COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

MAIL-IN APPLICATION FOR MEDICAL ASSISTANCE FOR WORKERS WITH DISABILITIES

Medical Assistance for Workers with Disabilities offers health care coverage for individuals with disabilities who are employed. There are two groups of coverage: *Worker with a Disability,* and *Worker with a Medically Improved Disability.* If you apply and are determined eligible for the program, you must pay a monthly premium in order to receive the health care coverage.

Ky eshte nje aplikim per perfitime. Ne rast se keni nevoje per perkthyes apo ndihme per mbushjen e aplikimit, kontaktoni Zyren e Asistences ne komunen/lagjen tuaj.

هذا طلب للحصول على الإعانات. إذا كنت تحتاج إلى مترجم شفهي أو مساعدة
في تعبئة الطلب، اتصل بمكتب المساعدات المحلي في مقاطعتك

[illegible]

这是福利申请表。如果您需要译员，或需要人帮助填写此申请表，请与当地的县府援助办公室联系。

Ceci est une demande pour des avantages sociaux. Si vous avez besoin d'un interprète ou d'aide pour compléter la demande, contactez le bureau local de l'Assistance Sociale de votre comté.

이 서류는 연금 신청서입니다. 통역이 필요하시거나 신청서 작성에 도움이 필요하신 분들은 가까운 관할 카운티 사무실에 연락하시기 바랍니다.

[illegible]

Niniejszy dokument jest podaniem o świadczenia. Jeżeli potrzebuje Pan/Pani tłumacza lub innej pomocy w wypełnieniu tego podania, proszę skontaktować się z Powiatowym Biurem Pomocy (County Assistance Office).

Это заявление на получение пособий. Если вам нужен переводчик или помощь при заполнении этого заявления, обратитесь в местный отдел социальной помощи вашего округа.

[illegible]

DO NOT COMPLETE
County Assistance Office Use

☐ MAIL ☐ WALK-IN		FILE CLEAR BY / DATE	SCREEN BY / DATE	
COUNTY	DISTRICT	APPLICATION REG. NO.	DATE STAMP	
WORKER ID		CASE LOAD	RECORD NUMBER	CAT
NAME			APPOINTMENT DATE / TIME	

	AUTHORIZED					NOT AUTHORIZED				
DATE										
BY										
CAT										
RESOURCE CODE										

Mail to:
Central MA Processing Unit
Philadelphia County Assistance Office
801 Market St., 5th Floor
Philadelphia, PA 19107
Fax (215) 560-2417
Phone (215) 560-3420

HOW DO I QUALIFY?

1. You must be at least 16 years of age but less than 65 years of age.
2. Your countable resources such as bank accounts, stocks, and bonds cannot exceed $10,000.
3. Your countable income, after allowable deductions, must be less than 250% of the Federal Poverty Income Guideline.
4. You must meet the definition of a disability according to the Social Security Administration.
   – To meet the definition of a disability, you must meet one of the following:
   - You must be currently receiving SSDI
   - You must have received SSI/SSDI within the past 12 months
   - You must be determined disabled by Departmental Review. You must submit documentation of your disability from your medical provider.
5. You must also be employed and receiving compensation to receive coverage as a *Worker with a Disability*.
6. To be covered as a *Worker with a Medically Improved Disability*, you must also meet the following criteria:
   - You were previously covered as a Worker with a Disability; and
   - You have a medically improved condition; and
   - You are working at least 40 hours per month, at minimum wage or higher

HOW DO I APPLY?

1. Complete the enclosed application. (If you need help to answer the questions, call the Helpline at 1-800-842-2020 or TDD 1-800-451-5886 for the hearing impaired.)
2. Attach proof of your income, impairment-related work expenses, resources, social security number, address, and identification.
3. Read the "Rights and Responsibilities" section and sign the application.
4. Mail the application to your County Assistance Office. A staff member from the County Assistance Office will contact you if additional information is needed. They will decide if you are eligible for Medicaid benefits, and will inform you of the decision.

If you need cash assistance or food stamps, you must complete a different application. Please call your County Assistance Office and they will send you the proper form.

