

## GENERAL INFORMATION

**This application is to be used by County Medical Assistance applicants.**

## COMPLETING THE APPLICATION

Complete all pages of this application as completely and accurately as possible. If you have trouble answering questions, getting information or records, or if you need an interpreter, ask your County Assistance Office for help.

## INTERVIEW

A face to face interview is required before you receive county medical assistance. In rare cases you may have a telephone interview. You will be required to provide proof of all information shown on your application. If you have any questions about this, ask your County Assistance Office.

## DOCUMENTATION

To establish eligibility for county medical assistance, you must provide the County Assistance Office with all of the following that apply:

1. Proof of identity, like photo identification card or driver's license or immigration cards.
2. Proof of application or award letters for Social Security, SSI, Medicaid, Medicare, Worker's Compensation or Crime Victims showing current benefit amount.
3. Proof of application for other forms of public assistance including:

Food stamps	Rental/energy assistance	Housing
TAFI	Aid to Aged Blind Disabled	
4. Proof of all household income from all sources for the **last six (6) months** including:

Wage stubs	Employer earning statement	Settlements	Interest
Social Security	Veteran Benefits	Unemployment	SSI
Rental/escrow	Child Support	Alimony	Pension
Student Loans	Scholarships	Grants	Stipends
5. A complete copy of the most recent federal and state income tax returns with schedules and W-2's.
6. If self employed, the year-to-date bookkeeping records including sales and expense records.
7. The **last six (6) months** of bank statements including checking, savings, escrow and credit union accounts.
8. Proof of value and balances owed for all real property.
9. Proof of value and balances owed for all personal property including:

Household goods including: art, jewelry, coins, guns, collections, electronic equipment, musical instruments, tools of the trade, etc.

Motor vehicles	Other vehicles	Trailers	Campers	Motorcycles
Recreational vehicles	Snowmobiles	Livestock	Mining Claims	Farm Equipment
Timber	Stocks	Bonds	IRA's	401K's
Trusts	Annuities	Inheritance	Certificates of Deposit	
10. Proof of the monthly expenses (**for the last 6 months**):

Current month rent	Land/house payment	Space rent	Utility bills
Child support	Child care	Medical expenses	Alimony
All insurance	Other monthly expenses including balances owed		
11. Proof of health insurance and life insurance.
12. Proof of veteran's status, i.e. military discharge papers (DD214)

**Immediately upon receipt, provide all medical bills to the county for which assistance is requested**

# GENERAL INFORMATION

## COUNTY APPLICANT INFORMATION, RIGHTS AND RESPONSIBILITIES

### APPLICANT RESPONSIBILITIES

#### You Must:

- Complete *every* question, sign, file an application with the county clerk within these time frames:
  - \* 10 days prior to receipt of non-emergency services.
  - \* Within 31 days beginning with the first day of emergency services or emergency admission.
  - \* Within 180 days beginning with the first day of the provision of necessary medical services provided that written documentation is included with the application or no later than 45 days after an application has been filed, showing that a bona fide application/claim for Social Security, Medicaid, Medicare, third party insurance, crime victims and/or worker's compensation has been filed with the appropriate agency. Bona fide application is defined in Section 31-3504(4)(a)(i-v) I.C. Failure to meet these requirements shall result in a denial.
  - \* With the correct county within 30 days from the date a county determines it is not the obligated county.
- Cooperate with the county in investigating your application by providing documentation and submitting to an interview.
- Notify the county when you receive resources after filing an application.
- Reimburse the county if assistance is provided and the county determines your ability to do so.

### THIRD PARTY APPLICANT

The application shall be as complete as practical, and presented in the same manner as Section 31-3504, Idaho Code, requires. The third party applicant shall cooperate, provide documentation and submit to an interview, ascertain eligibility and notify the county of any resources received after applying.

### LIENS AND ESTATE RECOVERY AND REIMBURSEMENT

When applying for county assistance, an automatic lien attaches to your real and personal property, all insurance benefits, and any additional resources to which it may legally attach pursuant to I.C. 31-3504 (4).

State law allows a county to recover funds paid on your behalf from your estate after your death or the death of your spouse, whichever is later.

Receipt of assistance, pursuant to I.C. 31-3510A, shall obligate an applicant to reimburse the county from which assistance is received.

