MEDICAID APPLICATION
Patient of Nursing Facility
State of Michigan
Department of Human Services

HELP IS AVAILABLE

FOR OFFICE USE ONLY				
Grantee Name				
Grantee Client ID				
Case Number				
County	District	Section	Unit	Specialist

THE DEPARTMENT OF HUMAN SERVICES MUST HELP ALL PERSONS FILL OUT THE APPLICATION, WHEN REQUESTED. IF YOU NEED HELP, PLEASE CALL OR VISIT YOUR SPECIALIST OR THE OFFICE NAMED BELOW. IF YOU NEED AN INTERPRETER, THE DEPARTMENT WILL PROVIDE ONE FREE OF CHARGE OR YOU MAY USE ONE OF YOUR CHOICE. IF YOU ARE REFUSED HELP IN FILLING OUT THE APPLICATION, YOU MAY CALL (517) 373-0707.

Do you need the Department to provide an interpreter to help you at the interview? ( ) Yes ( ) No

If yes, what language? _____

EL DEPARTMENT OF HUMAN SERVICES DEBE AYUDAR A TODAS LAS PERSONAS A COMPLETAR LA APLICACION CUANDO ASI LO PIDEN. SI UD. NECESITA AYUDA, POR FAVOR LLAME O VISITE A SU ESPECIALIST O LA OFICINA QUE SE MENCIONA ABAJO. SI NECESITA UN INTERPRETE, EL DEPARTMETO LE PROPORCIONARA UNO GRATIS O UD. PUEDE USAR UNO DE SU ELECCION. SI UD. ES NEGADO AYUDAPARA COMPLETAR LA APLICACION, PUEDE LLAMAR AL (517) 373-0707.

¿Necesita que el Departamento proporcione un interprete para que le ayude en la entrevista? ( ) si ( ) no
Si dice que si, ¿en que idioma?

يجب على هيئة الاستقلال العائلي لولاية ميشيغان أن يساعد كافة الأشخاص لملء الاستمارات عندما يطلب منهم ذلك. إذا كنت تحتاج إلى مساعدة، يرجى الاتصال أو زيارة الإخصائي الذي ينظر بقضيتك أو المكتب المبين أسمه أدناه. وإذا كنت تحتاج إلى مترجم، ستقوم الدائرة بتوفير مترجم لك بدون مقابل، أو باستطاعتك اختيار من ترغب. وإن تم رفض مساعدتك بملء الطلب، يمكنك الاتصال بالهيئة على الرقم ٣٧٣-٠٧٠٧ (٥١٧).

هل تريد من الدائرة أن توفر لك مترجماً كي يساعدك أثناء المقابلة؟ نعم ( ) لا ( ). إذا أجبت بنعم فما هي اللغة التي تتحدثها في المنزل؟

Department of Human Services (DHS) no discrimina contra ningún individuo o grupo a causa de su raza, religión, edad, origen nacional, color de piel, estatura, peso, estado matrimonial, sexo, orientación sexual, identidad de sexo o expresión, creencias políticas o incapacidad. Si usted necesita ayuda para leer, escribir, oír, etc., bajo la Acta de Americanos con Incapacidades, usted está invitado a hacer saber sus necesidades a una oficina de DHS en su área.

لن تميّز إدارة الخدمات الإنسانية (Department of Human Services - DHS) ضد أي شخص أو مجموعة بسبب العرق، أو الديانة، أو العمر، أو المنشأ الوطني، أو اللون، أو الطول، أو الوزن، أو الحالة الزوجية، أو الجنس، أو التوجّه الجنسي، أو الهوية الجنسية التي يتصورها الشخص لنفسه أو التعابير الجنسية التي يعطيها الشخص عن نفسه، أو المعتقدات السياسية، أو الإعاقة والعجز. إن كنت تحتاج إلى مساعدة في القراءة والكتابة والسمع، إلخ، ندعوك أن تجعل احتياجاتك معروفة لدى مكتب DHS في المنطقة التي تعيش فيها عملاً بقانون الأمريكيين المعاقين (Americans With Disabilities Act).

