OHIP-0020 (Rev. 3/09)

REQUEST FOR MEDICAID COVERAGE

Instruction

Pregnant women and child(ren) under the age of 19 do not have to fill out this form.

Before filling out the below information, you should read the "Explanation of the Income and Resource Documentation Requirements for Medicaid." It was given to you with your application and includes a list of long-term care services.

Print your name, check one of the boxes below and sign your name at the bottom:

I, _____, request that the Medical Assistance Program:

Determine my Medicaid eligibility for community coverage WITHOUT long-term care services.

I understand that I must tell you about the value of my resources beginning with the first month for which I am asking for Medicaid benefits. I understand that I will **NOT** be eligible for Long-Term Care Services.

I understand that at any time I may ask for an increase in Medicaid coverage for Long-Term Care Services. If I need nursing facility services, I must give proof of my resources for up to 60 months prior to my request for such services. If I need community-based long-term care services, I must give proof of my current resources.

Determine my Medicaid eligibility for community coverage WITH community-based long-term care services.

I understand that I must give proof of my current resources beginning with the first month for which I am requesting Medicaid benefits. I understand that I will **NOT** be eligible for nursing facility services.

If I need nursing facility services, I must request an increase in Medicaid coverage and I must give proof of my resources for up to 60 months prior to my request for such services.

Determine my Medicaid eligibility for all covered care and services (you must be in receipt of nursing facility services).

I understand that I must give proof of my resources for the transfer of assets look-back period (up to 60 months prior to the first month for which I am asking for Medicaid benefits).

_____ _____

Applicant or Authorized Representative Signature Date

_____ _____

Spouse (if applying) or Authorized Representative Signature Date

Return this completed form with your application to the local social services district.