### PROPERTY TRANSFER

An applicant can be denied county assistance if the applicant has divested himself/herself of resources within one year of filing a county application (31-3511(3))

### NONDISCRIMINATION

If you believe the county has practiced discrimination because of race, color, age, sex, handicap, national origin, religious creed or political belief, you can file a complaint.

County complaints should be addressed to the County Commissioners through the regular appeal process in the county where the determination was made.

### VIOLATIONS AND PENALTIES

#### If You:

- Fail to cooperate with the county, make a material misstatement or omission, you will be ineligible for non-emergency services for 2 years.
- Give false or misleading information to a hospital, county or its agent, or to any person in order to receive county assistance, or fail to disclose resources or benefits available to you as payment or reimbursement, you will be guilty of a misdemeanor and punishable under the law.
- Do not provide required material information or divest yourself of resources within 1 year prior to filing an application in order to become eligible for county assistance, your application will be denied.
- Are sanctioned by federal or state authorities and lose medical benefits, you will be ineligible for county assistance for the period of the sanction.
- Do not file your application in the manner described or within the time limits established, the Board of County Commissioners shall not hear or approve your application.

### NOTICE OF DETERMINATION AND APPEAL RIGHTS

- The Board of County Commissioners written determination will be mailed to you.
- You may appeal an adverse determination by filing a written notice of appeal with the Board within 28 days of the date of determination.
- You may seek judicial review of the Board's final determination denying your application.
- You may petition the Board to reduce an order of reimbursement.
- You may seek judicial review of a reimbursement order that you feel is excessive.

**COUNTY USE ONLY:**

Date Application Received: \_\_\_\_\_

Lien Instrument #: \_\_\_\_\_

Filing Date: \_\_\_\_\_

UCC Filing Date: \_\_\_\_\_

**UNIFORM COUNTY MEDICAL ASSISTANCE APPLICATION***(For informational purposes only)* Type of application:

Emergency 31 day \_\_\_\_\_; Non-emergency 10-day prior \_\_\_\_\_; Additional Request: \_\_\_\_\_;

180 Day Delayed (Justification must be attached) \_\_\_\_\_

**COUNTY ASSISTANCE REQUEST**

Patient Name:	If minor, Parent/Guardian Name:
Please list medical condition(s) and procedure(s) for which you are requesting assistance:	

Do you need an interpreter?	YES/NO
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In the appropriate columns, provide complete information for EACH medical provider that you are requesting the county to pay. (Attach additional pages if needed) **Providers listed below will be considered for payment. (31-3508; 31-3505(C); 31-3505(E); 31-3519)**

PROVIDER (Name, Address & Phone #)	DATES OF SERVICE		TYPE OF SERVICE	AMOUNT
	From:	To:		
	From:	To:		
	From:	To:		
	From:	To:		
	From:	To:		
	From:	To:		
	From:	To:		
	From:	To:		

**PERSONAL INFORMATION (Please circle appropriate response)**

<b><u>PATIENT/APPLICANT</u></b>						
First Name	Middle Initial	Last Name	Date of Birth		Social Security #	
Other Names Used:						
Physical Address		City	State	County		Zip Code
Mailing Address (if different)		City	State	County		Zip Code
Home Phone Number			Message Number:			
Marital Status (circle one):    Single            Married            Separated            Widowed            Divorced						
U.S. Citizen            Legal Alien            Other			Veteran:            YES / NO		Type of Discharge:	
If legal alien, please provide alien registration number: Name of Sponsor:			V.A. ID #:			
Are you registered to Vote:    YES / NO If YES, what state/county?			Are you licensed to Drive:    YES / NO If YES, what state?			
<b><u>SPOUSE/SIGNIFICANT OTHER</u></b>						
First Name	Middle Initial	Last Name	Date of Birth		Social Security #	
Other Names Used:						
Physical Address		City	State	County		Zip Code
Home Phone Number			Message Number:			
U.S. Citizen            Legal Alien            Other			Veteran:            YES / NO		Type of Discharge:	
If legal alien, please provide alien registration number: Name of Sponsor:			V.A. ID #:			
Are you registered to Vote:    YES / NO If YES, what state/county?			Are you licensed to Drive:    YES / NO If YES, what state?			
List the name, address, and phone number of a person <i>outside</i> your household who is aware of your circumstances:						
Name: _____			Relationship: _____			
Address: _____			Phone Number: _____			

