

Medicaid Application for Long Term Care Services

Use this application for persons who are planning to live or now live in a nursing facility, group home, or developmental center in Louisiana or who have been offered an opportunity for waiver or PACE in Louisiana.

We will need to know about:

- The applicant,
- Applicant's spouse,
- Applicant's dependents who live in the applicant's home, and
- For applicants under age 18, we will need information about their parents.

START HERE – Please use a black ink pen.

Check what you are applying for:

- Nursing Facility Services
- Intermediate Care/Developmental Disability Facility Services (group homes and developmental centers)
- HCBS Waiver (Home and Community Based Services)
- PACE (Program of All Inclusive Care for the Elderly)

What language do you speak best? English Spanish Vietnamese Other (specify) _____

What language do you write best? English Spanish Vietnamese Other (specify) _____

1. Person Applying for Medicaid (the applicant)

Name _____ Male Female
First Middle Initial Last

Home Address _____
Street Address Apartment/Lot Number

City State Zip Code

Mailing Address (if different) _____
P.O. Box or Street Address Apartment/Lot Number

City State Zip Code

Parish _____ Home Phone Number (_____)

Daytime Phone Number (_____) Cell Phone Number (_____)

E-mail Address _____

Date of Birth _____ Single Married Separated Divorced Widowed

Social Security Number _____ Medicare Claim Number _____

Louisiana Resident: Yes No Veteran: Yes No U.S. Citizen: Yes No

If **not a U.S. citizen**, are they a lawful permanent resident? Yes No Date Came to U.S. _____

Permanent Resident Card Number (green card): A _____

Race or Ethnic Background (you do not have to answer; you may mark one or more): White Black Asian
 Hispanic or Latino American Indian or Alaska Native Native Hawaiian or Pacific Islander

2. A. Does the applicant have someone helping them with their business affairs including this Medicaid application? Yes – Fill Out Below No – Go to Question B

Name _____

E-mail Address _____

Mailing Address _____
P.O. Box or Street Address Apartment/Lot Number

City State Zip Code

Daytime Phone Number (_____) Cell Phone Number (_____)

Relationship to Applicant _____

Questions - Call 1-888-342-6207

(TTY text telephone for deaf and hard of hearing: 1-800-220-5404)

B. Does anyone have power of attorney for handling the applicant's business affairs or is anyone the curator or under curator? Yes – Fill Out Below No – Go to Question 3

Give us information about this person. Check one: Power of Attorney Curator or Under Curator
If they are the same person listed in Question A above, check this box and go to Question 3.

Name _____

E-mail Address _____

Mailing Address _____

P.O. Box or Street Address

Apartment/Lot Number

City

State

Zip Code

Daytime Phone Number (_____) _____ Cell Phone Number (_____) _____

Relationship to Applicant _____

3. To what address should Medicaid send the applicant's mail? Applicant Someone Listed in Question 2
(give name) _____

Answer Question 4 if applying for nursing facility services or Intermediate Care/Developmental Disability Facility Services (group homes and developmental centers).

4. A. Check box that fits the applicant's current situation – Lives in a Facility Plans to Enter a Facility

B. Facility Name _____

Date Entered or Date Planning to Enter _____

C. Is the applicant expected to be in the facility for at least 30 days? Yes No

D. If living in a facility, where was the applicant living **before** they entered the facility?

Their Home Someone Else's Home Rented Other (specify) _____

E. If the applicant owns their home, does anyone live in the home? Yes – Answer Below No – Go to **F**

Relationship to Applicant: Spouse Child Parent Brother/Sister

Someone Else (give name) _____

Is this person paying rent to live there? Yes No How much is paid every month? \$ _____

F. If the applicant is medically able to leave the facility, where would they live? Return to Their Home

Somewhere Else (specify) _____

Answer Question 5 if applying for HCBS waiver services (Home and Community Based Services).

5. What type of HCBS waiver is the applicant applying for? Adult Day Health Care Children's Choice
 New Opportunities Elderly/Disabled Adult Other (specify) _____

Name of Case Management Agency _____

Is the applicant expected to get HCBS waiver services for at least 30 days? Yes No

Answer Question 6 if applicant is under age 65 and has a disability.

6. Was the disability caused by an accident? Yes No

When did the disability start? _____

What is the disability? Give us information about it. _____

Has the applicant ever applied for Social Security Disability or Supplemental Security Income (SSI) benefits?

