The Arc of New Jersey's Mainstreaming Medical Care Program
Medicaid Eligibility Problem Form

www.mainstreamingmedicalcare.org

Date of Report:

Name of individual with intellectual or developmental disability (I/DD):	**Date of Birth:**	**Current Age:**
	Social Security#	

Address: **County:**

Is the individual a DDD Client? ☐Yes ☐No

Name of Contact Person: **Relationship to Individual:**

Contact Person's Telephone: **Email:**

If answer is YES, please choose from one selection below:

Supports Program? ☐Yes ☐No

OR

CCP - (Community Care Program) Formally known as CCW, Community Care Waiver? ☐Yes ☐No

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)? $ _____

If there are assets in the name of the individual, was a special needs trust ever developed? ☐Yes ☐No

Comments:

Supplemental Security Income History Has the individual ever received SSI? ☐Yes ☐No

If yes, monthly amount: $ _____ At what age did SSI start? __

Is the person still receiving SSI? ☐Yes ☐No If no, at what age did person stop receiving SSI? __

Do you know the circumstances that caused the person to lose SSI? Please explain: _____

Comments:

Medicaid History Has the individual ever received Medicaid? ☐Yes ☐No

If yes, approximate age when Medicaid started: __ Approximate age when Medicaid ended: __

Do you know why Medicaid ended? ☐Yes ☐No If yes, please explain: _____

If the person has never received Medicaid, did he/she ever apply for Medicaid? ☐Yes ☐No

If yes, explain why Medicaid was denied: _____

If no, explain why no application was ever made to Medicaid: _____

Comments:

Social Security Disability? ☐Yes ☐No If yes, monthly amount: $ _____ At what approximate age did SSD start? ____

Did he/she begin receiving benefits from Social Security based on parent's work history?

☐Yes ☐ No If yes, please explain: _____

Medicare? ☐Yes ☐N

Employment Status of Parents

Mother: Working? ☐Yes ☐No

Retired? ☐Yes ☐No If yes, approx. year when mom retired: __

Deceased? ☐Yes ☐No If yes, approx. year when mom died: __

Disabled? ☐Yes ☐No If yes, approx. year when mom became disabled: __

Father: Working? ☐Yes ☐No

Retired? ☐Yes ☐No If yes, approx. year when dad retired: __

Deceased? ☐Yes ☐No If yes, approx. year when dad died:__

Disabled? ☐Yes ☐No If yes, approx. year when dad became disabled: __

Individual's Employment Questions

Currently employed? ☐Yes ☐No If yes, Number of hours/week: _____ Salary: $ _____ per month

If currently employed: Did individual apply for Medicaid's Workability Program ☐Yes ☐No Comments: _____

Receiving unemployment income? ☐Yes ☐No If yes, amount of unemployment income: $_____ per month

Receiving SSDI because of individual's work history? ☐Yes ☐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) ☐**Yes** ☐**No** If yes, what is the other income and amount, per month? _____

Miscellaneous

If applicable, Please mention any other issues that you think are relevant to this person's applying for Medicaid: _____

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:

Please email or fax the completed form to: Beverly Roberts at broberts@arcnj.org / fax (732)246-2567 or Jennifer Lynch at jlynch@arcnj.org / fax (732)784-6397.

We will get back to you as soon as possible. Thank you.

**Electronic Signature accepted: Typed signature with date indicates electronic verification of the information provided.*

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