**DEPARTMENT OF HUMAN SERVICES - DIVISION OF DEVELOPMENTAL DISABILITIES**

**Medicaid Eligibility Troubleshooting Form**

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| Date: | | Consumer Name: | | Date of Birth: |
| Name of individual/contact completing this form: | | | | Relationship to Consumer: |
| Contact Telephone: | | | | Contact Email: |
| ***Medicaid History*** | Has the consumer 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 consumer has never received Medicaid, did they ever apply for Medicaid? Yes No  If yes, explain why Medicaid was denied (please attach denial letter to this form):  If no, explain why an application was never made to Medicaid:  Comments: | | | |
| ***Supplemental Security Income (SSI)*** | Is the consumer currently receiving SSI? Yes No If yes, monthly amount: $  At what age did SSI start?    Is the consumer still receiving SSI? Yes No  If no, at what age did the consumer stop receiving SSI?  Do you know the circumstances that caused the consumer to lose SSI? Please explain:  Comments: | | | |
| ***Social Security Disability Insurance***  ***(SSDI)*** | Is the consumer currently receiving SSDI? Yes No If yes, monthly amount: $      At what approximate age did SSDI start?  Did consumer begin receiving benefits from Social Security based on parent's work history? Yes No If yes, please explain:  **Medicare?** Yes No | | | |
| ***ASSETS*** | Amount of money in the bank in the name of the consumer: $  Any other assets in the name of the consumer (e.g., stocks, bonds)? $  If there are assets in the name of the consumer, was a special needs trust ever developed? Yes No  Comments: | | | |
| ***Consumer Employment Questions*** | Is the consumer currently employed? Yes No If yes, Number of hours/week:       Salary: $      per month  If currently employed: Did consumer apply for Medicaid’s Workability Program Yes No Comments:  Receiving unemployment income? Yes No If yes, amount of unemployment income: $      per month  Receiving SSDI because of consumer's work history? Yes No If yes, amount of SSDI per month $  Does consumer have any other income not listed above? Yes No If yes, what is the other income and amount?  Comments: | | | |
| ***Employment Status of Parents*** | **Mother:** Working? Yes No  Retired? Yes No  If yes, age of consumer when mom retired:  Deceased? Yes No  If yes, age of consumer when mom died: | | **Father:** Working? Yes No  Retired? Yes No  If yes, age of consumer when dad retired:  Deceased? Yes No  If yes, age of consumer when dad died: | |
| ***Additional Comments*** | If applicable, Please mention any other issues that you think are relevant to this consumer's applying for Medicaid: | | | |
| **Please email this completed form to the DDD Medicaid Eligibility Helpdesk at** [**DDD.MediElighelpdesk@dhs.state.nj.us**](mailto:DDD.MediElighelpdesk@dhs.state.nj.us)**.**  **A copy of the Medicaid Denial letter should also be included with this form. DDD staff will be in contact with you to assist.** | | | | |