Yes No If yes, has a decision been made? Yes No

List the doctors, hospitals or other medical providers who give care to the applicant and can give us medical records to support their medical condition. **If more space is needed, use another sheet of paper.**

Name of Doctor, Hospital or Other Medical Provider	Medical Provider's Address and Phone Number

7. Did the applicant move to Louisiana from another state? Yes – Fill Out Below No – Go to Question 8
 When? _____ Does the applicant plan to stay in Louisiana? Yes No
8. **A.** Does (did) the applicant have a legal spouse (living or deceased)? Yes No
 If yes, does (did) the legal spouse live with the applicant before going to the nursing home? Yes No
 If no, explain? _____

Give us information about the spouse(s) in the spaces below.

Spouse's Name (First, Maiden, Last)	Social Security Number	Date of Birth	Date of Death	Divorced from Applicant
	____ - ____ - ____ Is the spouse a: <input type="checkbox"/> Railroad Retiree <input type="checkbox"/> Veteran		Date of Death: Has a succession been opened? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No Date and Parish/County of Divorce:
	____ - ____ - ____ Is the spouse a: <input type="checkbox"/> Railroad Retiree <input type="checkbox"/> Veteran		Date of Death: Has a succession been opened? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No Date and Parish/County of Divorce:

- B.** If the applicant is under age 18, does he live with his parents (or lived with them before going to the nursing home, group home, or developmental center)? Yes No Give us information about the parents below.

Name _____ Social Security Number _____
first, maiden, last

Name _____ Social Security Number _____
first, maiden, last

Is any parent listed above a veteran? Yes No Who? _____

Answer Questions C and D if applying for nursing facility services or Intermediate Care/Developmental Disability Facility Services (group homes and developmental centers).

- C.** Does the applicant have children under age 18 living with them now or before going to the nursing home, group home, or developmental center? Yes No Give us information about the children below.

Full Name _____ Social Security Number _____ Date of Birth _____

Full Name _____ Social Security Number _____ Date of Birth _____

- D.** Does the applicant wish to give any of his income to anyone listed in **A** and/or **C**? Yes No

- 9.** Is the applicant eligible to get benefits like Social Security, Veteran's benefits, or another type of income from anyone living or deceased? Yes – Fill Out Below No – Go to Question 10

From who? Spouse Parent **To show more than one spouse or parent, use another sheet of paper.**

Name _____ Social Security Number _____

Date of Birth _____ Veteran: Yes No Deceased: Yes No Date of Death _____

- 10.** Fill out the spaces below about the income of the applicant, their parents, spouse, or children under age 18.

Income Type	Who is the income for?	Where is it from? Who pays it?	How often is it received?	Gross Amount
Social Security <input type="checkbox"/> Yes <input type="checkbox"/> No				
SSI <input type="checkbox"/> Yes <input type="checkbox"/> No				
Veteran's Benefits (VA) <input type="checkbox"/> Yes <input type="checkbox"/> No		VA File Number:		
Railroad Retirement <input type="checkbox"/> Yes <input type="checkbox"/> No		Claim Number:		
Retirement/Pension <input type="checkbox"/> Yes <input type="checkbox"/> No				
Annuities <input type="checkbox"/> Yes <input type="checkbox"/> No				

Income Type	Who is the income for?	Where is it from? Who pays it?	How often is it received?	Gross Amount
Royalties	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Money from Friends/ Relatives	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Reverse Annuity Mortgage	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Rental Income	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Worker's Comp Unemployment	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Alimony Child Support	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Other (specify):	<input type="checkbox"/> Yes <input type="checkbox"/> No			

11. Has the applicant, their parents, spouse, or children under age 18 applied for income, such as Social Security or Veteran's benefits, but did not get it yet? Yes - Fill Out Below No - Go to Question 12

Who? _____ What is it? _____

12. Does the applicant, their parents, spouse, or children under age 18 work or are they self-employed? Yes - Fill Out Below No - Go to Question 13

Name of Employee	Employer's Name and Phone Number	Self- employed?	Gross Amount	How often is it received?
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		

13. Has the applicant, their parents, or spouse ever received any lump sum of money like an insurance or lawsuit settlement, worker's compensation settlement, inheritance, or a Social Security payment or are they expecting to receive a lump sum? Yes - Fill Out Below No - Go to Question 14

Who? _____ Amount \$ _____

When? _____ From whom? _____

For what reason? _____

Attorney's Name, Address, and Phone Number _____

14. Let us know if the applicant, their parents, or spouse have any of the things listed below or if they have access to these things (A-N).

