



Summary of e-Form # R26280320

Health and Human Services Signature Page

		Do not complete - For the County Assistance Office Use	
e-Form Number	R26280320	App Reg #	
e-Form Date	01-16-2023 12:38:53 PM	Date Stamp	
Primary Applicant	MICHAEL L UPSHUR Jr.	Caseload	
Address	3527 N 16TH ST APT 2F, PHILADELPHIA, PENNSYLVANIA, 19140-4156	Record #	
County	Philadelphia	Do not complete - For your Provider	
Organization Name		Provider Name	
Type of Community Based Organization		Provider Number	
Community Organization Provider Number		Inpatient	
Type of Medical Service		Outpatient	
Date of First Admission or Treatment		Emergency	
Contact First Name		Non-applicable	
Contact Last Name			
Contact Email			
Contact Phone Number			
Contact Fax Number			
Presumptive Eligibility			

You are applying for Health and Human Service Benefits for the following individuals

MICHAEL L UPSHUR Jr.

Rights & Responsibilities Summary Statement and Certification of Citizenship or Alien Status

- I certify to the best of my knowledge that I understand my rights and responsibilities.
- I authorize the release of my personal, financial, and medical information for the purpose of determining eligibility.
- I understand that my situation is subject to verification from employers, financial sources and other third parties.
- I understand I am required to report changes as stated on the Rights and Responsibilities page.
- I certify that all information in this application is true and correct under penalty of perjury.
- I certify that the person(s) that I am applying for are U.S. citizens or aliens in satisfactory immigration status. (This certification does not apply to an alien who is applying only for Medicaid emergency health care benefits.).

Signature of applicant or person applying for applicant

 MICHAEL L UPSHUR Jr.

01-16-2023 12:38:53 PM

Signature

Date



Summary of e-Form # R26280320

Application Information

Application Submitted Date	01-16-2023 12:38:53 PM
My COMPASS Account User ID	upshur_1906
County / Case Record	51/4761029

Household Information

Address

Street Address	3527 N 16TH ST APT 2F
City	PHILADELPHIA
State	PENNSYLVANIA
Zip	19140-4156
County	Philadelphia
Main Contact Number	302-569-1898 (M)

Mailing Address

Street Address	3527 N 16TH ST APT 2F
City	PHILADELPHIA
State	PENNSYLVANIA
Zip	19140-4156

Head of Household

Name	MICHAEL L UPSHUR Jr.
Birth Date	11-29-1982
Gender	Male
Social Security Number	222-64-9936

Household Individuals

Name	Birth Date	Gender	Social Security Number
MICHAEL L UPSHUR Jr.	11-29-1982	Male	222-64-9936

* denotes a person that does not live with applicants, but has a tax relationship to a member or members of the applicant household

Benefits Renewing

Medical Assistance (including MAWD)

MICHAEL L UPSHUR Jr.

Individual Details

Household

Is anyone currently in prison or another correctional facility? (Incarcerated)

No

Contact Information

Main Contact Number

302-569-1898 (M)

E-mail Address

mupshur2005@gmail.com

When is the best time to call?

12:00pm

Individual Information - MICHAEL L UPSHUR Jr.**General Details**

What is this individual's citizenship status?

US Citizen

If not eligible for full health care coverage, does MICHAEL L UPSHUR Jr. want to be reviewed for coverage for family planning services only?

No

What is this individual's marital status?

Divorced

Is this individual planning on filing a federal income tax return?

Yes

Will anyone claim this individual as a tax dependent?

No

Will this individual claim anyone as a tax dependent?

No

What is this individual's Social Security Number?

222-64-9936

Driver's License or state ID information

State or Territory

PENNSYLVANIA

Number

31759911

What is this individual's race?

Black or African American

Is this individual of Hispanic or Latino origin?

No

Has this individual ever been known by another name?

No

Voter Registration

Is MICHAEL UPSHUR interested in registering to vote at his current address or changing the information on his Pennsylvania voter registration?

Yes

Additional Details**Household**

Does anyone have a medical condition (including a disability), a chronic condition (such as arthritis), or an ongoing special health care need?

Yes

Who?

MICHAEL L UPSHUR Jr.

