Request for Payment of Long-Term Care Services

FIRST NAME	MI	LAST NAME	PMI NUMBER

1. Do you live in a long-term care facility?

Long-term care facilities include nursing homes, intermediate care facilities and nursing facility care in a hospital while waiting for nursing home placement.

◯ **No** – go to question 2 ◉ **Yes** – fill in below

FACILITY NAME: The Estates at Chateau

STREET ADDRESS	CITY	STATE	ZIP CODE
2106 2nd Ave S	Minneapolis	MN	55404

STREET ADDRESS BEFORE MOVING TO THIS FACILITY	CITY	STATE	ZIP CODE

Do you plan to return to your home? ◯ No ◯ Yes	Are you a veteran or a spouse of a veteran? ◯ No ◯ Yes

Are you employed under an Individual Plan for Rehabilitation? ◯ No ◯ Yes	IF YES, EMPLOYER'S NAME	Send proof you are employed under an Individual Plan of Rehabilitation. You may need to contact your case manager for this.	
Do you have a legal guardian or conservator? ◯ No ◯ Yes	IF YES, NAME (FIRST, LAST)	FEE PAID $	Send proof if you pay a fee.
Do you have court-ordered child support payments taken from your income? ◯ No ◯ Yes		IF YES, AMOUNT PER MONTH $	Send proof of amount paid.
Do you have court-ordered spousal maintenance payments taken from your income? ◯ No ◯ Yes		IF YES, AMOUNT PER MONTH $	Send proof of amount paid.

2. Have you had a Long-Term Care Consultation (LTCC) visit?

An LTCC is a visit from a person who talked with you about your needs and how you could meet your needs with a community support plan.

◯ **Don't know** – go to question 3 ◯ **No** – go to question 3 ◯ **Yes** – fill in below

DATE OF VISIT	CASE MANAGER OR ASSESSOR'S NAME

3. Do you have a spouse?

◯ **No** – go to question 4 ◯ **Yes** – fill in below

SPOUSE'S FIRST NAME	MI	LAST NAME

Does your spouse live in a long-term care facility or get services from a home and community-based waiver program?
Waiver programs are the Elderly Waiver (EW), Community Alternatives for Disabled Individuals (CADI), Community Alternative Care (CAC), Traumatic Brain Injury (TBI) and Developmental Disabilities (DD). ◯ No – fill in below ◯ Yes – go to question 4

Have you completed an asset assessment? ◯ Don't know ◯ No ◯ Yes	IF YES, LIST THE STATE OR COUNTY WHERE THIS WAS DONE		
You may be able to give part of your income to your spouse. Do you want us to see if you can? ◯ No ◯ Yes	IF YES, LIST TYPE(S) OF INCOME YOUR SPOUSE GETS	Does your spouse pay housing costs? ◯ No ◯ Yes	Send proof of your spouse's income and housing costs.

4. You may be able to give part of your income to:

- A child under 21
- A child 21 or older whom you list as a dependent on your tax forms
- A parent or sibling whom you list as a dependent on your tax forms

Do you want us to see if you can?

◯ **No** – go to question 5 ◯ **Yes** – fill in below ◯ **N/A**

Name	*Relationship*	*Date of birth*	*Type(s) of income*	*Living with your spouse?*
				◯ N/A ◯ No ◯ Yes
				◯ N/A ◯ No ◯ Yes

Send proof of each person's income.

5. Did you buy, exchange, or add a rider to a long-term care insurance policy on or after July 1, 2006?

◯ **No** – go to question 6 ◯ **Yes** – fill in below

Is this policy paying benefits now? ◯ No ◯ Yes	IF NO, DID THIS POLICY EVER PAY BENEFITS? ◯ No ◯ Yes	IF YES, DATE BENEFITS STOPPED
POLICY HOLDER'S NAME	INSURANCE COMPANY NAME	

6. Have you received medical care or had medical expenses within the three months before the month you want MA payment of LTC services to begin?