**HOUSEHOLD**

Complete the following information for all persons residing in your home. (*Attach additional pages if needed*)

Name	Relationship to Patient/Applicant	Date of Birth Mo/Day/Yr	Sex	Marital Status	Social Security # or Alien #
	<b>SELF</b>				

**HEALTH INSURANCE/OTHER ASSISTANCE**

- 1. Is anyone in your household covered by Health Insurance, Medicaid and/or Medicare? .... YES / NO
- 2. Did you or anyone in your household have health insurance in the last 6 months? ..... YES / NO
- 3. Did you or anyone in your household have health insurance in the last 60 days? ..... YES / NO
- 4. Did anyone in your household have a job in the last 90 days but is now unemployed? ..... YES / NO
- 5. If no longer employed, were COBRA Benefits available? ..... YES / NO  
Date employment ended \_\_\_\_\_ Have you received COBRA forms? ..... YES / NO
- 6. Do you or anyone in your household have insurance available through school? ..... YES / NO
- 7. Has a court ordered anyone to pay medical expenses or provide health insurance for anyone in your household? ..... YES / NO

**If you answered YES to any of the questions listed above, complete the table below.**

Eligible Person(s)	Subscriber	Insurance Company Name	Policy Number

- 8. Are you or anyone in your household an enrolled member of a Native American Tribe? YES / NO  
If YES, who? \_\_\_\_\_ Name of Tribe: \_\_\_\_\_  
If YES, phone number of Tribal Council/BIA offices for this tribe: \_\_\_\_\_
- 9. Have you or anyone in your household ever been disqualified from an assistance program? YES / NO  
If YES, list names of persons disqualified, program, and date.  
\_\_\_\_\_
- 10. Do you or anyone in your household have actions pending from which money may be received such as lawsuits, inheritance, accident claim, insurance settlement, etc.? ..... YES / NO
- 11. Have you or anyone in your household ever been approved for county assistance in Idaho? YES / NO  
If YES, which county and when? \_\_\_\_\_
- 12. Have you or anyone in your household applied for Medicaid, SSI, or Crime Victims in the past year? YES / NO  
If YES, name of program, date filed \_\_\_\_\_

**RESIDENCY**

During the last five years I have lived at the following places of residence: *(Attach additional pages if needed)*

Physical Address	Dates of Residence	Landlord
1. Street: City: State: County:	From: To:	Name: Phone #:
2. Street: City: State: County:	From: To:	Name: Phone #:
3. Street: City: State: County:	From: To:	Name: Phone #:
4. Street: City: State: County:	From: To:	Name: Phone #:
5. Street: City: State: County:	From: To:	Name: Phone #:

# INCOME

## EARNED INCOME

Employment Information. *(Attach additional pages if needed)*

PATIENT/APPLICANT				SPOUSE/SIGNIFICANT OTHER			
Current Employer		Phone		Current Employer		Phone	
Address	City	State	Zip	Address	City	State	Zip
Hours/Week	Hourly Rate	Monthly Gross		Hours/Week	Hourly Rate	Monthly Gross	
List Dates of Employment:				List Dates of Employment:			
Previous Employer:				Previous Employer:			
Address	City	State	Zip	Address	City	State	Zip
Hours/Week	Hourly Rate	Monthly Gross		Hours/Week	Hourly Rate	Monthly Gross	
List Dates of Employment:				List Dates of Employment:			

## UNEARNED INCOME

Are you or anyone in your household receiving income from any of the following sources? Please circle your response.

Social Security	YES / NO	Workers Compensation	YES / NO	Unemployment	YES / NO
SSI	YES / NO	Veteran's Benefits	YES / NO	Retirement	YES / NO
Child Support/ Alimony	YES / NO	Tribal/BIA Assistance/ Commodities	YES / NO	Gifts/Loans	YES / NO
Interest/ Dividends	YES / NO	Insurance Settlements	YES / NO	Contributions	YES / NO
Rental/Escrow Payments	YES / NO	State Cash Assistance	YES / NO	Church	YES / NO
Income Tax Refunds/ Earned Income Credit		Inheritance/Trust		Energy Assistance	YES / NO
		Payments	YES / NO	Food Stamp Benefits	YES / NO
			YES / NO	Other	YES / NO

If you circled YES to any of the above, please complete the information below.