Does anyone have any paid or unpaid medical bills that have a date of service that occurred this month or within the past 3 months?

No

Does anyone applying have a medical condition that requires health sustaining medication?

No

Has anyone in the household lost their job or had their work hours reduced through no fault of their own within the past year?

No

Medical Condition - MICHAEL L UPSHUR Jr.

Please describe the medical condition

chest pains

Resources**Household**

Does anyone have cash or other financial holdings, such as a checking or savings account?

Yes

Does anyone own any vehicles, such as car, truck, or motorcycle?

No

Does anyone own a life insurance policy?

No

Cash and Other Financial Holdings

What type of resource?

Checking Account

Who in your household owns the resource?

MICHAEL L UPSHUR Jr.

Location

Wells Fargo

Account Number

1146243983

What is the resource's estimated value?

\$100.00

Insurance**Household**

Does anyone have health (or medical) insurance (including Medicare or Long Term Care Insurance)?

No

Has anyone lost health insurance in the last 90 days?

No

Health Insurance - Employer

Is anyone who is applying offered health insurance from a job?

Select yes even if it is from someone else's job, such as a parent or spouse.

No

Income Details**Household Income**

Does anyone currently have income from one or more jobs, or will anyone start a job in the next 30 days (not including Self-Employment)?

Yes

Who has current employment?

MICHAEL L UPSHUR Jr.

Does anyone have income from Self-Employment, or receive money from one or more sources other than a job?

No

Income Information - MICHAEL L UPSHUR Jr.**Current Income**

Employer Name

Incubate IQ

Employer Street Address

2001 County Line Rd

City

Warrington

State

PENNSYLVANIA

Zip

18976

Employer Phone Number	267-281-8200
When did this individual begin working at this job?	03-21-2022
How many hours does this individual work at this job each week?	40
When does this individual get paid?	Every Two Weeks
What is this individual's gross income on each paycheck? This is the money he/she gets before paying for taxes and other deductions.	\$2115.39
When did he/she last receive a paycheck for this job?	01-13-2023

Expenses

Household Expenses

Does anyone drive to work or pay for transportation to go to work?	Yes
Who?	MICHAEL L UPSHUR Jr.
Does anyone pay legal fees to collect any income?	No
Does anyone have any tax deductible expenses they will claim on their federal tax return?	Yes
Who pays?	MICHAEL L UPSHUR Jr.

Household Shelter and Utility Expenses

Expenses Information - MICHAEL L UPSHUR Jr.

Transportation Expenses

For which employer does he/she have to pay for transportation to get to work?	Incubate IQ
If this individual drives with another person or takes the bus/subway/trolley, how much does it cost each week?	\$24.00

Tax Deductible Expenses

What is the source or type of the tax deductible expense?	Student loan interest deduction
What is the amount of the tax deductible expense?	\$4666.13
What is the frequency of this tax deductible expense?	Monthly
Tax deductible expense begin date	01-01-2022
Tax deductible expense end date	12-31-2022

Additional Information

What language do the applicants most easily understand?	English
If an interview is necessary, do you want an interpreter?	No
Renew my eligibility automatically for the next	Don't use my information from tax returns to renew my coverage
Please indicate if you would like to receive your notifications in English or Spanish:	English
Would you like to receive Text Message Notifications?	No

Would you like to receive Renewal Reminders?	No
Would you like to receive Verification Reminders?	No
Would you like to receive Child Care Reminders?	No
Would you like to receive Child Care email notifications?	No

Other Information

Just really looking for medical benifits. Currently do not have any and that is what I am looking for.

