

Joe Lombardo
Governor

Laura Rich
Director



DEPARTMENT OF HUMAN SERVICES

DIVISION OF SOCIAL SERVICES
Helping people. It's who we are and what we do.



Robert H. Thompson
Administrator

TANF MEDICAID SNAP

┌	┐	Date: _____
		Case Name: _____
		SSN _____
└	┘	Case Manager: _____

REQUIRED INFORMATION – MEDICAID

The following information is necessary to complete your case and must be **IN** our office on or before _____.
FAILURE TO PROVIDE THIS INFORMATION MAY CAUSE MEDICAID INELIGIBILITY.

IF ANY ITEM REQUESTED CANNOT BE PROVIDED, YOU MUST CONTACT YOUR WORKER BEFORE THE DUE DATE.

IF YOU HAVE QUESTIONS, CALL _____ NO LATER THAN _____.

1. Identification: a) Social Security card, b) Medicare card, c) Driver's License/State I.D., d) Current Alien Status (photocopy both sides of Alien card), e) Birth Certificate.
2. Medical expenses for: _____
3. Verification you have applied for: _____
4. Medical insurance:
 - a) Insurance identification card
 - b) Signed insurance claim form with: _____
 - c) _____
5. Resources: a) Checking/Savings/Time certificates, b) Patient Trust Account Ledger, c) Life insurance policy, d) Burial funds/contract/arrangements.
6. Income:
 - a) Verification of: _____
7. Completed and signed form: _____
8. Support Enforcement Application – completed and signed for: _____
9. Complete and return attached pages of application: _____

OTHER:

- | | | |
|--|--------------------------------------|---|
| <input type="checkbox"/> Possible Available Benefits | <input type="checkbox"/> Insurance | <input type="checkbox"/> Maintenance Allowance Deduction |
| <input type="checkbox"/> Resources | <input type="checkbox"/> Income | <input type="checkbox"/> Blindness/Disability Determination |
| <input type="checkbox"/> Residency | <input type="checkbox"/> Citizenship | <input type="checkbox"/> Other |

I agree to supply the above information by the above date.

Customer Signature N/A (Mailed)

cc: _____