Step 1. Tell us about yourself.

We need one adult in the family to be the contact person for your application.

First name, middle name, last name, and suffix Person applying for medicaid			
Home address (If you leave blank because you don't have one, you must give us a mailing address below.)			Apartment or suite number
City	State	ZIP code	County
Mailing address (if different from home address) POA name and addres			Apartment or suite number
City	State	ZIP code	County
Phone number		Other phone number	
Do you want to get information about this application by email? ☐ Yes ☐ No Email address:			
Preferred spoken or written language (if not English)			

Step 2. Tell us about your family.

Who do you need to include on this application?

Tell us about all the family members who live with you. If you file taxes, we need to know about everyone on your tax return. (You don't need to file taxes to get health coverage.)

DO include:

- Yourself
- Your spouse
- Your children under 21 who live with you
- Your unmarried partner who needs health coverage
- Your unmarried partner who lives with you when you have a child or children together
- Anyone you include on your tax return, even if they don't live with you
- Anyone else under 21 who you take care of and lives with you

You DON'T have to include:

- Your unmarried partner who lives with you and doesn't need health insurance unless you have a child or children together
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you're over 21)
- Other adult relatives who file their own tax return

The amount of assistance or type of program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone gets the best coverage they can.

Complete Step 2 for each person in your family. Start with yourself, then add other adults and children. If you have more than five people in your family, you'll need to make a copy of the pages and attach them. You don't need to provide immigration status or a Social Security Number (SSN) for family members who don't need health coverage. We'll keep all the information you provide private and secure as required by law. We'll use personal information only to check if you're eligible for health coverage.

Step 2. Person 1 (start with yourself) – Person needing medicaid

Complete Step 2 for yourself, your spouse or partner and children who live with you and anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

First name, middle name, last name, and suffix		Relationship to you? **SELF**
Date of birth (mm/dd/yyyy)	Sex: ☐ Male ☐ Female	Social Security Number (SSN)

We need your SSN if you want health coverage and have a SSN. Providing your SSN can be helpful if you don't want health coverage too since it can speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit www.socialsecurity.gov/. TTY users should call 1-800-325-0778.

Do you plan to file a federal income tax return THIS YEAR?

(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ Yes. **If yes**, please answer questions 1-3. ☒ No. **If no**, skip to question 3.

☐ Yes ☐ No 1. Will you file jointly with a spouse? **If yes**, name of spouse: _____

☐ Yes ☐ No 2. Will you claim any dependents on your tax return? **If yes**, list names of dependents: _____

☐ Yes ☐ No 3. Will you be claimed as a dependent on someone's tax return? **If yes**, list the name of the tax filer: _____
How are you related to the tax filer? _____

☐ Yes ☐ No Are you pregnant? **If yes**, how many babies are expected during this pregnancy? What is the due date? _____

☐ Yes ☐ No Are you currently incarcerated?

☐ Yes ☐ No Are you currently assigned to a work release program? **If yes**, what is the start date? _____

Do you need health coverage?

(Even if you have insurance, there might be a program with better coverage or lower costs.)

☐ Yes. **If yes**, answer all the questions below. ☐ No. **If no**, skip to the income questions on page 3. Leave the rest of this page blank.

☐ Yes ☐ No Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home?

☐ Yes ☐ No Are you a U.S. citizen or U.S. national?

☐ Yes ☐ No If you aren't a U.S. citizen or U.S. national, do you have eligible immigration status? **If yes**, fill in your document type and ID number below.
Document type: _____ Document ID number: _____

☐ Yes ☐ No Have you lived in the U.S. since before August 22, 1996?

☐ Yes ☐ No Are you or your spouse or parent an honorably discharged veteran or an active-duty member of the U.S. military?

☐ Yes ☐ No Are you a resident of Iowa?

☐ Yes ☐ No Do you need help paying for medical bills from the last three calendar months? If you answer yes and you fall into a category that allows for retroactive approval, we will determine if you are eligible for coverage during those months.

☐ Yes ☐ No Are you an adult who is a main person taking care of a child under the age of 19 living in the home?