Rights & Responsibilities

Rights & Responsibilities

- I understand that Pennsylvania receives information from the Income Eligibility Verification System (IEVS), financial institutions, consumer reporting and state and federal agencies to verify the information I give them. Information available through IEVS and other entities will be requested, used and may be verified through collateral contact when conflicting details are found by the State agency, and such information may affect my household's eligibility and level of benefits.
- I understand that by signing this application, I am authorizing any financial institution to disclose, through electronic or any other means, any and all financial information held by that institution, to the Department of Human Services or its designated agent or contractor for the purpose of identifying and verifying assets when needed to determine and re-determine eligibility for Medical Assistance. I understand that financial information includes deposits, withdrawals, account closures and other relevant information requested or received from the financial institution, including other transactions undertaken by the financial institution with respect to the account or asset. I understand that this authorization is effective until Medical Assistance eligibility is denied or ends, or if I decide to revoke it by written notification to the Department, whichever happens first. I understand that if I revoke this authorization, that may make me or my household ineligible for Medical Assistance.
- I understand that if I misrepresent, hide or withhold facts that may affect my eligibility for benefits, I may be required to repay my benefits and I may be prosecuted and disqualified from receiving certain future benefits.
- I understand that I can designate an authorized representative by completing the *Authorized Representative* section and submitting it with this application.
- I understand and agree that I am responsible for any fraudulent statements made on this application, even if the application is being submitted by someone acting on my behalf.
- I received a copy of my rights and responsibilities, have read them or someone has read them to me, and I understand them.
- I understand that the information entered in this application will be kept confidential and used only to administer benefits. I authorize the release of personal, financial and medical information for the purpose of determining eligibility.
- I understand that the Department of Human Services or its designees may contact me via methods including email and text messaging to help process my application or request feedback on the application process. If I do not want email or text messages, I understand the Department will still process my application.
- I understand that any changes I am required to report must be reported within the first 10 days of the month following the month of change or, for Long-Term Care and Home and Community-Based Services, within 10 days of the change.
- I understand that my household may lose SNAP benefits if a household member receives lottery or gambling winnings equal to or greater than the SNAP resource limit for elderly or disabled households.
- I understand that I will receive a written notice explaining the benefits. If benefits are denied, changed, suspended or stopped, the written notice will explain why.
- I understand that I will have 30 days (90 days for SNAP (food stamp) benefits) from the date of the notice to request a hearing if I do not agree with the decision made on this application.
- I understand that my situation is subject to verification from employers, financial sources and other third parties.
- I understand any person enriched as a result of a transfer of assets or income, which would have affected my eligibility for Long-Term Care or Home and Community-Based Services, will be liable for repayment of those benefits issued incorrectly.
- I understand that applicants must provide their Social Security number or apply for one if they do not have one. This number may be used to check the information on this application.

- I understand that I must use the Electronic Benefit Transfer (EBT) or the PA ACCESS Card only during the period I am eligible. I must use the EBT or the PA ACCESS Card only for the person who is eligible and may get only the benefits that are needed and reasonable.
- I understand that I may not use Cash Assistance funds issued through my PA ACCESS card to make EBT transactions in liquor stores, casinos (gambling casinos, gaming establishments), or places for adult entertainment.
- I understand that I am required to report lottery and gambling winnings.
- I understand that I do not have to provide a Social Security number for anyone who is not applying for assistance. If I do provide their Social Security number, it may be used to check the information on this application.
- I certify that all information that has been entered is true under penalty of perjury.
- I understand that I have the right to a certificate of creditable coverage to verify my medical coverage. Federal law limits when health care coverage may be denied or limited for a pre-existing condition. If I enroll in a group health plan that has a pre-existing condition clause, I can get credit for the time I received Medical Assistance.
- I understand that if I am determined eligible for Medical Assistance, I will be placed in the most comprehensive health care benefit package that is available to me. I understand that I may be required to enroll in a health plan. I understand that enrolling in a health plan may be free or low cost to me, because the Department pays a monthly fee to the health plan for me. I understand that the monthly fee is a capitation fee. I understand that if I receive Medical Assistance that I am not eligible for, due to error, fraud, or any other reason, then I may be required to repay the Department all monthly fees paid on my behalf.
- If I receive cash benefits, I will cooperate with the requirements of the child support enforcement program as directed by the department. I give the department and the Domestic Relations Section the right to pursue and collect cash and/or medical support for me and others for whom I am applying.
- I understand that if I report and provide proof of the household expenses, I will get the maximum amount of SNAP (food stamp) benefits allowed. Failure to report or provide proof of the household expenses will be regarded as my statement that I do not want to receive a deduction for the unreported or unproved expense. (Authority: United States Department of Agriculture, Food and Nutrition Service, Mid-Atlantic Region, Administrative Notice 6-99, issued January 4, 1999).
- I understand that I have the right to receive credit for the household expenses at the time I report and provide proof of them at any time during my SNAP (food stamps) certification period.
- I understand that I have the right to ask the county assistance office (CAO) for assistance in getting proof of expenses and that the CAO can contact other people for confirmation if I am having trouble getting proof of anything.
- I understand that if some or all of the individuals applying do not qualify for Medical Assistance, that they may be eligible for CHIP. If this is the case, I authorize the Department of Human Service to give my name and information on this application to a CHIP contractor.
- I understand that if some or all of the individuals applying do not qualify for Medical Assistance, that they may be eligible for federal benefits and/or explore private health care options through Pennsylvania's Health Insurance Marketplace (Pennie). If this is the case, I authorize the department to give my name and information on this application to Pennie.

