

## MEDICAL ASSISTANCE (MEDICAID) FINANCIAL ELIGIBILITY APPLICATION FOR LONG TERM CARE, SUPPORTS AND SERVICES

*You may also apply online at [www.compass.state.pa.us](http://www.compass.state.pa.us)*

Check any that you are applying for:

- Care in a Facility
- Home and Community Waiver Services (Type/Name: \_\_\_\_\_ )
- Other ( \_\_\_\_\_ )

- \* Please read the entire application form
- \* Print the requested information in the unshaded sections
- \* If you need help, another person can help you or you can get help from your County Assistance Office

You or any representative you choose may complete this application. Your representative can be your spouse, a friend, a relative, a person who has your power of attorney, or your medical provider. It should be someone who knows and can provide information about your income and resources. If you are married, information in some sections must be completed for both you and your spouse.

After the form is completed, bring it, have someone else bring it, or mail it to the County Assistance Office unless you are instructed otherwise. The County Assistance Office will tell you if a face to face interview is needed. You will need to prove your identity and other information on the form unless we already have the information in our records. If you need help to obtain any information ask the County Assistance Office for help. You should attach verification to this form.

Persons who have given away assets (income or resources) within three years or set up or transferred assets to a trust within five years prior to applying for Medical Assistance for long term care, supports and services may be ineligible for benefits. Because of this requirement, you may need to provide verification of assets owned during the past three/five years, even though you may no longer own them. We will use your Social Security Number to get information about your assets for the three years prior to your application.

If the information is complete and you have provided the necessary verification (with this form, if possible), the County Assistance Office will notify you within 30 days of receiving your application if you are eligible, ineligible or if additional information is needed.

| PROVIDER USE                          |                            |                          |
|---------------------------------------|----------------------------|--------------------------|
| Name                                  | Number                     |                          |
| Address                               | Number                     |                          |
| Date of Admission                     | Date of Options Assessment | Requested Effective Date |
| Contact Name/Telephone Number/Address |                            |                          |

| CAO USE  |      |               |                 |                |
|--|------|---------------|-----------------|----------------|
| Co.  | Dist | Record Number | File Cleared by | Appl. Reg. No. |
| Worker I.D.                                    |      |               | Caseload        |                |
| <input type="checkbox"/> Authorized Reason     |      |               |                 | Category       |
| <input type="checkbox"/> Not Authorized Reason |      |               |                 | Date           |

Please Complete the Following Information for the Person Requesting Medical Assistance Benefits:

|  |          |            |                 |                |                                |                |
|--|----------|------------|-----------------|----------------|--------------------------------|----------------|
| Last Name  |          | First Name |                 | Middle Initial | (Jr., Sr., I, etc.)            |                |
| Current Address (If in a facility, use facility address)   |          |            | City            | State          | Zip Code + 4                   | Admission Date |
| Date Moved To This Address   | Township |            | School District |                | Area Code and Telephone Number |                |
| Previous Address (If in a Facility, give your home address. If you are married, give your spouse's address.) |          |            |                 |                | Area Code and Telephone Number |                |

|  |   |
|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you want an interpreter? If yes, what language? _____<br>_____   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you need your notices in Spanish? ¿Necessita sus avisos en espanol?  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you ever applied for or received cash, medical or food stamp benefits in another county in Pennsylvania or in another state?<br>If yes: What State _____ County _____ How Long _____ Record Number _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you ever applied for or received benefits using a different Social Security Number?<br>If yes, what is the number? _____   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you previously lived in a nursing facility? If yes, provide name, address and dates:<br>Name _____<br>Address _____<br>Dates _____   |

1. Complete all information in this section for yourself, your spouse if you are married, and any dependent children or siblings.

\* Attach an additional sheet of paper if you have more dependents.

| Relationship | Last Name | First Name | MI | Jr/Sr | Alias/Maiden Name | Birth Date | Sex | *Race | SSN |
|--------------|-----------|------------|----|-------|-------------------|------------|-----|-------|-----|
| Self         |           |            |    |       |                   |            |     |       |     |
| Spouse       |           |            |    |       |                   |            |     |       |     |
| Dependent    |           |            |    |       |                   |            |     |       |     |

\* For Race: Your benefits will not be affected if you do not answer. Use one of the following codes:

1. Black 2. Hispanic 3. North American Indian or Alaskan Native 4. Asian or Pacific Islander 5. White (Not Hispanic) 6. Other