PLEASE READ CAREFULLY

FOR NURSING FACILITY PATIENTS ONLY

Complete this form if your are in a nursing facility. Please read each item carefully before you answer it. The answers you give will be used to determine if you are eligible for Medicaid. Be sure to sign your name on pages 2 and 4.

You can apply for Medicaid by mailing or having someone take this form into your local Department of Human Services office. Your application must be approved or denied within:

- 45 days, or
- 90 days if disability is a factor in determining your Medicaid eligibility.

Use Form DHS-1171, Assistance Application, if other family members want help with medical expenses.

LOCAL OFFICE:

Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.

AUTHORITY: 42 CFR PART 435.
COMPLETION: Voluntary.
PENALTY: No Medicaid.

FOR OFFICE USE ONLY
NOTES

DHS-4574 (Rev. 1-13) Previous edition obsolete.

FOR OFFICE USE ONLY
NOTES

DHS-4574 (Rev. 1-13) Previous edition obsolete.

FOR OFFICE USE ONLY
NOTES

ASSETS DECLARATION
PATIENT AND SPOUSE

Michigan Department of Human Services
(Skip if no spouse)

FOR OFFICE USE ONLY				
Grantee Name				
Grantee Client ID				
Case Number				
County	District	Section	Unit	Specialist

PLEASE PRINT

Patient's Name (First, Middle, Last)	Phone No. of Nursing Home		Spouse's Name (First, Middle, Last)	Spouse's Phone No.	
Address of Nursing Home (Number, Street, Rural Route)			Spouse's Address (Number, Street, Rural Route)		
City	State	Zip Code	City	State	Zip Code
Patient's Birthdate (Mo/Day/Yr)	Patient's Social Security		Spouse's Birthdate (Mo/Day/Yr	Spouse's Social Security*	

This form asks questions about the property or assets owned by you and/or your spouse. This information is needed to determine your eligibility for Medicaid and the amount of assets that can be protected for the benefit of your spouse. Answer the following questions by providing information about all assets owned by you and/or your spouse as of _____. Include assets you or your spouse own jointly with family or other persons.

ASSETS

1. Do you and/or your spouse have any assets (include assets held jointly)?

☐ Yes ▶ Check all types of assets your household has and complete the table ☐ No

- ☐ Checking/draft account
- ☐ Money market accounts
- ☐ Savings/share accounts
- ☐ Certificates of Deposit (CD)
- ☐ Christmas club accounts
- ☐ Patient trust fund
- ☐ Case on hand or in safe deposit
- ☐ Savings, bonds, stocks or mutual funds
- ☐ IRA, KEOGH, 401K or Deferred Compensation account(s)
- ☐ Trust or Annuity
- ☐ Land contract, mortgage or other notes payable to household member
- ☐ Real estate (including place you live)
- ☐ Life estate/life lease
- ☐ Burial plot(s), casket, etc.
- ☐ Tools, equipment, livestock or crops
- ☐ Life insurance
- ☐ Other Assets _____
- ☐ Health Savings Account
- ☐ Burial trust/funeral contract(s)

Owner(s) of asset(s)	Type(s) of Asset(s)	Balance amount of value	Name and address (bank, insurance company, etc.)	Account/policy number, etc.

AUTHORITY: 42 CFR Part 435.
COMPLETION: Voluntary.
PENALTY: No Medicaid.

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*Optional if the community spouse is not requesting assistance.

ASSETS

2. Does anyone in your household have any vehicles?

☐ Yes ▸ Check all types of assets your household has and complete the table ☐ No

☐ Car ☐ Truck ☐ Boat ☐ Camper/trailer ☐ Motorcycle ☐ RV ☐ Other Vehicle

Owner(s) (As shown on vehicle title or registration)	Year	Make/Model	Amount Owed

3. Has anyone in your household:

- sold or given away property, land, vehicles, stocks, bonds, savings, cash, checking, income, etc., closed any accounts or removed or added a name on any asset within the last 60 months? ☐ Yes ▸ Who: ☐ No
- filed a pending lawsuit which may bring money, property, etc.? ☐ Yes ▸ Who: ☐ No
- received a one-time cash payment (such as worker's compensation, lottery winnings, insurance settlement, lawsuit award, etc.) within the last 60 months? ☐ Yes ▸ Who: ☐ No
- or has anyone acting for any household member, ever put any money, lawsuit settlement, income or assets in a trust, annuity or similar legal device? ☐ Yes ▸ Who: ☐ No

AFFIDAVIT

I swear or affirm that all the information that I have written on this form or told to a specialist is true. I understand that I can be prosecuted for perjury if I have intentionally given false information. I also know that I may be asked to show proof of any information I have given. I also know that if I have intentionally left out any information or if I have given false information, which causes me to receive assistance I am not entitled to or more assistance than I am entitled to, I can be prosecuted for fraud.