Prohibitions and Penalties

Read about your responsibilities:

	IF THIS HAPPENS WITHOUT GOOD CAUSE	THIS MAY HAPPEN (PENALTY)
ALL BENEFITS SNAP CASH HEALTH CARE	Misuse Electronic Benefits Transfer (EBT) Card or PA ACCESS Card.	Fine, prison, or both.
	Do not report changes, as required.	Benefits cut or stopped.
	On purpose, give information that is false, incorrect or incomplete, or not report changes.	<p>Fine, disqualification and/or jail time for Welfare Fraud, disqualification for administrative hearing proceedings.</p> <p>Not eligible for cash:</p> <ul style="list-style-type: none"> • First time - 6 months. • Second time - 12 months. • Third time - forever. <p>Not eligible for SNAP:</p> <ul style="list-style-type: none"> • First time - 12 months. • Second time - 24 months. • Third time - forever.
	Trade, sell or attempt to trade, sell, buy or use another person's ACCESS Card.	<p>Not eligible:</p> <ul style="list-style-type: none"> • All court convictions - 12 months.

SNAP	On purpose, misuse SNAP benefits, for example, trade, sell, or buy EBT Card or SNAP benefits; convert benefits; or dump containers purchased with SNAP benefits to receive deposits - or buy things not covered by SNAP, such as alcohol or tobacco - or use SNAP benefits to pay for food already received or food on credit.	Not eligible: <ul style="list-style-type: none">• First time - 12 months.• Second time - 24 months.• Third time - forever.• First time court conviction over \$500 - forever.
	Purchase a product with SNAP benefits with the intent of obtaining cash or consideration other than eligible food by reselling the product in exchange for cash or consideration other than eligible food.	
	On purpose, purchase products originally purchased with SNAP benefits in exchange for cash or consideration other than eligible food.	
	Use/receive SNAP benefits to buy drugs or controlled substances.	Not eligible: <ul style="list-style-type: none">• First time - 24 months.• Second time - forever.
	Use/receive SNAP benefits in sale of firearms, ammunition, or explosives.	First time - not eligible forever.
	Be convicted for buying, selling or trading SNAP benefits for total of \$500 or more.	Not eligible forever.
	Lie about who you are or where you live to receive more than one SNAP benefit.	Not eligible for 10 years.
	Flee to avoid prosecution, custody, or confinement because of a felony/attempted felony - or flee because of breaking probation or parole.	Not eligible until you do what the law says.
CASH	Do not comply with your court penalty, including payment of fines, for a felony or misdemeanor.	Not eligible until you comply with your penalty.
	Lie about where you live to receive cash in two or more states.	Not eligible for 10 years.
	Flee to avoid prosecution, custody, or confinement because of a felony conviction/attempted felony; fail to appear as a defendant at a criminal court proceeding when issued a summons or a bench warrant for a summary offense, felony or misdemeanor; flee because of breaking probation/parole; or have any active warrant against you.	Not eligible until you do what the law says.
If you are found guilty of fraud or breaking above rules:		<ul style="list-style-type: none">• Fine up to \$250,000 for SNAP and up to \$15,000 for Cash;• Jail up to 20 years for SNAP and up to seven years for Cash; and/or• Paying back benefits received.• Disqualification from benefits for periods stated above by program.
SNAP WORK RULES	For household members - physically and mentally fit - over age 15 and under 60 - not otherwise exempt or with good cause.	Not eligible: <ul style="list-style-type: none">• First time - one month and until you do what is required.• Second time - three months and until you do what is required.• Three or more times - six months each time and until you do what is required.
	Refuse to: <ul style="list-style-type: none">• Accept a job.• Tell CAO about work status and job availability.	On purpose, take action to: <ul style="list-style-type: none">• Quit a job.• Cut work hours to less than 30 per week (unless another job already meets work requirements).
CASH WORK RULES	Do not meet cash work requirements on purpose, as written on the Agreement of Mutual Responsibility (AMR)	Not eligible: <ul style="list-style-type: none">• 1st violation - You will be ineligible for a minimum of 30 days or until the failure to comply ceases, whichever is longer.• 2nd violation - You will be ineligible for a minimum of 60 days or until the failure to comply ceases, whichever is longer.• 3rd violation - You will be permanently disqualified. <p>If the reason for sanction occurs within the first 24 months of receipt of cash assistance, whether consecutive or interrupted, the sanction applies only to the individual.</p> <p>If the reason for sanction occurs after 24 months of receipt of cash assistance, whether consecutive or interrupted, the sanction applies to the entire family.</p>

