State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

CHRISTINE TODD WHITMAN
Governor

WILLIAM WALDMAN
Commissioner

VELVET G. MILLER
Director

MEDICAID COMMUNICATION NO. 96-24 **DATE: October 21, 1996**

TO: County Welfare Agency Directors

SUBJECT: Revision of Form PA-1G

Medicaid Communication No. 95-16 advised that the Form PA-1G, Application and Affidavit for: Medical Assistance Only, Emergency Assistance for SSI Recipients, was being revised. Subsequently, a draft of this form was distributed at the March 19, 1996 Medicaid Supervisors' Meeting. Changes in the form include the revision of the authorization page which reflects a change in the minimum age for estate recoveries from individuals 65 to 55 years of age. Additionally, the requirement to provide a Social Security Number has been added and the requirement for notarizing the form has been deleted.

The form has since been formalized and may be utilized upon availability of supplies. As in the past, responsibility for the reproduction and dissemination of the form remains with the counties. Please note that the form should be reproduced on yellow-colored paper as in past years.

Questions concerning this communication should be referred to the Medicaid field service staff assigned to your county.

Sincerely,

Karen L. Sy for
Velvet G. Miller
Director

VGM:Sa

c: Len Fishman, Commissioner
Susan C. Reinhard, Ph.D., Deputy Commissioner
Department of Health and Senior Services

Karen Highsmith, Acting Director
Division of Family Development

Patricia Balasco-Barr, Director
Division of Youth and Family Services

APPLICATION AND AFFIDAVIT FOR:
( ) MEDICAL ASSISTANCE ONLY
( ) EMERGENCY ASSISTANCE FOR SSI RECIPIENTS*

Agency name, address and phone no.

Case No. _____ **Date Registered** _____
Related Registration Nos. _____
Program _____
Status ( ) **NA** ( ) **RA** ( ) **RO** ( ) **TR** ( ) **CA**

IMPORTANT: The law prohibits duplication of assistance. Applicants receiving Medicaid through the Supplemental Security Income (SSI) program, are ineligible for medical assistance through this program.
INSTRUCTIONS: This form is to be completed by the applicant whenever possible. If it is necessary for someone other than the applicant to complete or assist in completion of this form, note that the word "you" is used to mean the applicant. PLEASE PRINT YOUR ANSWERS AND DO NOT WRITE IN THE SHADED BOXES.

SECTION I BASIC INFORMATION - Complete the following:

1. Applicant's Name _____ (Last / First / M.I. / Maiden)
1A. Applicant's Phone No. _____

2. Date of Birth _____
3. Place of Birth _____
4. Are you, or your spouse (or parent if applying for a child) a veteran? ( ) yes ( ) no If "yes", veteran's name is: _____ VA number is _____
5. Social Security or Railroad Retirement Number _____
6. Medicare Claim Number _____ Suffix _____
7. Do you receive or have you applied for SSI benefits? Check appropriately.
( ) receive ( ) do not receive ( ) applied for on (date) _____
8. Do you plan to continue living in New Jersey: ( ) yes ( ) no. If No, Explain: _____
9. Are you a citizen of the U.S.? ( ) yes ( ) no. If your answer is no, explain citizenship status, give date of entry into the U.S., alien registration number, etc. _____

Sponsor's Name and Address _____

OFFICE USE VERIFICATION

SECTION II RESIDENCY - Complete the following information on residence for the past 2 years. If you need more room, use the back of this form.

Address where you now live: _____
(number) (street or road) (apt. no.)
_____
(city, town or township) (state) (zip)
Your mailing address (if different from residence) is: _____
(zip)

Prior Address from _____ to _____ Lived at: _____

Prior Address from _____ to _____ Lived at: _____

_____ (Date)
(signature of person initiating application)
Phone number _____
_____
(relationship to applicant - i.e., applicant, parent, spouse, legal guardian, authorized representative, etc.)

* SSI RECIPIENTS APPLYING FOR EMERGENCY ASSISTANCE ARE TO COMPLETE PAGES 1, 3, 4, 5, 7 AND 8 ONLY.