☐ Yes ☐ No Are you a full-time student?

☐ Yes ☐ No Were you in foster care at age 18 or older?

☐ Yes ☐ No If you are under age 19, do you want help with child support?

The following ethnicity and race questions are optional. Check all that apply.

If Hispanic or Latino, ethnicity:
- ☐ Mexican
- ☐ Mexican American
- ☐ Chicano/a
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Other: _____

Race:
- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander
- ☐ Other: _____

Current Job and Income Information: You must tell us about the income of the people in your household. If someone has more than one job, tell us about all jobs. If you leave a space blank, we will assume that you have no income of this kind.

- ☐ **Employed.** If you're currently employed, tell us about your income. Start with **Current Job 1**.
- ☐ **Not employed.** Skip to the **Other Income This Month** section.
- ☐ **Self-employed.** Skip to the **Self-Employment** section.

Current Job 1:

Employer name and address				Employer phone number
Wages and tips (before taxes) $	☐ Hourly ☐ Twice a month	☐ Weekly ☐ Monthly	☐ Every 2 weeks ☐ Yearly	Average hours worked each month:

Current Job 2: If you have more jobs and need more space, attach another sheet of paper.

Employer name and address				Employer phone number
Wages and tips (before taxes) $	☐ Hourly ☐ Twice a month	☐ Weekly ☐ Monthly	☐ Every 2 weeks ☐ Yearly	Average hours worked each month:

Will the amount of money from jobs stay about the same? ☐ Yes ☐ No
If no, explain: _____

In the past three months, did you:
☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

Self-Employment: If self-employed, answer the following questions.

Type of work _____

How much net income (profits once business expenses are paid) will you get from this self-employment this month? $ _____

Will the amount of monthly income from self-employment stay about the same? ☐ Yes ☐ No
If no, how much do you expect to average over a 12 month period? $ _____

Other Income This Month: Check all that apply, and give the amount and how often you get it. **NOTE:** You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

		How often?			How often?
☐ None	Gross income				
☐ Unemployment	$ _____	_____	☐ Alimony received	$ _____	_____
☐ Pensions	$ _____	_____	☐ Net farming/fishing	$ _____	_____
☐ Social Security	$ _____	_____	☐ Net rental/royalty	$ _____	_____
☐ Retirement accounts	$ _____	_____	☐ Other income	$ _____	_____
			Type	_____	

Will the amount of money from other income stay about the same? ☐ Yes ☐ No
If no, explain: _____

Deductions: If you pay for certain things that can be deducted on a federal income tax return, check all that apply and give the amount and how often you pay. This information can be found on the Adjusted Gross Income section of your Federal 1040 form. **NOTE:** You shouldn't include a cost that you already considered in your answer to net self-employment.

		How often?			How often?
☐ Alimony paid	$ _____	_____	☐ Other deductions	$ _____	_____
☐ Student loan interest	$ _____	_____	Type	_____	

Step 2. Person 2 Maried Spuse

Complete Step 2 for your spouse or partner and children who live with you and anyone on your same federal income tax return if you file one. See Page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

First name, middle name, last name, and suffix		Relationship to you?
Date of birth (mm/dd/yyyy)	Sex: ☐ Male ☐ Female	Social Security Number (SSN)

We need your SSN if you want health coverage and have a SSN. Providing your SSN can be helpful if you don't want health coverage too since it can speed up the application process.

☐ Yes ☐ No Does *Person 2* live at the same address as you? **If no**, list address:

Does *Person 2* plan to file a federal income tax return THIS YEAR?

(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ Yes. **If yes**, please answer questions 1-3. ☒ No. **If no**, skip to question 3.

☐ Yes ☐ No 1. Will *Person 2* file jointly with a spouse? **If yes**, name of spouse:

☐ Yes ☐ No 2. Will *Person 2* claim any dependents on *Person 2's* tax return? **If yes**, list names of dependents:

☐ Yes ☐ No 3. Will *Person 2* be claimed as a dependent on someone's tax return? **If yes**, list the name of the tax filer: How is *Person 2* related to the tax filer?