A. Bank Accounts and Certificates of Deposit (CDs): Yes - Fill Out Below No - Go to B
If more than 4, use another sheet of paper.

Type of Account	Who does it belong to?	Name of Bank or Credit Union	Account Number	How much is in it?
<input type="checkbox"/> checking <input type="checkbox"/> savings <input type="checkbox"/> Christmas club <input type="checkbox"/> CD				
<input type="checkbox"/> checking <input type="checkbox"/> savings <input type="checkbox"/> Christmas club <input type="checkbox"/> CD				
<input type="checkbox"/> checking <input type="checkbox"/> savings <input type="checkbox"/> Christmas club <input type="checkbox"/> CD				
<input type="checkbox"/> checking <input type="checkbox"/> savings <input type="checkbox"/> Christmas club <input type="checkbox"/> CD				

B. Annuities and/or Retirement Accounts (IRA, Keogh, 401-K): Yes - Fill Out Below No - Go to C

Who does it belong to? Applicant Spouse Applicant and Spouse Parent(s)

Account Number(s) _____

How much is in it? _____

Are regular payments being received? Yes No

How much? \$ _____ How often? _____

If **no**, are regular payments available? Yes No Don't Know

Can a lump sum withdrawal of these funds be made? Yes No Don't Know

Date of Purchase of Annuity _____

Who is the beneficiary of the annuity? _____

Who is the remainder beneficiary of the annuity? _____

C. Patient Fund Account at Nursing Facility: Yes – Balance \$ _____ No – Go to **D**

D. Cash on Hand or Held by Someone Else: Yes – Fill Out Below No – Go to **E**

Amount \$ _____ Who does it belong to? Applicant Spouse Applicant and Spouse Parent(s)

Who is holding this cash? _____

Where did this cash come from? _____

E. Safe-Deposit Box(es): Yes – Fill Out Below No – Go to **F**

Who does it belong to? Applicant Spouse Applicant and Spouse Parent(s)

Name of the Bank or Credit Union _____

What is inside the box or boxes? _____

What are the things inside the box worth? _____

F. Stocks: Yes – Fill Out Below No – Go to **G**

Who does it belong to? Applicant Spouse Applicant and Spouse Parent(s)

How much is the stock(s) worth? _____

What is the name of the company? _____

G. Bonds: Yes – Fill Out Below No – Go to **H**

Who does it belong to? Applicant Spouse Applicant and Spouse Parent(s)

What is the bond worth? _____

Bond Number(s) _____

What type of bond is it? _____

H. Cars, Trucks, Boats, Campers, Motorcycles, ATVs (All Terrain Vehicles): Yes – Fill Out Below
 No – Go to **I** *If more than 3, use another sheet of paper.*

Owner	What is it?	Make, Model, Year	What is it worth?	How much is owed on it?

I. Home Property:

Does the applicant own or co-own a home? Yes – Fill Out Below No – Go to **J**

Who are the owners (if it is inherited, list all owners)? _____

How much is it worth? _____

How much is owed on it? _____

Give us information about it like the location, lot size or number of acres, and if there are buildings on it. _____

J. Property that is Not the Primary Home - such as a second home, land, out of state property, or inherited property (divided or undivided share): Yes – Fill Out Below No – Go to **K**

Who does it belong to? Applicant Spouse Applicant and Spouse Parent(s)

How much is it worth? _____

Who gets the tax notice? _____
 What is their interest or share in the divided/undivided property? _____
 How much is owed on it? _____
 Give us information about it like the location, lot size, number of acres, and if there are buildings on it. _____

K. Money in a Bank Account(s) for Burial, or a Pre-arranged Burial Contract with a Funeral Home:
 Yes – Fill Out Below No – Go to L *If more than 2, use another sheet of paper.*

Who owns it?	Whose burial?	Bank/Credit Union/Funeral Home	How much is it worth?