YOUR NAME – Last, First, Middle Initial			SOCIAL SECURITY NUMBER	
ADDRESS		STATE	ZIP CODE	PLUS 4
TELEPHONE NUMBER	SCHOOL DISTRICT	TOWNSHIP		

STEP #1 (If additional space is needed, please attach a separate sheet.)

HOUSEHOLD MEMBERS

List all Household Members

OFFICE USE LINE NO.	NAME – Last, First, Middle Initial	JR / SR ETC.	ARE YOU APPLYING FOR THIS PERSON? YES	NO	BIRTH DATE MM	DD	YY	SEX M	F

INCOME

For each person that you included on this application who has income, including children under 21, list the income below. List t

- Wages
- Baby-sitting
- Rent
- Veterans Benefits
- Self-Employment
- Room and Board
- Social Security / SSI
- Support or Alimony

NAME	EMPLOYER OR SOURCE OF INCOME	EMPLOYER'S ADDRESS	TELEPH

EXPENSES

List any expenses necessary in order to be eligible for or continue receiving this income. Expenses include but not limited to • Court Costs • Transportation • Attorney Fee • impairment related work expenses; such as: Medical devices, attendant care, or transportation

NAME	TYPE OF EXPENSE	AMOUNT	HOW OFTEN PAID

RESOURCES

Does anyone have any of the following resources?

☐YES ☐NO Cash-on-hand (01)
☐YES ☐NO Savings Account (02)
☐YES ☐NO Checking Account (03)
☐YES ☐NO Certificate of Deposit (26)
☐YES ☐NO Non-resident Property
☐YES ☐NO Burial Spaces, Reserves, or Trusts
☐YES ☐NO U.S. Savings Bonds (05)
☐YES ☐NO Christmas or Vacation Club (040)
☐YES ☐NO Stocks or Bonds (05)
☐YES ☐NO Trust Fund (06)
☐YES ☐NO IRA, KEOGH, or other retirement plan (27)
☐YES ☐NO Other (99)

NAME OF OWNER	TYPE / ACCOUNT NO. / LOCATION OF THE RESOURCE	CURRENT VALUE

FOR CITIZENSHIP Use one of the following codes.
1. US CITIZEN 2. PERMANENT ALIEN 3. TEMPORARY ALIEN 4. REFUGEE 5. ILLEGAL ALIEN

FOR RACE Use any of the following codes that apply. Your benefits will not be affected if you do not answer.
1. BLACK 2. HISPANIC 3. NORTH AMERICAN INDIAN OR ALASKAN NATIVE 4. ASIAN OR PACIFIC ISLANDER 5. WHITE (NOT HISPANIC) 6. OTHER

	SOCIAL SECURITY NUMBER	HOW IS THE PERSON RELATED TO YOU?	CITIZENSHIP CODE	ALIEN REGISTRATION NUMBER	RACE CODE	MEDICARE CLAIM NUMBER	DO YOU HAVE A PA ACCESS CARD? YES	NO

he income amount before deductions (such as taxes or insurance) are taken out. Income includes but is not limited to:

- Sick Benefits
- Unemployment or Worker's Compensation
- Dividends or interest
- Pensions
- Commissions
- Money for College or Training

ONE	HOURS WORKED PER WEEK	HOURLY WAGE	HOW OFTEN IS INCOME RECEIVED? (circle one)	GROSS AMOUNT BEFORE DEDUCTIONS
			Weekly/Bi-Weekly/Monthly/Other (Explain)	
			Weekly/Bi-Weekly/Monthly/Other (Explain)	
			Weekly/Bi-Weekly/Monthly/Other (Explain)	
			Weekly/Bi-Weekly/Monthly/Other (Explain)	
			Weekly/Bi-Weekly/Monthly/Other (Explain)	

RESOURCES

Does anyone own or is anyone buying a car, truck, motorcycle? ☐ YES ☐ NO

NAME OF OWNER	YEAR	MAKE	MODEL	LICENSED	AMOUNT OWED
				☐YES ☐NO	
				☐YES ☐NO	
				☐YES ☐NO	
				☐YES ☐NO	
				☐YES ☐NO	

Does anyone have a Life Insurance Policy? ☐ YES ☐ NO

POLICY OWNER	NAME OF INSURANCE CO. / POLICY NO.	FACE VALUE	CASH VALUE	WHO IS COVERED?

