

Medicaid Purchase may be the answer to your needs!

What is Medicaid Purchase?

Louisiana's Medicaid Purchase Plan is **AFFORDABLE** health coverage that's available **ONLY** to workers with disabilities.

What are the benefits?

This plan gives full medical coverage that includes



prescription drugs



hospital care

doctor services



medical equipment & supplies

medical transportation



personal assistant services (PAS)

You may get PAS if you need help with activities of daily living, like eating and bathing, to find and keep a job.

How do I qualify?

To get health coverage through Medicaid Purchase, you **must**

- ❖ have a severe disability (one that matches Social Security standards);
- ❖ work;
- ❖ be at least age 16 but not yet age 65;
- ❖ have **countable** monthly income that is less than \$2257;
- ❖ have **countable** assets that are less than \$25,000;
- ❖ take other health insurance coverage, if you can get it at no cost to you; **and**
- ❖ pay a premium when your **countable** monthly income is more than \$1354.



We will **count** less than half of the money you earn (work for) and all but \$20 of any other money you get.

Income limits go up each year in April.

What are assets?

Assets are things like:



- ❖ bank accounts;
- ❖ stocks, bonds, and other cash resources;
- ❖ cars, trucks, boats, and other vehicles;
- ❖ property, including heir or estate property; **and**
- ❖ anything else you own.



GOOD NEWS!

Your home, one vehicle, any life insurance policies, medical savings and retirement accounts, and your spouse's share of any community property **will not count** in this program.

How much will it cost me?

Your "premium" (what you pay each month) will be based on your **countable** income – not your age or health condition.

Countable Income

less than \$1354
\$1354 to \$1805
\$1806 to \$2257



Monthly Premium

\$0
\$80
\$110

How do I apply?

You just need to:



- ❖ fill out the attached form;
- ❖ get the information we need together; and
- ❖ mail or bring the form and information to us as soon as you can.

What information will you need from me?

You will need to give us your:

- ❖ Social Security number;
- ❖ proof of your total income for the last month;
- ❖ Medicare and any other health insurance card; **and**
- ❖ alien registration card or immigration papers, if you are not a U.S. citizen.

Send copies of as many of these items as soon as you can. **Do not wait** to send in the form. We can give you more time to give us any missing information after we get your application.



← (TEAR-OFF THE APPLICATION HERE BEFORE MAILING.)

What will happen then?

In most cases, we will decide if you qualify and let you know our decision within 45 days after we get your form. If you don't get Social Security benefits we will have to make a decision about your disability and it may take us up to 90 days.



Who can I call to get help?

If you need help to fill out this form, call your local Medicaid office.

If you have questions or need more information about Medicaid Purchase, call us toll-free at 1+888+544-7996 or TTY 1+800+220-5404,



OR

visit us on-line at www.dhh.state.la.us.



Louisiana's Benefits Planning Assistance and Outreach (BPAO) project can help you understand how working could change your benefits. Call them toll-free at 1+888+942-8104 or TDD 1+504+942-5900, or send an e-mail to ssbenplan@lsuhsc.edu.



← (TEAR-OFF THE APPLICATION HERE BEFORE MAILING.)

The Protection and Advocacy for Beneficiaries of Social Security (PABSS) program can help with job-related advocacy and other support services. Call them toll-free (voice and TDD) at 1+800+960-7705.

Can someone help me find a job?

If you get money from the Social Security Administration because of your disability, the Ticket to Work program can help. Call them toll free at 1+866+968-7842 or TTY 1+866+833-2967. You can also get more information at www.yourtickettowork.com.



What if I quit or lose my job?

You may be able to keep Medicaid Purchase coverage for up to 6 months, as long as you plan to go back to work.

What are my rights?

If you think the decision we make is

- ✓ unfair,
- ✓ incorrect, or
- ✓ being made too late,



you may ask for a Fair Hearing.

To ask for a hearing, call or write to your local Medicaid office and/or write directly to:

DHH Bureau of Appeals
P. O. Box 4183
Baton Rouge, LA 70821-4183

Louisiana's Medicaid Program is an equal opportunity program. You can't be treated differently because of your race, color, sex, age, disability, religion, nationality or political belief.

If you think we have treated you differently, call the U.S. DHHS Regional Office for Civil Rights in Dallas, TX at 1+800+368-1019, call or write to your local Medicaid office, and/or write directly to:

Department of Health & Hospitals
P. O. Box 1349
Baton Rouge, LA 70821-1349

This public document was published at a total cost of \$3,800.48. Fifteen thousand copies of this public document were published in this first printing at a cost of \$3,550.48. The total cost of all printings of this document, including reprints, is \$3,800.48. This document was published by Office of State Printing, 950 Brickyard Lane, Baton Rouge, LA 70804-9095 to advise applicants, recipients and other individuals of the Medicaid Purchase Plan under authority of 42 CFR 435.905 (a)(1). This material was printed in accordance with the standards for printing by state agencies established pursuant to R.S. 43:31. Printing of this material was purchased in accordance with provisions of Title 43 of the Louisiana Revised Statutes.

BHSF Form 1-MPP Cover
Issued 06/09



Do you have a disability?

Do you want to work, or to work more?

Do you need healthcare coverage?



1+888+544-7996



For Agency Use Only	
Request date _____	(Application date)
Date mailed _____	
Agency Rep _____	

To protect your application date, we must receive this application by _____.
(for agency use only)

What language do you **speak** best? English Spanish Vietnamese Other (specify) _____
 What language do you **write** best? English Spanish Vietnamese Other (specify) _____

If you do not speak English we can get interpreter services to help at no cost to you. If you need help to fill out this form, call your local Medicaid office or call us toll free at 1+888+544-7996. If you are deaf or have hearing problems, call the TTY line toll free at 1+800+220-5404.