L. Life or Burial Insurance: Yes – Fill Out Below No – Go to M *If more than 6, use another sheet of paper.*

Name of Insured	Owner of Policy	Insurance Company	Face Value	Policy Number

M. Burial Space Items (cemetery plot, grave site, crypt, mausoleum, vault, casket, urn, niche or other repository, burial markers, headstones, and costs for opening/closing grave that are not covered in a pre-arranged burial contract): Yes – Fill Out Below No – Go to N

Who owns it? Applicant Spouse Applicant and Spouse Parent(s)
 What is it? _____
 Whose burial is it for? Applicant Spouse Parent(s) Is it paid in full? Yes No

N. Is there anything else that is owned? Yes – Fill Out Below No – Go to Question 15

Who owns it? Applicant Spouse Applicant and Spouse Parent(s)
 What is it? _____
 How much is it worth? _____
 Give us information about it. _____

15. A. Does the applicant, their spouse, or parents have their name on **anyone else's** bank or credit union account?
 Yes No

B. Does **anyone else** have a bank or credit union account that has money in it belonging to the applicant, their spouse, or parents? Yes No

If **yes** to **A** or **B**, answer the questions below.

Whose name is on the account? _____
 Whose money is in the account? _____
 How much money is in the account? _____ Account Number: _____
 How much belongs to the applicant? _____
 How much belongs to the applicant's spouse? _____
 How much belongs to the applicant's parent(s)? _____
 What is the name of the bank or credit union? _____

16. Has the applicant, their spouse, or parents ever created a trust, placed any items in trust, or had a trust set up for them? Yes No **(What is a trust?** – A trust is a legal relationship in which a person called a “trustee” holds money or other assets for the benefit of another, the “beneficiary”. The trust must be valid under State law. The trust document will specify how the assets and money in trust will be handled. It can be set up by a will.)

17. Does the applicant, their spouse, or children under age 18 have any paid or unpaid medical bills for services received in the last 3 months? Yes No If **yes**, how much? \$ _____

How much does the applicant, their spouse, or children under age 18 pay for prescriptions each month (best guess or average)? \$ _____

18. Has the applicant, their spouse, or anyone acting for them **ever** given away, sold, cashed in, or changed the name listed on a policy or deed for any item of value such as land, houses, home property, life or burial insurance, vehicles, or bank accounts? Yes – Fill Out Below No – Go to Question **19**
If more than 2 things or if more space is needed, use another sheet of paper.

What was it? What was it worth?	Why?	When did this happen?	Who received the item?	If recorded, tell us when and where.	What was received in return? (Amount of money or value of item.)	What happened to the money or item that was received?

19. Give us information about the applicant’s health insurance, Medicare supplement, Medicare Prescription Drug Plan, and Long Term Care insurance. No Insurance – Sign Application on Next Page
For more space, use another sheet of paper.

What is it?	Policyholder	Insurance Name and Phone Number	Coverage Start Date	What does it cover?	Policy Number	Group Number	Cost per Month
<input type="checkbox"/> Medicare supplement <input type="checkbox"/> Medicare drug plan <input type="checkbox"/> Health insurance <input type="checkbox"/> Long Term Care				<input type="checkbox"/> Hospital <input type="checkbox"/> Doctor <input type="checkbox"/> Dental <input type="checkbox"/> Ambulance <input type="checkbox"/> Medicine <input type="checkbox"/> Cancer only			
<input type="checkbox"/> Medicare supplement <input type="checkbox"/> Medicare drug plan <input type="checkbox"/> Health insurance <input type="checkbox"/> Long Term Care				<input type="checkbox"/> Hospital <input type="checkbox"/> Doctor <input type="checkbox"/> Dental <input type="checkbox"/> Ambulance <input type="checkbox"/> Medicine <input type="checkbox"/> Cancer only			
<input type="checkbox"/> Medicare supplement <input type="checkbox"/> Medicare drug plan <input type="checkbox"/> Health insurance <input type="checkbox"/> Long Term Care				<input type="checkbox"/> Hospital <input type="checkbox"/> Doctor <input type="checkbox"/> Dental <input type="checkbox"/> Ambulance <input type="checkbox"/> Medicine <input type="checkbox"/> Cancer only			

Comments from Medicaid Staff/Applicant/Applicant’s Representative:

Person Making Comments Signs Here: _____ Date _____

This is the end of the application. You must sign the application on the next page.

Your Rights and Responsibilities

WHAT MEDICAID HAS THE RIGHT TO EXPECT OF YOU (the person applying for Medicaid)

CITIZENSHIP AND IMMIGRATION STATUS: You state that the information about citizenship and immigration status given at the beginning of this application form is true and correct.