Children's Health Insurance Program (CHIP) Rights & Responsibilities

You have a right to:

- **Confidentiality** – All information on this application will be kept confidential. This application will be shared only with the government programs for which you apply and/or may be eligible, such as the Medical Assistance and Pennie premium assistance.
- **Designate a Personal Representative** – You may select another person to receive health related information regarding you or your minor child(ren) by completing a Personal Representative Designation form.
- **Certificate of Creditable Coverage** – When you leave the program, you will receive a certificate of creditable coverage to verify medical coverage, if you are eligible.
- **Written Notice** – You will be given a written notice explaining your eligibility.
- **Appeal** – You may request an impartial review if you do not agree with any decision made regarding this application, if the request is made within 30 days of the decision.

You have a responsibility to:

- Read and fully understand this application.
- Provide true, correct and complete information, understanding that there are penalties for knowingly giving false information: it is a serious offense and considered criminal insurance fraud.
- Help with the review of this application, which may include interviews and reviewing health records.
- Be aware that certain information may be subject to verification from employers, financial sources and other third parties.
- Provide proof of identity and U.S. citizenship if that information is not obtained through this application process.
- Provide proof of legal immigration status by presenting documentation from the U.S. Citizenship and Immigration Services if you are applying for someone who is not a U.S. Citizen.
- Report all changes regarding your household including income, address and telephone number as soon as they occur.

I understand:

- I certify that, to the best of my knowledge, I understand my rights and responsibilities and that the information included in this application is complete and true under penalty of perjury. I also certify that knowingly providing false or incomplete information on this application is insurance fraud.
- If some or all of the individuals applying do not qualify for CHIP, that they may be eligible for Medical Assistance. If this is the case, I authorize the CHIP Contractor to give any and all information found on this application to the Department of Human Services. I understand my rights and responsibilities under Medical Assistance.
- If some or all of the individuals applying do not qualify for CHIP, that they may be eligible for federal benefits and/or explore private health care options through Pennsylvania's Health Insurance Marketplace (Pennie). If this is the case, I authorize the Department to give any and all information on this application to Pennie. I understand my rights and responsibilities under Pennie.
- I certify that the person(s) I am applying for are U.S. citizens or aliens in lawful immigration status. (I understand this certification does not apply to an alien who is applying only for Medical Assistance Emergency Health Care benefits.)
- If it is determined that my child is eligible for or enrolled in state employees' health care benefits from a public agency and the agency would pay even a small portion of the benefit or premium cost, then my child is not eligible for CHIP. If this is the case and my child has been receiving CHIP benefits, my child's CHIP benefits may be retroactively terminated.