2. Please Answer and Sign:

Are you a U.S. Citizen?  Yes  No

If No Check One  Permanent Resident  Temporary Resident  Refugee  Illegal Alien

Alien # \_\_\_\_\_ Country of Origin \_\_\_\_\_ Date of Entry \_\_\_\_\_

Sign to declare your citizenship or alien status as marked above:

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

Name and address of sponsor, if you have one

3. Marital Status - Check One

Are you:  Married  Single  Widowed  Divorced  Separated

If you checked widowed, what was the date of your spouse's death? \_\_\_\_\_ Name: \_\_\_\_\_

If you checked separated, what was the date of separation? \_\_\_\_\_ Please Complete item #1 above for spouse.

4. Military Status - Check One

Are you:  Veteran  Active Military  National Guard  Reserves  Widow/Spouse or Dependent Child of a Veteran

Veteran's Name: \_\_\_\_\_

Branch of Service \_\_\_\_\_ Date Entered \_\_\_\_\_ Date Left \_\_\_\_\_ Claim No. \_\_\_\_\_

5. Opportunity for Voter Registration

Are you (and your spouse, if you are married) interested in registering to vote?

| Yes | No | Already Registered | Last Name | First Name |
|-----|----|--------------------|-----------|------------|
|     |    |                    |           |            |
|     |    |                    |           |            |

If you do not check any box, we will assume you have decided not to register to vote at this time. Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency. All information will be used only for voter registration purposes. If you register to vote, the name of the office at which you submit this registration application will remain confidential. If you decline or do not wish to register to vote, the fact that you have declined to register will remain confidential. If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

CAO use   Given to Client     /    /     *Date*      Hand carried to County Voter Registration     /    /     *Date*      Mailed to County Voter Registration     /    /     *Date*

6. If you are receiving or have received long term care, supports, and services, how were your expenses being paid?

\_\_\_\_\_

\_\_\_\_\_

7. Do you have unpaid medical bills?  Yes  No If you are requesting Medical Assistance for these bills, attach copies.

\_\_\_\_\_

\_\_\_\_\_

8. MEDICAL INSURANCE INFORMATION (Including Long Term Care Insurance)

| Insurance Company/Medicare | Insurance Company Address | Agreement/ Policy Number | Group Name Number | Effective Date of Coverage | Premium Amount | Paid How Often | Policy Holder Name and Address |
|----------------------------|---------------------------|--------------------------|-------------------|----------------------------|----------------|----------------|--------------------------------|
|                            |                           |                          |                   |                            |                |                |                                |
|                            |                           |                          |                   |                            |                |                |                                |
|                            |                           |                          |                   |                            |                |                |                                |
|                            |                           |                          |                   |                            |                |                |                                |

Add an additional sheet of paper if more space is needed. Please label what question number you are answering.

9. Complete the following resource information for you and your spouse (if you are married):

**A. Real Estate**

|  |       |  |  |   |
|--|-------|--|--|---|
| Location   | Owner | Value<br>\$  | Income Producing<br><input type="checkbox"/> Yes <input type="checkbox"/> No | None <input type="checkbox"/><br>Resident<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
| Who lives in the property?   |       | Is the property listed for sale?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  | If Yes - Date Listed  |
| Realtor's Name and Telephone Number<br>If Yes give ▶   |       | * Remember to report the property sale to us.  |  |   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are you planning to return to the property? |       | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you own any other real estate?   |  |   |

**B. Mobile Home**

|   |                               |             |  |   |
|---|-------------------------------|-------------|--|---|
| Location  | Owner                         | Value<br>\$ | Income Producing<br><input type="checkbox"/> Yes <input type="checkbox"/> No | None <input type="checkbox"/><br>Resident<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
| Year and Model  | Who Lives in the mobile home? |             |  |   |
| Realtor's Name and Telephone Number   |                               |             |  |   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Is the mobile home listed for sale? - If Yes ▶ |                               |             |  |   |

**C. Burial Arrangements**

|  |  |   |                  |  |
|--|--|---|------------------|--|
| Bank/Insurance Company Name and Address  | None <input type="checkbox"/><br>Account Numbers |   |                  |  |
| Funeral Home   | Value of Account<br>\$                           | Date Established  |                  |  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Can money be withdrawn before death of individual?    |  | <input type="checkbox"/> Yes <input type="checkbox"/> No Can interest be withdrawn? |                  |  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you own any burial spaces? If Yes, give location ▶ |  |   | Number of Spaces |  |

