Number
Date of Birth	Age	Sex	U.S. Citizen ◯Yes ◯No	Hispanic or Latino ◯Yes ◯No
Marital Status: Select One ◯Divorced ◯Married ◯Never Married ◯Separated ◯Widowed				
Race: Select One ◯American Indian or Alaska Native ◯Asian ◯Black or African American ◯White or Caucasian ◯Native Hawaiian or Pacific Islander				
If you do not want Medicaid for all members of the household previously specified, list members you DO NOT want Medicaid for:				

List Households Members Enrolled in a Federally Recognized Indian Tribe

Member Name	Tribe Name	Tribal Enrollment Number

If you are applying for Medicaid you may be eligible for no enrollment fees or premium payments under certain Medicaid.

Tell Us About Your Household	
I/We have lived in North Dakota since what month, day, and year?	
Do you intend to remain in North Dakota? ◯Yes ◯No	
List other names that have been used by household members - maiden name, prior married name, or nicknames	
List household members temporarily out of the home	
Explain why are they out of the home?	Date Expected to Return
List household members who are disabled	

If you have recently applied for disability and the decision by the Social Security Administration is still pending, you must provide proof of your pending status along with this application.

List household members who are a veteran, a spouse, parent, or dependent of a veteran, or are an active-duty member in the U.S. Military:
Have household members received, or are they currently receiving, medical assistance in another state? ◯ No ◯ Yes

If Yes, When?	Which City, County, and State:

Does anyone in your household require nursing care services? ◯ No ◯ Yes
If yes, when did or when will they start receiving nursing care services?

If receiving nursing care services in a facility, provide the name and address of the facility

Name of Facility			
Address	City	State	ZIP Code

Tell Us About Your Medical Bills

Medicaid can help pay medical bills, including prescription costs, for up to three months prior to the month of your application. Would you like help paying any of these bills? ◯ No ◯ Yes
If yes, list which months and provide verification of income, assets and expenses for those months:
Medicaid can allow unpaid medical bills older than three months to reduce your out-of-pocket costs. Do household members have unpaid medical bills older than three months? ◯ No ◯ Yes
If yes, explain:

Tell Us About Your Household Assets

Select yes by the assets owned, jointly owned, or being purchased by household members.
Select no, if no such asset

Annuities	◯ No	◯ Yes	Burial Plots	◯ No	◯ Yes
Assets Owned with Another Person	◯ No	◯ Yes	Business Accounts	◯ No	◯ Yes
Business Inventory or Equipment	◯ No	◯ Yes	Cash on Hand	◯ No	◯ Yes
Certificates of Deposit	◯ No	◯ Yes	Checking, Credit Union Accounts	◯ No	◯ Yes
Income Producing Tools, Equipment	◯ No	◯ Yes	Inheritance	◯ No	◯ Yes
Irrevocable Burial Fund	◯ No	◯ Yes	Life Estate, Life Lease	◯ No	◯ Yes
Money Market Account	◯ No	◯ Yes	Notes or Contract for Deed	◯ No	◯ Yes
Retirement Funds-IRA/KEOGH/401K	◯ No	◯ Yes	Prepaid Funeral Plans	◯ No	◯ Yes
Safe Deposit Box	◯ No	◯ Yes	Savings Bonds	◯ No	◯ Yes
Savings, Credit Union Accounts	◯ No	◯ Yes	Trusts	◯ No	◯ Yes

Burial Space Items - Casket, Vault, or Marker	◯ No	◯ Yes
Debit Card Account - Not Checking or Savings	◯ No	◯ Yes
Farm Equipment, Livestock, Stored Grain	◯ No	◯ Yes
Home, Mobile Home - Not Owner Occupied	◯ No	◯ Yes
Home, Mobile Home - Owner Occupied	◯ No	◯ Yes
Individual Indian Monies (IIM) - is required if applying for Basic Care ONLY	◯ No	◯ Yes
Mineral Rights - Oil, Gas, Gravel, or Coal	◯ No	◯ Yes
Real Property - Land, Rental Property, or Buildings	◯ No	◯ Yes
Stocks, Bonds, and Mutual Funds	◯ No	◯ Yes

If Other, Specify:

For all assets that were selected yes, enter the following information:

Type of Asset	Location or Description	Total Value	Amount Owed	Owners

Are any assets subject to a "Transfer at Death"? ◯ No ◯ Yes

If yes, describe the property and approximate value.