Does anyone have any additional Health Insurance Policies? ☐ YES ☐ NO

POLICY OWNER	NAME, ADDRESS AND PHONE NO. OF INSURANCE CO.	POLICY NUMBER	WHO IS COVERED?

There are additional benefits which may be available to pregnant women. Complete this section if you wish us to make a referral for someone in your family who is pregnant.

NAME	PREGNANCY DUE DATE

For anyone who is disabled, please list and explain the disability, its status, and list any other Medicaid coverage. Please provide documentation of the disability.

NAME	DESCRIBE THE DISABILITY	ADDITIONAL MEDICAID COVERAGE
		☐ YES ☐ NO
		☐ YES ☐ NO

WHEN WILL BENEFITS BEGIN?

Your eligibility under this program will begin on the first day of the month in which your application is received, if you choose to pay the premium for that month. If you wish to pay that premium, check the first box below. If you do not want eligibility to start in the month you apply, check the second box below. Your coverage would then start on the first day of the following month.

☐ I wish to start coverage on the first day of the month in which my application is received.

☐ I wish to start coverage on the first day of the following month.

Please Note: To determine your eligibility for the program, it will be necessary to review your disability. Because of this, you may not receive a decision on your eligibility within 30 days. When the decision is made, you may elect to receive coverage starting in the month your application was received. You would then be responsible for premium payments starting with the month in which your application was received. However, you may instead choose to start coverage in the month the decision on your disability is made. You would then be responsible for premium payments starting from that month forward.

RETROACTIVE COVERAGE

If you have unpaid medical bills for up to three months before the application (but not before January 1, 2002), those bills could be covered by this program. If you are determined eligible for retroactive coverage, you will be responsible for premium payments for each retroactive month. Please note that your retroactive bills will not be covered until these premium payments are received. If you think your bills might be less than the premium payment, you may not want to apply for retroactive coverage. Complete the section below if you wish to be considered for retroactive coverage. Please list any additional bills on a separate sheet of paper.
Please Note: You must submit verification of your income and resources for all months in which retroactive coverage is requested.

DATE OF SERVICE	HOSPITAL / DOCTOR / PRESCRIPTION	AMOUNT OF BILL	DATE OF SERVICE	HOSPITAL / DOCTOR / PRESCRIPTION	AMOUNT OF BILL

HOW TO PAY THE PREMIUM

To participate in this program, you must pay a monthly premium[1]. The preferred method of payment is payroll deduction. With payroll deduction, your employer will deduct the monthly premium amount directly from your paycheck. ***Please check the box below if you want payroll deduction.***

☐ **YES**, I want payroll deduction

If you are self-employed, do not want payroll deduction, or your employer doesn't offer payroll deduction, you will be sent a monthly statement. You will be responsible for mailing that statement each month with your payment. ***Please check the box below if you want a monthly statement, and do not want payroll deduction.***

☐ **NO**, I do not want payroll deduction

[1] In some cases, you may not be required to pay a premium, due to income or good cause

STEP #2 – ATTACH PROOF

We will need proof of the information you have provided to process your application. Examples of proof are listed below. You are not limited to these examples.

PLEASE SEND COPIES – NOT ORIGINALS

Address (One Source)	Rent Receipt, Utility Bill, Drivers License (with current address), Mortgage Bill or Receipt, Post Office Records, Tax Records, etc.
Identification	Drivers License, Passport, Photo ID
Social Security Number	Social Security Card
Income	One Month's Current Pay Stubs, Award Letters for Social Security or SSI, Proof of Pension, Financial Eligibility Notice for Unemployment Compensation, Tax Forms or other Records of Self-employment Income, Copies of Check Stubs or Statements form the Source of Income
Expenses	Bills/Receipts from Impairment - related work expenses, and other expenses related to receiving income
Resources	Bank Statements, Insurance Policies, Tax Assessment Notices
Disability	Medical Documentation

If you are unable to obtain proof of the information you have provided, the County Assistance Office will help you. Please attach a note explaining why you are unable to provide the proof.