☐ Yes ☐ No Is *Person 2* pregnant? **If yes**, how many babies are expected during this pregnancy? What is the due date?

☐ Yes ☐ No Is *Person 2* currently incarcerated?

☐ Yes ☐ No Is *Person 2* currently assigned to a work release program? **If yes**, what is the start date?

Does *Person 2* need health coverage?

(Even if they have insurance, there might be a program with better coverage or lower costs.)

☐ Yes. **If yes**, answer all the questions below. ☐ No. **If no**, skip to the income questions on page 5. Leave the rest of this page blank.

☐ Yes ☐ No Does *Person 2* have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home?

☐ Yes ☐ No Is *Person 2* a U.S. citizen or U.S. national?

☐ Yes ☐ No If *Person 2* isn't a U.S. citizen or U.S. national, does *Person 2* have eligible immigration status? **If yes**, fill in their document type and ID number below.

Document type: _____ Document ID number: _____

☐ Yes ☐ No Has *Person 2* lived in the U.S. since before August 22, 1996?

☐ Yes ☐ No Is *Person 2* or their spouse or parent an honorably discharged veteran or an active-duty member in the U.S. military?

☐ Yes ☐ No Is *Person 2* a resident of Iowa?

☐ Yes ☐ No Does *Person 2* need help paying for medical bills from the last three calendar months? If you answer yes and this person falls into a category that allows for retroactive approval, we will determine if this person is eligible for coverage during those months.

☐ Yes ☐ No Is *Person 2* an adult who is a main person taking care of a child under the age of 19 living in the home?

☐ Yes ☐ No Was *Person 2* in foster care at age 18 or older?

☐ Yes ☐ No If *Person 2* is under age 19, do you want help with child support?

Please answer the following questions if *Person 2* is 22 or younger:

☐ Yes ☐ No Did *Person 2* have insurance through a job and lose it within the past three months? **If yes**, end date: _____ Reason insurance ended: _____

☐ Yes ☐ No Is *Person 2* a full-time student?

The following ethnicity and race questions are optional. Check all that apply.

If Hispanic or Latino, ethnicity:
- ☐ Mexican
- ☐ Mexican American
- ☐ Chicano/a
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Other: _____

Race:
- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander
- ☐ Other: _____

Current Job and Income Information: You must tell us about the income of the people in your household. If someone has more than one job, tell us about all jobs. If you leave a space blank, we will assume that you have no income of this kind.

- ☐ **Employed.** If you're currently employed, tell us about your income. Start with **Current Job 1**.
- ☐ **Not employed.** Skip to the **Other Income This Month** section.
- ☐ **Self-employed.** Skip to the **Self-Employment** section.

Current Job 1:

Employer name and address				Employer phone number
Wages and tips (before taxes) $	☐ Hourly ☐ Twice a month	☐ Weekly ☐ Monthly	☐ Every 2 weeks ☐ Yearly	Average hours worked each month:

Current Job 2: If you have more jobs and need more space, attach another sheet of paper.

Employer name and address				Employer phone number
Wages and tips (before taxes) $	☐ Hourly ☐ Twice a month	☐ Weekly ☐ Monthly	☐ Every 2 weeks ☐ Yearly	Average hours worked each month:

Will the amount of money from jobs stay about the same? ☐ Yes ☐ No
If no, explain: _____

In the past three months, did *Person 2*:
☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

Self-Employment: If self-employed, answer the following questions.

Type of work _____

How much net income (profits once business expenses are paid) will you get from this self-employment this month? $ _____

Will the amount of monthly income from self-employment stay about the same? ☐ Yes ☐ No
If no, how much do you expect to average over a 12 month period? $ _____

Other Income This Month: Check all that apply, and give the amount and how often you get it. **NOTE:** You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

		How often?			How often?
☐ None	Gross Income				
☐ Unemployment	$		☐ Alimony received	$	
☐ Pensions	$		☐ Net farming/fishing	$	
☐ Social Security	$		☐ Net rental/royalty	$	
☐ Retirement accounts	$		☐ Other income	$	
			Type		

Will the amount of money from other income stay about the same? ☐ Yes ☐ No
If no, explain: _____

Deductions: If *Person 2* pays for certain things that can be deducted on a federal income tax return, check all that apply and give the amount and how often *Person 2* pays. This information can be found on the Adjusted Gross Income section of *Person 2's* Federal 1040 form. **NOTE:** You shouldn't include a cost that you already considered in your answer to net self-employment.

