



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:
		Social Security#	
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)? \$ ____ If there are assets in the name of the individual, was a special needs trust ever developed? <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 History 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 the circumstances that caused the person to lose SSI? Please explain: ____ Comments:			
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 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's 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 individual apply for Medicaid's Workability Program <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 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: Connor Griffin at cgriffin@arcnj.org / fax (732) 246-2567.

Revised 04/25

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