**D. Life Insurance**

| Company Name | Policy Number | Face Value | Current Cash Value | Who Owns the Policy? |
|--------------|---------------|------------|--------------------|----------------------|
|              |               |            |                    |                      |
|              |               |            |                    |                      |
|              |               |            |                    |                      |
|              |               |            |                    |                      |

E. Automobiles, Recreational Vehicles, Trucks, Motorcycles

None

| Name of Owner(s) | Year | Make | Model | Licensed? | Plate Number | Account Owed |
|------------------|------|------|-------|-----------|--------------|--------------|
|                  |      |      |       |           |              |              |
|                  |      |      |       |           |              |              |
|                  |      |      |       |           |              |              |
|                  |      |      |       |           |              |              |

F. Bank Accounts (Checking, Savings, IRA, etc.) List all accounts that include applicant's and/or spouse's name and money.

None

| Bank Name/Branch | Account Type | Account Number | Current Balance | Name(s) on Account/Owner |
|------------------|--------------|----------------|-----------------|--------------------------|
|                  |              |                |                 |                          |
|                  |              |                |                 |                          |
|                  |              |                |                 |                          |
|                  |              |                |                 |                          |
|                  |              |                |                 |                          |
|                  |              |                |                 |                          |
|                  |              |                |                 |                          |
|                  |              |                |                 |                          |
|                  |              |                |                 |                          |
|                  |              |                |                 |                          |

G. Stocks, Bonds (including U.S. Savings Bonds), Trusts, Mutual Funds, Cash on hand, etc.

None

| Name on Investment | Type Account | Account Number | Current Account Value | Name(s) on Account/Owner |
|--------------------|--------------|----------------|-----------------------|--------------------------|
|                    |              |                |                       |                          |
|                    |              |                |                       |                          |
|                    |              |                |                       |                          |
|                    |              |                |                       |                          |
|                    |              |                |                       |                          |
|                    |              |                |                       |                          |
|                    |              |                |                       |                          |
|                    |              |                |                       |                          |
|                    |              |                |                       |                          |
|                    |              |                |                       |                          |

10. Within the past 36 months have you (or your spouse) closed, given away, sold or transferred any assets such as: a home, land, personal property, life insurance policies, annuities, bank accounts, certificates of deposit, stocks, IRA, bonds, trust funds or a right to income?  
 Yes  No - If yes, explain circumstances (Attach extra paper if needed) \_\_\_\_\_

|                     |                                  |    |                             |
|---------------------|----------------------------------|----|-----------------------------|
| Type of Resource(s) | Market Value at time of transfer | \$ | Date of transfer or closing |
|---------------------|----------------------------------|----|-----------------------------|

11. If you closed or depleted any accounts because you paid for nursing services, list these accounts.

| Type of Resource | Location | Account Number | Owner(s) | Date of Closing |
|------------------|----------|----------------|----------|-----------------|
|                  |          |                |          |                 |
|                  |          |                |          |                 |
|                  |          |                |          |                 |
|                  |          |                |          |                 |

12. Have you (or your spouse, if you are married) established a trust or added any money to a trust within the past 5 years?

Yes  No – If yes, explain: \_\_\_\_\_  
 \_\_\_\_\_

13. Have you or your spouse received or does either of you expect to receive any income/asset/settlement/lump sum/inheritance?

Yes  No – If yes, describe: \_\_\_\_\_ Amount \$ \_\_\_\_\_  
 \_\_\_\_\_ Date expected \_\_\_\_\_

14. Income information for the applicant:

| Income Sources  | Identify Investment Type/Name | Gross Income Amount | How Often Paid |
|---|-------------------------------|---------------------|----------------|
| <input type="checkbox"/> Social Security                        | _____                         | _____               | _____          |
| <input type="checkbox"/> Veterans Benefit<br>Aid and Attendance | _____                         | _____               | _____          |
| <input type="checkbox"/> Pensions                               | _____                         | _____               | _____          |
| <input type="checkbox"/> Worker's Compensation                  | _____                         | _____               | _____          |
| <input type="checkbox"/> Railroad Retirement                    | _____                         | _____               | _____          |
| <input type="checkbox"/> Black Lung                             | _____                         | _____               | _____          |
| <input type="checkbox"/> Annuity (Company)                      | _____                         | _____               | _____          |
| <input type="checkbox"/> Payments From a Trust                  | _____                         | _____               | _____          |
| <input type="checkbox"/> Interest/Dividend (Source)             | _____                         | _____               | _____          |
| <input type="checkbox"/> Other Income                           | _____                         | _____               | _____          |

To whom are the checks sent?  
 (Guardian, Representative Payee) ►

Address: \_\_\_\_\_

Complete this section if you have a spouse or dependent.  
 Skip this section if you are not married or do not have a dependent child.