Signature (Patient or Representative)		Date (Month, Day, Year)
Two Witnesses Only If Signed by Mark X	Signature of First Witness	Signature of Second Witness

NOTE: If you signed this application on behalf of someone else, complete the information below.

Name (First, Middle, Last)	Phone Number	Relationship to patient	
Street Address	City	State	Zip Code

Note: This application requests information about the patient in the nursing facility. The words **"You"** and **"Your"** refer to the patient.

1. Patient's Name (First, Middle, Last)	2. Name of Nursing Facility			
3. Address of Nursing Facility	City	State	Zip Code	
4. Phone No. of Nursing Facility	5. County	6. Birthdate	7. Sex	8. Social Security Number
9. Marital Status: ☐ Never married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed				
10. Date of Nursing Facility Admission	11. Address where you lived before you entered the nursing facility			

12. **If married, tell us about your spouse and all persons living with your spouse.**
If not married, tell us about your children under age 18 living in your home.

Name	Date of Birth	Social Security Number*	Relationship to you

If you have a court-appointed guardian/conservator, enter information below:

13. Name of Guardian/Conservator	Phone Number	Do you pay guardian/conservator expenses? ☐ **YES** ☐ **NO**		
Guardian's/Conservator's Address	City	State	Zip Code	

		YES	NO
14.	Have you ever applied for or received assistance in Michigan?	☐	☐
15.	Have you received money or benefits such as Medical Assistance **from another state** in the last 30 days?	☐	☐
16.	Are you a U.S. citizen?	☐	☐
17.	Do you intend to stay in Michigan?	☐	☐
18.	Enter your racial heritage from codes below. If you are multiracial, you may enter all the codes that apply. (Answering is voluntary.) I = American Indian, A = Alaskan Native, S = Asian, B = Black or African American, P = Native Hawaiian or Other Pacific Islander, W = White _____		
19.	Check the box if your are Hispanic or Latino (Answering is voluntary).	☐	☐
20.	Are you a veteran or the spouse, dependent or parent of a veteran?	☐	☐
21.	Do you have unpaid medical expenses for services provided in the last 3 months?	☐	☐
22.	Do you pay health insurance premiums?	☐	☐
23.	Do you have Medicare?	☐	☐
24.	Are you covered by a health, hospital, or long-term care insurance policy or were you covered in the last 3 months?	☐	☐
25.	Has a court ordered anyone to pay your medical expenses or provide health insurance for you?	☐	☐
26.	Have you had an accident or work-related illness or injury resulting in medical costs that may be paid by another person or an insurance company?	☐	☐
27.	Have you set up a plan or entered into a contract, such as a life care contract, that will pay for your medical care?	☐	☐
28.	Is there a plan for you to return home within six months from the date of admittance?	☐	☐

*Optional if the community spouse and/or children are not applying for Medicaid.

28. Assets: Complete the **assets** section by providing the requested asset information for you and your spouse. List your assets and your spouse's assets. Include assets you own jointly with family or other persons, including your spouse. Include assets your spouse owns jointly with you, family or other persons. Each item must be answered **YES** or **NO**. If answered **YES**, enter amount or current value and owner(s).

