Application for Disproportionate Share Hospital Program (DSH) and Medicaid/KCHIP Screening Form

The following information is used to determine if an individual who requests or has already received hospital services is eligible for Disproportionate Share Hospital services or should be referred instead to the Department for Community Based Services (DCBS) or to benefind.ky.gov to apply for Medicaid or KCHIP. Refer all children aged 19 and under to benefind.ky.gov or to the DCBS office in the county of the individual's residence for a KCHIP eligibility determination. Please provide the DCBS call center number,* 1-866-306-8959, *to each individual for further assistance.

Section 1: Individual Information

1. Today's Date:		9. Work Phone:	
2. Patient's Name:		10. Dates Hospital Provided Service:	
3. Street Address:		11. Married/Single:	
4. City:		12. Name of Spouse:	
State:	Zip Code:	13. Is the patient pregnant? ☐Yes ☐No	
5. *Social Security Number:		***If YES**, refer the patient to DCBS or benefind for Medicaid eligibility determination*	
6. Date of Birth:	7. Patient's Sex:	14. Is the patient a resident of Kentucky? ☐ Yes ☐No	
8. Home Phone:		*("Resident" is defined as a person living in Kentucky and who is not receiving public assistance in another state.)*	

** Please note that a Social Security Number is **not** required, and does not need to be provided. This information is only used to determine if the patient is currently receiving Medicaid. This information will not be shared, and will not be used for any other purpose.*

If the answer to question 14 is yes, go to question 15. If the answer to question 14 is no, advise the patient that he/she does not meet criteria for eligibility for DSH and complete Section V.

15. List the name, relationship, and age of each person living in the household.

Household Member's Name		Relationship		Age

16. Does the individual have dependent children living in the home? ☐Yes ☐No

(a) If the answer to question 16 is **YES, refer the individual to DCBS or benefind for Medicaid;**
(b) If the answer to question 16 is **NO**, refer the individual to DCBS or benefind Medicaid **ONLY IF** the individual has **NOT** received a denial from Medicaid within 30 days; or,
(c) If the individual, who has no children less than 18 years of age, claims to be disabled, refer the individual both to DCBS or benefind to apply for Medicaid and to the Social Security Administration to apply for SSI
**** See Criteria for Medicaid and KCHIP Eligibility on Page 4***.

17. **Income information**

a. Patient/Responsible Party Employer:			
b. Spouse Employer:			
c. Work Phone:			
d. Total Gross Monthly Income:			
e. Other Income:			
i. Unemployment:			
ii. Child Support:			
iii. Social Security:			
iv. Workers Comp:			
v. Other:			
Total Family Unit Gross Monthly Income:	$		

18. **Insurance Information**

a. Health/Life Insurance:	
b. Phone Number:	
c. Policy Number	
d. Group Number:	
e. Policy Holder:	
f. Relation to Patient:	

19. **Countable Resources**:

	Bank Name	Balance Value
a. Checking:		
b. Savings		
c. Money Market		
d, Mutual Fund		
e. Stocks		
f, Bonds		
g. Other		
* Total Health Bills Owed:		
*Total Resources:		

**Countable Resources shall be reduced by unpaid medical expenses of the family unit to establish eligibility.*

20. Other Information: a. Was date of service related to an auto accident? ☐Yes ☐No
b. Have you applied for and been denied Medicaid or KCHIP Benefits? ☐Yes ☐No

Section 2: Hospital Indigent Care Criteria

1. An individual must meet all of the following conditions:
   a. The individual is a resident of Kentucky
   b. The individual is **not eligible** for Medicaid or KCHIP
   c. The individual is **not** covered by a 3rd party payor
   d. The individual is **not** in the custody of a unit of government which is responsible for coverage of the acute care needs of the individual.
   e. The individual meets the following income and resource criteria:

Household Size	Resource Limit	100% of the Poverty Level (Monthly Income Limit)*	(Annual Income Limit)*
1	$2,000.00	$1005.00	$12,060.00
2	$4,000.00	$1,353.00	$16,240.00
3	$4,050.00	$1,702.00	$20,420.00
4	$4,100.00	$2,050.00	$24,600.00
5	$4,150.00	$2,398.00	$28,780.00

Add an additional $4,180.00 for each person. **Income limits are effective April 1, 2017.*

2. All income of a family unit is to be counted and a family unit includes:
   a. The individual;
   b. The Individual spouse who lives in the home;
   c. A parent or parents, of a minor child, who lives in the home;
   d. All minor children who live in the home.
3. Related and nonrelated household member(s) who do not fall into one of the groups listed above shall be considered a separate family unit.
4. Countable resources are limited to cash, checking and savings accounts, stocks, bonds, certificates of deposit, and money market accounts.
5. Countable resources may be reduced by unpaid medical expenses of the family unit to determine eligibility.

