ST. LAWRENCE COUNTY
DEPARTMENT OF SOCIAL SERVICES

CHRIS REDIEHS, COMMISSIONER
6 Judson Street
Canton, New York 13617-1196
(315) 379-2111 (phone) · (315) 379-2108 (fax)

APPLICATION FOR ADD TO ACTIVE CASE FOR: Medicaid Medicare Savings Program
Case #

Full Name: _____ Marital Status: _____

Street Address: _____ Telephone #: _____

City: _____ State: _____ Zip Code: _____

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HOUSEHOLD COMP:
Name of people who are in your household:

Name:	Relationship to you	Date of Birth	Does this person want Medicaid? Yes	No
_____	self	_____	☐	☐
_____		_____	☐	☐
_____		_____	☐	☐
_____		_____	☐	☐
_____		_____	☐	☐
_____		_____	☐	☐

Has anyone been known by any other name?
Name: _____ Known as: _____

Is anyone listed above pregnant? ☐ Yes ☐ No
If yes, who _____ Doctor's statement with expected birth date is required to verify pregnancy.

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The Family Planning Benefit Program may be available to males and females between the ages of 10 and 64. FDA approved birth control methods, sterilization procedures, emergency contraception, pre-pregnancy counseling, and other family planning related services may be covered under this program.
Is anyone in your household interested in being considered for this program? ☐ Yes ☐ No
If yes, who? _____, _____, _____

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ADD TO ACTIVE FORM
Revised 01/26/2010

INCOME:

You must indicate if anyone in the household receives money from the following:

☐ Earned Income YES ☐ NO ☐ If yes, complete the following section.
NAME _____ START DATE _____
EMPLOYER _____ ADDRESS _____
FREQUENCY: Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly
GROSS INCOME AMOUNT (before any deductions) _____
Do you have health insurance through this employment? Yes ☐ No ☐
If yes, send copy of front and back of all insurance cards.

NAME _____ START DATE _____
EMPLOYER _____ ADDRESS _____
FREQUENCY: Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly
GROSS INCOME AMOUNT (before any deductions) _____
Do you have health insurance through this employment? Yes ☐ No ☐
If yes, send copy of front and back of all insurance cards.

Self-Employment YES ☐ NO ☐
If yes, submit copies of last years federal income tax (including all attachments and schedules).

Odd Jobs YES ☐ NO ☐
If yes, submit a signed statement from the individual who pays you, indicating the type of work being done, how much you are paid, and how often this work is performed.

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UNEARNED INCOME:

You must indicate if you or anyone who lives with you has and/or is applying for:

	Yes	No	Person Receiving	Amount
Social Security	☐	☐	_____	$_____
GI Dependency Allotments	☐	☐	_____	$_____
Income (rent) from Boarder/Lodger	☐	☐	_____	$_____
Rental Income	☐	☐	_____	$_____
NYS Disability Benefits	☐	☐	_____	$_____
Retirement Benefits	☐	☐	_____	$_____
Unemployment Benefits	☐	☐	_____	$_____
Union Benefits-Strike Pay	☐	☐	_____	$_____
Veteran Benefits	☐	☐	_____	$_____
Workmen's Compensation	☐	☐	_____	$_____
Other (specify)_____	☐	☐	_____	$_____

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RESOURCES:

You must indicate if you or anyone who lives with you has and/or is in the process of setting up or purchasing: You must provide bank account information even if there is a zero or negative account balance.

	Yes	No	**Whose Name is it in?**	**Amount**	**Account #**	**Company or Bank Name**
Cash on hand	☐	☐	_____	$_____		_____
Life Insurance	☐	☐	_____	$_____	_____	_____
Stocks, Bonds, Mutual Funds	☐	☐	_____	$_____	_____	_____
IRA, KEOGH, 401-K	☐	☐	_____	$_____	_____	_____
Burial Fund	☐	☐	_____	$_____	_____	_____
Eligible for Income Tax Refund	☐	☐	_____	$_____		
Named as a Beneficiary	☐	☐	_____			
Checking Account	☐	☐	_____	$_____	_____	_____
Savings Account	☐	☐	_____	$_____	_____	_____
Credit Union Account	☐	☐	_____	$_____	_____	_____
Deferred Compensation Account	☐	☐	_____	$_____	_____	_____
Burial Space	☐	☐	_____			_____
An Annuity	☐	☐	_____	$_____	_____	_____
In Trust or Pass Account	☐	☐	_____	$_____	_____	_____
Has Own Home	☐	☐	_____			
Automobile	☐	☐	Year _____	Make/Model _____		
Other Vehicles	☐	☐	Type _____	Year _____		

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SHELTER EXPENSE:

Mortgage/Rent: $_____

Yearly Taxes: $_____ Fire Insurance: $_____

Water Bill? YES _____ NO _____
If yes, send a copy of your most recent bill.

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HEALTH INSURANCE:

Is anyone in the household covered by other health insurance? YES _____ NO _____
If yes, who? _____ Send a copy of front and back of all insurance cards.

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You are hereby advised to report to your Medicaid worker **in writing**, immediately any and **all** changes. These changes **may or may not** affect your medical coverage.

Listed below are **some** examples of changes which must be reported:

1. Your new address when you plan to move;
2. Changes in amount of rent or mortgage you pay or when a HUD payment starts or changes;
3. Anyone who moves in or out of your household;
4. Income from work and/or self-employment, when you start a job (even if you don't get paid in cash), get a raise in pay, have a change in the number of hours you work, get done with a job;
5. Income from family members or friends;
6. Income from insurance or disability;
7. Income from Veteran's Administration;
8. Income from Worker's Compensation;
9. Income from Unemployment Benefits (UIB);
10. Income from Social Security or Supplemental Security Income (SSI);
11. Income from any source (including winnings from lottery, bingo, raffles, Income Tax Refunds, support, etc.);
12. If you receive an inheritance;
13. If you start or settle a lawsuit;
14. If you open/close a checking, savings or Credit Union account;
15. When you buy, sell, trade or change vehicles (car, truck, motorcycle, boat and trailers);
16. When anyone 16 or older starts or stops school (high school or college).

I understand and I agree to inform the St. Lawrence County Department of Social Services of any and all changes in my needs, income, property, living arrangements or address to the best of my knowledge or belief. I also understand that my failure to notify the Agency of these changes may result in incorrectly paid medical expenses, which will result in either a recoupment or possible legal action to recover the incorrectly paid medical expenses.

It is a crime, punishable as a Class A misdemeanor under the laws of the State of New York, for a person, in and by a written instrument, to knowingly make a false statement or to make a statement which such person does not believe it to be true.

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ALL ADULT HOUSEHOLD MEMBERS WHO ARE APPLYING FOR MEDICAID MUST READ AND SIGN THIS FORM.

Signature	Date
Signature	Date
Examiner Signature	Date
Supervisor Signature	Date

ADD TO ACTIVE FORM
Revised 01/26/2010

Reset Form Print Form