SECTION III REASON FOR APPLYING

WHY DO YOU NEED HELP? _____

IF DISABLED, WHAT DATE DID YOU BECOME DISABLED? _____

WHAT IS THE NATURE OF YOUR DISABILITY? _____

UNTIL NOW, WHAT HAS BEEN THE SOURCE OF YOUR INCOME? _____

IF YOUR INCOME HAS CHANGED RECENTLY, EXPLAIN HOW AND WHEN. _____

SECTION IV MARITAL STATUS – CHECK APPROPRIATELY AND COMPLETE:

OFFICE USE ONLY

YOU ARE: ( ) SINGLE ( ) MARRIED ( ) SEPARATED ( ) DIVORCED ( ) WIDOWED ( ) CHILD*

NAME OF PRESENT HUSBAND/WIFE _____

DATE AND PLACE OF MARRIAGE _____

DATE OF SEPARATION _____

NAME OF FORMER HUSBAND/WIFE _____

DATE AND PLACE OF DIVORCE _____

DATE AND PLACE OF DEATH _____

*NAME OF MOTHER, FATHER, STEPMOTHER OR STEPFATHER _____

SECTION V LIVING ARRANGEMENTS

1. COMPLETE THE FOLLOWING TO SHOW YOUR CURRENT LIVING ARRANGEMENT, AND IF INSTITUTIONALIZED, YOUR LIVING ARRANGEMENT PRIOR TO ENTERING THE HOSPITAL OR INSTITUTION.

( ) OWN OR BUYING YOUR OWN HOME
( ) RENT(ED) A: ( ) HOUSE ( ) ROOM OR ( ) APARTMENT
( ) LIVE(D) IN A RESIDENTIAL HEALTH CARE FACILITY (LICENSED BOARDING HOME)
( ) LIVE(D) ALONE, OR WITH YOUR SPOUSE ONLY (NO CHILDREN)
( ) LIVE(D) WITH ANOTHER HOUSEHOLD, AND
  ( ) PURCHASE(D) AND PREPARE(D) MEALS WITH THAT HOUSEHOLD
  ( ) PURCHASE(D) AND PREPARE(D) MEALS SEPARATELY FROM THE HOUSEHOLD
  ( ) RECEIVE(D) FOOD STAMPS AS A SEPARATE HOUSEHOLD. IF SO, GIVE FS CASE # _____
  ( ) PAY (PAID) THE HOUSEHOLD A SET AMOUNT TO LIVE WITH THEM.
( ) OTHER LIVING ARRANGEMENTS. EXPLAIN _____

2. LIST OTHER PERSONS LIVING WITH YOU. INCLUDE NAME, AGE AND RELATIONSHIP _____

3. HOW MUCH DO (DID) YOU PAY PER MONTH FOR RENT OR MORTGAGE? $ _____

NAME AND ADDRESS OF MORTGAGE COMPANY OR LANDLORD _____

OFFICE USE:

MEDICAID STANDARD - TABLE B IS $_____FOR (CIRCLE ONE) INDIVIDUAL, COUPLE
VERIFICATION OF LIVING ARRANGEMENT
HOW STANDARD IS JUSTIFIED:

SECTION VI RESOURCES

USING THE FOLLOWING LIST; PLACE A CHECK MARK BEFORE ANY RESOURCE OWNED BY YOU, YOUR SPOUSE AND/OR PARENTS/STEPPARENTS OF APPLICANT CHILD LIVING AT HOME. THESE MAY BE OWNED BY THE INDIVIDUAL OR JOINTLY WITH OTHERS:

OFFICE USE:

( ) CASH ON HAND
( ) CASH THAT SOMEONE ELSE IS HOLDING FOR YOU
( ) SAVINGS OR CHECKING ACCOUNTS, OR SAVINGS CERTIFICATES
( ) CHRISTMAS, VACATION OR OTHER CLUB SAVINGS ACCOUNTS
( ) MONEY OR OTHER VALUABLES IN A SAFE DEPOSIT BOX
( ) CREDIT UNION MEMBERSHIP OR MUTUAL FUND SHARES
( ) U.S. SAVINGS BONDS OR OTHER STOCKS OR BONDS
( ) TRUST FUNDS
( ) IRA, KEOGH/OTHER SIMILAR TAX DEFERRED INCOME
( ) NOTES OR CONTRACTS OF VALUE
( ) OWNERSHIP OF MORTGAGES
( ) NONE OF THE ABOVE
( ) OTHER - IDENTIFY: _____

IF YOU NEED MORE ROOM, USE THE BACK OF THIS FORM.

A. IF YOU CHECKED ANY RESOURCE ABOVE, COMPLETE THE FOLLOWING:

TYPE OF RESOURCE AND OWNER(S)	VALUE	ACCOUNT OR CERTIFICATE NUMBERS	BANK NAMES, LOCATION OF THE RESOURCE AND OTHER IDENTIFYING INFORMATION
	$		
	$		
	$		
	$		
	$		

2. ANSWER "YES" OR "NO' FOR EACH OF THE FOLLOWING AND EXPLAIN "YES" ANSWERS WHERE INDICATED. DO YOU, YOUR SPOUSE OR PARENTS/STEPPARENTS OF APPLICANT CHILD LIVING AT HOME HAVE:

A. PART OR FULL OWNERSHIP OF ANY REAL PROPERTY IN THIS OR ANY OTHER STATE OR OTHER COUNTRY, WHETHER PURCHASED OR INHERITED?
( ) YES ( ) NO

OWNER(S) _____ VALUE $_____

TYPE OF PROPERTY _____ IS IT A RENTAL PROPERTY? ( ) YES ( ) NO

LOCATION _____

(IF OWNERSHIP OF MORE THAN ONE PROPERTY, REGARDLESS OF WHERE IT IS SITUATED, LIST AND GIVE DETAILS AS REQUESTED ABOVE. IF YOU NEED MORE ROOM, USE THE BACK OF THIS FORM.)