STEP #3

Read the "Rights and Responsibilities" section and sign and date your application.

OTHER INFORMATION

GOOD CAUSE/IF YOU CANNOT PAY YOUR PREMIUM

Good cause for not paying the premium can be granted for reasons such as an ongoing health problem, loss of employment, layoff from employment, discrimination, or other factors beyond your control. You must also intend to return to the former position or be making a bona fide effort to seek other employment. When good cause is considered, your premium will be waived for the good cause period.

PRE-EXISTING MEDICAL CONDITION EXCLUSION

Federal law limits when health coverage may be denied or limited for a pre-existing condition. If you enroll in a group or individual health plan that has a pre-existing condition exclusion, you can get credit for the time you received Medicaid. You may request a certification to verify your Medicaid coverage. To request this certificate, contact your caseworker.

CLIENT RIGHTS

RIGHT TO NON-DISCRIMINATION

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 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 which will forward the complaint to the appropriate federal or state agency.

RIGHT TO CONFIDENTIALITY

We keep information you give confidential and use it only to administer the programs you apply for and/or may be eligible for.

RIGHT TO CERTIFICATE OF CREDITABLE COVERAGE

I understand that I have a right to a certificate coverage to verify my medical coverage. Federal law limits when healthcare coverage may be denied or limited for a pre-existing condition. If I enroll in a group plan that allows for a pre-existing condition. If I enroll in a group plan that allows for a pre-existing condition, I may get credit for the time I received Medicaid.

RIGHT TO APPEAL

You have a right to ask for a Departmental hearing to appeal a decision of or a 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 relative, may represent you. 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.

CLIENT RESPONSIBILITIES

RESPONSIBILITY TO PROVIDE SOCIAL SECURITY NUMBERS

You must provide a Social Security Number (SSN) for each person for whom you are applying. If you do not have an SSN, we will help you apply for one. Refusal or failure to provide an SSN may result in disqualification. We will also ask you to supply an SSN to verify identity and administer our programs. We will use your SSN to prevent duplication in state and federal programs and to get information about income to determine eligibility for benefits.

RESPONSIBILITY TO PROVIDE INFORMATION

You must give true, correct, and complete information. You must cooperate to document or prove the information you give. If you cannot provide proof, you should ask the County Assistance Office to help.

RESPONSIBILITY TO REPORT CHANGES

You must report changes within 7 days. You must report changes in the number of people in your household, address, income or resources. You must report any new employment or change in employment. You must report any plans to leave the state. If you are not sure if you must report a change, you should report the change. You can report to a County Assistance Office staff person by telephone or by mail.

RESPONSIBILITY TO PAY MONTHLY PREMIUM

You are responsible for the payment of your monthly premium. If you do not pay your premium timely, you may lose your health care coverage.

RESPONSIBILITY TO CONTACT PROVIDERS FOR REFUNDS

If you pay for any medical bills between the date of application and the determination of your eligibility, you are responsible for contacting the provider for a refund.

WHEN I SIGN THIS FORM I AGREE THAT:

- I have read this application in full or someone has read it to me and I understand the questions asked.
- I received a copy of my rights and responsibilities, have read them or someone has read them to me, and I understand them.
- I will provide or cooperate in getting any information needed to prove my statements.
- I must report any changes in my circumstances within 7 days.
- I am responsible for any fraudulent statements made on this application even if the application is submitted by someone acting on my behalf.
- I certify that, subject to penalties provided by law, the information I gave is true, correct, and complete to the best of my knowledge.

WHEN I SIGN THIS FORM I UNDERSTAND THAT:

- If I do not report changes as required, my benefits may be reduced or stopped. If I purposely fail to give correct information or report changes, I may be fined and/or put in jail.
- 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.

CLIENT OR REPRESENTATIVE SIGNATURE

Signature	Date	Signature	Date

ADDRESS OF REPRESENTATIVE - STREET, CITY, STATE			
SECOND WITNESS IF AN (X) SIGNED ABOVE	ADDRESS OF WITNESS	TELEPHONE	DATE

STEP #4 – MAIL YOUR APPLICATION AND ATTACHED INFORMATION

or Fax