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

The Arc of New Jersey

Date of Report:

Name of individual with intellectual or developmental disability (I/DD):

Date of Birth: | **Current Age:**

Social Security #:

Individual's Diagnosis:

Address: **County:**

Name of Contact Person: **Relationship to Individual:**

Contact Person's Telephone: **Email:**

Is the individual a DDD Client?
☐Yes ☐ No

If answer is YES, please choose from one selection below:

Supports Program?
☐Yes ☐ No

OR

CCP - (Community Care Program) Formally known as CCW, Community Care Waiver?
☐Yes ☐ No

DDD ID #:

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? ☐ Yes ☐No
Comments:

Supplemental Security Income History Has the individual ever received SSI? ☐ Yes ☐No
If yes, monthly amount: $ _____ At what age did SSI start?
Is the person still receiving SSI? ☐Yes ☐ No If yes, 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? ☐Yes ☐No
If yes, approximate age when Medicaid started: __ Approximate age when Medicaid ended:
Do you know why Medicaid ended? ☐Yes ☐No If yes, please explain:
If the person has never received Medicaid, did he/she ever apply for Medicaid? ☐Yes ☐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)
☐ Yes ☐ 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?
☐ Yes ☐ No If yes, please explain:
Medicare? ☐Yes ☐No
Private or Employer-Sponsored Health Insurance? ☐Yes ☐ No

Employment Status of Parents

Mother: Working? ☐Yes ☐No
Retired? ☐Yes ☐No If yes, approx. year when mom retired:
Deceased? ☐Yes ☐No If yes, approx. year when mom died:
Disabled? ☐Yes ☐No If yes, approx. year when mom became disabled:

Father: Working? ☐Yes ☐No
Retired? ☐Yes ☐No If yes, approx. year when dad retired:
Deceased? ☐Yes ☐No If yes, approx. year when dad died:
Disabled? ☐Yes ☐No If yes, approx. year when dad became disabled:

Individual's Employment Questions
Currently employed? ☐Yes ☐No If yes, Number of hours/week: _____ Salary: $ _____ per month
If currently employed: Did individual apply for NJ Medicaid Workability Program? ☐Yes ☐No Comments:
Receiving unemployment income? ☐Yes ☐No If yes, amount of unemployment income: $_____ per month
Receiving SSDI because of individual's work history? ☐Yes ☐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) ☐Yes ☐No If yes, what is the other income and amount, per month?

**Electronic Signature accepted: Typed signature with date indicates electronic verification of the information provided.*

If 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.