Type of Asset	YES	NO	Amount or Value	Owner(s) of Asset
Cash on hand, in a safety deposit box or patient trust fund				
Home, life estate/life lease				
Real estate, not your home				
Mortgage, land contract or other notes payable to you				
Savings bonds or money market funds				
Stocks or mutual funds				
Pension, IRA, KEOGH, 401K or deferred compensation account(s)				
Trust funds				
Life Insurance				
Annuity				
Cars, vans, trucks, campers, boats, snowmobiles, other vehicles				
Tools, equipment, livestock, or crops				
Funeral contracts				
Burial plot, casket, etc.				
Health Savings Account				
Are there any other assets? (Please Explain)				

Checking/Draft Accounts — Savings/Share Accounts — Certificates of Deposit

Name(s) on the Account	Name and Address of Bank Credit Union, Savings and Loan	Account Number	Balance

		YES	NO
29.	Have you received a one-time cash payment in the last 60 months (5 years) such as an insurance settlement, lawsuit award, worker's compensation, lottery winnings, etc.?.	☐	☐
30.	Do you have a pending lawsuit that may bring property or money to you?.	☐	☐
31.	Within the last 60 months (5 years) have you or a joint owner or other person whose name is also listed on the asset:		
	• sold, given away, or transferred ownership in any asset such as those listed above?	☐	☐
	• removed or added a name on any asset such as those listed above?	☐	☐
32.	Have you or someone acting for you ever put any money, income, lawsuit settlement or assets in a trust, annuity or similar device?.	☐	☐

33. **Income:** Include income for yourself and everyone listed in question 12.
Is anyone employed or self-employed? ☐ **YES** ☐ **NO** If **YES**, complete the following for each employed person.

Persons employed or self-employed	Employer name	Wages before deductions	How often paid: weekly, every 2 wks, monthly, other
		$	
		$	

Every item below must be answered **YES** or **NO**.

Type of Income	YES	NO	Amount	Whose Income
Social Security Benefits (RSDI) Claim #				
Social Security Benefits (RSDI) Claim #				
Supplemental Security Income (SSI)				
Supplemental Security Income (SSI)				
Retirement Benefits				
Veterans Benefits				
Disability Benefits				
Rental Income				
Worker's Compensation				
Child Support				
Unemployment Compensation				
Military Allotments				
Gaming Distributions (Casino Profit Sharing)				
Is there any other income? (Please explain)				

34.

Address where your spouse lives			Spouse's Phone Number
City	State	Zip Code	County

Household Expenses – Check **YES** or **NO** and write in the answer about you and/or your spouse's home.

	YES	NO	AMOUNT	HOW OFTEN PAID
Do you and/or your spouse have a rent, mortgage or other shelter expense?				
Do you and/or your spouse have the following expenses separate from rent or mortgage:				
• Renter's Insurance				
• Property Taxes				
• Mobile Home Lot Rent				
• Special Assessments				
• Homeowner's Insurance				
• Mortgage Guarantee Insurance				
• Cooperative or Condominium Fee				
Do you and/or your spouse have an obligation to pay for heat and/or utilities?				

ASSIGNMENT OF BENEFITS

Recovery of Medical Costs. I understand that when the Michigan Department of Community Health (MDCH) pays the cost of hospital, surgical, or medical services, any right to recover costs from a third person or public or private contractor, except Medicare, is transferred to the MDCH. Payment of any recovery under such right is to be made directly to the State of Michigan — MDCH.

RELEASES

Social Security Information. I will allow the Social Security Administration to give to the Department of Human Services all information necessary to determine my eligibility for benefits under the Medicaid program until the second month following the expiration of my eligibility based on the current application.

Eligibility Information. I understand that the information I have provided will be used to determine my eligibility for Medicaid only and for purposes of administering the Medicaid program.

AFFIDAVIT

Under penalties of perjury, I swear that this application has been examined by or read to me, and, to the best of my knowledge, the facts are true and complete. If I am a third party applying on behalf of another person, I swear that this application has been examined by or read to the applicant, and, to the best of my knowledge, the facts are true and complete.

I certify, under penalty of perjury, that all information that I have written on this form or told to a specialist is true. I understand that I can be prosecuted for perjury if I have intentionally given false information. I also know that I may be asked to show proof of any information I have given. I also know that if I have intentionally left out any information or if I have given false information, which causes me to receive assistance I am not entitled to or more assistance that I am entitled to, I can be prosecuted for fraud. **I understand I must report changes in income, assets or health insurance coverage to the department within 10 days of the change.**

If you have any questions, contact your specialist or the local Department of Human Services before signing the application.

