Kansas
Eligibility Enforcement System (KEES)

SCREENING FOR THE BIG 4

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BIG 4 CRITERIA

To be processed at DCF, all persons requesting coverage must meet one of the following criteria:

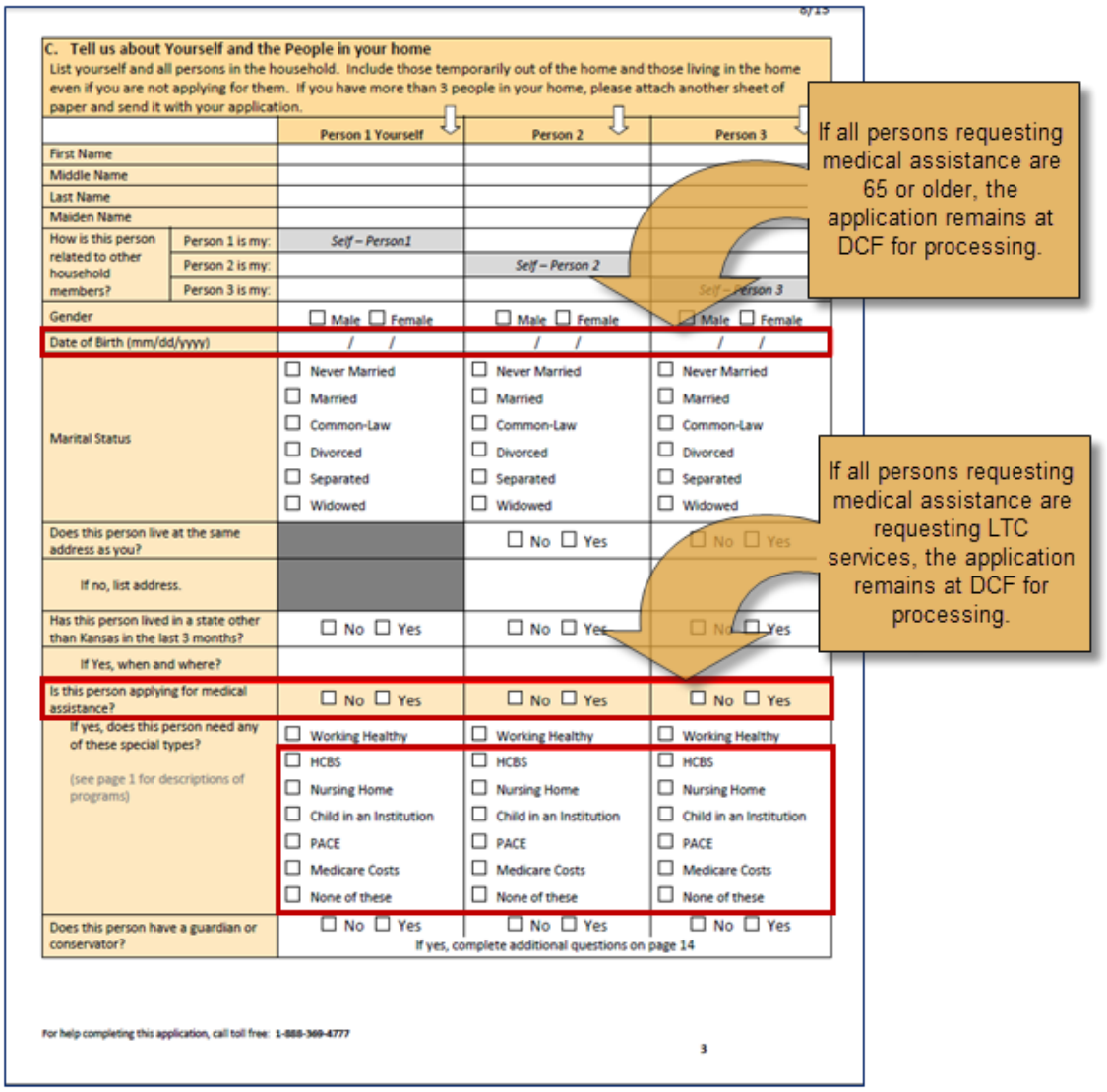
Requesting Long Term Care (Nursing Home, HCBS, PACE, CI (Child in an Institution))
Requesting Medicare Savings Programs (MSP) only
Age 65 or older and NOT pregnant or the caretaker of a minor child
A Medicare beneficiary and NOT pregnant or the caretaker of a minor child

NOTE: SSI medical requests are not subject to screening for the Big 4 Criteria, and should be processed where received. Applications that request medical coverage for children and/or pregnant women must be referred to the KanCare Clearinghouse.

1.0 KC–1500: Medical Assistance Application for the Elderly and Persons with Disabilities

KC-1500 Page 3:

- Date of Birth: Is this person age 65 and over?
- Is this person applying for Medical Assistance?
    - If yes, does this person need any of these special types?



C. Tell us about Yourself and the People in your home

List yourself and all persons in the household. Include those temporarily out of the home and those living in the home even if you are not applying for them. If you have more than 3 people in your home, please attach another sheet of paper and send it with your application.

	Person 1 Yourself	Person 2	Person 3
First Name			
Middle Name			
Last Name			
Maiden Name			
How is this person related to other household members? Person 1 is my:	*Self – Person1*		
Person 2 is my:		*Self – Person 2*	
Person 3 is my:			*Self – Person 3*
Gender	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Date of Birth (mm/dd/yyyy)	/ /	/ /	/ /
Marital Status	☐ Never Married ☐ Married ☐ Common-Law ☐ Divorced ☐ Separated ☐ Widowed	☐ Never Married ☐ Married ☐ Common-Law ☐ Divorced ☐ Separated ☐ Widowed	☐ Never Married ☐ Married ☐ Common-Law ☐ Divorced ☐ Separated ☐ Widowed
Does this person live at the same address as you?		☐ No ☐ Yes	☐ No ☐ Yes
If no, list address.			
Has this person lived in a state other than Kansas in the last 3 months?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If Yes, when and where?			
Is this person applying for medical assistance?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, does this person need any of these special types? (see page 1 for descriptions of programs)	☐ Working Healthy ☐ HCBS ☐ Nursing Home ☐ Child in an Institution ☐ PACE ☐ Medicare Costs ☐ None of these	☐ Working Healthy ☐ HCBS ☐ Nursing Home ☐ Child in an Institution ☐ PACE ☐ Medicare Costs ☐ None of these	☐ Working Healthy ☐ HCBS ☐ Nursing Home ☐ Child in an Institution ☐ PACE ☐ Medicare Costs ☐ None of these
Does this person have a guardian or conservator?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes

If yes, complete additional questions on page 14

For help completing this application, call toll free: 1-888-369-4777

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If all persons requesting medical assistance are 65 or older, the application remains at DCF for processing.

If all persons requesting medical assistance are requesting LTC services, the application remains at DCF for processing.

KC-1500 Page 4:

- Which of the following best describes this person's current living situation?

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Persons 1, 2, and 3 (continued)

Please continue to answer questions about Yourself, Person 2 and Person 3. Write their names on the first line.

