Note: This application requests information about the patient in the nursing facility. The words **"You"** and **"Your"** refer to the patient.

1. Patient's Name (First, Middle, Last)	2. Name of Nursing Facility		
3. Address of Nursing Facility	City	State	Zip Code
4. Phone No. of Nursing Facility	5. County	6. Birthdate	7. Sex	8. Social Security Number
9. Marital Status: ☐ Never married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed				
10. Date of Nursing Facility Admission	11. Address where you lived before you entered the nursing facility			

12. **If married, tell us about your spouse and all persons living with your spouse.**
If not married, tell us about your children under age 18 living in your home.

Name	Date of Birth	Social Security Number*	Relationship to you

If you have a court-appointed guardian/conservator, enter information below:

13. Name of Guardian/Conservator	Phone Number	Do you pay guardian/conservator expenses? ☐ **YES** ☐ **NO**	
Guardian's/Conservator's Address	City	State	Zip Code

		YES	NO
14.	Have you ever applied for or received assistance in Michigan?	☐	☐
15.	Have you received money or benefits such as Medical Assistance **from another state** in the last 30 days?	☐	☐
16.	Are you a U.S. citizen or U.S. national?	☐	☐
17.	If you **are not** a U.S. citizen or U.S. national, do you have eligible immigration status? If Yes: a. Immigration document type _____ b. Document ID number _____ c. Have you lived in the U.S. since 1996?	☐	☐
	d. Are you, or your spouse or parent a veteran or an active-duty member of the U.S. military?	☐	☐
	e. U.S. entry date _____		
18.	Enter your racial heritage from codes below. If you are multiracial, enter all the codes that apply (answering is voluntary) I = American Indian, A = Alaskan Native, S = Asian, B = Black or African American, P = Native Hawaiian or Other Pacific Islander, W = White _____		
19.	Check the box if you are Hispanic or Latino (answering is voluntary).	☐	
20.	Are you a veteran or the spouse, dependent or parent of a veteran?	☐	☐

		YES	NO
21.	Do you have unpaid medical expenses for services provided in the last 3 months?	☐	☐
22.	Do you pay health insurance premiums?	☐	☐
23.	Do you have Medicare Coverage? Do you need help paying premiums?	☐ ☐	☐ ☐
24.	Are you covered by a health, hospital, or long-term care insurance policy or were you covered in the last 3 months?	☐	☐
25.	Has a court ordered anyone to pay your medical expenses or provide health insurance for you?	☐	☐
26.	Have you had an accident or work-related illness or injury resulting in medical costs that may be paid by another person or an insurance company?	☐	☐
27.	Have you set up a plan or entered into a contract, such as a life care contract, that will pay for your medical care?	☐	☐
28.	Is there a plan for you to return home within six months from the date of admittance?	☐	☐

*Optional if the community spouse and/or children are not applying for Healthcare Coverage.

29. **Assets:** Complete the **assets** section by providing the requested asset information for you and your spouse. List your assets and your spouse's assets. Include assets you own jointly with family or other persons, including your spouse. Include assets your spouse owns jointly with you, family or other persons. Each item must be answered **YES** or **NO**. If answered **YES**, enter amount or current value and owner(s).

Type of Asset	YES	NO	Amount or Value	Owner(s) of Asset
Has anyone in your household received a federal tax refund in the last 12 months?				
Cash on hand, in a safety deposit box or patient trust fund				
Home, life estate/life lease				
Real estate, not your home				
Mortgage, land contract or other notes payable to you				
Savings bonds or money market funds				
Stocks or mutual funds				
Pension, IRA, KEOGH, 401K or deferred compensation account(s)				
Trust funds				
Life Insurance				
Annuity				
Cars, vans, trucks, campers, boats, snow-mobiles, other vehicles				
Tools, equipment, livestock, or crops				
Funeral contracts				
Burial plot, casket, etc.				
Health Savings Account				
Are there any other assets? (Please Explain)				

Checking/Draft Accounts — Savings/Share Accounts — Certificates of Deposit

Name(s) on the Account	Name and Address of Bank Credit Union, Savings and Loan	Account Number	Balance

		YES	NO
30.	Have you received a one-time cash payment in the last 60 months (5 years) such as an insurance settlement, lawsuit award, worker's compensation, lottery winnings, etc.?	☐	☐
31.	Do you have a pending lawsuit that may bring property or money to you?	☐	☐
32.	Within the last 60 months (5 years) have you or a joint owner or other person whose name is also listed on the asset:		
	• sold, given away, or transferred ownership in any asset such as those listed above?	☐	☐
	• removed or added a name on any asset such as those listed above?	☐	☐
33.	Have you or someone acting for you ever put any money, income, lawsuit settlement or assets in a trust, annuity or similar device?	☐	☐

34. **Income:** Include income for yourself and everyone listed in question 12.
Is anyone employed or self-employed? ☐ **YES** ☐ **NO** If **YES**, complete the following for each employed person.