IMPORTANT: YOU MUST SIGN THE APPLICATION

I certify that I have received and reviewed a copy of the Acknowledgments that explains additional information about applying for and receiving Medicaid.

Signature (Patient or Representative) Date	Two Witnesses only if signed by X Date 1. _____ 2. _____
Signature (Patient or Representative) Date	Two Witnesses only if signed by X Date 1. _____ 2. _____

If you are signing this application on behalf of someone else, complete the information below.

Name of person completing application	Phone Number	Relationship to patient	
Street Address	City	State	Zip Code

PLEASE KEEP THIS PAGE.
Tear out along the dotted line.

INFORMATION ABOUT MEDICAID

Rules may have changed since this was printed. Check with your local DHS office.

"You" and "Your" below refer to the patient. "We" means the Department of Human Services.

If you need help with past, unpaid medical expenses, Medicaid coverage may begin three months before you apply.

You can have Medicaid even if you are not a U.S. citizen. Coverage might be limited to just emergency services.

There are limits on the amount of income and assets you can have and be eligible for Medicaid.

Receiving Medicaid Services

You must tell all your providers (doctors, hospital, pharmacy, etc.) that you have applied for Medicaid before you receive any new medical services. Not all providers accept Medicaid. Choose a provider who does accept Medicaid.

You must give your medical provider a copy of your mihealth card or approval letter as soon as it is received. This letter tells when your eligibility began. Your providers need this information to receive prompt payment for medical services provided to you. This information is needed to issue you a refund if you pay for a Medicaid-covered service before you received the approval letter.

We might approve Medicaid for up to 3 months before you applied. If we do, ask your providers to bill Medicaid for any covered services you received during those months. If you paid for any of these bills before you received the approval letter, ask your health providers if they will refund your money and bill Medicaid. Providers are not required to do this, but many will.

Your providers must submit your bills to Medicaid within 12 months after the date you received the services. If they wait more than 12 months, then Medicaid may not pay the bill unless the delay in billing is because you had to file an appeal to get Medicaid benefits.

Income

You meet the income test if your income is not enough to pay your medical expenses. Usually you will pay part of your nursing facility expenses and Medicaid will pay the rest. If you have a spouse or children at home, a portion of your income might be protected for them.

We count income such as Social Security benefits, pensions, rent income and veterans benefits.

Assets

Countable assets must be at or below the $2,000 asset limit at least part of each month for which Medicaid is requested. If you have a spouse at home:

We count your assets and your spouse's assets initially. We protect a substantial amount of assets for your spouse. The remainder cannot exceed $2,000 for you to be eligible for Medicaid.

Once initial eligibility is established, we only count your assets. The asset limit is $2,000.

If your assets are more than the asset limit, you may become eligible for Medicaid if you use your excess assets to pay some of your medical bills, living expenses, or other debts. You may be asked to verify when and for what purposes you used your excess assets.

Medicaid might not pay for your care if you or your spouse transfer assets or income for less than fair market value. We look at transfers that occur up to 60 months (5 years) before, or any time after, your first date of application for Medicaid while in a nursing facility.

Nursing Facility Eligibility (MDCH Publication 726) - explains eligibility for persons in or entering a nursing facility.

DHS-4574 (Rev. 1-13) Previous edition obsolete.

ACKNOWLEDGMENTS

State of Michigan
Department of Human Services

This is your copy of your rights and responsibilities as an applicant for or recipient of Medicaid benefits. By signing the application you acknowledge that you understood your rights and responsibilities and that you applied only for Medicaid.

ASSIGNMENT OF BENEFITS

1. **Recovery of Medical Costs.** I understand that when the Michigan Department of Community Health (MDCH) pays the cost of hospital, surgical, or medical services, any right to recover costs from a third person or public or private contractor, except Medicare, is transferred to the MDCH. Payment of any recovery under such right is to be made directly to the State of Michigan - MDCH.

ACKNOWLEDGEMENTS

2. **Non-discrimination.** I understand that if I believe I have been discriminated against because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs, I have the right to file a complaint with the: Regional Manager, Region V, Office for Civil Rights, U.S. Department of Health and Human Services, 233 N. Michigan Ave., Chicago, IL 60601, 800-368-1019, 800-537-7697 TDD.

