



The Arc of New Jersey Health Care Advocacy Program Medicaid Eligibility Problem Form

www.thearcnjhealthcareadvocacy.org

Date of Report: _____

Name of individual with intellectual or developmental disability (IDD): _____		Date of Birth: _____	Current Age: _____
		Medicaid or DDD #: _____	
Address: _____		County: _____	
Name of Contact Person: _____		Relationship to Individual: _____	
Contact Person's Telephone: _____		Email: _____	
Assets Amount of money in the bank in the name of the individual: \$ _____ Any other assets in the name of the individual (e.g., stocks, bonds)? \$ _____ Was a Special Needs Trust and/or an ABLE account ever created to save excess assets? <input type="checkbox"/> Yes <input type="checkbox"/> No Comments: _____		Is the individual a DDD Client? <input type="checkbox"/> Yes <input type="checkbox"/> No If answer is YES, please choose from one selection below: Supports Program? <input type="checkbox"/> Yes <input type="checkbox"/> No or CCP - (Community Care Program) formally known as CCW, Community Care Waiver? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Supplemental Security Income (SSI) Has the individual ever received SSI? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, monthly amount: \$ _____ At what age did SSI start? ____ Is the person still receiving SSI? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, at what age did person stop receiving SSI? ____ Do you know why the person lost SSI? Please explain: _____			
Medicaid History Has the individual ever received Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, approximate age when Medicaid started: ____ Approximate age when Medicaid ended: ____ Do you know why Medicaid ended? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain: If the person has never received Medicaid, did he/she ever apply for Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain why Medicaid was denied: If no, explain why no application was ever made to Medicaid Comments: _____			
Social Security Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, monthly amount: \$ _____ At what approximate age did SSD start? ____ Did he/she begin receiving benefits from Social Security based on a parent's work history? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain: Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Employment Status of Parents			
Mother: Working? <input type="checkbox"/> Yes <input type="checkbox"/> No Retired? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, approx. year when mom retired: ____ Deceased? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, approx. year when mom died: ____ Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, approx. year when mom became disabled: _____		Father: Working? <input type="checkbox"/> Yes <input type="checkbox"/> No Retired? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, approx. year when dad retired: ____ Deceased? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, approx. year when dad died: ____ Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, approx. year when dad became disabled: _____	
Individual Employment Questions Currently employed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Number of hours/week: _____ Salary: \$ _____ per month If currently employed: Did the individual apply for NJ Workability Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No Comments? Receiving unemployment income? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, amount of unemployment income: \$ _____ per month Receiving SSDI because of individual's work history? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, amount of SSDI per month \$ _____			
Does individual receive any other income not listed above? (Including child support, pension from a parent or income from any other source) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is the other income and amount, per month? _____			
Miscellaneous Please mention any other relevant information: _____			
I give permission for this information to be forwarded to The Arc of New Jersey, and also give permission for it to be forwarded to the NJ Division of Medical Assistance and Health Services (NJ Medicaid) and/or the Division of Developmental Disabilities (DDD). *Signature: _____ Date: _____			