	Person 1 Yourself	Person 2	Person 3
First and Last Name			
We need Social Security Numbers (SSNs) for everyone applying for medical assistance. A SSN is optional for people not applying for medical assistance, but providing a SSN can speed up the application process. We use SSNs to check income and other information to see who is eligible for help with medical assistance. If someone doesn't have a SSN, call 1-800-772-1213 or visit www.socialsecurity.gov			
Social Security #			
U.S. citizen? (required to answer if applying for medical assistance)	☐ No ☐ Yes	☐ No ☐ Yes If no, please see page 5 for more information.	☐ No ☐ Yes
State and Country of birth			
Race (optional) Check all that apply	☐ White ☐ Black ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Vietnamese ☐ Other Asian ☐ Asian Indian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ American Indian or Alaska Native ☐ Other	☐ White ☐ Black ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Vietnamese ☐ Other Asian ☐ Asian Indian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ American Indian or Alaska Native ☐ Other	☐ White ☐ Black ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Vietnamese ☐ Other Asian ☐ Asian Indian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ American Indian or Alaska Native ☐ Other
Ethnicity (optional) If Hispanic/Latino ethnicity, check all that apply	☐ Mexican ☐ Puerto Rican ☐ Mexican American Chicano/a ☐ Cuban ☐ Other	☐ Mexican ☐ Puerto Rican ☐ Mexican American Chicano/a ☐ Cuban ☐ Other	☐ Mexican ☐ Puerto Rican ☐ Mexican American Chicano/a ☐ Cuban ☐ Other
Has this person delivered a baby in the last 3 months?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Did this person have emergency care in the last 3 months to save life, organs, or bodily function?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Does this person need help paying medical bills from the last 3 months (including Medicare premiums)? If yes, please see additional questions on page 5.	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Which of the following best describes this person's current living situation?	☐ Own home ☐ Renting ☐ Live with someone else ☐ Assisted Living ☐ Hospital ☐ Nursing Facility or other institution ☐ Other	☐ Own home ☐ Renting ☐ Live with someone else ☐ Assisted Living ☐ Hospital ☐ Nursing Facility or other institution ☐ Other	☐ Own home ☐ Renting ☐ Live with someone else ☐ Assisted Living ☐ Hospital ☐ Nursing Facility or other institution ☐ Other

There may be times an application does not meet the "Big 4" Criteria, however, the current living situation selected may indicate a possible LTC case. Further research may be warranted to determine if this application should remain at DCF.

For help completing this application, call toll free: 1-888-369-4777

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KC-1500 Page 12:

- Does this person have Medicare?

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H. Tell us about your Medical Insurance

Health Insurance Policy Information
Answer the questions below for everyone who has Medicare or other health insurance

	Person 1 Yourself	Person 2	Person 3
First and Last Name			
Does this person have Medicare? If yes, answer the questions below	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Medicare Claim #			
Medicare Part A?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Part A Effective Date	/ /	/ /	/ /
Part A Premium Amount	$	$	$
Medicare Part B?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Part B Effective Date	/ /	/ /	/ /
Part B Premium Amount	$	$	$
Medicare Part C? (Medicare Advantage)	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Part C Effective Date	/ /	/ /	/ /
Part C Premium Amount	$	$	$
Part C Plan Name			
Medicare Part D?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Part D Effective Date	/ /	/ /	/ /
Part D Premium Amount	$	$	$
Part D Plan Name			
Answer the questions below for everyone who has insurance OTHER than Medicare.			
Does this person have other health insurance?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Policyholder's name			
Policyholder's SSN			
Insurance Company Name			
Insurance Company Address			
Date Began	/ /	/ /	/ /
Date Ended	/ /	/ /	/ /
Policy #			
Group #			
Type of Coverage	☐ Catastrophic Only ☐ Dental ☐ Doctor ☐ Hospital ☐ Long Term Care ☐ Medicare Supplement ☐ Prescription ☐ Vision ☐ Other _____	☐ Catastrophic Only ☐ Dental ☐ Doctor ☐ Hospital ☐ Long Term Care ☐ Medicare Supplement ☐ Prescription ☐ Vision ☐ Other _____	☐ Catastrophic Only ☐ Dental ☐ Doctor ☐ Hospital ☐ Long Term Care ☐ Medicare Supplement ☐ Prescription ☐ Vision ☐ Other _____

I. Tell Us About Your Dependents and Household Expenses

For help completing this application, call toll free: 1-888-369-4777

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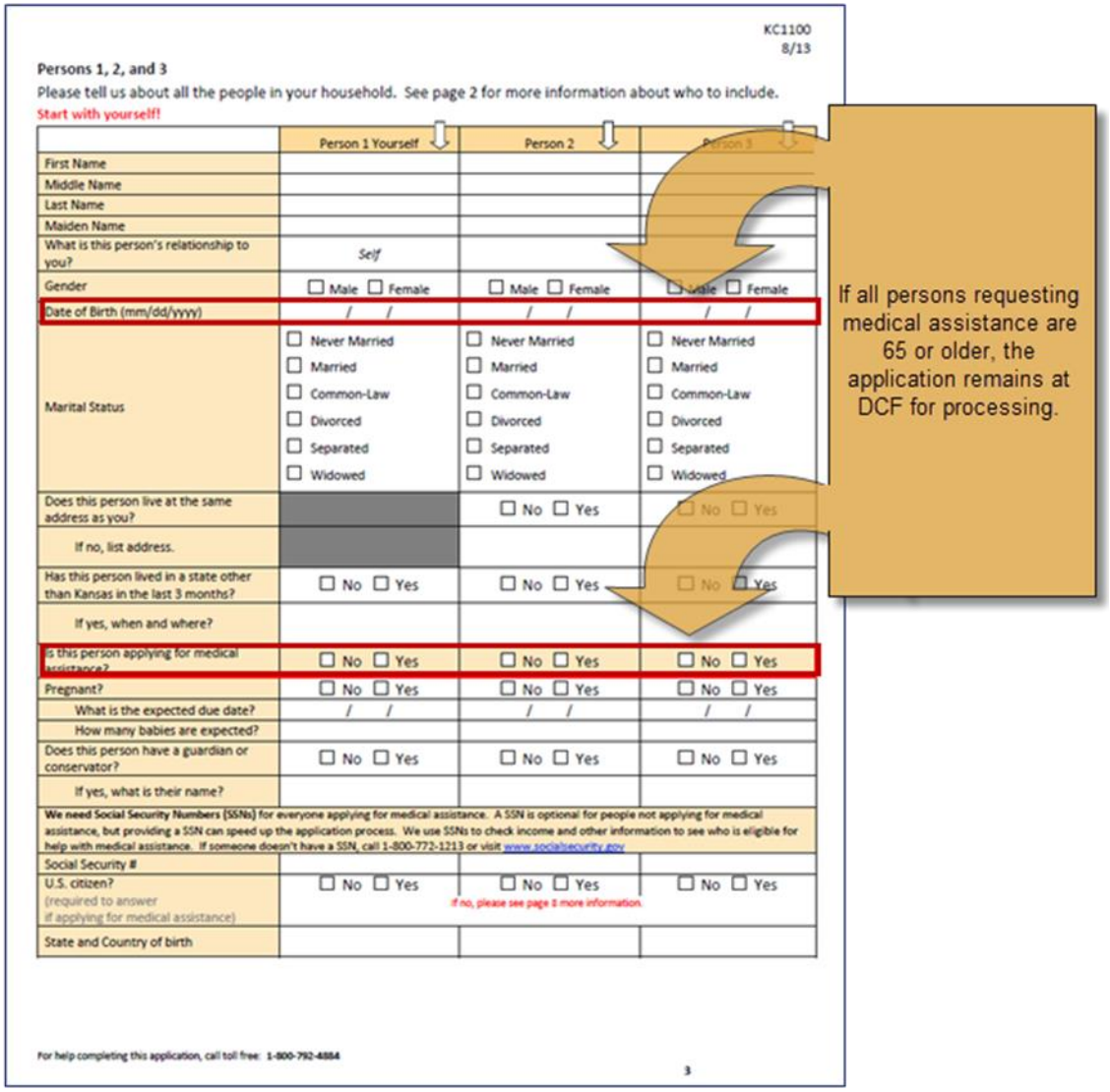
If all persons requesting medical assistance are Medicare recipients, the application remains at DCF for processing

2.0 KC-1100: Medical Assistance for Families with Children

KC-1100 Page 3:

- Date of Birth: Is this person age 65 and over?



