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 page 6**.**
5. Determine if you would like to complete the voluntary **kynect resources Needs Assessment** on pages 7-9 that can provide you with additional community programs/services/resources.
6. 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	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
TAX FILING STATUS:	Primary Applicant Spoken Language (If Not English):	

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 to Social 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 make any 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**

kynect Resources Needs Assessment

The following is an additional resource needs assessment that is **voluntary** and does not impact your Medicaid benefits. This assessment helps us to identify and understand other needs you and your household may have that can impact your health and connect you with community resources/services/programs that may be helpful, such as transportation, utilities, food, childcare, etc. You may review your results by logging into your kynect account at https://kynect.ky.gov/resources or by calling 2-1-1 to be referred to community resources/services/programs.

Any additional household members may complete their own individual needs assessment by logging onto their kynect account online at https://kynect.ky.gov/resources or by calling 2-1-1.

Circle the letter that best describes your situation:

1. **Which best describes your housing situation?**
   a. I do not have stable housing.
   b. I am temporarily living with a friend or family member.
   c. I am currently not paying my rent/mortgage and in danger of eviction.
   d. I am paying my rent/mortgage, but it is unaffordable (over 30% of income).
   e. I am currently utilizing a rent/mortgage assistance program.
   f. I pay my rent/mortgage without difficulty.

2. **Which best describes your housing utilities (water, electricity, heating) situation?**
   a. I do not have housing/do not have utilities for my housing situation.
   b. My utilities are often shut off due to not paying.
   c. I use programs that help pay for my utilities.
   d. I have trouble paying for my utilities, but I mostly am able to pay.
   e. I can pay my utilities so that they are never turned off.

3. **Which best describes your current employment situation?**
   a. No job.
   b. I have temporary, seasonal, or part-time work that does NOT meet my needs; I need more employment.
   c. Full-time with no benefits or benefits that do not meet my needs.
      (Note: Benefits may include medical, dental, and vision insurance and retirement packages)
   d. I have temporary, seasonal, or part-time work that DOES meet my needs; I do not need more employment.
   e. Full-time with benefits that meet my needs.

4. **Which best describes your income situation?**
   a. No income.
   b. My income is irregular.
   c. My income is not enough to meet my needs.
   d. I can meet my basic needs with help from assistance programs.
   e. I can meet my basic needs without assistance.
   f. My income meets my needs, is well-managed, and I can save.

5. **Which best describes your food situation?**

a. I am unable to get food.
b. I can get food, but do not have the space or time to prepare a meal.
c. My household receives help for food such as SNAP (food stamps) or other food assistance.
d. I can meet my basic food needs, but I require occasional assistance such as a food pantry.
e. I can meet my basic food needs without assistance.
f. I can choose to purchase any food my household desires.

6. **Which best describes your childcare situation?**

a. I need childcare, but I am not able to afford childcare at this time.
b. I can afford Childcare, but the Childcare options are unreliable or inaccessible.
c. Childcare is provided by a personal friend or family member.
d. I can select quality childcare of my choice.
e. I do not need childcare at this time.

7. **Which best describes your level of education?**

a. I have no high school diploma/GED, or need help with reading and writing.
b. I have a high school diploma/GED, but language is a barrier.
c. I have a high school diploma/GED, but I need additional education/training to improve my job situation.
d. I have completed the education/training necessary for employment.
e. I am currently in high school or an education/training institution.

8. **Which best describes your health care coverage?**

a. I have no medical coverage and need coverage as soon as possible.
b. I have no medical coverage and no immediate need for coverage.
c. Some members of my household (such as children) have medical coverage, but I would like help in understanding how to use it.
d. Some members of my household (such as children) have medical coverage, and we understand how to use it.
e. All members of my household are covered by affordable health insurance, but I would like help understanding how to use it.
f. All members of my household are covered by affordable health insurance, and we understand how to use it.

9. **Which best describes your transportation situation?**

a. I do not have any access to transportation.
b. I have a car but cannot drive it or it is unreliable.
c. I use public transportation or a bike, but it is inconvenient or limited.
d. I do not need help with transportation.

10. **Do you need resources related to mental well-being?**

a. Yes, I am in need of assistance with my mental well-being.
b. No**-** I am not in need of assistance with my mental well-being.

11. **Do you need resources related to substance use?**

    a. Yes, I am in need of resources for Substance Use.

    b. No, I am not in need of resources for Substance Use.

12. **Do you need resources related to Domestic Violence?**

    a. Yes, I am in need of resources for Domestic Violence.

    b. No, I am not in need of resources for Domestic Violence.

13. **Which best describes your situation for care of the elderly and/or the disabled?**

    a. I have immediate need for assistance for either myself or someone who is in my care because of age or disability.
    b. I or someone in my care could use assistance with care because of age or disability.
    c. I have no need for assistance with care for the elderly/disabled.

14. **Which best describes your children's school experience?**

    a. I have one or more school-aged children not enrolled in school.
    b. My child or children are enrolled in school but only attend some of the time.
    c. My child or children are enrolled and attending classes most or all of the time.
    d. I do not have school aged children.

15. **Which best describes your ability to fulfill your basic needs daily?**

    a. I do not have the ability to meet basic needs such as food, clothing, or a place to bath regularly.
    b. I can meet a few, but not all of my basic needs.
    c. I am able to fulfill most but not all of my basic needs.
    d. I am able to meet all of my basic needs daily.

16. **Which best describes your social connections and friendships?**

    a. I am isolated and/or I do not want to interact with people.
    b. I would like to be more involved with family or groups but need more information or support.
    c. I have strong family/social supports and/or I am actively involved in my community or support groups.

17. **Which best describes your need for legal support?**

    a. I have outstanding warrant(s) or have charges pending.
    b. I am fully compliant with probation or parole terms.
    c. I have no felony criminal history or have had no criminal justice involvement in more than 12 months.

18. **Which best describes your parenting skills?**

    a. I need resources to improve my parenting skills.
    b. My parenting skills are adequate or well developed.
    c. I do not have children.