Pennsylvania's Health Insurance Marketplace (Pennie)

- I certify that all information that has been entered is true under penalty of perjury. I know that I may be subject to penalties under federal law if I knowingly provide false and/or untrue information.
- I know that I must tell Pennie if anything changes (and is different than) what I wrote on this application. I can visit Pennie.com or call 1-844-844-8040 to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file (<http://www.hhs.gov/ocr/office/file>).
- Renewal of coverage in future years: To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow Pennie to use my income data, including information from tax returns. Pennie will send me a notice, let me make any changes, and I can opt out at any time.
- I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed).
- I certify that, to the best of my knowledge, I understand my rights and responsibilities and that the information included in this application is complete and true under penalty of perjury. I also certify that knowingly providing false or incomplete information on this application is insurance fraud.
- I understand that I can designate an authorized representative by completing the Authorized Representative section and submitting it with this application.
- I understand and agree that I am responsible for any fraudulent statements made on this application, even if the application is submitted by someone acting on my behalf.
- I understand that all individuals applying will be provided access to coverage under the program for which they are eligible, if they are found eligible for Medical Assistance, CHIP or federal benefits through Pennie.
- I will allow the Department of Human Services to give my name and information on this application to a CHIP contractor if any applicants may be eligible for CHIP.
- I will allow the CHIP Contractor to give any and all information found on this application to the Department of Human Services if any applicants may be eligible for Medical Assistance.
- I will allow the Pennsylvania Department of Human Services to give any and all information found on this application to Pennie if any applicants may be eligible for federal benefits and/or would like to explore private health care options.
- I authorize the release of personal, financial, and medical information for the purpose of determining eligibility and for review of the CHIP, Medical Assistance and Pennie programs.
- I certify that the person(s) I am applying for are U.S. citizens or aliens in lawful immigration status.



Verification Documents Required for e-Form # R26280320

In order to finish processing this case, please obtain copies of the documents below:

Note: If information is missing or you have any questions please contact HELPLINE at 1-800-692-7462

Department of Human Services

Individual

Provide Proof of	Individual	Provide copy of one of the following
Disability	MICHAEL L UPSHUR Jr.	Medical information to verify disability and/or need for medication

Income

Provide Proof of	Individual	Provide copy of one of the following
Current Income - Employer	MICHAEL L UPSHUR Jr.	Most recently filed Federal Income Tax Return, Employment Verification Form, Pay Stubs, Employee's W2, Income Producing Contract, Pay Envelope, Wage Tax Receipts, Self Employment Bookkeeping Records, Statement from Company

Expense

Provide Proof of	Individual	Provide copy of one of the following
Expenses - Student Loan Interest	MICHAEL L UPSHUR Jr.	Current/most recent tax form 1040 showing deduction, Monthly statement from financial institution showing interest paid, End of year statement from financial institution showing interest paid

Resource

Provide Proof of	Individual	Provide copy of one of the following
Resources - Cash or Financial Holdings - Checking Account	MICHAEL L UPSHUR Jr.	Bank Records, Sales Agreement, Articles of Agreement, Notes, Financial Institution Statements, Insurance Appraisal, Bond Certificates, Securities, Check for Lump Sum Payment, Will, Stock Certificates, Real Estate Tax Receipt, Life Estate Agreement, Life Insurance Policy, Income Tax Record

Address Information

Please mail, fax, or hand-deliver the documents above as soon as possible, but no later than Feb-15-2023 :

Philadelphia County Somerset District

2701 North Broad Street - 2nd Floor

Philadelphia, PA 19132-2743

Info Number: 215-560-5400

Fax Number: 215-560-5403

Email: C-PCAOSMT@PA.GOV



Routing & Provider Information of e-Form #R26280320

Department of Human Services

Philadelphia County Somerset District

2701 North Broad Street - 2nd Floor
Philadelphia, PA 19132-2743

Info Number: 215-560-5400

Fax Number: 215-560-5403

Email: C-PCAOSMT@PA.GOV

The information on this application will be sent to the County Assistance Office for processing. **Eligibility** for the following program(s) will be evaluated.

- **Medical Assistance (including MAWD)**

Based on the information you have given us, this application will be processed for **Medical Assistance health care coverage.**

COMPASS automatically sends your application to the program(s) for which the applicant is most likely to be found eligible. If someone in the household does not qualify for **Medical Assistance**, they may be able to receive **CHIP**, or be eligible for federal benefits and/or explore private health care options through Pennie. In cases where it looks like someone may be eligible for a different health care program, the information in this application will be transferred to the program for which the applicant is most likely to be found eligible.