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Persons 1, 2, and 3

Please tell us about all the people in your household. See page 2 for more information about who to include.

Start with yourself!

	Person 1 Yourself	Person 2	Person 3
First Name			
Middle Name			
Last Name			
Maiden Name			
What is this person's relationship to you?	*Self*		
Gender	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Date of Birth (mm/dd/yyyy)	/ /	/ /	/ /
Marital Status	☐ Never Married ☐ Married ☐ Common-Law ☐ Divorced ☐ Separated ☐ Widowed	☐ Never Married ☐ Married ☐ Common-Law ☐ Divorced ☐ Separated ☐ Widowed	☐ Never Married ☐ Married ☐ Common-Law ☐ Divorced ☐ Separated ☐ Widowed
Does this person live at the same address as you?		☐ No ☐ Yes	☐ No ☐ Yes
If no, list address.			
Has this person lived in a state other than Kansas in the last 3 months?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, when and where?			
Is this person applying for medical assistance?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Pregnant?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
What is the expected due date?	/ /	/ /	/ /
How many babies are expected?			
Does this person have a guardian or conservator?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, what is their name?			

We need Social Security Numbers (SSNs) for everyone applying for medical assistance. A SSN is optional for people not applying for medical assistance, but providing a SSN can speed up the application process. We use SSNs to check income and other information to see who is eligible for help with medical assistance. If someone doesn't have a SSN, call 1-800-772-1213 or visit www.socialsecurity.gov

Social Security #			
U.S. citizen? (required to answer if applying for medical assistance)	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
	If no, please see page 3 more information.		
State and Country of birth			

For help completing this application, call toll free: 1-800-792-4884

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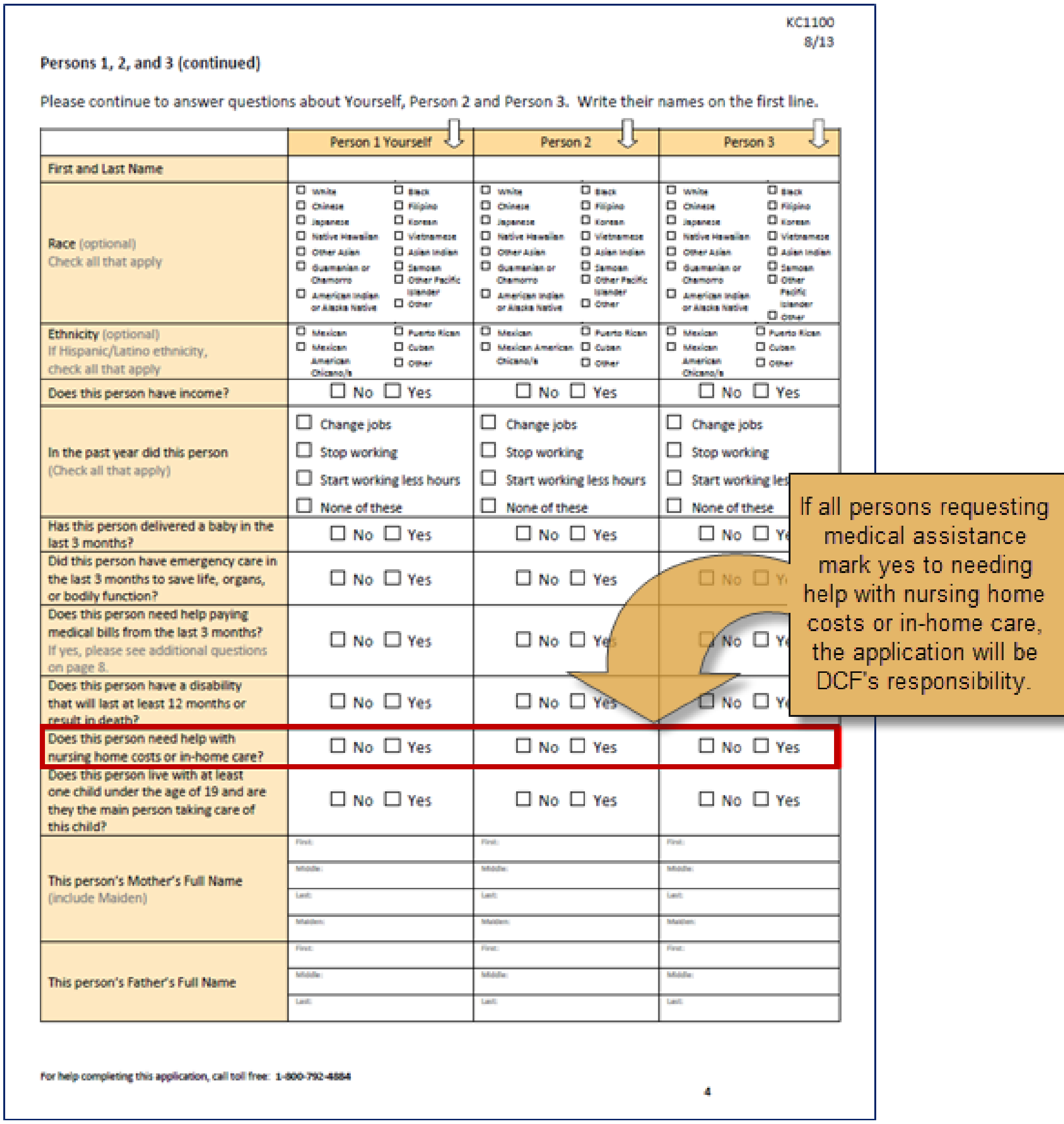
If all persons requesting medical assistance are 65 or older, the application remains at DCF for processing.

- Is this person applying for Medical Assistance?

KC-1100 Page 4:

- Does this person need help with nursing home costs or in-home care?



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Persons 1, 2, and 3 (continued)

Please continue to answer questions about Yourself, Person 2 and Person 3. Write their names on the first line.

	Person 1 Yourself	Person 2	Person 3
First and Last Name			
Race (optional) Check all that apply	☐ White ☐ Black ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Vietnamese ☐ Other Asian ☐ Asian Indian ☐ Guamanian or Chamorro ☐ Samoan ☐ American Indian or Alaska Native ☐ Other Pacific Islander ☐ Other	☐ White ☐ Black ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Vietnamese ☐ Other Asian ☐ Asian Indian ☐ Guamanian or Chamorro ☐ Samoan ☐ American Indian or Alaska Native ☐ Other Pacific Islander ☐ Other	☐ White ☐ Black ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Vietnamese ☐ Other Asian ☐ Asian Indian ☐ Guamanian or Chamorro ☐ Samoan ☐ American Indian or Alaska Native ☐ Other Pacific Islander ☐ Other
Ethnicity (optional) If Hispanic/Latino ethnicity, check all that apply	☐ Mexican ☐ Puerto Rican ☐ Mexican American Chicano/a ☐ Cuban ☐ Other	☐ Mexican ☐ Puerto Rican ☐ Mexican American Chicano/a ☐ Cuban ☐ Other	☐ Mexican ☐ Puerto Rican ☐ Mexican American Chicano/a ☐ Cuban ☐ Other
Does this person have income?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
In the past year did this person (Check all that apply)	☐ Change jobs ☐ Stop working ☐ Start working less hours ☐ None of these	☐ Change jobs ☐ Stop working ☐ Start working less hours ☐ None of these	☐ Change jobs ☐ Stop working ☐ Start working les[s hours] ☐ None of these
Has this person delivered a baby in the last 3 months?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Y[es]
Did this person have emergency care in the last 3 months to save life, organs, or bodily function?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Y[es]
Does this person need help paying medical bills from the last 3 months? If yes, please see additional questions on page 8.	☐ No ☐ Yes	☐ No ☐ Ye[s]	☐ No ☐ Y[es]
Does this person have a disability that will last at least 12 months or result in death?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Y[es]
Does this person need help with nursing home costs or in-home care?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Does this person live with at least one child under the age of 19 and are they the main person taking care of this child?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
This person's Mother's Full Name (include Maiden)	First: Middle: Last: Maiden:	First: Middle: Last: Maiden:	First: Middle: Last: Maiden:
This person's Father's Full Name	First: Middle: Last:	First: Middle: Last:	First: Middle: Last:

For help completing this application, call toll free: 1-800-792-4884

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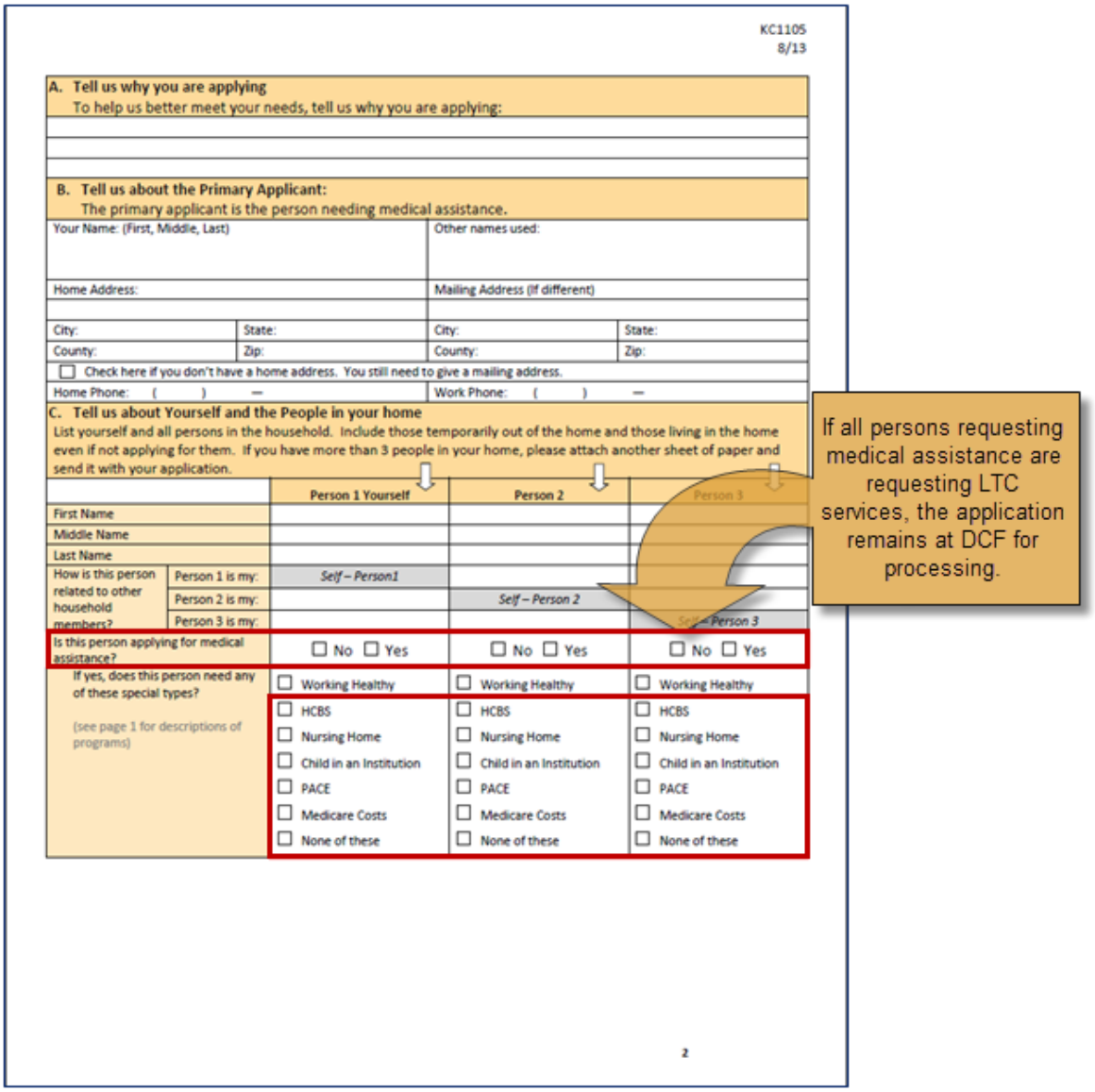
3.0 KC-1105: E and D Supplement to KC1100

KC-1105 Page 2:

- Is this person applying for medical assistance?
- If yes, does this person need any of these special types?



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A. Tell us why you are applying
To help us better meet your needs, tell us why you are applying:

B. Tell us about the Primary Applicant:
The primary applicant is the person needing medical assistance.

Your Name: (First, Middle, Last)		Other names used:	
Home Address:		Mailing Address (If different)	
City:	State:	City:	State:
County:	Zip:	County:	Zip:

☐ Check here if you don't have a home address. You still need to give a mailing address.

Home Phone: ( ) — Work Phone: ( ) —

C. Tell us about Yourself and the People in your home
List yourself and all persons in the household. Include those temporarily out of the home and those living in the home even if not applying for them. If you have more than 3 people in your home, please attach another sheet of paper and send it with your application.

		Person 1 Yourself	Person 2	Person 3
First Name				
Middle Name				
Last Name				
How is this person related to other household members?	Person 1 is my:	*Self – Person1*		
	Person 2 is my:		*Self – Person 2*	
	Person 3 is my:			*Self – Person 3*
Is this person applying for medical assistance?		☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, does this person need any of these special types? (see page 1 for descriptions of programs)		☐ Working Healthy ☐ HCBS ☐ Nursing Home ☐ Child in an Institution ☐ PACE ☐ Medicare Costs ☐ None of these	☐ Working Healthy ☐ HCBS ☐ Nursing Home ☐ Child in an Institution ☐ PACE ☐ Medicare Costs ☐ None of these	☐ Working Healthy ☐ HCBS ☐ Nursing Home ☐ Child in an Institution ☐ PACE ☐ Medicare Costs ☐ None of these

