MAP-205
(07/2022)

Commonwealth of Kentucky
Cabinet for Health & Family Services
Department for Community Based Services

APPLICATION FOR MEDICAID OR MEDICARE SAVINGS PROGRAMS

Please select the type of Medicaid you are applying for, if known:

☐ Regular Medicaid

☐ Waiver Medicaid

☐ Long Term Care Medicaid

☐ Medicare Savings Program

☐ Spend Down

Questions? Need Help?
Call 1-855-306-8959

For Hearing Impaired
Call 1-800-648-6056

Instructions:

1. Complete the whole form. If you need more room to write, attach additional pages.
2. Include copies of documents where requested.
3. Read your rights and responsibilities on the last page.
4. Sign the application at the bottom of the last page and return to your local Department for Community Based Services (DCBS) office in the county where you live. You may locate your local office by calling 1-855-306-8959 or visiting the DCBS local office search at: https://prd.webapps.chfs.ky.gov/Office_Phone/index.aspx.
   You can also fax the application to the Centralized Mail Room at 1-502-573-2005 or 1-502-573-2007.

TELL US ABOUT YOURSELF:

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:	SEX: DATE OF BIRTH:

PHYSICAL ADDRESS: IS THIS A FACILITY/INSTITUTION? ☐YES ☐NO	CITY:	STATE:	ZIP:
MAILING ADDRESS:	CITY:	STATE:	ZIP:

SOCIAL SECURITY NUMBER:	TELEPHONE NUMBER:	COUNTY WHERE YOU LIVE:
MARITAL STATUS: ☐ SINGLE ☐ MARRIED, LIVING TOGETHER ☐ MARRIED, LIVING APART ☐ DIVORCED ☐ WIDOWED TAX FILING STATUS:	SSI STATUS: ☐ NEVER APPLIED ☐ CURRENTLY RECEIVING ☐ PENDING ☐ DENIED/DISCONTINUED REASON:	TECHNICAL ELIGIBILITY: ☐ AGED (65 OR OLDER) ☐ BLIND ☐ DISABLED IN NURSING FACILITY OR WAIVER PROGRAM? ☐ YES ☐ NO

DID SOMEONE HELP YOU WITH THIS APPLICATION? IF YES, PLEASE PROVIDE THEIR INFORMATION BELOW:

RELATIONSHIP: ☐ SPOUSE ☐ POWER OF ATTORNEY ☐ GUARDIAN ☐ AUTHORIZED REPRESENTATIVE			
IF OTHER, PLEASE EXPLAIN:			
LAST NAME:	FIRST NAME:	MIDDLE INITIAL:	TELEPHONE NUMBER:

ADDRESS:	CITY:	STATE:	ZIP:

I APPOINT THIS PERSON TO BE MY AUTHORIZED REPRESENTATIVE TO APPLY FOR MEDICAID FOR ME.

APPLICANT SIGNATURE: X_____ DATE: _____

PLEASE PROVIDE PROOF OF AUTHORIZED REPRESENTATIVE STATUS. EXAMPLES OF ACCEPTABLE AUTHORIZED REPRESENTATIVE VERIFICATION INCLUDE:

- **THE MAP-14 AUTHORIZED REPRESENTATIVE DESIGNATION FORM - WHICH CAN BE FOUND HERE: https://chfs.ky.gov/agencies/dms/MAPForms/MAP14.pdf**
- **POWER OF ATTORNEY DOCUMENTS**
- **COURT DOCUMENTS TO VERIFY GUARDIANSHIP**

HOUSEHOLD INFORMATION
LIST EVERYONE LIVING IN YOUR HOME

Relationship	Last Name	First Name	Middle Initial	Date of Birth	Sex	Social Security Number	Race *	Hispanic/ Latino?	US Citizen?
SELF					☐ M ☐ F			☐ Y ☐ N	☐ Y ☐ N
					☐ M ☐ F			☐ Y ☐ N	☐ Y ☐ N
					☐ M ☐ F			☐ Y ☐ N	☐ Y ☐ N
					☐ M ☐ F			☐ Y ☐ N	☐ Y ☐ N
					☐ M ☐ F			☐ Y ☐ N	☐ Y ☐ N

***FOR RACE:** Use any of these codes that apply. Your coverage will not be affected if you do not answer. (A) American Indian/Alaskan Native; (B) Black; (P) Native Hawaiian/Pacific Islander; (S) Asian; (W) White.

DO YOU OR YOUR SPOUSE HAVE HEALTH INSURANCE?
(SEND COPIES OF THE FRONT AND BACK OF CARDS WITH APPLICATION)

☐ MEDICARE PART A Self ☐ Spouse ☐	CLAIM NO. (ON CARD): CLAIM NO. (ON CARD):	EFFECTIVE DATE:
☐ MEDICARE PART B Self ☐ Spouse ☐	CLAIM NO. (ON CARD): CLAIM NO. (ON CARD):	EFFECTIVE DATE:
☐ MEDICARE PART C Self ☐ Spouse ☐	CLAIM NO. (ON CARD): CLAIM NO. (ON CARD):	EFFECTIVE DATE:
☐ MEDICARE PART D Self ☐ Spouse ☐	CLAIM NO. (ON CARD): CLAIM NO. (ON CARD):	EFFECTIVE DATE:
NAME OF PROVIDER: Self ☐ Spouse ☐		
☐ OTHER INSURANCE POLICY	CLAIM NO. (ON CARD):	EFFECTIVE DATE:
NAME AND ADDRESS OF COMPANY:		
☐ OTHER INSURANCE POLICY	CLAIM NO. (ON CARD):	EFFECTIVE DATE:
NAME AND ADDRESS OF COMPANY:		