Tell Us About Your Household Assets

List household members who have made arrangements for funeral expenses or gave money, property, or insurance to someone else to pay for funeral expenses:

Explain:

Do you expect changes in assets next month? ◯No ◯Yes

If yes, explain:

Transfer of Assets

Have household members sold, given away or transferred anything of value within the past 5 years?
◯No ◯Yes

If yes, list items	Date

Tell Us About the Income or Money Your Household Receives

Self-Employment

Are any household members self-employed? ◯No ◯Yes - If yes, answer following questions:

Name of Household Members	Name of Business

Type of Business	Date Business Started

Employment

Are any household members employed? ◯No ◯Yes

If Yes, list information about pay from employment such as wages, commissions, bonuses, and incentives for all household members. If employment stopped last month or this month, also list income received this month here.

Household Member 1

Household Member Name		Employer	
Hours Worked per Week	Hourly Pay	This Month's Pay Before Taxes-Gross	
Next Month's Pay Before Taxes-Gross		Amount of Tips	Date of Next Check

How Often Paid: Select One
◯Monthly ◯Twice A Month ◯Weekly ◯Every Two Weeks ◯Other-Specify:

Day Paid: Select One
◯Monday ◯Tuesday ◯Wednesday ◯Thursday ◯Friday ◯Saturday ◯Sunday

Household Member 2

Household Member Name		Employer	
Hours Worked per Week	Hourly Pay	This Month's Pay Before Taxes-Gross	
Next Month's Pay Before Taxes-Gross		Amount of Tips	Date of Next Check
How Often Paid: Select One ◯Monthly ◯Twice A Month ◯Weekly ◯Every Two Weeks ◯Other-Specify:			
Day Paid: Select One ◯Monday ◯Tuesday ◯Wednesday ◯Thursday ◯Friday ◯Saturday ◯Sunday			

Household Member 3

Household Member Name		Employer	
Hours Worked per Week	Hourly Pay	This Month's Pay Before Taxes-Gross	
Next Month's Pay Before Taxes-Gross		Amount of Tips	Date of Next Check
How Often Paid: Select One ◯Monthly ◯Twice A Month ◯Weekly ◯Every Two Weeks ◯Other-Specify:			
Day Paid: Select One ◯Monday ◯Tuesday ◯Wednesday ◯Thursday ◯Friday ◯Saturday ◯Sunday			

Have any household members received commissions, bonuses or incentives other than those described previously within the last year? ◯No ◯Yes - answer the following questions:

Name of Household Member	Date Received	Amount Received

Unearned Income or Other Money Received

The following is a list of different kinds of unearned income. Select yes for each unearned income or other money received by household members. Select no, if not received.

Benefits while on Strike	◯ No	◯ Yes	BIA or Tribal General Assistance	◯ No	◯ Yes
Bingo, Gambling Winnings	◯ No	◯ Yes	Child Support or Spousal Support	◯ No	◯ Yes
Contract Sale or Rental Income	◯ No	◯ Yes	Income from CRP	◯ No	◯ Yes
Income from Roomer or Boarder	◯ No	◯ Yes	Income from Tribes	◯ No	◯ Yes
Insurance or Lawsuit Settlement	◯ No	◯ Yes	Interest or Dividend Income	◯ No	◯ Yes
Money from Inheritance	◯ No	◯ Yes	Oil, Mineral Rights or Royalties	◯ No	◯ Yes
Pension or Retirement Benefits	◯ No	◯ Yes	Railroad Retirement Benefits	◯ No	◯ Yes
Refugee Assistance	◯ No	◯ Yes	Social Security Benefits	◯ No	◯ Yes
Supplemental Security Income (SSI)	◯ No	◯ Yes	Unemployment Benefits	◯ No	◯ Yes
Veteran's or Military Benefits	◯ No	◯ Yes	Workers' Compensation	◯ No	◯ Yes
Individual Indian Monies (IIM) - Required if applying for Basic Care ONLY				◯ No	◯ Yes
Money Deposited into a Bank Account from an Individual Outside of Your Household				◯ No	◯ Yes
Money from Friends, Relatives or Others	◯ No	◯ Yes			
Temporary Assistance for Needy Families (TANF)	◯ No	◯ Yes			

If Other, Specify:

For all income or money received that were selected yes, enter the following information:

Type of Unearned Income or Other Money Received	Household Member	How Often Received	Amount This Month	Amount Next Month