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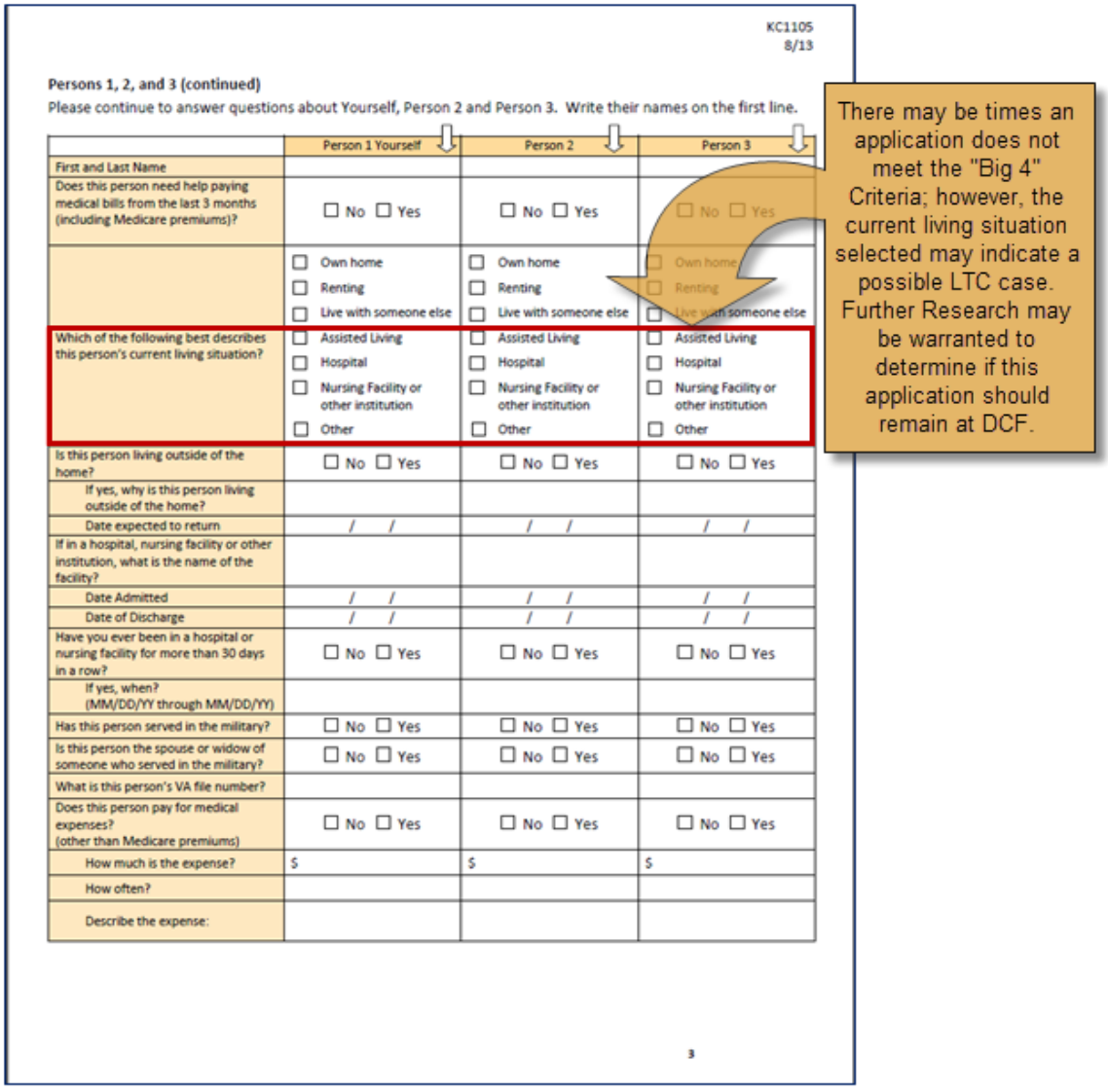
If all persons requesting medical assistance are requesting LTC services, the application remains at DCF for processing.

KC-1105 Page 3:

- Which of the following best describes this person's current living situation?
- Assisted Living, Hospital, Nursing Facility, Other Institution, Other Living Situation.



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Persons 1, 2, and 3 (continued)

Please continue to answer questions about Yourself, Person 2 and Person 3. Write their names on the first line.

	Person 1 Yourself	Person 2	Person 3
First and Last Name			
Does this person need help paying medical bills from the last 3 months (including Medicare premiums)?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Which of the following best describes this person's current living situation?	☐ Own home ☐ Renting ☐ Live with someone else ☐ Assisted Living ☐ Hospital ☐ Nursing Facility or other institution ☐ Other	☐ Own home ☐ Renting ☐ Live with someone else ☐ Assisted Living ☐ Hospital ☐ Nursing Facility or other institution ☐ Other	☐ Own home ☐ Renting ☐ Live with someone else ☐ Assisted Living ☐ Hospital ☐ Nursing Facility or other institution ☐ Other
Is this person living outside of the home?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, why is this person living outside of the home?			
Date expected to return	/ /	/ /	/ /
If in a hospital, nursing facility or other institution, what is the name of the facility?			
Date Admitted	/ /	/ /	/ /
Date of Discharge	/ /	/ /	/ /
Have you ever been in a hospital or nursing facility for more than 30 days in a row?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, when? (MM/DD/YY through MM/DD/YY)			
Has this person served in the military?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Is this person the spouse or widow of someone who served in the military?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
What is this person's VA file number?			
Does this person pay for medical expenses? (other than Medicare premiums)	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
How much is the expense?	$	$	$
How often?			
Describe the expense:			

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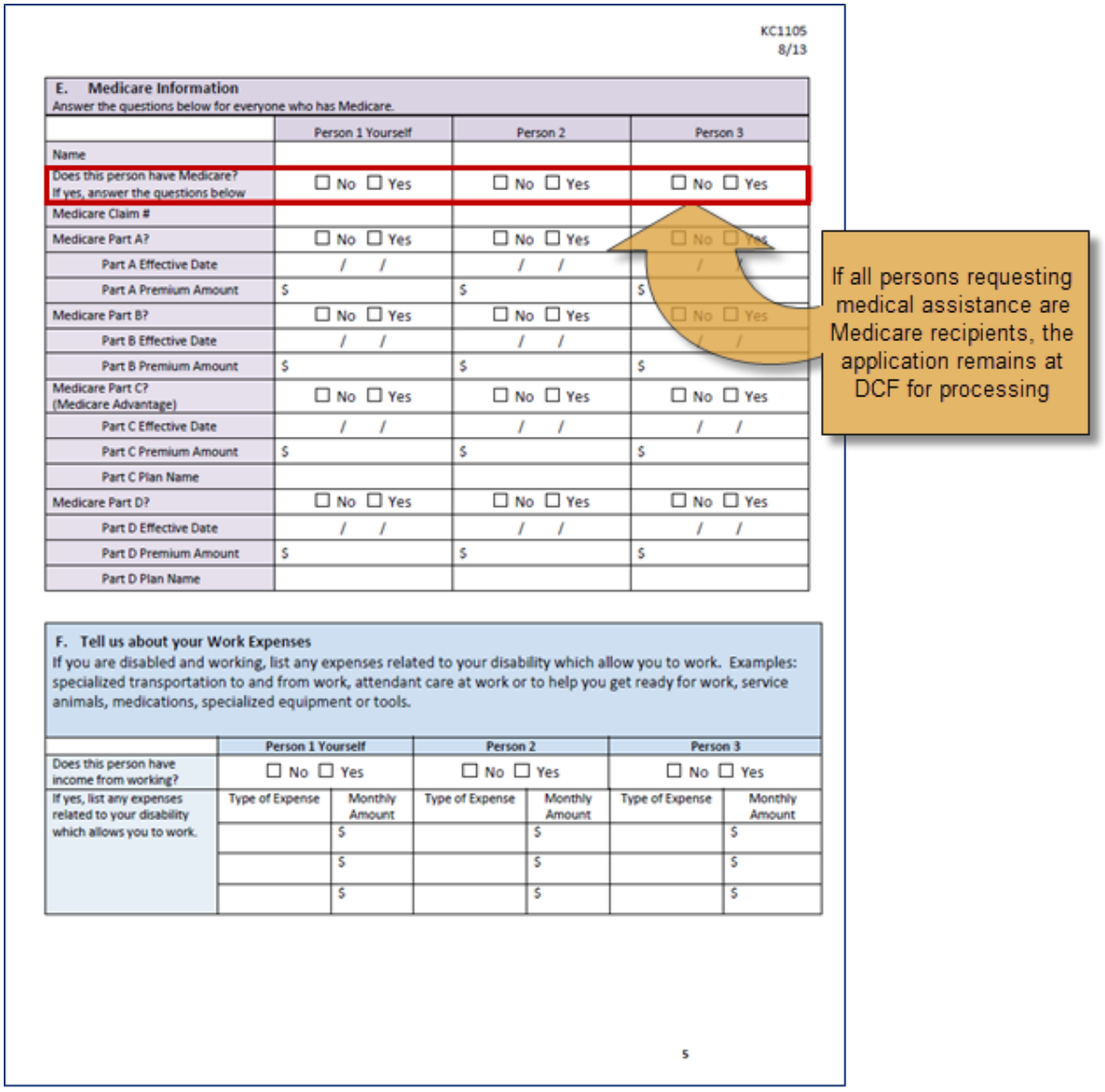
There may be times an application does not meet the "Big 4" Criteria; however, the current living situation selected may indicate a possible LTC case. Further Research may be warranted to determine if this application should remain at DCF.