3. **Reporting Changes.** I understand that the department needs to know about changes that may affect my Medicaid. I will tell the department of any changes within 10 days of the change. I understand that if I intentionally do not do this, I can be prosecuted for fraud or perjury.

   The types of changes that **MUST** be reported are:

   - Receipt of or increase in income such as social security, veterans benefits, railroad retirement, pensions, retirement, disability or sick benefits.
   - Discharge or move from the nursing facility to another living arrangement.
   - Changes in health or hospital insurance coverage or amount of premiums.
   - Any accident or work-related illness or injury where medical costs may be paid by another person or an insurance company.
   - Another person or an insurance company has agreed to pay my medical expenses or is ordered to by the court.
   - Receipt of a sum of money.
   - Receipt of an inheritance, bank account, or other property or income from or on behalf of another person.

   If you have any doubt about whether you should report a change in circumstances, ask your local Department of Human Services.

4. **Hearings.** I understand that if I do not agree with any decision made on any matter concerning my case I have the right to ask for an Administrative Hearing. I understand that I can ask for information about an Administrative Hearing by calling my local Department of Human Services.

   I understand that if I want someone else to request a hearing for me or represent me in a hearing, that person must first have written authorization to do so unless that person is my attorney or my spouse. The Department of Human Services Administrative Hearings must have one of the following:

   - my original signed statement authorizing the person to request a hearing, **or**
   - a copy of the court order naming the person as my guardian or conservator.

   Otherwise, my hearing request will be denied.

5. **Repayment of Benefits.** I understand that if I receive more benefits than I am entitled to receive, through my fault, I may have to repay any extra benefits.

6. **Immigration Status.** I understand that, as part of determining my eligibility for Medicaid, information about me may be submitted to the Bureau of Citizenship and Immigration Services in order to verify my immigration status.

7. **Investigations.** I understand that my application might be one of those chosen for a complete investigation and a Department of Human Services representative might call on me and might contact other people in order to verify my eligibility for assistance.

8. **Computer Cross-checking**. I understand that, as part of determining my eligibility for Medicaid, information I give on this application will be verified by computer cross-checking with other public and private agencies.

   Wages reported by my employer(s) to the Department of Labor and Economic Growth will be checked against wage information I report to the Department of Human Services. My Social Security Number will be used to check this information. Throughout the year, my Social Security Number will also be checked with other sources such as the Internal Revenue Service (IRS), Unemployment Compensation, and the Social Security Administration concerning income or assets.

   The information obtained through this cross-checking may be verified through collateral contact when discrepancies are found. The information may affect both my eligibility and the level of my benefits.

9. **Medical Information**. By signing this application, I understand that the Department of Human Services and Michigan Department of Community Health, may get and use* necessary medical information about me or any of my wards or my minor children, including any information relative to HIV, ARC or AIDS, if applicable. This information will only be obtained and used as necessary to determine eligibility for a specific program or for other program administration purposes.

   *Some examples of uses are with auditors, caregivers, etc. State law (MCL 333.5131 (8)) provides that a person who shares HIV, ARC or AIDS information except as authorized by this release or by law may be found “guilty of a misdemeanor punishable by imprisonment for not more than 1 year or a fine of not more than $5,000.00, or both, and is liable in a civil action for actual damages or $1,000.00, whichever is greater, and costs and reasonable attorney fees.”

10. **Social Security Information.** I will allow the Social Security Administration to give to the Department of Human Services all information necessary to determine my right to benefits under Medicaid until the second month following the expiration of my eligibility based on the current application.

11. **Eligibility Information.** I understand that the information I have provided will be used to determine my eligibility for Medicaid only and for purposes of administering the Medicaid Program.

12. **Estate Recovery.** I understand that upon my death the Michigan Department of Community Health (MDCH) has the legal right to seek recovery from my estate for services paid by Medicaid. MDCH will not make a claim against the estate while there is a legal surviving spouse or a legal surviving child who is under the age of 21, blind, or disabled. An estate consists of real and personal property. Estate Recovery only applies to certain Medicaid recipients who received Medicaid services after the effective date of the estate recovery statue. MDCH may agree not to pursue recovery if an undue hardship exists. For further information regarding Estate Recovery, call 1-800-642-3195.