Source of Unearned Income	Person Receiving Income	Amount Received

# RESOURCES

## FINANCIAL ASSETS

Complete the following information regarding any items that you or your spouse/significant other have or on which either of your names appear.

Description	Circle One	Names on Account	Bank Name/ Location	Account Number	Amount/ Value	
Cash	YES / NO					001
Checking Acct.	YES / NO					002
Other Checking	YES / NO					
Line of Credit	YES / NO					
Savings Acct.	YES / NO					003
Certificates of Deposit	YES / NO					010
Stocks/Bonds	YES / NO					040
Mutual Funds	YES / NO					
Trusts/Annuities	YES / NO					
Retirement (IRA, 401K, etc.)	YES / NO					031
Credit Cards	YES / NO					
Other	YES / NO					190

## REAL/PERSONAL PROPERTY

Real/Personal Property	Circle One	Description	Market Value	Amount Owed	Equity
Home Residence <sup>111</sup>	YES / NO				
Manufactured Home: Year/Make/Model	YES / NO				
Land	YES / NO				
Rental Property <sup>111</sup>	YES / NO				
Vehicle: <sup>120</sup>	YES / NO				
Is It Licensed:	YES / NO				
Used for Business:	YES / NO				
Other Vehicle:	YES / NO				
Is It Licensed:	YES / NO				
Used for Business:	YES / NO				
Recreational Vehicle/ <sup>121</sup> Trailer/Camper/Other	YES / NO				
Livestock <sup>153</sup>	YES / NO				
Tools of Trade	YES / NO				
Mining Claims	YES / NO				
Burial Plots	YES / NO				
Life Insurance	YES / NO				
Other <sup>190</sup>	YES / NO				

Have you or your spouse sold, traded, given away, or put into a trust, money or any resources within the last year? YES / NO **If YES, complete the information below. (Attach additional pages if needed)**

Description	When Sold	Amount Received

## CURRENT MONTHLY HOUSEHOLD EXPENSES

Description	Monthly Amount	Past Due	Balance Due	County Use Only
Rent/Mortgage To: Subsidized: YES / NO				400
Space Rent To:				400
Food/Other Special Food Needs				410
Non Food				411
Utilities: Heat Source				603
Electricity				420
Water: Sewer/Trash:				422
Telephone (Base Rate)				423/CELL 602
Other				429
Insurance: Health/Accident				430
Home				431
Life				432
Auto				433
Transportation – Car Payment: To:				440
Fuel				441
Maintenance				442
Alternate (i.e. bus, taxi)				449
Previous Medical: Doctors				450
Hospitals				451
Medications				452
Other				459
Taxes: Payroll				460
Property				461
Education Expenses				
Child Care: Subsidized YES/ NO				470
Dues and Tithing				
Court Ordered: Child Support				500
Garnishment				510
Fines				520
Contract/Credit Card Payments				481
Other:				489
Other:				489
<b>Total Expenses</b>				

<b>COUNTY USE ONLY</b>		
Total Monthly Income	Total Allowable Monthly Expenses	Balance Available

I/we, \_\_\_\_\_, will fully cooperate with and will supply all information requested to the representative of \_\_\_\_\_ County in order that my/our application can be acted upon within a reasonable time

I/we understand that the county may record the automatic lien on my/our real/personal property and that I/we will be required to reimburse the county for any expense which I/we have requested or has been requested on my/our behalf.

***I/we hereby certify under penalty of perjury that the information contained in this application for county medical assistance is true and correct to the best of my/our knowledge.***

DATED this \_\_\_\_ day of \_\_\_\_\_, 200\_\_.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Signature of Spouse

If by a third party applicant on behalf of the applicant:

By \_\_\_\_\_  
Signature of Third Party Applicant

\_\_\_\_\_  
Printed Name of Third Party Applicant

Name of Facility: \_\_\_\_\_

Phone: \_\_\_\_\_

STATE OF IDAHO )  
 ):  
County of \_\_\_\_\_ )

On this \_\_\_\_ day of \_\_\_\_\_ 200\_\_, \_\_\_\_\_ personally appeared before me \_\_\_\_\_, and proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to this instrument and acknowledged to me that he/she/they executed the same.