Persons employed or self-employed	Employer name	Wages before deductions	How often paid: weekly, every 2 wks, monthly, other
		$	
		$	

Every item below must be answered **YES** or **NO**.

Type of Income	YES	NO	Amount	Whose Income
Social Security Benefits (RSDI) Claim #				
Social Security Benefits (RSDI) Claim #				
Supplemental Security Income (SSI)				
Supplemental Security Income (SSI)				
Retirement Benefits				
Veterans Benefits				
Disability Benefits				
Rental Income				
Worker's Compensation				
Child Support				
Unemployment Compensation				
Military Allotments				
Gaming Distributions (Casino Profit Sharing)				
Is there any other income? (Please explain)				

35.

Address where your spouse lives			Spouse's Phone Number
City	State	Zip Code	County

Household Expenses Check **YES** or **NO** and write in the answer about you and/or your spouse's home.

	YES	NO	AMOUNT	HOW OFTEN PAID
Do you and/or your spouse have a rent, mortgage or other shelter expense?				
Do you and/or your spouse have the following expenses separate from rent or mortgage:				
• Renter's Insurance				
• Property Taxes				
• Mobile Home Lot Rent				
• Special Assessments				
• Homeowner's Insurance				
• Mortgage Guarantee Insurance				
• Cooperative or Condominium Fee				
Do you and/or your spouse have an obligation to pay for heat and/or utilities?				

ASSIGNMENT OF BENEFITS

Recovery of Medical Costs. I understand that when the Michigan Department of Health and Human Services (MDHHS) pays the cost of hospital, surgical, or medical services, any right to recover costs from a third person or public or private contractor, except Medicare, is transferred to the MDHHS. Payment of any recovery under such right is to be made directly to the State of Michigan — MDHHS.

RELEASES

Social Security Information. I will allow the Social Security Administration to give to the MDHHS all information necessary to determine my eligibility for benefits under the Healthcare Coverage program until the second month following the expiration of my eligibility based on the current application.

Eligibility Information. I understand that the information I have provided will be used to determine my eligibility for Healthcare Coverage only and for purposes of administering the Healthcare Coverage program.

AFFIDAVIT

Under penalties of perjury, I swear that this application has been examined by or read to me, and, to the best of my knowledge, the facts are true and complete. If I am a third party applying on behalf of another person, I swear that this application has been examined by or read to the applicant, and, to the best of my knowledge, the facts are true and complete.

I certify, under penalty of perjury, that all information that I have written on this form or told to a specialist is true. I understand that I can be prosecuted for perjury if I have intentionally given false information. I also know that I may be asked to show proof of any information I have given. I also know that if I have intentionally left out any information or if I have given false information, which causes me to receive assistance I am not entitled to or more assistance that I am entitled to, I can be prosecuted for fraud. **I understand I must report changes in income, assets or health insurance coverage to the department within 10 days of the change.**

If you have any questions, contact your specialist or the local MDHHS before signing the application.

I understand that upon my death the Michigan Department of Health and Human Services (MDHHS) has the legal right to seek recovery from my estate for services paid by Healthcare Coverage. This means that some of all of my estate may be recovered. MDHHS will not seek to recover against the estate while there is a legal surviving spouse or a legal surviving child who is under the age of 21, blind, or disabled. An estate consists of real and personal property. If you have received an asset disregard due to a long-term care partnership policy, Estate Recovery applies to all assets whether they are subject to probate administration or not. Estate recovery only applies to certain Healthcare Coverage recipients who received Healthcare Coverage services after the effective date of the estate recovery statute. MDHHS may agree not to pursue recovery if an undue hardship exists. An application must be submitted to determine if the applicant qualifies for an undue hardship waiver. Undue hardship waivers are temporary. For further information regarding Estate Recovery, call 800-642-3195.

IMPORTANT: YOU MUST SIGN THE APPLICATION

I certify that I have received and reviewed a copy of the Acknowledgments that explains additional information about applying for and receiving Healthcare Coverage.

Signature (Patient or Representative) Date	Two Witnesses only if signed by X Date 1. _____ 2. _____
Signature (Patient or Representative) Date	Two Witnesses only if signed by X Date 1. _____ 2. _____

If you are signing this application on behalf of someone else, complete the information below.

Name of person completing application	Phone Number	Relationship to patient	
Street Address	City	State	Zip Code