

Return application to:  
 DWS/CIU  
 PO Box 143245  
 SLC, UT 84114-3245  
 Fax: 801-526-9500



# Addendum

## for Medical Assistance

Date Received
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Name \_\_\_\_\_ Case Number \_\_\_\_\_

### 1 Assets & Vehicles

**A. ASSETS.** List any assets that are owned by you and anyone who lives with you. Type of asset includes bank accounts, cash, stocks/bonds, life insurance/burial funds, homes, property, livestock, trailers, trust funds, antiques/collectibles, annuities, investment properties, etc. Include any items that you have partial ownership in. **List vehicles separately in part B.**

Type of Asset	Name of Owners	Joint? Y/N	Value	Amount Owed

**B. VEHICLES.** List any vehicles that are owned by you and anyone who lives with you. Type of vehicle includes all cars, trucks, vans, snowmobiles, motorcycles, motor home, boats/motors or other vehicles.

Type of Vehicle	Make	Model	Year	License Plate #	State	Owner/Joint Owners	Amount Owed	Current Value

### 2 Income & Expenses

- Yes No A. Are you employed? If yes, list the date you started (mm/dd/yy): \_\_\_\_\_
- Yes No B. Do you expect any changes in earnings or number of hours worked?  
If yes, explain: \_\_\_\_\_
- Yes No C. Does anyone in the household pay for dependent care so he/she can go to work?  
If yes, list name and amount paid: \_\_\_\_\_
- Yes No D. Has anyone applied for Social Security Income, VA, Unemployment or Worker's Compensation?  
If yes, explain: \_\_\_\_\_
- Yes No E. Is child support or alimony paid by a parent or spouse of a disabled person?  
If yes, list name and amount paid: \_\_\_\_\_
- Yes No F. Does anyone help you pay mortgage/rent, food, or utility bills?  
If yes, explain: \_\_\_\_\_
- Yes No G. Does anyone in the household work in exchange for mortgage/rent, food, or utility bills?  
If yes, explain: \_\_\_\_\_
- Yes No H. Has anyone in your home received medical services in the past 90 days?  
If yes, explain: \_\_\_\_\_
- Yes No I. Is anyone in your household pregnant or has been pregnant in the last 90 days?  
If yes, who: \_\_\_\_\_ Expected due date: \_\_\_\_\_
- Yes No J. If pregnant, have you smoked or used tobacco in the past 6 months?

### 3 Health Insurance Information

- Yes  No A. Is any other person required to pay medical expenses for anyone in your household?  
If yes, name: \_\_\_\_\_ Phone: \_\_\_\_\_
- Yes  No B. Has anyone in your household been injured or been a victim of assault in the last 12 months?  
If yes, please fill out the following information:  
What type of incident?  automobile  assault  work-related  slip/fall  
 medical malpractice  other, please explain \_\_\_\_\_  
Name of person(s) injured: \_\_\_\_\_  
Date of Incident: \_\_\_\_\_ Was a police report filed?  Yes  No  
Police Department: \_\_\_\_\_ Police Report #: \_\_\_\_\_  
Name of Attorney: \_\_\_\_\_ Phone: \_\_\_\_\_
- Yes  No C. Does anyone in your household have a major medical need? (This includes pregnancy/cancer/  
kidney disease, etc.) If yes, who: \_\_\_\_\_  
What is the medical need? \_\_\_\_\_
- Yes  No D. Do you have insurance available to you which you have not purchased or do you have insurance  
that has ended in the past 60 days?
- E. If you answered "yes" to both C and D, please fill out the following information:  
Name of Insurance Company \_\_\_\_\_ Phone: \_\_\_\_\_  
Policyholder Name: \_\_\_\_\_ Policy #: \_\_\_\_\_  
Employer Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
If not through an employer, how is insurance available? \_\_\_\_\_

### 4 Signature

I, (print name) \_\_\_\_\_, under penalty of perjury, swear that the answers I have given on this application are complete and correct. I am the person represented by the signature on this document.

\_\_\_\_\_  
Signature of Applicant or Representative

\_\_\_\_\_  
Date

Please tear off this page and keep for your information.