SECTION VI RESOURCES (CONTINUED)

B. Part or full ownership of valuable personal property such as jewelry, coin/stamp collections, furs, etc.?
( ) Yes ( ) No
Owner(s)_____

Type(s) _____ Value $_____

C. Any burial plots, contracts or funds set aside for anyone's burial? ( ) Yes ( ) No

Give Details: _____

_____ Value $_____

D. Ownership of and access to Life Insurance Policies? ( ) Yes ( ) No

NAME OF POLICY HOLDER	NAME OF INSURED	INSURANCE COMPANY	POLICY NUMBER	FACE VALUE	CASH VALUE

1. Who is the named beneficiary?_____

2. Contingent beneficiaries?_____

E. Any knowledge being named beneficiary on someone else's insurance Policy?
( ) Yes ( ) No. Give name and relationship:_____

_____

F. Any pending claims such as lawsuits, divorce settlements, inheritance, accident claims, sale of property, other claims, or does anyone owe you money? ( ) Yes ( ) No. Provide details: _____

_____

_____

Attorney's Name_____ Phone No. _____

3. Did you or anyone trade, give away or sell real or personal property in which you had an interest (include cash, real estate, vehicles, business, stocks, etc.) within the past 30 months? ( ) Yes ( ) No.
What was sold or given away?_____

By whom? _____ To whom? _____

Location (if land or property) _____

Date of sale or gift_____ Total Market value $_____ Amount received $_____

OFFICE USE:

4. List all vehicles owned by you, your spouse, or parents/stepparents of applicant child living at home. Include all types of transportation such as cars, vans, tractor trailers, pick-up trucks, trailers, motor homes, motorcycles, boats, etc.

OWNER'S NAME	YEAR/MAKE	MODEL/STYLE	USE	AMOUNT OWED

OFFICE USE:

SECTION VII EARNINGS INFORMATION

1. Complete the following for YOU, YOUR SPOUSE, or PARENT(S)/STEPPARENT(S) living with applicant child who are now working (include self-employment). If not employed, check here ( ).

	Person Employed	Name and Address of Employer	Gross/Net Pay Amts.	How Often Paid
A.	_____	_____	Gross $_____	per _____
		_____	Net $_____	
B.	_____	_____	Gross $_____	per _____
		_____	Net $_____	

OFFICE USE:

SECTION VIII BENEFITS/OTHER INCOME

If you, your spouse, or parents/stepparents with whom the applicant child lives, receives or has applied for income from any of the sources listed below; complete the information in that entry. If you have no such income or no potential entitlement, check here ( ).

Other Income	Check Appropriately: Received	Applied For	Potential For	Name of Recipient or Potential Recipient	Amount Received and How Often or Date of Application
Social Security					
Black Lung Benefits					
Railroad Retirement					
Sup. Security Income (SSI)					
Fed. Civil Service Annuity					
Veterans Benefits					
Government Pensions					
Unemployment Comp. (UIB)					
Workers' Compensation					
Private Pension					
Public Assistance (cash)					
Sick or Disability Payments					
Strike Benefits					
Rents, Dividends, Royalties, Interest					
Military Allotments					
Insurance Annuity					
Payment from Boarders					
Cash Support (include child support/ alimony)					
Maintenance in Kind					

OFFICE USE:

Benefit Status: / Type(s)	Receiving	Approved	Denied	Pending

If approved:

Amt. $_____ **per** _____

Effective_____

Date/Method of Verification:

Lump Sum Income: Give source, gross amt. and date received (include winnings, gifts, inheritance, retroactive wages or benefits, etc.)_____

_____

Other Income (not wages). Explain: _____

_____

SECTION IX MEDICAL/INSURANCE COVERAGE

Complete the following as it concerns health/medical/disability insurance coverage. Include all medical, hospitalization, health care (including dental, optical and prescription) plans which may be available to pay for your (the applicant's) health care needs. The insurance may be in your (the applicant's) name or coverage carried by a spouse or parent for the applicant.

1.