KC-1105 Page 5:

- Does this person have Medicare?



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E. Medicare Information
Answer the questions below for everyone who has Medicare.

	Person 1 Yourself	Person 2	Person 3
Name			
Does this person have Medicare? If yes, answer the questions below	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Medicare Claim #			
Medicare Part A?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Part A Effective Date	/ /	/ /	/ /
Part A Premium Amount	$	$	$
Medicare Part B?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Part B Effective Date	/ /	/ /	/ /
Part B Premium Amount	$	$	$
Medicare Part C? (Medicare Advantage)	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Part C Effective Date	/ /	/ /	/ /
Part C Premium Amount	$	$	$
Part C Plan Name			
Medicare Part D?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Part D Effective Date	/ /	/ /	/ /
Part D Premium Amount	$	$	$
Part D Plan Name			

If all persons requesting medical assistance are Medicare recipients, the application remains at DCF for processing

F. Tell us about your Work Expenses
If you are disabled and working, list any expenses related to your disability which allow you to work. Examples: specialized transportation to and from work, attendant care at work or to help you get ready for work, service animals, medications, specialized equipment or tools.

	Person 1 Yourself		Person 2		Person 3	
Does this person have income from working?	☐ No ☐ Yes		☐ No ☐ Yes		☐ No ☐ Yes	
If yes, list any expenses related to your disability which allows you to work.	Type of Expense	Monthly Amount	Type of Expense	Monthly Amount	Type of Expense	Monthly Amount
		$		$		$
		$		$		$
		$		$		$

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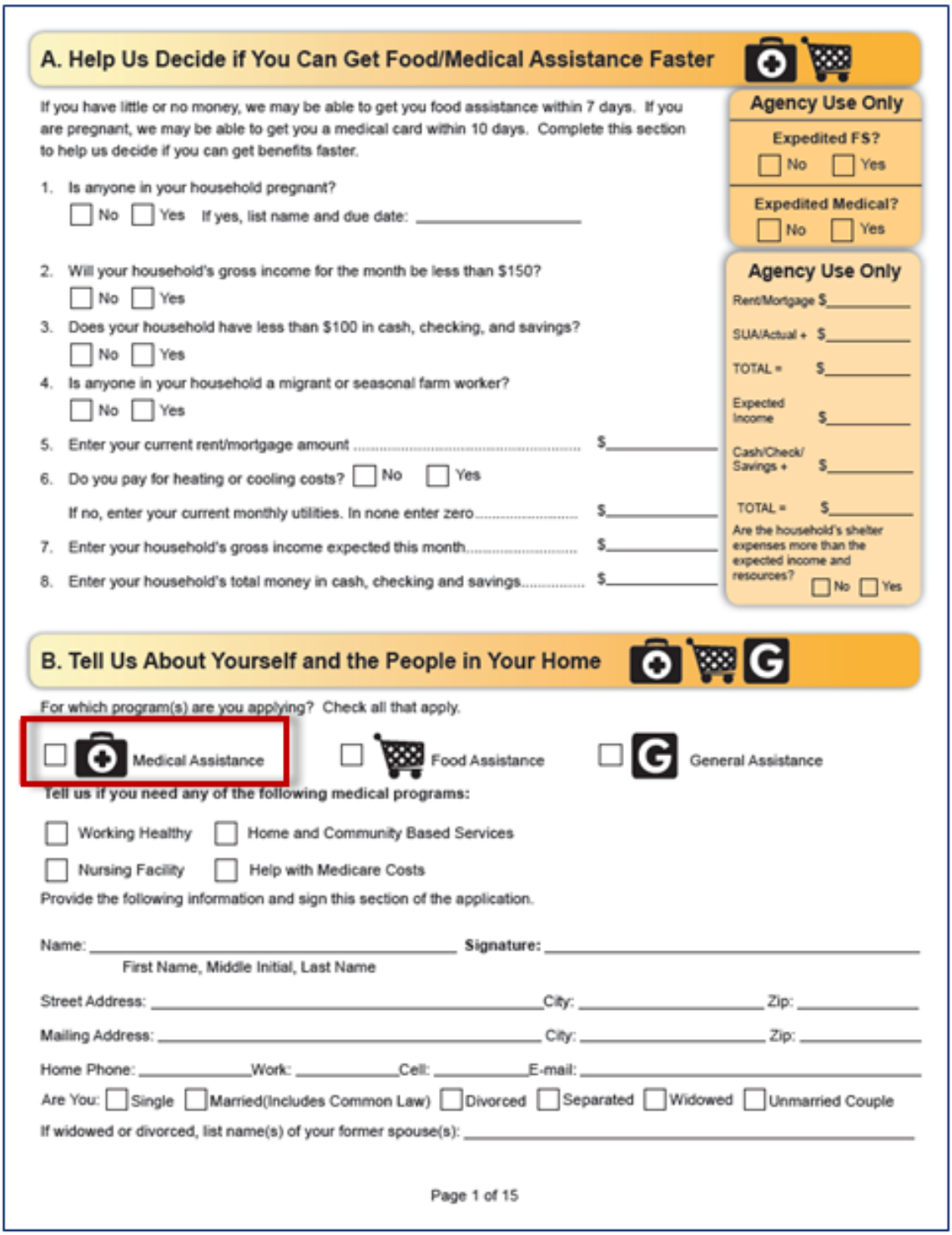
4.0 ES-3100.1: Application for Benefits for the Elderly and Persons with Disabilities

ES-3100.1 Page 1:

- For which programs are you applying?



A. Help Us Decide if You Can Get Food/Medical Assistance Faster

If you have little or no money, we may be able to get you food assistance within 7 days. If you are pregnant, we may be able to get you a medical card within 10 days. Complete this section to help us decide if you can get benefits faster.

Agency Use Only
Expedited FS? ☐ No ☐ Yes
Expedited Medical? ☐ No ☐ Yes

1. Is anyone in your household pregnant? ☐ No ☐ Yes If yes, list name and due date: _____
2. Will your household's gross income for the month be less than $150? ☐ No ☐ Yes
3. Does your household have less than $100 in cash, checking, and savings? ☐ No ☐ Yes
4. Is anyone in your household a migrant or seasonal farm worker? ☐ No ☐ Yes
5. Enter your current rent/mortgage amount ..... $_____
6. Do you pay for heating or cooling costs? ☐ No ☐ Yes
   If no, enter your current monthly utilities. In none enter zero ..... $_____
7. Enter your household's gross income expected this month ..... $_____
8. Enter your household's total money in cash, checking and savings ..... $_____

Agency Use Only
Rent/Mortgage $_____
SUA/Actual + $_____
TOTAL = $_____
Expected Income $_____
Cash/Check/ Savings + $_____
TOTAL = $_____
Are the household's shelter expenses more than the expected income and resources? ☐ No ☐ Yes

B. Tell Us About Yourself and the People in Your Home

For which program(s) are you applying? Check all that apply.

☐ Medical Assistance ☐ Food Assistance ☐ General Assistance

Tell us if you need any of the following medical programs:

☐ Working Healthy ☐ Home and Community Based Services
☐ Nursing Facility ☐ Help with Medicare Costs

Provide the following information and sign this section of the application.