REPORTING THE TRUTH: You state that the information you give on this application form is true and correct. You understand if you purposely give information that is not true or if you purposely do not tell information that you are supposed to, you may get health benefits that you should not get. If that happens, you can by law be punished for fraud. Also, you may have to pay money back to Medicaid for the bills it paid by mistake.

VERIFICATION OF INFORMATION: You understand that the information you give will be checked. You agree to help with this and let Medicaid get information it needs from government agencies, employers, medical providers, and others.

SOCIAL SECURITY NUMBERS: You understand Social Security numbers will only be used to get information from other government agencies to make a decision about your eligibility for Medicaid.

PAYMENT OF MEDICAL CARE BY A THIRD PARTY: You understand by accepting Medicaid, the Department has the right to get money received by you from other sources like insurance payments or lawsuit settlements for services that Medicaid has paid for you.

REPORTING CHANGES: You agree to tell Medicaid within 10 days of these changes: 1) if you move out of state; 2) changes in mailing or home address; 3) if anyone moves in or out of your home; 4) changes in health insurance and premiums; 5) changes in income; and 6) changes in things you own.

CHILD SUPPORT ENFORCEMENT: You understand that Medicaid will only send information to Child Support Enforcement for medical support if you ask them to.

ANNUITIES: You agree that by accepting Medicaid, the State of Louisiana will be named as the remainder beneficiary of all annuities purchased on or after Feb. 8, 2006 for the total amount of medical assistance paid on your behalf, unless you have a spouse, minor child, or a child with a disability. In these cases, the State must be named as beneficiary after these individuals. You agree to tell Medicaid about any annuity you and your spouse own or co-own regardless if the annuity is irrevocable (cannot be changed) or Medicaid counts it. You understand that you must tell Medicaid about changes made to any annuity which may affect when payments begin, the amount paid, frequency of payments, and additions to the principal.

WHAT YOU (the person applying for Medicaid) HAVE THE RIGHT TO EXPECT FROM MEDICAID

RIGHT TO A FAIR HEARING: You understand that you can ask for a Fair Hearing if you think any decision made on the case is unfair, incorrect, or made too late.

NO DISCRIMINATION: You understand Medicaid cannot treat you differently because of race, color, sex, age, disability, religion, nationality, or political belief. If you think it has, you can call the U.S. DHHS Regional Office for Civil Rights in Dallas, TX at 1-800-368-1019 or write to Louisiana's Department of Health & Hospitals, Human Resources at P. O. Box 4818 Baton Rouge, LA 70821-4818.

OTHER SERVICES: You understand Medicaid will send you information about WIC, KIDMED, and other Medicaid services.

ESTATE RECOVERY: You understand that Estate Recovery rules require the Department to recover the cost of certain Medicaid payments from your estate. These costs include the total amount of payments for facility services, hospital care, payments to HCBS or PACE providers, and prescription drugs received at age 55 or older. The estate is the property owned at the time of death. The Department will not make a claim against the estate while you or your legal spouse is still living. The Department will not make a claim if you have a dependent child who is under age 21, blind, or disabled. Collection may not be made if it is not cost effective for the Department to do so, or if your heirs apply for a hardship waiver after your death. A hardship may exist if the estate property is the only source of income for the heirs, if that income is limited, or other convincing situations.

↓ **SIGN BELOW** ↓

Applicant or Representative Signs Here: _____ **Date** _____

Applicant's Spouse Signs Here: _____ **Date** _____

If anyone signs with an "X", two witnesses must sign.

_____ **Date** _____ _____ **Date** _____

If Medicaid filled out this application, they will sign here. _____ **Date** _____

See next page for a list of documents you may need to send us.

Documents of Proof We May Need From You

If someone from Medicaid interviewed you, then...

Please send the documents of proof marked with a check ✓ to the Medicaid office at:

_____ by _____. *You may keep this page and the next page.*

If you filled out the application, then...

Keep in mind **not** everything will apply. To help you decide what to send, enter a check ✓ next to each document of proof you think does apply. *You may keep this page and the next page.*

Let us know if you do not have or cannot get any of these documents of proof, because we may be able to get them or help you get them. Please trust that the information you give us on your application and everything you send us will be kept confidential. We are required by law to keep it private.

