

ALPENA COUNTY DHHS
 711 WEST CHISHOLM STREET
 ALPENA MI 49707

Case Name: _____
 Case Number: _____
 Date: _____
 DHS Office:
 Specialist / ID: GR8North11 /
 Phone: 844 464-3447
 Fax: 517 346-9888
 Individual ID: _____

STATE OF MICHIGAN
Department of Human Services

If you do not understand this, call a DHS office in your area.
 DHS employees are prohibited by law from providing legal advice.
 Si usted no entiende esto, llame a una oficina de DHS en su área.
 La ley prohíbe a los empleados de DHS proporcionar asesoría legal.
 إذا واجهت صعوبة في فهم هذا الطلب، فاتصل بمكتب DHS الموجود في منطقتك.
 يحرم القانون على موظفي DHS إعطاء النصيحة القانونية.

Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.

AUTHORITY: Federal 42 CFR 435
COMPLETION: Voluntary
PENALTY: No medical coverage will be authorized.

RETROACTIVE MEDICAID APPLICATION

1. My family has unpaid medical bills for the month(s) of:

First Month	Month	Year	Second Month	Month	Year	Third Month	Month	Year
ANSWER QUESTIONS 2-9 FOR EACH MONTH APPLIED FOR IN QUESTION 1.								
2. List yourself and the name of each family member who lived with you at any time during the first month or who you claim as a dependent on your tax return. Check yes if the person has unpaid medical expenses this month.			2. List yourself and the name of each family member who lived with you at any time during the second month or who you claim as a dependent on your tax return. Check yes if the person has unpaid medical expenses this month.			2. List yourself and the name of each family member who lived with you at any time during the third month or who you claim as a dependent on your tax return. Check yes if the person has unpaid medical expenses this month.		
<input type="checkbox"/> YES			<input type="checkbox"/> YES			<input type="checkbox"/> YES		
<input type="checkbox"/> YES			<input type="checkbox"/> YES			<input type="checkbox"/> YES		
<input type="checkbox"/> YES			<input type="checkbox"/> YES			<input type="checkbox"/> YES		
<input type="checkbox"/> YES			<input type="checkbox"/> YES			<input type="checkbox"/> YES		
<input type="checkbox"/> YES			<input type="checkbox"/> YES			<input type="checkbox"/> YES		
3. Was a family member(s) in a hospital, nursing home, or away from home on the last day of the first month? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, enter name of family member(s):			3. Was a family member(s) in a hospital, nursing home, or away from home on the last day of the second month? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, enter name of family member(s):			3. Was a family member(s) in a hospital, nursing home, or away from home on the last day of the third month? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, enter name of family member(s):		
4. Explain any changes during the first month (child born, family member left or returned home, married, divorced, died, began or ended pregnancy, began or quit work) and indicate date of change.			4. Explain any changes during the second month (child born, family member left or returned home, married, divorced, died, began or ended pregnancy, began or quit work) and indicate date of change.			4. Explain any changes during the third month (child born, family member left or returned home, married, divorced, died, began or ended pregnancy, began or quit work) and indicate date of change.		

Case Name	Case Number	Specialist GR8North11
-----------	-------------	--------------------------

INCOME: For each month applied for, attach proof of all income received.

5 Was any family member employed or self-employed in any of the months listed in question 1? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, complete the following:	FIRST MONTH		SECOND MONTH		THIRD MONTH	
	Total monthly earned income before deductions.	Names of children receiving child care due to employment.	Total monthly earned income before deductions.	Names of children receiving child care due to employment.	Total monthly earned income before deductions.	Names of children receiving child care due to employment.
Person employed:	\$		\$		\$	
	\$		\$		\$	
Name of Self-Employed Person	Gross Monthly income, minus allowable federal tax deductions (DEPRECIATION not allowed)		Gross Monthly income, minus allowable federal tax deductions (DEPRECIATION not allowed)		Gross Monthly income, minus allowable federal tax deductions (DEPRECIATION not allowed)	

EXPENSES: Attach copy of court order(s) for child support paid.