Name: _____ Signature: _____
First Name, Middle Initial, Last Name

Street Address: _____ City: _____ Zip: _____

Mailing Address: _____ City: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____ E-mail: _____

Are You: ☐ Single ☐ Married(Includes Common Law) ☐ Divorced ☐ Separated ☐ Widowed ☐ Unmarried Couple

If widowed or divorced, list name(s) of your former spouse(s): _____

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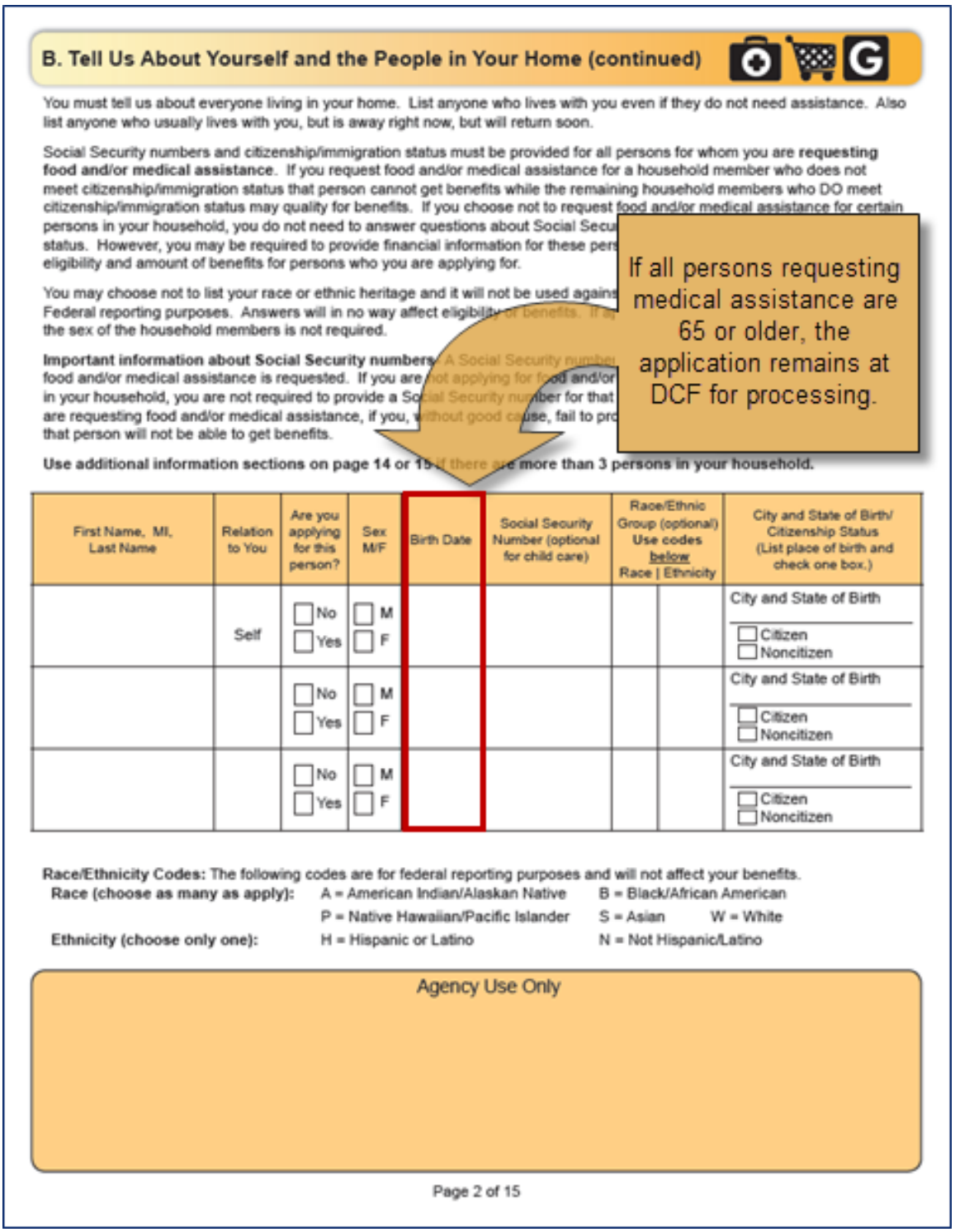
ES-3100.1 Page 2:

- Birth Date: Is this person age 65 years and over?



B. Tell Us About Yourself and the People in Your Home (continued)

You must tell us about everyone living in your home. List anyone who lives with you even if they do not need assistance. Also list anyone who usually lives with you, but is away right now, but will return soon.

Social Security numbers and citizenship/immigration status must be provided for all persons for whom you are **requesting food and/or medical assistance**. If you request food and/or medical assistance for a household member who does not meet citizenship/immigration status that person cannot get benefits while the remaining household members who DO meet citizenship/immigration status may quality for benefits. If you choose not to request food and/or medical assistance for certain persons in your household, you do not need to answer questions about Social Secu status. However, you may be required to provide financial information for these pers eligibility and amount of benefits for persons who you are applying for.

You may choose not to list your race or ethnic heritage and it will not be used agains Federal reporting purposes. Answers will in no way affect eligibility or benefits. If a the sex of the household members is not required.

Important information about Social Security numbers: A Social Security numbe food and/or medical assistance is requested. If you are not applying for food and/or in your household, you are not required to provide a Social Security number for that are requesting food and/or medical assistance, if you, without good cause, fail to pro that person will not be able to get benefits.

If all persons requesting medical assistance are 65 or older, the application remains at DCF for processing.

Use additional information sections on page 14 or 15 if there are more than 3 persons in your household.

First Name, MI, Last Name	Relation to You	Are you applying for this person?	Sex M/F	Birth Date	Social Security Number (optional for child care)	Race/Ethnic Group (optional) Use codes below Race | Ethnicity		City and State of Birth/ Citizenship Status (List place of birth and check one box.)
	Self	☐ No ☐ Yes	☐ M ☐ F					City and State of Birth ☐ Citizen ☐ Noncitizen
		☐ No ☐ Yes	☐ M ☐ F					City and State of Birth ☐ Citizen ☐ Noncitizen
		☐ No ☐ Yes	☐ M ☐ F					City and State of Birth ☐ Citizen ☐ Noncitizen

Race/Ethnicity Codes: The following codes are for federal reporting purposes and will not affect your benefits.

Race (choose as many as apply): A = American Indian/Alaskan Native; B = Black/African American; P = Native Hawaiian/Pacific Islander; S = Asian; W = White