Subscribed and sworn before me:

(SEAL)

\_\_\_\_\_  
Notary Public for the State of Idaho  
Residing at: \_\_\_\_\_  
My Commission Expires On: \_\_\_\_\_

# RELEASE OF INFORMATION

I/we also request my/our relatives, banker(s), credit union(s), physician(s), hospital(s), creditor(s), and any other persons or organizations including the State Department of Health and Welfare, Social Security Administration, public health districts, Veterans Administration, Crime Victims Compensation Program, utility companies or departments, law enforcement agencies, courts, Idaho Department of Labor, or employer(s), having any information concerning me/us or my/our circumstances to provide the information to such representative of \_\_\_\_\_ County, inasmuch as it is pertinent to this application.

I/we hereby authorize \_\_\_\_\_ County and its representatives to release pertinent information regarding this application, the contents thereof and action taken thereon to all parties of interest as provided by Chapter 35, Title 31, Idaho Code. I/we acknowledge that my/our medical indigency application waives any confidentiality granted by state law to the extent necessary to carry out the intent of Idaho Code 31-3504 regarding such applications. I/we hereby authorize a copy of this agreement to be used when necessary and give it full force as the original.

I/we understand that I/we may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that unless consent is sooner revoked; this release is valid as long as it is pertinent to this application.

DATED this \_\_\_\_ day of \_\_\_\_\_, 200\_\_.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Signature of Spouse

STATE OF IDAHO )  
 ):  
County of \_\_\_\_\_ )

On this \_\_\_\_ day of \_\_\_\_\_ 200\_\_, \_\_\_\_\_ personally appeared before me \_\_\_\_\_, and proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to this instrument and acknowledged to me that he/she/they executed the same.

Subscribed and sworn before me:

(SEAL)

\_\_\_\_\_  
Notary Public for the State of Idaho  
Residing at: \_\_\_\_\_  
My Commission Expires On: \_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION/RECORDS**  
**(Including information from federally protected assistance programs)**

I, \_\_\_\_\_ (name of patient), authorize any hospital, doctor, or other person that has provided care to the above named patient ("Providers") to release medical records (as defined in the hospital's policy as belonging to the medical record set including any and all office notes, radiographs, or reports), to representatives of \_\_\_\_\_ County as the records are pertinent to the investigation and eligibility determination of medical indigency pursuant to Chapter 35, Title 31 Idaho Code. I acknowledge that the County may disclose the information it receives to my providers participating in the medical indigency process and to representatives of the State Catastrophic Health Care Cost Program. I acknowledge that the purpose of the release is to determine whether or not I meet the statutory requirements for medical indigency assistance from the County.

I acknowledge that some records pertaining to treatment I have received for which I am seeking payment from \_\_\_\_\_ County may include information that is protected under the Federal Law. Specific authorization is given to release information concerning a federal-assisted drug or alcohol abuse program, drug-alcohol abuse information, mental health information, HIV information, or any other information that may be protected by law. I understand that I am waiving the confidentiality of such records for the limited purpose of this application for medical indigency and any supplements or amendments thereto.

Federally protected records obtained as authorized by this release will be maintained in accordance with federal confidentiality regulations (Title 42CFR) which prohibits re-disclosure.

This authorization is subject to my revocation at any time, except to the extent that Providers have taken action relying on it. Unless I have revoked the authorization and provided the County with notice of the revocation, it is valid for a period of one year from the date of my signature. This authorization can be revoked by sending a written notice to the County.

I understand that my ability to obtain medical indigency benefits from the County may be contingent upon the execution of this release, but that medically necessary treatment will not be denied based upon refusal to sign this authorization.

This authorization conforms to the regulations promulgated under Section 333 of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, and Section 408 of the Drug Abuse Offense and Treatment Act of 1972 and the Health Insurance Portability and Accountability Act of 1996.

DATED this \_\_\_\_ day of \_\_\_\_\_, 200\_\_.

\_\_\_\_\_  
Signature of Patient or Legal Representative

STATE OF IDAHO )  
 )  
 ):ss.  
County of \_\_\_\_\_ )

\_\_\_\_\_  
Relationship/Authority to sign

On this \_\_\_\_ day of \_\_\_\_\_ 200\_\_, \_\_\_\_\_ personally appeared before me \_\_\_\_\_, and proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to this instrument and acknowledged to me that he/she/they executed the same.

Subscribed and sworn before me:

(SEAL)

\_\_\_\_\_  
Notary Public for the State of Idaho

Residing at: \_\_\_\_\_

My Commission expires: \_\_\_\_\_