		How often?			How often?
☐ Alimony paid	$		☐ Other deductions	$	
☐ Student loan interest	$		Type		

Step 3. American Indian or Alaska Native (AI/AN) Family Members

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

☐ Yes ☐ No Are you or is anyone in your family an American Indian or Alaska Native? **If yes**, fill in the information below. **If no**, skip to Step 4.

AI/AN Person 1:

Name (first, middle, last)

AI/AN Person 2:

Name (first, middle, last)

AI/AN Person 1:		AI/AN Person 2:
☐ Yes ☐ No	Member of a federally recognized tribe? **If yes**, tribe name:	☐ Yes ☐ No
☐ Yes ☐ No	Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program or through a referral from one of these programs?	☐ Yes ☐ No
☐ Yes ☐ No	**If no**, is this person eligible to get any of these services?	☐ Yes ☐ No
$ _____ How often? _____	Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources: ▪ Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties. ▪ Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations). ▪ Money from selling things that have cultural significance.	$ _____ How often? _____

Step 4. Your Family's Health Coverage

Answer these questions for anyone who needs health coverage.

☐ Yes ☐ No Is anyone enrolled in health coverage now from the following? **If yes**, check the type of coverage and write the persons' names next to the coverage they have.

- ☐ Medicaid _____
- ☐ CHIP _____
- ☐ Medicare _____
- ☐ TRICARE (Don't check if you have direct care or Line of Duty) _____
- ☐ VA health care programs _____
- ☐ Peace Corps _____
- ☐ Employer Insurance
  - Name of health insurance _____
  - Policy number _____
  - Is this COBRA coverage? ☐ Yes ☐ No
  - Is this a retiree health plan? ☐ Yes ☐ No
- ☐ Other
  - Name of health insurance _____
  - Policy number _____
  - Is this a limited-benefit plan (like a school accident policy?) ☐ Yes ☐ No

☐ Yes ☐ No Has anyone moved in or out of your home in the past three months? **If yes**, answer the following questions.

- Name _____
- Date of birth (mm/dd/yyyy) _____
- Social Security Number (SSN) _____
- Relationship to you? _____
- Date moved in? _____
- Date moved out? _____

☐ Yes ☐ No Is anyone listed on this application offered health coverage from a job? Check yes even if the coverage is from someone else's job, such as a parent or spouse.

If yes, answer the following question and the questions in Step 5.

If no, skip to Step 6.

☐ Yes ☐ No Is this a state employee benefit plan?

Step 5. Health Coverage from Jobs only for working Spouse

You **don't** need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage. Tell us about the **job** that offers coverage.

Employee Information. The **employee** needs to fill out this section.

Employee name (first, middle, last)	Social security number

Employer Information. Ask the **employer** for this information.

Employer name	Employer identification number (EIN)	
Employer address (the Marketplace will send notices to this address)	Employer phone number	
City	State	ZIP code
Who can we contact about employee health coverage at this job?		
Phone number (if difference from above)	Email address	

☐ Yes ☐ No Are you currently eligible for coverage offered by this employer, or will you become eligible in the next three months? **If yes**, fill out the information below. **If no**, skip to Step 6.

If you're in a waiting or probationary period, when can you enroll in coverage?

List the names of anyone else who is eligible for coverage from this job.

Health Plan. Tell us about the **health plan** offered by this employer.

☐ Yes ☐ No Does the employer offer a health plan that covers an employee's spouse or dependent?

If yes, which people? ☐ Spouse ☐ Dependents

☐ Yes ☐ No Does the employer offer a health plan that meets the minimum value standard*?