Have household members applied for benefits not yet received such as Social Security, SSI, Worker's Compensation, Unemployment Compensation, Veterans, or Military Benefits?
◯ No ◯ Yes

If yes, explain:

Does anyone outside of the household deposit money into a household member's bank account?
◯ No ◯ Yes

If yes, explain:

Transfer of Income
Have household members sold, given away or transferred any income or stream of income within the past 5 years? Example: annuity payments or VA improved pension ◯ No ◯ Yes
If yes, explain:

Life Insurance

Does any household member have life insurance? ◯ No ◯ Yes- If Yes Complete the following:
Designated irrevocable itemized burial fund? ◯ No ◯ Yes - Provide copy of life insurance policy.

Name of Insured Person	Name and Address of Company	Policy Number	Face Value	Cash Surrender Value	Owners

Vehicles

List vehicles such as, cars, trucks, motor home, snowmobile, motorcycle, 3 wheeler, 4 wheeler, boat or other watercraft, camper, or trailer owned, jointly owned or being purchased for all household members, even if these vehicles are not running or not in your possession. Include vehicles licensed through North Dakota, tribal motor vehicle or another state.

Make and Model	Year	Value	Amount Owed	Licensed No	Licensed Yes	Owners
				◯	◯	
				◯	◯	
				◯	◯	
				◯	◯	
				◯	◯	
				◯	◯	

Tell Us About Court Ordered Expenses

Is any household member court ordered to pay child support, spousal support, other support or health insurance?	◯ No	◯ Yes
If yes, who?	Who are the payments for?	
Amount Court Ordered:	Amount Paid:	

Tell Us About Your Health Insurance Coverage

List household members who have health insurance: Provide copy, front and back, of insurance card.

Household Member 1

Name of Person Covered		Policyholder Name		
Policyholder Address		City	State	ZIP Code
Name of Health Insurance Company			Telephone Number	
Health Insurance Address		City	State	ZIP Code
Effective Date	Policy Number	Group Number	Monthly Premium	

Type of Coverage: Select all that apply

☐ Hospital	☐ Doctor	☐ Major Medical/Lab/X-Ray	☐ Dental
☐ Vision	☐ Nursing Home	☐ Cancer	☐ Champus/Tricare
☐ HMO Insurance	☐ Court Ordered	☐ Medicare Part A	☐ Medicare Part B
☐ Medicare Supplement/Advantage		☐ Prescription Drug Insurance	☐ Medicare Part D
☐ Workers Compensation or Accident		☐ Veterans Administration	

Household Member 2

Name of Person Covered		Policyholder Name		
Policyholder Address		City	State	ZIP Code
Name of Health Insurance Company			Telephone Number	
Health Insurance Address		City	State	ZIP Code
Effective Date	Policy Number	Group Number	Monthly Premium	

Type of Coverage: Select all that apply

☐ Hospital	☐ Doctor	☐ Major Medical/Lab/X-Ray	☐ Dental
☐ Vision	☐ Nursing Home	☐ Cancer	☐ Champus/Tricare
☐ HMO Insurance	☐ Court Ordered	☐ Medicare Part A	☐ Medicare Part B
☐ Medicare Supplement/Advantage		☐ Prescription Drug Insurance	☐ Medicare Part D
☐ Workers Compensation or Accident		☐ Veterans Administration	

Household Member 3

Name of Person Covered		Policyholder Name		
Policyholder Address		City	State	ZIP Code
Name of Health Insurance Company			Telephone Number	
Health Insurance Address		City	State	ZIP Code
Effective Date	Policy Number	Group Number	Monthly Premium	

Type of Coverage: Select all that apply

☐ Hospital	☐ Doctor	☐ Major Medical/Lab/X-Ray	☐ Dental
☐ Vision	☐ Nursing Home	☐ Cancer	☐ Champus/Tricare
☐ HMO Insurance	☐ Court Ordered	☐ Medicare Part A	☐ Medicare Part B
☐ Medicare Supplement/Advantage		☐ Prescription Drug Insurance	☐ Medicare Part D
☐ Workers Compensation or Accident		☐ Veterans Administration	

Household Member 4

Name of Person Covered		Policyholder Name		
Policyholder Address		City	State	ZIP Code
Name of Health Insurance Company			Telephone Number	
Health Insurance Address		City	State	ZIP Code
Effective Date	Policy Number	Group Number	Monthly Premium	