6 Did any family member pay child support in any of the months listed in question 1? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, complete the following:	Total monthly child support paid per person	Total monthly child support paid per person	Total monthly child support paid per person
Person(s) paying child support:	\$	\$	\$
7 Did any family member pay guardianship/conservator expenses in any of the months listed in question 1? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, who pays?	Total monthly guardianship/conservator expenses paid per person	Total monthly guardianship/conservator expenses paid per person	Total monthly guardianship/conservator expenses paid per person
Person(s) paying guardianship/conservator expenses:	\$	\$	\$
8 Does any family member pay alimony expenses in any of the months listed in question 1? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, who pays?	Total monthly alimony expenses paid per person	Total monthly alimony expenses paid per person	Total monthly alimony expenses paid per person
Person(s) paying alimony	\$	\$	\$
9 Did any family member pay student loan expenses in any of the months listed in question 1? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, who pays?	Total monthly student loan expenses paid per person	Total monthly student loan expenses paid per person	Total monthly student loan expenses paid per person
Person(s) paying student loan	\$	\$	\$
10. Did any family member pay other expenses in any of the months listed in question 1? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, who pays?	Total monthly other expenses paid per person	Total monthly other expenses paid per person	Total monthly other expenses paid per person
Person(s) paying other expenses:	\$	\$	\$

11. **OTHER INCOME:** Include income of all family members. Each item must be answered YES or NO.

INCOME TYPE	FIRST MONTH			SECOND MONTH			THIRD MONTH		
	YES/NO	MONTHLY AMOUNT	WHOSE INCOME	YES/NO	MONTHLY AMOUNT	WHOSE INCOME	YES/NO	MONTHLY AMOUNT	WHOSE INCOME
Social Security Benefits (RSDI)		\$			\$			\$	
Supplemental Security Income (SSI)		\$			\$			\$	
Retirement or Pension Benefits		\$			\$			\$	
Veterans Benefits		\$			\$			\$	
Disability Benefits		\$			\$			\$	

Case Name			Case Number			Specialist GR8North11		
Rental Income		\$			\$			\$
Workers Compensation		\$			\$			\$
Child Support		\$			\$			\$
Allimony		\$			\$			\$
Unemployment compensation		\$			\$			\$
Military Allotments		\$			\$			\$
Gambling Distributions (Casino profit sharing)		\$			\$			\$
Other		\$			\$			\$

12. **ASSETS:** Include assets of all family members. Each item must be answered YES or NO. Attach proof of asset value for each retro month applied for.

ASSET TYPE	FIRST MONTH		OWNER(S)	SECOND MONTH		OWNER(S)	THIRD MONTH		OWNER(S)
	YES/NO	AMOUNT/VALUE		Month	Year		Month	Year	
Cash on hand, in a safety deposit box or patient trust fund		\$			\$			\$	
Savings, Checking or Credit Union Accounts		\$			\$			\$	
Home, life estate, life lease		\$			\$			\$	
Real Estate (not your home)		\$			\$			\$	
Mortgage, land contract or other notes payable to household member		\$			\$			\$	
Savings bonds or money market funds		\$			\$			\$	
Stocks or mutual funds		\$			\$			\$	
IRA, KEOGH, 401K or deferred compensation accounts		\$			\$			\$	
Trust Fund(s)		\$			\$			\$	
Life insurance		\$			\$			\$	
Annuity		\$			\$			\$	
Cars, trucks, boats, motorcycles, other vehicles		\$			\$			\$	
Tools & Equipment, Livestock or Crops		\$			\$			\$	
Funeral contracts		\$			\$			\$	
Burial plot(s), casket, etc.		\$			\$			\$	
Certificates of Deposit (C.D.) or savings certificates		\$			\$			\$	
Other		\$			\$			\$	

I CERTIFY THAT ALL INFORMATION I HAVE WRITTEN ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE.

Signature	Date
-----------	------