15. Income information for the spouse and/or dependent child:

| Income  | Sources | Gross Income Amount | How Often Paid |
|---|---------|---------------------|----------------|
| <input type="checkbox"/> Social Security                        | _____   | _____               | _____          |
| <input type="checkbox"/> Veterans Benefit<br>Aid and Attendance | _____   | _____               | _____          |
| <input type="checkbox"/> Pensions                               | _____   | _____               | _____          |
| <input type="checkbox"/> Worker's Compensation                  | _____   | _____               | _____          |
| <input type="checkbox"/> Railroad Retirement                    | _____   | _____               | _____          |
| <input type="checkbox"/> Black Lung                             | _____   | _____               | _____          |
| <input type="checkbox"/> Annuity (Company)                      | _____   | _____               | _____          |
| <input type="checkbox"/> Payments From a Trust                  | _____   | _____               | _____          |
| <input type="checkbox"/> Interest/Dividend (Source)             | _____   | _____               | _____          |
| <input type="checkbox"/> Other Income                           | _____   | _____               | _____          |
| <input type="checkbox"/> Wages (Employer)                       | _____   | _____               | _____          |

16. Shelter expense information for the spouse:

|  |          |                 |          |
|--|----------|-----------------|----------|
| Monthly Rent/Mortgage                            | \$ _____ | Basic Telephone | \$ _____ |
| Sales or Lease Purchase Agreement                | \$ _____ | Gas             | \$ _____ |
| Personal Care or Domiciliary Care Rental Charge  | \$ _____ | Electric        | \$ _____ |
| Maintenance Charges for Condo or Co-op Residence | \$ _____ | Heating Fuel    | \$ _____ |
| Lot Rent for Mobile Home                         | \$ _____ | Water           | \$ _____ |
| Property Taxes - Annual Amount                   | \$ _____ | Sewer           | \$ _____ |
| Homeowners Insurance - Annual Amount             | \$ _____ | Garbage         | \$ _____ |

Yes    No - Do you pay for heating and/or air conditioning separate from your rent?



**RIGHT TO NONDISCRIMINATION**

We may not discriminate on the basis of age, sex, race, color, ancestry, disability, religious creed, national origin, sexual preference, life-style, union membership, political belief, or because you applied for and/or received assistance before. If you feel you have been discriminated against by the Department or anyone providing services for the Department, you may file a verbal or written complaint with the Department or the County Assistance Office. The Department or County Assistance Office will then forward the complaint to the appropriate Federal or State agency.

**RIGHT TO APPEAL**

You have the right to ask for a Departmental hearing to appeal a decision of or failure to act by the Department which affects your benefits or that you feel is unfair or incorrect. You may file the appeal at the County Assistance Office. At the appeal hearing, you may represent yourself or someone else, such as a lawyer, friend, or a relative may represent you.

**RIGHT TO AN AGENCY CONFERENCE**

If you appeal, you may have an agency conference before the hearing.

**RIGHT TO A WRITTEN NOTICE**

We will give you a written notice explaining your benefits. If we deny, change, suspend, or stop benefits, we will explain the reason on the notice. You have 30 days from the date of the notice to ask for a hearing if you disagree with the action taken and/or the reasons given.

**RIGHT TO CONFIDENTIALITY**

We keep information you give confidential and use it only to administer the programs you apply for and may be eligible for. Any person knowingly violating any of the rules and regulations of this Department made in accordance with this article shall be guilty of a misdemeanor, and upon conviction thereof, shall be sentenced to pay a fine, not exceeding one hundred dollars (\$100), or to undergo imprisonment, not exceeding six months, or both (62 P.S. Section 483).

**ESTATE RECOVERY**

If you are age 55 or older and receive medical assistance to pay for nursing facility services, home and community-based waiver services and any related hospital and prescription drug service, you will be required to repay the cost of these services from your probate estate. You may call the MA Estate Recovery Program at 800-528-3708.