Ethnicity (choose only one): H = Hispanic or Latino; N = Not Hispanic/Latino

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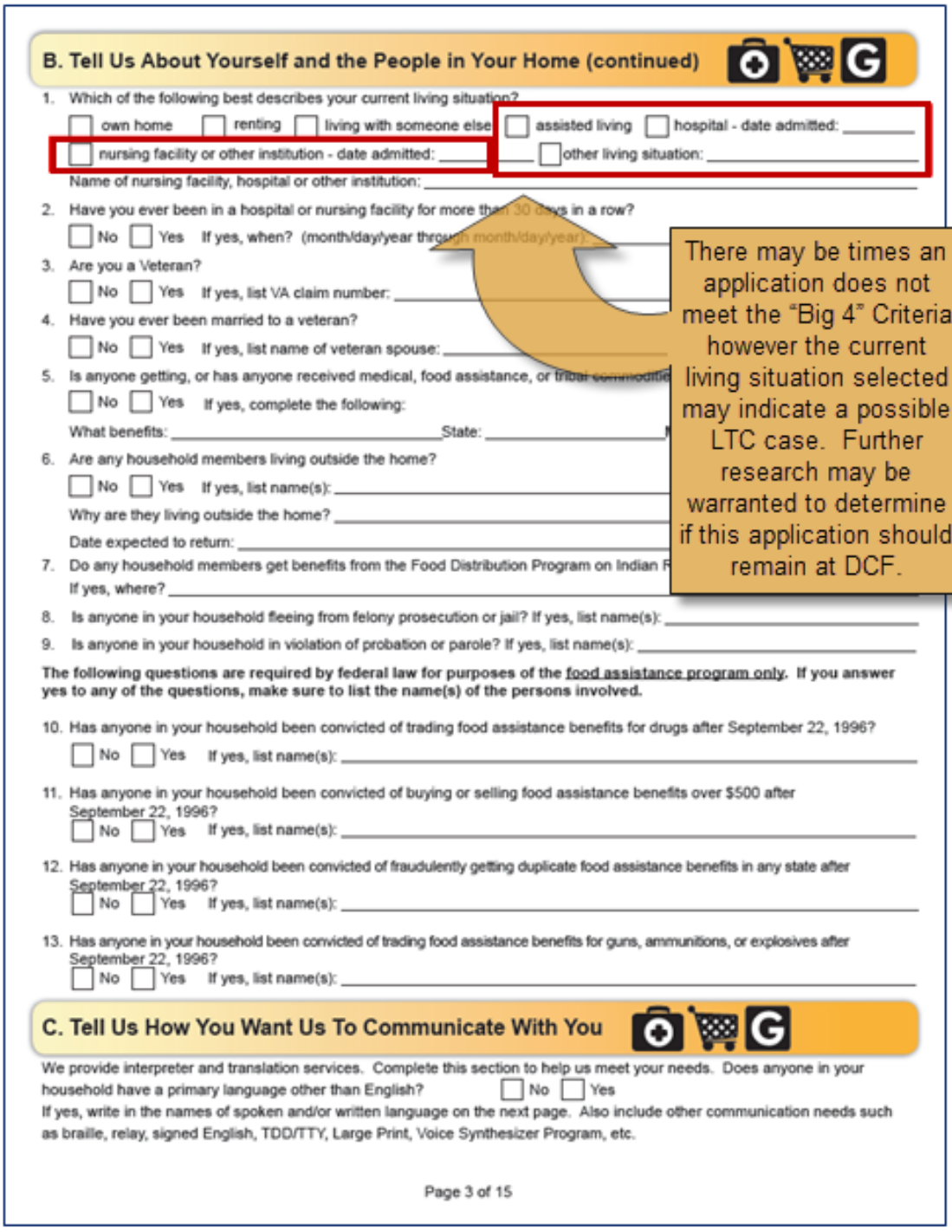
- Which of the following best describes your current living situation?
- Assisted Living, Hospital, Nursing Facility, Other Institution, Other Living Situation.



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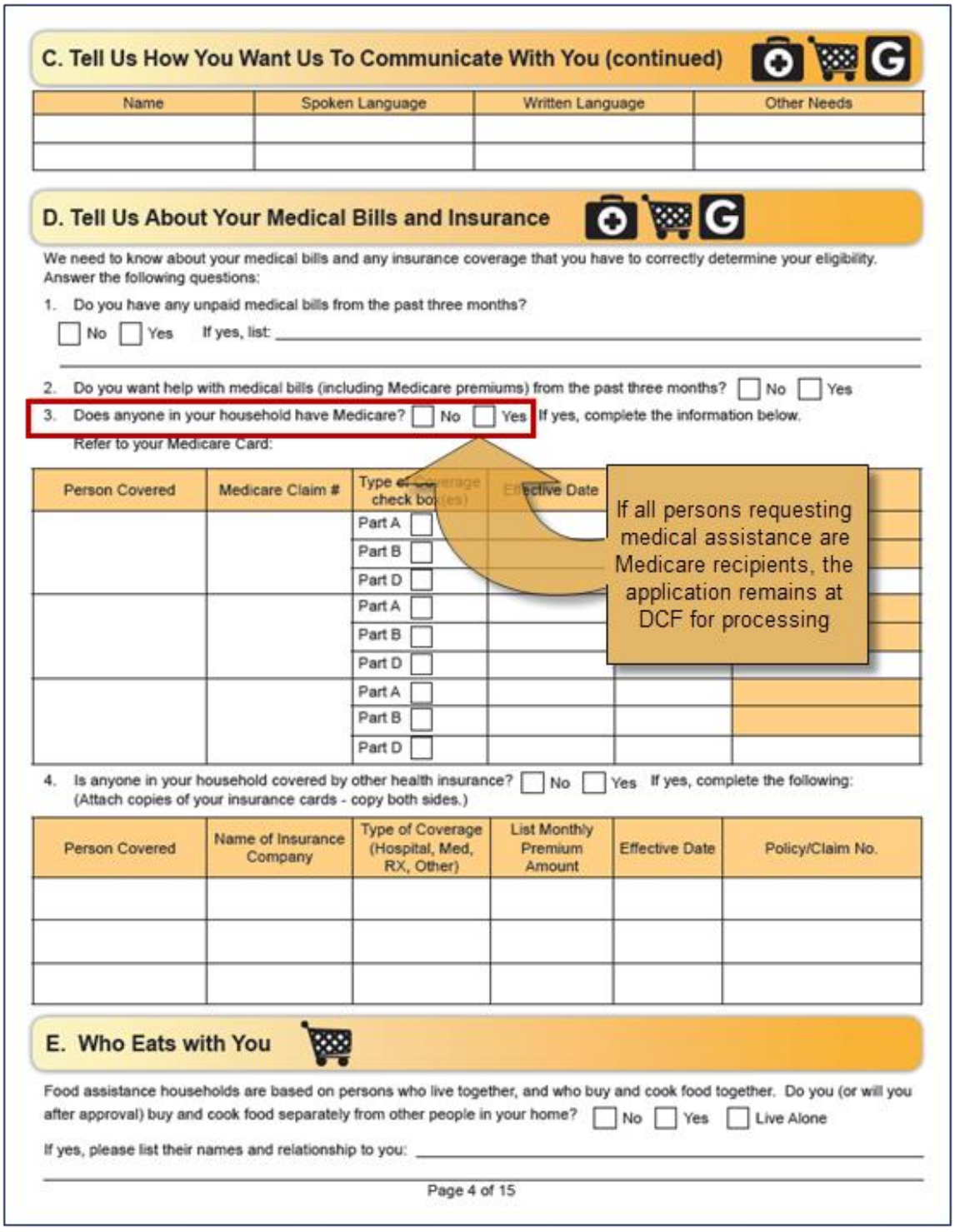
- Does anyone in your household have Medicare?



C. Tell Us How You Want Us To Communicate With You (continued)

Name	Spoken Language	Written Language	Other Needs

D. Tell Us About Your Medical Bills and Insurance

We need to know about your medical bills and any insurance coverage that you have to correctly determine your eligibility. Answer the following questions:

1. Do you have any unpaid medical bills from the past three months?
   ☐ No ☐ Yes If yes, list: _____
2. Do you want help with medical bills (including Medicare premiums) from the past three months? ☐ No ☐ Yes
3. Does anyone in your household have Medicare? ☐ No ☐ Yes If yes, complete the information below.
   Refer to your Medicare Card:

Person Covered	Medicare Claim #	Type of Coverage check box(es)	Effective Date		
		Part A ☐			
		Part B ☐			
		Part D ☐			
		Part A ☐			
		Part B ☐			
		Part D ☐			
		Part A ☐			
		Part B ☐			
		Part D ☐			

If all persons requesting medical assistance are Medicare recipients, the application remains at DCF for processing

4. Is anyone in your household covered by other health insurance? ☐ No ☐ Yes If yes, complete the following:
   (Attach copies of your insurance cards - copy both sides.)

Person Covered	Name of Insurance Company	Type of Coverage (Hospital, Med, RX, Other)	List Monthly Premium Amount	Effective Date	Policy/Claim No.

E. Who Eats with You

Food assistance households are based on persons who live together, and who buy and cook food together. Do you (or will you after approval) buy and cook food separately from other people in your home? ☐ No ☐ Yes ☐ Live Alone

If yes, please list their names and relationship to you: _____

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