◯ **No** – go to question 7 ◯ **Yes** – fill in below

Type of medical expense	*Medical provider*	*Date of service*	*Did or will insurance or anyone else pay part or all of this expense?*
			◯ Don't know ◯ No ◯ Yes
			◯ Don't know ◯ No ◯ Yes
			◯ Don't know ◯ No ◯ Yes

If you have more medical expenses, write the same information on a separate piece of paper. Attach it to this form. Send copies of bills or receipts for each expense. Send proof of payments made by Medicare, other insurance or anyone else.

7. Do you own a home?

◯ **No** – go to question 8 ◯ **Yes** – fill in below

Does your spouse, a child under the age of 21 or a blind or disabled child of any age live in the home?
◯ Yes – go to question 8 ◯ No – fill in below

OWNER(S) NAME	VALUE $	AMOUNT OWED $	FOR SALE? ◯ No ◯ Yes
ADDRESS	CITY	STATE	ZIP CODE

Send proof of how much money you owe on your home, if any.

8. Do you or your spouse have any interest in an annuity?

◯ **No** – go to question 9 ◯ **Yes** – fill in below

Owner(s) name	***Interest type*** (owner, annuitant, beneficiary)

Send proof of your interest in an annuity.

9. Did you or your spouse create a trust within the 60 months before the month you want MA payment of LTC services to begin?

◯ **No** – go to question 10 ◯ **Yes** – fill in below

NAME(S) OF WHO CREATED THE TRUST	DATE CREATED

10. Did you or your spouse buy an annuity, life estate in another person's home, a promissory note, loan or mortgage within the 60 months before the month you want MA payment of LTC services to begin?

◯ **No** – go to question 11 ◯ **Yes** – fill in below

WHAT WAS BOUGHT?	DATE BOUGHT

11. Did you or your spouse not accept items or income you could have taken, such as an inheritance or a pension, within the 60 months before the month you want MA payment of LTC services to begin?

◯ **No** – go to question 12 ◯ **Yes** – fill in below

ITEMS YOU DID NOT TAKE	VALUE	DATE HAPPENED
	$	

12. Did you or your spouse sell, trade or give away items or income within the 60 months before the month you want MA payment of LTC services to begin?

◯ **No** – go to question 13 ◯ **Yes** – fill in below

Owner(s) name	***Items or income***	***Value***	***Who was it given, traded or sold to?***	***Date***	***Amount you were paid***
		$			$
		$			$
		$			$
		$			$
		$			$

If you have more items to report, write the same information on a separate piece of paper. Attach it to this form. Send proof to show what was sold, traded or given away.

13. Write anything else you think we should know below.

I declare that, under penalty of perjury, all parts of this form are true and correct statements, to the best of my knowledge. I understand what happens to people convicted of perjury (not telling the truth). They may be sentenced to prison for up to five years, a fine up to $10,000, or both.

YOUR SIGNATURE	DATE
SIGNATURE OF AUTHORIZED REPRESENTATIVE	DATE

Clear Form

Minnesota Department of **Human Services**

DHS-3549-ENG 1-13

General Consent/Authorization for Release of Information

Office Use Only

CASE NUMBER

To be completed by the person giving consent/authorization *(please print)*: This information is being requested solely to verify the identity of the person giving consent/authorization.

NAME			
ADDRESS 2106 2nd Ave S	CITY Minneapolis	STATE MN	ZIP CODE 55404
BIRTH DATE (mm/dd/yyyy)	SOCIAL SECURITY NUMBER		

If you are receiving SNAP, cash assistance, health care or child support services, or are a license holder, please provide at least **one** of the following numbers:

MEDICAID IDENTIFIER (PMI)	NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER	SINGLE MEMBER INDEX (SMI) NUMBER
FAMILY DAY CARE LICENSE NUMBER	FOSTER CARE LICENSE NUMBER	

Authorization/Consent: I authorize the Minnesota Department of Human Services ("DHS") to release the following information about me: **(Must be completed)**

All pertinent information related to Medicaid eligibility.

The information will be released to: (Must be completed)

NAME	COMPANY/AGENCY Monarch Healthcare		
ADDRESS 2106 2nd Ave S	CITY Minneapolis	STATE MN	ZIP CODE 55404

This information will be used for: (Must be completed)

All activities to ensure active coverage of Medical Assistance.