This application is to get healthcare coverage for persons with **disabilities** who **work** and who are at least age 16 but not yet age 65. If you want Medicaid for anyone else, check (✓) this . We will send you information about applying for other Medicaid coverage. Please fill out every item on this form. If an answer to a question is none or 0, write "none". If you need more space for any item, use a separate sheet.

1. Tell us who YOU are, where YOU live, and where YOU get your mail:

Name _____ Parish _____
 Home address _____ City _____ State _____ Zip code _____
 Mailing address _____ City _____ State _____ Zip code _____
 Home phone (____) _____ Daytime phone (____) _____

2. Tell us about yourself and your spouse. You do not have to give your spouse's Social Security number if he or she is not applying. If given, the number will only be used to verify assets. You do not have to give race information. If you choose to do so, use the following codes: 1=White; 2=Black; 3=American Indian/Alaskan; 4=Asian; 5=Hispanic/Latino; 6=Hawaiian/Pacific Islander; 7=Hispanic/Latino & Other; 8=Multi-Race, Not Hispanic; 9=Unknown

Name - first, middle initial, last	Social Security number	Date of birth			Sex M/F	Race	US citizen/ Legal alien		Louisiana resident		Relation to you
		Month	Day	Year			Yes	No	Yes	No	
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	self
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	spouse

3. Tell us about EACH job or business that you have. Show the amount of total or gross income before any deductions, **not** your take-home pay. (Send copies of pay check stubs or other proof of your earnings for last month. If you are self-employed, send copies of your most recent federal tax form with all schedule attachments. Send other proof if you do not have tax forms.)

Employer name, address & phone OR Self-employment information	Amount paid	How often do you get paid?	# of hours worked per week
	\$		
	\$		

4. Do you get any money like the kinds listed below? Yes No

- * Social Security
- * Unemployment
- * Money from friends or relatives
- * Retirement/Pensions/Annuities
- * Workman's Compensation
- * **Any** other not listed
- * Veteran's Benefits
- * Interest/Dividends/Royalties

(Show **all** money that you get and send proof of the income. You **do not** have to send proof of Social Security or Unemployment income.)

Income type	Source name, address, & phone	How much do you get?	How often do you get it?
		\$	
		\$	

Have you ever applied for money from any of these sources? Yes No If **Yes**, when and from which ones? _____

5. Do you have Medicare or other health insurance? Yes No If **Yes**, answer the following. (Send proof of coverage and premium payment.)

Insurance company name, address, & phone	Group/policy number	Monthly cost	Policy covers:		
			hospital	doctor	ambulance
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Can you get health insurance from your employer? Yes No

6. Do you, or you jointly with your spouse, have any assets or resources like those listed below?

Yes No If **Yes**, give us the following information. (Send proof of ownership and value.)

Asset/Resource	Company name, address, & phone; Account number and/or description	Value	Amount owed
Checking/Savings accounts (type)		\$	
Certificates of Deposit		\$	
Retirement accounts		\$	
Annuities/Trusts		\$	
Stocks/Bonds		\$	
Vehicles (if more than one)		\$	\$
Property, other than your home		\$	\$
Other (please be specific)		\$	\$

7. Did you ever apply for or get Social Security Disability or Supplemental Security Income (SSI) benefits? Yes No If **Yes**, when? _____ Was a decision made? Yes No If **Yes**, what was the decision? _____

8. What is your disability? _____

Tell us about the doctors or other medical providers who care for you:

Provider's name(s)	Address & phone of this medical provider

9. Where did you find out about the Medicaid Purchase Plan? _____

Rights and Responsibilities

- ❖ I declare that I am a U.S. citizen or in this country legally.
- ❖ The information I gave on this form is true and correct to the best of my knowledge. I realize if I knowingly give information that is not true OR if I knowingly hold back information, I may get health benefits for which I am not eligible. If that happens, I can be lawfully punished for fraud. I may also have to pay Medicaid back for any medical bills which are paid incorrectly.
- ❖ I understand that the information I give about my situation will be checked. I agree to help do that, and to let Medicaid get information it needs from government agencies, employers, medical providers, and other sources. If I refuse to help with this process or in later reviews caused by reported changes, or as part of a Recipient Eligibility review, it will mean that I can't get Medicaid until I do help.
- ❖ I know that Social Security numbers will only be used to get information from other government agencies to prove my eligibility.
- ❖ I agree to tell Medicaid within 10 days if 1) I move out of state; 2) there are changes in where I live or get my mail; 3) there are any changes in other health insurance coverage; 4) there is any change in my work status.
- ❖ By accepting Medicaid, I agree that any medical payments received from other sources will be sent to the Department of Health and Hospitals for any services that were covered by Medicaid.
- ❖ I can ask for a Fair Hearing if I think the decision made on my case is unfair, incorrect or being made too late.
- ❖ Medicaid can't treat me differently because of my race, color, sex, age, disability, religion, nationality or political belief. If I think they have, I can call the U.S. DHHS Regional Office for Civil Rights in Dallas, TX at 1+800+368-1019 or write to Louisiana's Department of Health & Hospitals, Human Resources at P. O. Box 1349 Baton Rouge, LA 70821-1349.

Signature of Applicant or Authorized Representative

Date

Signature of Agency Representative, if applicable

Date