

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

Date of Report:

Name of individual with intellectual or developmental disability (I/DD):		Date of Birth:	Current Age:		
		Social Security #:			
Individual's Diagnosis:		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 DDD ID #:			
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:					
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:					
Social Security Disability? (May also be called a Survivor's benefit, if a parent has passed away) <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 Private or Employer-Sponsored Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Employment Status of Parents <table style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> 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: </td> <td style="width: 50%; vertical-align: top;"> 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: </td> </tr> </table>				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:
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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 NJ Medicaid 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?					

It 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

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