Consequences: I know that state and federal privacy laws protect my records. I know:

- Why I am being asked to release this information
- I do not have to consent to the release of this information
- That, generally, I must give my written consent for DHS to give out the information
- If I do not consent, the information will not be released unless the law otherwise allows it
- I may stop this consent with a written notice at any time, but this written notice will not affect information the agency has already released
- The person or agency who gets my information may be able to pass it on to others
- If my information is passed on to others by DHS, it may no longer be protected by this authorization
- This consent will end one year from the date I sign it, unless the law allows for a longer period.

CLIENT SIGNATURE	OR	SIGNATURE OF PARENT/GUARDIAN/AUTHORIZED REPRESENTATIVE
DATE:		DATE:

Clear Form

DEPARTMENT OF HUMAN SERVICES

DHS-7823-ENG

DHS-7823-ENG 7-19

HEALTH CARE ADMINISTRATION - HEALTH CARE ELIGIBILITY AND ACCESS

Authorization to Obtain Financial Information from the Account Validation Service (AVS)

Giving authorization

By signing this form, I am giving permission to the Department of Human Services, or the county or tribal agency, to access my information held by financial institutions participating in the AVS. This information will be used to determine eligibility for Medical Assistance (MA), MA for Employed Persons with a Disability (MA-EPD), or the Medicare Savings Program (MSP). I understand that if I am the spouse or sponsor, any financial information DHS or the county or tribal agency obtains about me may be shared with the person applying for MA, MA-EPD or MSP.

Who needs to sign the authorization?

- People who are applying for or enrolled in MA for people who are age 65 or older, blind or have a disability, MA-EPD or MSP.
- The person's spouse, unless the person is applying for or enrolled in MA-EPD.
- The sponsor of the person or the person's spouse. A sponsor is someone who signed an Affidavit of Support (USCIS I-864) as a condition of the person's or his or her spouse's entry to the country.

The applicant or enrollee's MA benefits may be denied or discontinued if the people who must give permission fail to provide the requested information, sign, date or submit this authorization.

When will this authorization end?

This authorization will end if the application for MA, MA-EPD or MSP is denied; the person is no longer eligible for MA as a person who is age 65 or older, blind or who has a disability, MA-EPD, or MSP; or the person who signs the authorization cancels it in writing. The agency will have access to and can use any information requested through the AVS before the authorization ends or is canceled.

Provide the information requested for each person who needs to sign the authorization

APPLICANT OR ENROLLEE NAME	OTHER NAMES USED ON FINANCIAL ACCOUNTS	SOCIAL SECURITY NUMBER (SSN)	DATE OF BIRTH (DOB)
APPLICANT OR LEGAL REPRESENTATIVE SIGNATURE		DATE SIGNED	

SPOUSE NAME	OTHER NAMES USED ON FINANCIAL ACCOUNTS	SPOUSE SSN	SPOUSE DOB
SPOUSE OR SPOUSE'S LEGAL REPRESENTATIVE SIGNATURE		DATE SIGNED	

SPONSOR NAME	OTHER NAMES USED ON FINANCIAL ACCOUNTS	SPONSOR SSN	SPONSOR DOB
SPONSOR OR SPONSOR'S LEGAL REPRESENTATIVE SIGNATURE		DATE SIGNED	

SPONSOR'S SPOUSE NAME	OTHER NAMES USED ON FINANCIAL ACCOUNTS	SPONSOR'S SPOUSE SSN	SPOUSE DOB
SPONSOR'S SPOUSE OR SPONSOR'S SPOUSE'S LEGAL REPRESENTATIVE SIGNATURE		DATE SIGNED	

Estimated Recipient Resource

Income

Social Security	
Pension	
VA	
LTC Insurance	
Other Income	
Total	$ -

Expenses

Personal Needs	$ 121.00	$121.00 for 2023
Home Maintenance		Max is $1,133.00
Health Insurance		Part B = $144.60
Guardian Fee		
Rep Payee Fee		
Spousal Allowance		
Utilities		Max = $586.00
Other		
Total		

Estimated RR Total	$ -

Gather all rent/mortgage, insurance premium, utilities, guardian fee, etc. documents from the resident or family and submit to county. If the document is not given to you or proof that it was sent to the county, do not include it in your estimation