YOUR INCOME AND THE INCOME OF YOUR SPOUSE, IF MARRIED:

UNEARNED INCOME EXAMPLES: SOCIAL SECURITY, VETERANS, RAILROAD RETIREMENT, PENSIONS, SUPPORT OR ALIMONY, RENTAL INCOME, TOBACCO SETTLEMENT, PAYMENT FROM ANNUITIES/INVESTMENTS			
WHOSE INCOME	TYPE OF INCOME	GROSS AMOUNT (BEFORE DEDUCTIONS)	HOW OFTEN RECEIVED

EARNED INCOME EXAMPLES: WAGES FROM A JOB OR SELF EMPLOYMENT INCOME				
WHOSE INCOME	TYPE OF INCOME	GROSS AMOUNT (BEFORE DEDUCTIONS)	HOW OFTEN RECEIVED	NAME AND ADDRESS OF EMPLOYER

PLEASE PROVIDE PROOF OF ALL INCOME. EXAMPLES OF ACCEPTABLE VERIFICATION INCLUDE:

- **AWARD LETTERS FROM SOCIAL SECURITY, VETERANS AFFAIRS, OR RAILROAD RETIREMENT**
- **COPIES OF PAY STUBS**
- **COPIES OF TAX RECORDS FOR SELF-EMPLOYMENT**
- **COURT ORDERS FOR ALIMONY OR SUPPORT**
- **COMPANY STATEMENTS FOR PENSIONS AND RETIREMENTS**

DO YOU OR YOUR SPOUSE HAVE ANY RESOURCES?

EXAMPLES OF RESOURCES INCLUDE: BANK ACCOUNTS, STOCKS AND BONDS, TRUSTS, ANNUITIES, VEHICLES. YOU MUST PROVIDE PROOF OF THESE RESOURCES.ACCEPTABLE PROOF INCLUDES BANK STATEMENTS, BROKERAGE STATEMENTS, COPIES OF TRUSTS/ANNUITIES.

TYPE OF RESOURCE	BALANCE/ VALUE	RESOURCE HELD BY? (NAME OF BANK OR COMPANY)	OWNERS	ACCOUNT NUMBER
HAVE YOU TRANSFERRED OR SOLD A RESOURCE WITHIN THE PAST 5 YEARS? IF YES, PLEASE EXPLAIN:				

RESOURCES ALSO INCLUDE LIFE INSURANCE POLICIES OR PREPAID FUNERAL ARRANGEMENTS MADE FOR YOU OR YOUR SPOUSE:

POLICY OWNER	INSURANCE COMPANY/FUNERAL HOME	POLICY NUMBER	FACE VALUE	CASH SURRENDER VALUE OF POLICY

DO YOU OR YOUR SPOUSE OWN THE HOME WHERE YOU LIVE? IF YES, PLEASE ENTER INFORMATION BELOW:	DO YOU OR YOUR SPOUSE OWN PROPERTY YOU DO NOT LIVE IN? IF YES, PLEASE ENTER INFORMATION BELOW:
ADDRESS:	ADDRESS:
CURRENT PVA VALUE:	CURRENT PVA VALUE:

STATEMENT OF UNDERSTANDING AND AGREEMENT

I certify that this information is correct and true to the best of my knowledge. I understand that the Social Security Act requires that all recipients of assistance furnish and be identified by a social security number and if an individual refuses to apply for a number, that the Department cannot make a payment or provide Medicaid. I understand that social security numbers shall be used for various State and Federal matches through the Income and Eligibility Verification System (IEVS). These matches include, but are not limited toSocial Security, IRS, SSI, Wage Records, Unemployment Insurance, and other matches as provided under the authority of IEVS. This information may be verified through collateral contact when discrepancies are found. Information provided under IEVS, after verification, may affect eligibility for and amount of benefits.This information shall be disclosed to other agencies only as permitted by law. I declare that all persons for whom application is made are U.S. citizens or are admitted under approved alien status. I certify under penalty of perjury, the information, including citizenship or alien status, provided by me in this statement is correct and true to the best of my knowledge and give my consent to the Department for Community Based Services to make any necessary contacts to verify my statements. I understand information on this application is used to determine if I am eligible for benefits from the Department for Community Based Services. I understand if I give false information, withhold information, or fail to report changes within 10 days, I may be subject to prosecution for fraud, reduction or loss of benefits and I may be required to repay benefits I have received. I further give my consent to the Department for Community Based Services to makeany necessary contacts to verify my statement or gain additional information pertinent to my eligibility. All applications for assistance are considered without regard to race, color, sex, disability, religious creed, national origin, or political belief. You or your representative may request a fair hearing by contacting your worker if you disagree with any action taken in your case. Your case may be presented at the hearing by any person you choose.

X_____ _____
Signature of Applicant **Date**

X_____ _____
Signature of Applicant's Spouse or Authorized Representative **Date**

X_____ _____
Signature of Witness (If signed by mark) **Date**