MEDICAID/MEDICARE BUY-IN APPLICATION

Demographic Information:

Please complete all information for you and your spouse. If no spouse, indicate "None".

Your Name (Applicant): _____ ____ _____
First MI Last

Your Social Security Number: _____ Sex: ☐ Male ☐ Female

Name of Spouse: _____ ____ _____
First MI Last

Spouse's Social Security Number (*if applying*): _____ Sex: ☐ Male ☐ Female

Do you and your spouse live together? ☐ Yes ☐ No

Your Medicare claim number: _____

Spouse's Medicare # (*if applying*): _____

Living Address: _____
Number Street Apt # City Zip Code

Mailing Address: _____
Number Street Apt # City Zip Code

Telephone Number: _____
Telephone #

Contact Person: _____
(Other than Yourself) First Last MI

_____
Number Street Apt # City Zip Code

_____
Telephone #

Date Stamp: (Official DCF use only)

Relationship of Contact Person to you: _____

Do you want eligibility determined for the three months before the month of application? ☐ Yes ☐ No

Technical Information:

Please complete all information for you and your spouse.

Date of Birth: _____ _____
You Spouse

Are you a U.S. Citizen? **You:** ☐ Yes ☐ No **Spouse:** ☐ Yes ☐ No

If not a citizen, provide alien number and status: _____ ; _____
You Spouse *(if applying)*

Do you intend to remain in the State of Florida? **You:** ☐ Yes ☐ No **Spouse:** ☐ Yes ☐ No

Do you and/or spouse have any other insurance other than Medicare? **You:** ☐ Yes ☐ No **Spouse:** ☐ Yes ☐ No
If *Yes*, Complete the following information:

Name of Other Insurance Company Other Insurance Policy Number

Address of Other Insurance Company Who is Covered by This Insurance

Asset Information: Please list all assets owned by you and/or spouse (even if your spouse is not applying).

TYPE	NAME OF BANK/ FINANCIAL INSTITUTION	ADDRESS	ACCOUNT NUMBER	VALUE OF ASSET	IN WHOSE NAME IS IT HELD
CASH					
SAVINGS ACCOUNT					
CHECKING ACCOUNT					
CAR Make/Model/Year:					
HOMESTEAD					
OTHER PROPERTY					
TRUST FUND					
STOCKS/BONDS					
TAX SHELTERED ACCOUNTS					
LIFE INSURANCE					
KEOGH PLAN					
Other: Please Specify					

Income Information: Please complete all information for you and your spouse (even if spouse is not applying).

Are you or your spouse self-employed?

Applicant ☐ **Yes** ☐ **No** _____ **Gross Amount Earned Monthly**

Spouse ☐ **Yes** ☐ **No** _____ **Gross Amount Earned Monthly**

Do you or your spouse work for someone else?

Applicant ☐ **Yes** ☐ **No** _____ **Gross Amount Earned Monthly**

Spouse ☐ **Yes** ☐ **No** _____ **Gross Amount Earned Monthly**

Do you or your spouse receive income from any of the following?

		Gross Amount Received Each Month (Before Any Deductions)	
Type	**Benefit No.**	**Applicant**	**Spouse**
Veterans Benefits			
Pension			
Interest/Dividends			
Civil Service Annuity			
Income from another person			
Black Lung			
Social Security			
Other (e.g. SSI, Annuities): (specify)			

YOUR RIGHTS AND RESPONSIBILITIES: *Read this sheet before you sign your name.*

YOU HAVE THE RIGHT TO:

- Apply for assistance and have a determination of your eligibility made without regard to race, color, sex, age, handicap, religion, national origin, marital status or political belief.
- Have a representative help you fill out the eligibility forms.
- Have action taken on your application promptly and be notified of such action.
- Be informed of other available services of the Department of Children and Families.
- Request a fair hearing when you disagree with a decision of the Department of Children and Families.
- Have the information about you and/or your spouse that is collected by the department treated confidentially in accordance with federal and state laws.

YOU HAVE THE RESPONSIBILITY TO (things you must do):

- Assist in determining your eligibility by giving complete and correct information and provide written proof of information, as requested, within the time limits given.
- Declare the citizenship or alien status for you and your spouse by signing the Medicaid/Medicare Buy-In Application.
- File for any payments or benefits from other sources if this application, or other information, indicates that you or your spouse may be eligible for such payments or benefits.
- Assign your rights to third party benefits and cooperate in reporting any insurance or other health plan that covers medical costs for you (and/or your spouse, if applying) unless good cause can be shown not to do so.
- Report changes in your situation (e.g., income, assets) within 10 days of the change.
- Report your (and your spouse's, if applying) Social Security numbers. Without accurate numbers, we will be unable to provide Medicaid/Medicare buy-in benefits if you are determined eligible for any benefits.

IMPORTANT INFORMATION ABOUT MEDICAID:

Any person (including the designated representative) who knowingly withholds information or knowingly misrepresents the truth may be punished under federal or state law or both. If you get medical assistance for which you do not qualify, you may have to repay the cash value of that assistance.

Certification of Citizenship/Alien Status: I certify, under the penalty of perjury, by signing my name on this application, that I and my spouse (if applicable) are U.S. citizens or nationals of the United States or qualified aliens.

Certification: In signing this application, I swear and affirm, under penalty of perjury, that the information I have given on this application is correct and complete to the best of my knowledge. I have read and understand the above rights and responsibilities and important information about Medicaid.

Applicant
Signature:_____ Date:_____

Spouse
Signature:_____ Date:_____

Designated
Representative Signature:_____ Date:_____

HELPING PERSON: (Official use only)

_____ Date:_____
Signature of Individual Who Assisted Applicant in Completing Buy-In Application Form

In accordance with Federal law and our policy, the Department of Children and Families is prohibited from discriminating on the basis of race, color, national origin, sex, age, disability, religion, political belief, or marital status.