**CHANGES**

If you are not sure if you must report a particular change, you should report the change. You can report to a member of the County Assistance Office staff in person, by telephone, or by mail.

**USE OF THE PA ACCESS CARD**

You may use the PA ACCESS card for services only during the period you are eligible. You must use the card only for the person who is eligible and you may get only services that are needed and reasonable.

**RESPONSIBILITY TO PROVIDE SSNs**

You must provide a Social Security Number (SSN). If you do not have an SSN, you must apply for one. Refusal or failure to provide an SSN may result in disqualification. If you have a community spouse, he or she must also supply an SSN. We use the SSN to verify identity, administer our programs, prevent duplication in state and federal programs, for computer matches with other programs, and to get information about income and resources to determine eligibility for and/or the amount of your benefits (42 U.S.C. Section 1320b-7).

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If you do not report changes as required, your benefits may be reduced or stopped. If you purposely fail to give correct information or report changes, you may be fined and/or put in jail. Improper use of the PA Access Card for services may result in a fine or imprisonment, or both.

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You must give true, correct and complete information to the best of your ability. You must cooperate in documenting or proving the information you give. If you cannot provide proof, you should ask the County Assistance Office to help. You must cooperate fully with quality control and with persons from the Department or the Inspector General's Office who are conducting investigations.

***I Understand:***

My benefits may be reduced or I can be penalized for giving incomplete or false information or for not reporting changes that would affect my benefits.

Any person enriched as a result of a transfer of assets or income, which would have affected my eligibility, will be liable for repayment of those benefits issued incorrectly.

I am giving the state the right to seek, with or without legal action, payment from private or public health insurance or liable third party. The amount recovered will not exceed the amount paid by Medical Assistance.

The state has the right to review all records of medical service paid for by Medical Assistance.

Payment for medical services will be made directly to the provider, not to me. This includes payments from Medicare.

I received a copy of my rights and responsibilities, have read them or someone has read them to me, and I understand them.

I agree to provide or cooperate in getting any information needed to prove my statements.

I must report any changes in my circumstances within 7 days of the change.

I am responsible for any fraudulent statements made on this application even if the application is submitted by someone acting on my behalf.

The state operates a fraud control program under which local, state, and federal officials may verify the information I have given.

The state may obtain information about my circumstances from other persons or organizations, including computer matches and Immigration and Naturalization.

My Social Security Number will be used to obtain information to verify my circumstances and eligibility.

## AFFIDAVIT

I certify, subject to penalties provided by law, that the information I gave is true and correct and complete to the best of my knowledge. I have read this application in full or someone has read it to me and I understand the questions asked. I have received a copy of and read my rights and responsibilities, or someone has read them to me, and I understand them.

|  |      |               |  |              |                         |
|--|------|---------------|--|--------------|-------------------------|
| Applicant or Authorized Representative Signature | Date | I.D. Verified | Relationship to Applicant                                  |              |                         |
| Address of Representative                        |      | City          | State  | Zip Code + 4 | ( )<br>Telephone Number |
| Witness (if signed with an X above)              | Date |               |  |              |                         |
| Address of Witness                               |      | City          | State  | Zip Code + 4 | ( )<br>Telephone Number |
| Provider Signature (if submitted by provider)    | Date |               |  |              |                         |
| CAO or OPTIONS                                   | Date |               | <input type="checkbox"/> Face to Face Interview With _____ |              |                         |
|  |      |               | <input type="checkbox"/> Telephone Interview With _____    |              |                         |
|  |      |               | <input type="checkbox"/> Interview Waived                  |              |                         |

### Who is your representative or power of attorney? Copies of notices will be sent to the person named.

|                                       |      |       |                           |                         |   |
|---------------------------------------|------|-------|---------------------------|-------------------------|---|
| Last Name, First Name, Middle Initial |      |       | Relationship to Applicant |                         | <input type="checkbox"/> Representative<br><input type="checkbox"/> Power of Attorney |
| Address                               | City | State | Zip Code + 4              | Telephone Number<br>( ) |   |

### I WISH TO WITHDRAW MY APPLICATION

|           |  |     |  |      |
|-----------|--|-----|--|------|
| Signature |  | / / |  | Date |
|-----------|--|-----|--|------|

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