Attachment 1

REQUEST FOR MEDICAID COVERAGE

Instruction

Pregnant women and child(ren) under the age of 19 do not have to fill out this form.

Before filling out the below information, you should read the "Explanation of the Resource Documentation Requirements for Medicaid." It was given to you with your application and includes a list of long-term care services.

Print your name, check one of the boxes below and sign your name at the bottom:

I, _____, request that the Medical Assistance Program:

☐ **Determine my Medicaid eligibility for community coverage WITHOUT long-term care services.**

I understand that I must tell you about the value of my resources beginning with the first month for which I am asking for Medicaid benefits. I understand that I will **NOT** be eligible for Long-Term Care Services.

I understand that at any time I may ask for Long-Term Care Services. If I need nursing facility services, I must give proof of my resources for up to 36 months (60 months for trusts) prior to my request for such services. If I need community-based long-term care services, I must give proof of my current resources.

☐ **Determine my Medicaid eligibility for community coverage WITH community-based long-term care services.**

I understand that I must give proof of my current resources beginning with the first month for which I am requesting Medicaid benefits. I understand that I will **NOT** be eligible for nursing facility services.

I understand that at any time I may ask for nursing facility services. If I need nursing facility services, I must give proof of my resources for up to 36 months (60 months for trusts) prior to my request for such services.

☐ **Determine my Medicaid eligibility for all covered care and services.**

I understand that I must give proof of my resources for the past 36 months (60 months for trusts) prior to the first month for which I am asking for Medicaid benefits.

_____ _____

Applicant or Authorized Representative Signature Date

_____ _____

Spouse (if applying) or Authorized Representative Signature Date

Return this completed form with your application to the local social services district.

Under the Home and Community-Based Services (HCBS) waivers (1915c), local districts have the authority to determine the Medicaid eligibility of a waiver child without consideration of parental income and resources.

This chart can be used to help determine the correct treatment of the waiver child's resources.

Waiver	**Resource Test**	**36/60 Month Lookback**
Care At Home I, II, III, IV, VI	***** Yes	Yes
OMRDD HCBS	Yes	Yes
OMH HCBS ADC-related Child SSI-related Child	 No Yes	 No Yes

***Child must first be determined ineligible under regular Medicaid rules (counting parental income and resources). If ineligible, parental income and resources are disregarded and an SSI-related budget is done for the child based on the child's income and resources.**