✓	What to send:	See Question
	Proof of applicant's marriage such as a marriage certificate (not needed if applicant's spouse gets Long Term Care Medicaid)	1
	Copy of Permanent Resident Card (green card) or other forms from U.S. Citizenship and Immigration Services - for applicant who <u>is not</u> a U.S. citizen	1
	Copy of legal documents to show power of attorney, curator, or interdiction	2
	If applicant is widowed, copy of succession documents	8
	Proof of income such as the 1099 from the last tax year, a check stub, or award letter showing amount of gross income (before withholdings) from retirement, pension, Veteran's Benefits, annuities, mineral rights, worker's compensation, child support, reverse annuity mortgages, and royalties - for applicant, applicant's spouse, applicant's parents (if applicant is under 18), and applicant's dependents under age 18	10
	If the applicant, applicant's spouse, or applicant's parents (if applicant is under 18) own property that is rented out, send proof of the amount of rental income received (letter from renters or cancelled check) and proof of expenses of rental property.	10
	Statement from friends and/or relatives who give money to applicant and/or their spouse	10
	For anyone who works, send pay stubs or letter from employer showing gross pay (before taxes) for the last month. If self-employed, send copies of tax return and all schedule attachments - for applicant, applicant's spouse, applicant's parents (if applicant is under 18), and applicant's dependents under age 18	12
	Proof of any lump sum payments received in the last three years from an insurance or lawsuit settlement, inheritance, worker's compensation settlement, or Social Security - for applicant, applicant's spouse, and applicant's parents (if applicant is under 18)	13
	Copies of bank statements for the last month. Send ALL pages showing the check images, account numbers, name and address of bank, all deposits and withdrawals, and all names on the accounts. - for applicant, applicant's spouse, and applicant's parents (if applicant is under 18)	14 A
	Copy of annuity and last bank statement - for applicant, applicant's spouse, and applicant's parents (if applicant is under 18)	14 B
	Last statement for certificates of deposit (CDs), IRAs, 401-Ks, Keoghs, and retirement accounts - for applicant, applicant's spouse, and applicant's parents (if applicant is under 18)	14 A, 14 B
	A list of what is inside any safe-deposit box. This must be a written statement by a bank employee or a sworn statement from someone who looked inside. - for applicant, applicant's spouse, and applicant's parents (if applicant is under 18)	14 E

✓	What to send:	See Question
	Copies of stocks and bonds, including any account statements - for applicant, applicant's spouse, and applicant's parents (if applicant is under 18)	14 F, 14 G
	Copies of vehicle registrations or titles if more than one vehicle is owned and proof of what is owed on each vehicle like a statement from creditor - for applicant, applicant's spouse, and applicant's parents (if applicant is under 18)	14 H
	For property that is owned (not their home) or property that has been inherited (can be undivided), send proof to show what it is worth and how much of a share they have - for applicant, applicant's spouse, and applicant's parents (if applicant is under 18)	14 J
	Copy of the last bank statement for burial or funeral accounts - for applicant, applicant's spouse, and applicant's parents (if applicant is under 18)	14 K
	Copies of pre-arranged burial contracts with funeral homes which includes a list of services - for applicant, applicant's spouse, and applicant's parents (if applicant is under 18)	14 K
	Copies of life or burial insurance policies if the face value for all is more than \$10,000 for each person - for applicant, applicant's spouse, and applicant's parents (if applicant is under 18)	14 L
	For any burial space items such as a mausoleum or cemetery plot that are not paid in full, send proof of how much is owed and how much the item(s) is worth - for applicant, applicant's spouse, and applicant's parents (if applicant is under 18)	14 M
	Copies of trust documents filed at the courthouse - for applicant, applicant's spouse, and applicant's parents (if applicant is under 18)	16
	Copies of paid or unpaid medical bills for services received in the last 3 months (if applying for Medicaid for those months) - for applicant, applicant's spouse, and applicant's parents (if applicant is under 18)	17
	Copy of the Act of Donation, Bill of Sale, or some other document to show items that were given away, sold, or deed was changed - for applicant, applicant's spouse, and applicant's parents (if applicant is under 18)	18
	Copies of front and back of all health insurance cards, including Medicare, long term care insurance, Medicare prescription drug plans, and Medicare supplements - for applicant Also, send proof of monthly premium amount.	19
	Other:	
	Other:	
	Other:	

Please mail, fax, or drop off the application and documents of proof to your local Medicaid office.

For the office closest to you, call 1-888-342-6207.

(TTY text telephone for deaf and hard of hearing: call 1-800-220-5404)