For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans):

If the employer has wellness programs, provide the premium that the employee would pay if the employee received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

How much would the employee have to pay in premiums for this plan? $

How often? ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Employer Changes. What change will the employer make for the new plan year (if known)?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard. (Premium should reflect discount for wellness programs.)

How much will the employee have to pay in premiums for that plan? $

How often? ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Quarterly ☐ Yearly

Date of change:

Step 6. Assistance with Completing this Application

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, let us know. If you're a legally appointed representative for someone on this application, submit proof with the application.

Name of authorized representative (first name, middle name, last name)		
Address		Apartment or suite number
City	State	ZIP code
Phone number		
Organization name		ID number (if applicable)

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.

NOTE: Your signature here does not complete the application. You **must** sign and date on page 16 to complete this application.

Your signature	Date (mm/dd/yyyy)
POA	

For certified application counselors, navigators, agents, and brokers only.

Complete this section if you're a certified application counselor, navigator, agent, or broker filing out this application for somebody else.

Application start date (mm/dd/yyyy)	
First name, middle name, last name, and suffix	N/A
Organization name	ID number (if applicable)

Step 7. Read and Sign this Application

Renewal of coverage in future years

To make it easier to determine eligibility for health coverage in future years, your income data, including information from tax returns, can be verified electronically. You can also change your mind and not allow the Department of Health and Human Services to check this information.

Do you want this information to be verified in the future and used to automatically renew your eligibility?

☐ Yes, renew my eligibility automatically.

How long? ☐ 5 years ☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year

☒ No, don't use my information from tax returns to renew my coverage.

Estate Recovery

Federal law requires Iowa to have an estate recovery program. If you get Medicaid, you may be subject to estate recovery. This means any Medicaid funds used to pay for your healthcare, including the **full** monthly fee paid to a Managed Care Organization (MCO), including medical and dental, even if the plan did not pay for any services, will need to be paid back from your estate after your death. Estate recovery applies if you get Medicaid and are:

- Age 55 or older, or
- Are under age 55 and live in a medical facility and cannot reasonably be expected to return home.

For more information, call the Iowa Medicaid Estate Recovery Program at 1-877-463-7887 or go online to http://hhs.iowa.gov/sites/default/files/Comm123.pdf (English) or http://hhs.iowa.gov/sites/default/files/Comm123S.pdf (Spanish).

Sign this application

The person who filled out Step 1 should sign this application. If you're an authorized representative, you may sign here as long as you have provided the information required in Step 6.

If I leave a question on this application blank, I am reporting that the question does not apply to me and all persons listed on this application.

I agree to allow my information to be used and retrieved from data sources, including an asset verification system database, for this application. I have consent for all people I will list on the application that allows their information to be retrieved and used from data sources for this application.

I acknowledge that I have read and agree to the contents of *Rights and Responsibilities*, Comm. 233. *Rights and Responsibilities*, Comm. 233 is pages 23 to 27 of this application.

By signing this application, I certify under penalty of perjury and false swearing that my answers are correct and complete to the best of my knowledge, including information provided about the citizenship or alien status for each household member applying for benefits. I know I may be subject to penalties under federal law if I provide false or untrue information.

I declare under penalty of perjury under the laws of the United States of America that the information contained in this statement of facts is true, correct, and complete.

Signature	Date (mm/dd/yyyy)
, POA	

Step 8. Provide the Completed Application

- In-person – Bring to your local HHS office.
- Fax – Send to (515) 564-4017
- Email – Send to imagingcenter4@dhs.state.ia.us
- By mail – Send your signed application to:

  Imaging Center 4
  PO Box 2027
  Cedar Rapids, Iowa 52406

If you want to register to vote, you can complete a voter registration form at: https://hhs.iowa.gov/sites/default/files/Voter_Registration.pdf. Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

IOWA
Health and Human Services

Iowa Department of Health and Human Services

Appendix A for Health Coverage

Case Number:

Complete this section if you or someone in the household is aged (65 and older), blind, or disabled.