Section 3: Certifying Accuracy of Information

I hereby agree to furnish the Hospital all necessary information to allow them to determine my need to receive financial assistance for health care services received. I agree that the Hospital will be provided with or may obtain all documents necessary to verify my current income, employment status, and resources, and that failure to supply requested information within sixty (60) working days is grounds for denial of my application for assistance. I also agree to notify the Hospital immediately of any change of address, telephone number, employment status, or income.

I agree to allow the Hospital representative to determine eligibility and pursue state and federal assistance with Medicaid, KCHIP and DSH.

I certify that the information provided on this application is correct to the best of my knowledge and belief. I understand that if I give false information or withhold information in accepting assistance, I may be subject to prosecution for fraud. I understand that I have a right to request a fair hearing if I am dissatisfied with any action taken on my application. I understand that I must contact the hospital to make a hearing request.

_____ _____
Individual or Responsible Party's Signature Date

_____ _____
Hospital Employee Signature Date

Does the individual appear to qualify for Medicaid? ☐Yes ☐ No
If yes, then refer the individual to benefind or to the DCBS office in the county of the individual's residence. The

individual should take a copy of this form with him/her to the DCBS office.

Section 4: Refusal to Apply for Medicaid

The individual or his responsible party shall sign below if he refuses to apply for Medicaid.

I refuse to apply for Medicaid or KCHIP coverage. I understand that this refusal may result in me being billed for any services performed.

Individual or Responsible Party's Signature _____ Date _____

Section 5: Indigent Care Denial

The individual does not meet the criteria for indigent care for the following reason (please check what applies):

1. ☐ The individual is not a resident of Kentucky
2. ☐ The individual has been referred to apply for Medicaid or KCHIP but has refused to apply.
3. ☐ The individual already receives or has been approved for Medicaid or KCHIP.
4. ☐ The individual has been referred to apply for Medicaid or KCHIP but has not shown at the end of 30 days that the application was filed
5. ☐ The individual has been referred to an applied for Medicaid or KCHIP within 30 days but has not shown at the end of 120 days that the application has been denied or the application is pending.
6. ☐ The individual did not provide within 60 days information needed to verify income, resources or employment status.
7. ☐ The individual is covered by the following third party payor: _____
8. ☐ The individual is in the custody of the following unit of government which is responsible for the coverage of the acute care needs of the individual: _____
9. ☐ The household income of $ _____ is too high
10. ☐ The household resources of $ _____ are too high, even when reduced by unpaid medical bills.

*The individual believes that he/she is eligible for indigent care for the following reason:

_____

Section 6: Hearing Request

The individual may request a fair hearing within 90 days of this determination either by:

1. Signing and dating the hearing request below and returning a copy of this application to the hospital, or
2. Sending a letter to the hospital requesting a hearing.

Hearing requests must be post marked or hand-delivered within 90 days of the date below to:

Name or Department: _____

Hospital: _____

Address: _____

I request a hearing on this denial. I believe I am eligible for indigent care.

Patients Signature _____ Date _____

The hospital shall conduct a fair hearing within 30 days of receiving the individual's hearing request.

Section 7: Signature

This determination was made by:

Hospital Employee Signature _____ Date _____

Witness _____ Date _____

Please see Page 4 for information regarding application stipulations.

RETAIN A COPY OF THIS APPLICATION IN THE PATIENT'S RECORDS.
THIS DETERMINATION IS VALID FOR A PERIOD OF SIX MONTHS UNLESS THE INDIVIDUAL'S FINANCIAL SITUATION CHANGES.

Medicaid and KCHIP Eligibility

If the patient or household appear to be eligible for Medicaid or KCHIP:

- complete the rest of this application and give a copy to the patient
- explain to the patient the requirement to apply for Medicaid or KCHIP within 30 days and report back within 120 days on whether the application:
  - has been approved or
  - has been denied or
  - is still pending

Refer to DCBS or benefind.ky.gov to apply for KCHIP or Medicaid if the patient has income below 138% of the federal poverty level.

Do not refer a patient to DCBS or benefind to apply for Medicaid or KCHIP if the individual received a denial of Medicaid or KCHIP within the past 30 days.

If an individual claims to be permanently and totally disabled, refer the individual both to DCBS or benefind to apply for Medicaid and to the Social Security Administration to apply for SSI.

If a patient demonstrates that s/he has applied for Medicaid or SSI but the application is still pending after the end of 120 days, approve this application.

Application Stipulations

- Hand or mail a copy of this application to any individual denied coverage with a cover letter stating the reason for denial and that the individual has 90 days to appeal.

- If the individual has been referred to apply for Medicaid or KCHIP, attempt to contact after 30 days to see whether the individual has applied.

- If an individual has applied for Medicaid (including SSI) or KCHIP, attempt contact at 60, 90 and 120 days to see whether the application was approved or denied.

- If information needed to verify income, resources or employment is missing, attempt contact at 15, 30 and 45 days to remind the patient. Assist persons with disabilities as needed.

- If a Medicaid or SSI application has been made but is still pending after 120 days, you may approve this application.