# Your Rights & Responsibilities

## You Have the Right to:

- Apply or reapply any time you wish for any medical program offered by the Department of Health. Applications for PCN, CHIP, and UPP are only accepted during open enrollment periods. If you need help, someone will help you apply.
- Receive a notice that we have either approved or denied your application and the reasons for the decision. For medical assistance, we have 30 days (90 days if you claim to be disabled) to process your application. If you need more time, please talk to your eligibility worker.
- Receive a notice if we reduce, stop or hold your assistance and why. In most cases, we must mail the notice 10 days before we do this.
- Do the following things if you do not agree with decisions made regarding your case:
  - A. Talk to your worker. Make sure you are not misunderstanding each other.
  - B. Talk to your worker's supervisor.
  - C. Talk to Constituent Services. Salt Lake 538-6417 or call toll-free 1-877-291-5583.
  - D. Request a Fair Hearing within 90 days of the decision; 10 days to get benefits while the hearing is held. If you were denied disability status, you may also ask for a reconsideration as part of the fair hearing. If SSA denied your disability, you would have to go through their appeal process.
  - E. Request legal representation regarding your fair hearing. You may be entitled to free legal assistance from Utah Legal Services. In Ogden, 394-9431; Salt Lake, 328-8891. The toll free number is 1-800-662-2538. You may also receive a referral for legal advice from the Salt Lake Lawyer Referral at 531-9075.
- Look at information in your case. Information about you and your case is confidential. We may give information to other agencies to administer a program to help you.

## Your Responsibilities:

- **Verify Information** - The Social Security Act (U.S.C. 1320 b - 7 (a) (1) requires that you give us a Social Security number for each household member who wants medical assistance. If you do not have a number, you must prove you have applied. You may be eligible for assistance while you are waiting to receive a number. If you are applying only for emergency Medicaid, you do not have to have a Social Security Number.

Your Social Security number will be used with the State Income and Eligibility Verification System to make sure that your household is eligible for federal assistance programs. Computer matching, program reviews, and audits will be done with Job Service, Immigration and Naturalization, Social Security, and Internal Revenue Service records. We may also do inquiries to banking and loan institutions and any other organizations or individuals who may have eligibility information about your household. You must give us proofs to show that you are eligible for assistance. The Department will not report undocumented household members to INS.

- Children enrolled in Medicaid are automatically enrolled in the Utah Statewide Immunization Information System (USIIS). If you do not want your children enrolled in this system, you must call the USIIS HelpLine at 801-538-6872 or the Immunization Hotline at 1-800-275-0659.

(continued)

- **Cooperate** - You must cooperate in any review of your case by Quality Control, Recovery Services, and the Bureau of Eligibility Services. You must also cooperate in providing information about any other sources of medical payments and obtaining medical support. If you feel you could be harmed by giving this information, you can request a 'good cause' claim. Your worker can explain this procedure.

**You and your household must also obey the medical assistance program rules.**

## Changes You Must Report

Remember that **YOU** are required to report changes in your situation **WITHIN 10 DAYS** of the day you learn of the change. Do not delay reporting changes. Changes can effect your eligibility. If you receive benefits which you are not eligible to receive, you will have to repay that amount.

**Change in Income**

- Change of more than \$25 in gross monthly income or deductions.
- Receipt of a one time payment from any source.

**Change in Marital Status or Living Arrangements**

- Getting married, separated, or divorced; absent parent moves in, birth of a baby or end of a pregnancy, household member moves in or out, death of a household member.
- Hospital stays for more than 30 days.
- If anyone in your household goes to jail or prison.
- If you move.

**Change in Any Asset(s)**

- Report changes in ownership or value of anything you own that is worth money.

**Change in Insurance Coverage**

- Changes in the ability to enroll in insurance.
- Coverage or enrollment in any health coverage plan (including Medicare) for anyone in the household.
- You must also report accidents or injuries which may be payable by a third party.

Case Worker \_\_\_\_\_ Phone \_\_\_\_\_ Case # \_\_\_\_\_