Name of Person Requesting Services	Marital Status	Date of Birth	Social Security Number

Please indicate if you or someone in the household is in need of any of the following coverage:

- ☐ Help paying your facility costs (nursing facility, PMIC, skilled facility)
- ☐ Services to remain in your home (includes assisted living)
  - ☐ AIDS/HIV waiver – No age limit and diagnosis of AIDS or infected with HIV
  - ☐ Brain Injury waiver – At least 1 month old and diagnosis of brain injury
  - ☐ Children's Mental Health waiver - Under age 18 and diagnosis of serious emotional disturbance
  - ☐ Elderly waiver – Age 65 or older and in need of nursing or skilled level of care
  - ☐ Health and Disability waiver – Under 65 and determined disabled
  - ☐ Intellectual Disability waiver – No age limit and diagnosis of an intellectual disability
  - ☐ Physical Disability waiver – Between 18 and 64 with a Physical disability
  - ☐ Program for All-Inclusive Care for the Elderly (PACE) – Age 55 or older, live in a PACE county and meet Level of Care
- ☐ Assistance paying Medicare premiums
- ☐ State Supplementary Assistance (residential care facility, in-home health-related care, dependent person)
- ☐ Help paying for a hospital stay of 30 days or more.
- ☐ Other

PLEASE PROVIDE VERIFICATION OF ALL ITEMS YOU MARK BELOW (copies, not originals).

If you have more information to report, please use an additional sheet of paper.

1. **Income** – Tell us about any additional sources of income for each individual in your household, such as child support, veteran's payments, Black Lung, Railroad, Supplemental Security Income (SSI), worker's compensation, interest, alimony, and dividends, etc.

Name of Person with Income	Income Type	Amount	How often received?

2. **Resources** – Tell us about all resources for each individual in your household, including cash on-hand, checking and savings accounts, social security debit card, stocks, bonds, mutual funds, annuities, safe deposit box, 401ks, IRAs, CDs, etc.

Name of Owner of Resource	Resource Type	Name/Location of Financial Institution	Account	Current Value

3. **Motor Vehicles** – Tell us about all the vehicles owned for each individual in your household, even if the vehicle is not in working condition.

Owner	Year/Make/Model	Fair Market Value	Amount Owed

4. **Unmet Medical Expenses** – Tell us about all medical expenses for each individual in your household not being reimbursed by a third party.

Name of Person with Unmet Medical Expenses	Type of Medical Expense	Amount	How often incurred?

5. **Burial/Funeral** – Tell us about all burial plots, burial or funeral funds, or burial contracts for each individual in your household.

Type	Location	How Many/ For Whom	Current Value

6. **Life Insurance** – Tell us about all life insurance policies owned by each individual in your household.

Policy Owner	Company Name and Address	Policy #

Do you intend to use your life insurance for burial expenses? ☐ Yes ☐ No

7. **Property** – Tell us about all property for each individual in your household including homestead (the home you live in) and non-homestead (other property such as vacation home, rental home, vacant lots, buildings, etc.).

Property Owner	Property Address	Property Value

8. Do you or anyone in your household have a life estate? ☐ Yes ☐ No

   If yes, who: _____

9. Do you or anyone in your household have a trust? ☐ Yes ☐ No

   If yes, who: _____

10. Have you or anyone in your household not accepted an inheritance in the past five years? ☐ Yes ☐ No

    If yes, who: _____

11. Have you or anyone in your household transferred, sold or given away resources for less than their value in the past five years? ☐ Yes ☐ No

    If yes, who/what: _____

    Date this occurred: _____

12. Does anyone applying for benefits live in a medical institution (nursing facility, hospital, PMIC, etc.)? ☐ Yes ☐ No

    If yes, who: _____ Date of entry: _____

    Name of facility: _____ Phone: _____

13. Do you or anyone in your household receive Long-Term Care insurance? ☐ Yes ☐ No

    Name of company: _____

14. If you are currently living in a medical institution and own your home, do you intend to return home? ☐ Yes ☐ No

15. Does anyone who is applying have a pending application for Social Security Disability? ☐ Yes ☐ No

    If yes, who: _____