**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 [ ] NoIf 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 [ ] NoComments:       |
| ***Consumer Employment Questions*** | Is the consumer currently employed? [ ] Yes [ ] No If yes, Number of hours/week:       Salary: $      per monthIf 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 monthReceiving 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 [ ] NoRetired? [ ] Yes [ ] No If yes, age of consumer when mom retired:   Deceased? [ ] Yes [ ] No If yes, age of consumer when mom died:    | **Father:** Working? [ ] Yes [ ] NoRetired? [ ] 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****.****A copy of the Medicaid Denial letter should also be included with this form. DDD staff will be in contact with you to assist.** |