	MEDICAL INSURANCE - COMPANY NAME AND ADDRESS	NAME OF PERSON CARRYING THIS COVERAGE FOR APPLICANT	TYPE OF COVERAGE	POLICY/CERTIFICATE GROUP NO.	ELIGIBILITY DATE
A.	Medicare		( ) Part A ( ) Part B		
B.					
C.					
D.					
E.					

2. Do you expect a change in insurance coverage? (Example: you, your parent or spouse recently started/left employment and will receive/drop coverage in a few months) ( ) Yes ( ) No. If "Yes", give carrier name, policy number, and date the insurance will go into effect/expires.

3. Is your absent parent or separated/divorced spouse under court order to provide medical care or carry medical coverage for you? ( ) Yes ( ) No. If "Yes", Explain: _____

4. Does anyone help you to pay for medical bills? ( ) Yes ( ) No.. If so, give the person's name, amount of payment and frequency. State if this is a loan and if so, explain terms of the repayment agreement._____

5. Is the disability, illness or injury accident related? ( ) Yes ( ) No. If "Yes", Explain:

6. Do you have unpaid bills for medical services incurred within the past 3 months? ( ) Yes ( ) No.

OFFICE USE:

SECTION X Check those items below that you wish to discuss with the agency worker.

( ) Housing ( ) Home Management ( ) Money Management
( ) Medical, Dental, or Eye Care ( ) Home Energy Assistance ( ) Transportation
( ) Food Stamps ( ) Legal Services ( ) None
( ) Other financial, family, or personal problems: (Explain) _____

BEFORE YOU SIGN, READ THE STATEMENTS BELOW. IF YOU DO NOT UNDERSTAND OR HAVE ANY QUESTIONS, PLEASE ASK

*I (We) agree that the statements made on this form are true and complete to the best of my (our) knowledge. I (We) know that lying about my (our) situation, failing to give necessary information or causing others to hold back information is against the law and may subject me (us) to prosecution.

*I (We) understand that any information (We) give is subject to verification by the County Welfare Agency (CWA) and/or other agencies or officers of the Division of Family Development (DFD) and the Division of Medical Assistance and Health Services (DMAHS).

*I (We) hereby authorize the County Welfare Agency, Division of Family Development, and/or the Division of Medical Assistance and Health Services to contact any individual or other source who may have knowledge about my (our) circumstances (including but not limited to IRS, Social Security Wage and Benefit files, State Wage and Unemployment files, and/or credit reporting services), for the sole purpose of verifying the statements I (We) have made.

*I (We) know that any information I (We) give will be used only in connection with my (our) application for public assistance and receipt of Medicaid benefits.

*I (We) understand that Medicaid benefits received after age 55 may be reimbursable to the State of New Jersey from my estate.

*I (We) agree to let the CWA, DFD, and/or the DMAHS know immediately, of any change in living arrangements, status of health insurance coverage, family situation or money received from any source. If disabled, I (We) agree to report any improvement in my (our) medical condition.

*I (We) understand that as a condition of eligibility for medical assistance, it is deemed that I (We) have assigned to the Commissioner of Human Services, any rights to support for the purpose of medical care as determined by a court or administrative order and any rights to payment for medical care from any third party.

*I (We) understand that I (We) may request a fair hearing, if I (We) am (are) not satisfied with any action taken by the CWA, DFD, or DMAHS.

*I (We), understand that I (we) may apply for retroactive Medicaid coverage, for unpaid covered medical services provided during the three months prior to this application. I (We) further understand that such retroactive benefits will only apply in the month(s) I (we) met all eligibility criteria, and that I must apply separately for such benefits within six months from the date of this application. An application form and assistance in completing it is available from your caseworker.

*I (We) understand that I (We) will not be discriminated against because of race, color, religion, sex, handicap, national origin or marital, parental or birth status.

*I (We), by signing below, attest that I (We) have read and agree to these statements and fully realize that the County Welfare Agency and/or the Division of Family Development and/or the Division of Medical Assistance and Health Services rely upon the truth and accuracy of my (our) statements.

SIGNATURES

Applicant _____ *or* Authorized Agent _____ Date _____

Spouse _____ Date _____ Relationship to Client _____

Address _____

Witness _____ Date _____

NOTE: The submission of a Social Security Number (SSN) is mandatory in accordance with 42 USC 1320b-7. Your SSN will be used to check your identity, prevent duplicate participation and facilitate making mass changes. Your SSN will also be used in computer matching and program reviews or audits and to make sure you are eligible for Medicaid. These procedures are designed to identify persons who fraudulently or wrongfully participate in the Medicaid programs. Such persons may be subjected to criminal action, administrative claims and/or possible loss of all benefits. Failure to file for a SSN may result in disqualification for Medicaid.