Type of Coverage: Select all that apply

☐ Hospital	☐ Doctor	☐ Major Medical/Lab/X-Ray	☐ Dental
☐ Vision	☐ Nursing Home	☐ Cancer	☐ Champus/Tricare
☐ HMO Insurance	☐ Court Ordered	☐ Medicare Part A	☐ Medicare Part B
☐ Medicare Supplement/Advantage		☐ Prescription Drug Insurance	☐ Medicare Part D
☐ Workers Compensation or Accident		☐ Veterans Administration	

Does anyone outside the household pay the premium? ◯ No ◯ Yes	If yes, who pays the premium?
Do household members expect changes in health insurance coverage? ◯ No ◯ Yes	
If yes, explain:	

Long Term Care Insurance

Does any household member have a long-term care insurance policy? The information may allow you to protect additional assets.

◯ No ◯ Yes

Has the policy paid any benefits?

◯ No ◯ Yes - provide documentation

Tell Us if Someone Else May Help With Your Medical Costs

Does anyone help pay your medical costs?

◯ No ◯ Yes - Explain: _____

Do household members have medical problems due to an accident?

◯ No ◯ Yes - answer the following questions:

Type of Accident:	Date of Accident:

Do household members have a pending legal action from which they may receive money or medical benefits, including inheritance?

◯ No ◯ Yes

Basic Care Applicants Only

If you are requesting coverage for the month you enter a Basic Care Facility, list the amount of rent and utilities you will pay this month. This includes rent, mortgage, lot rent, electricity, heating, water, garbage, property taxes, and telephone. These expenses may be deducted from your first month's room rate at the basic care facility.

Provide hard copy verification for each expense listed.

Type of Expense	Total Amount Paid	Type of Expense	Total Amount Paid

Application for Medicaid-Notice of Rights

Read The Following Information

I have received, reviewed and understand my rights and responsibilities as explained in the Guidebook.

I understand that additional information on privacy practices and civil rights protections are further explained in the guidebook.

I declare under penalty of perjury, the information on this application is correct. This includes information about identity, citizenship and alien status of the household members applying for assistance.

I understand that alien status information and other information will be verified when discrepancies are found. The alien status of applicant household members may be subject to verification by USCIS through the submission of information from the application to USCIS. Verification received may affect eligibility and level of benefits.

I understand the information I provide on or with this application is subject to verification by federal, state and local officials to determine if the information is correct, which may include electronic verification. If any of the information is incorrect, assistance may be denied and I may be subject to criminal prosecution for knowingly providing incorrect information.

I agree to report to the Customer Support Center any changes in income, assets, or living arrangements as required.

I understand I will not receive a deduction for any allowable expenses I do not report and provide proof of.

The Department of Health and Human Services (HHS) is prohibited from discriminating on the basis of race, color, sex including gender identity and sexual orientation, age, disability, national origin, religion, or status with respect to marriage or public assistance, and in some cases political beliefs.

Estate Recovery

State and Federal law requires the Department of Health and Human Services (Department) to make claims against the estate of a Medicaid member who:

1 - was age 55 or older when the individual received Medicaid services;
2 - who has been permanently institutionalized and received services, regardless of age; or
3 - is a spouse of a Medicaid member who was age 55 or older or permanently institutionalized when the Medicaid benefits were provided. Effective August 1, 2015, except for the portion of the payment made to a private carrier for nursing facility services, home and community-based services and hospital and prescription drug services received while in a nursing home or while receiving home and community-based services, the Department may not file a claim against the estate to recover payments made on behalf of members who received coverage through a private carrier. Effective January 1, 2020, pharmacy services are no longer part of the coverage through a private carrier and are provided by the Department and are subject to Medicaid estate recovery. Individuals eligible under the Medicaid Expansion coverage receive their coverage through a private carrier.

Authorization To Release Information

I/We authorize any person having custody or knowledge of the information relating to me or other household members to disclose any requested information, including confidential information other than protected health information, to any authorized agent of the Department of Health and Human Services. This authorization will remain valid until 90 days past case closure or until revoked in writing. I/We authorize Child Support to release any records of child support payments that I/we have made or received. A copy of this authorization is as valid as the original.

Sign And Date The Application Here

☐ I understand that by checking this box and typing my name below, I am signing this SFN 958 Medicaid Application For The Elderly and Disabled electronically. I agree that my electronic signature is the legal equivalent of my handwritten signature.

Signature of Applicant	Date
Signature of Spouse, Guardian or Other Adult	Date