APPLICATION FOR PATH2HEALTH & COUNTY MEDICAL SERVICES PROGRAM (CMSP)

To apply for Path2Health & County Medical Services Program (CMSP), complete the items 1 –20 to the best of your knowledge and sign the form. Give or mail the form to your county welfare office. If you have a disability and need help to complete this form, tell the county. You must give us all the facts we ask for on this form and/or answer any additional questions your eligibility worker may have about your application. We use the facts you give us to figure your eligibility for Path2Health or CMSP benefits.

1. Name (First) (Middle) (Last)

County Use Only

Date:
Case number: _____

2.	Living address (number, street)	City	State	ZIP code	Home telephone number ( )
	Mailing address (if different)	City	State	ZIP code	Work telephone number ( )

EW name/number: _____

3. Marital status
☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widow(er)

County resident? ☐ Yes ☐ No

☐ Identification

4. a. List all persons with whom you live, **including** yourself:

Name	Sex	Date of Birth	Social Security Number	Relationship	Path2Health or CMSP Requested
Applicant	☐ F ☐ M			Self	☐ Yes ☐ No
	☐ F ☐ M				☐ Yes ☐ No
	☐ F ☐ M				☐ Yes ☐ No
	☐ F ☐ M				☐ Yes ☐ No

b. Are any of the persons listed above pregnant? ☐ Yes ☐ No
If yes, who is pregnant: _____

c. ***For Path2Health & CMSP applicants only provide citizenship information:***

Name	Place of Birth (STATE or Country)	U.S. Citizen
		☐ Yes ☐ No
		☐ Yes ☐ No

☐ MC 13
☐ *DRA met*

☐ MC 13
☐ *DRA met*

5. Do you or any family member have any health insurance which is currently in effect? ☐ Yes ☐ No
If you don't have it, is it possible to get it through an employer or school that is attended? ☐ Yes ☐ No
If your answer is yes to any of the above, please complete the following:

☐ CMSP 203 completed and sent

Name of Health Insurance	Person(s) Insured	Premium Amount and How Often Paid
Expiration date (If applicable): / /		

☐ Other health coverage

6. a. Have you been hospitalized recently or are you currently under a doctor's care? ☐ Yes ☐ No
If yes, for what problem? _____

b. Do you or any family member have a physical or emotional problem which makes it difficult to work or take care of your needs AND has lasted or is expected to last at least one year? ☐ Yes ☐ No
If yes, please complete the following:

☐ Presumptive

☐ DDSD packet

Name of Person with Problem(s)	Type of Problem(s)	Beginning Date of Problem(s)	Expected Recovery Date if Known

c. Was the problem(s) listed in 6.a. and b. above caused by an injury or accident? ☐ Yes ☐ No

d. With treatment, do you expect to be able to work in the next year? ☐ Yes ☐ No

e. Are you appealing a social security disability denial? ☐ Yes ☐ No

☐ Social security disability denial date: _____

7. Have you filed a lawsuit, workers compensation, or insurance claim regarding any injury or accident for which you received medical treatment? ☐ Yes ☐ No

☐ Third party liability

8. a. Are you or any family member working or expecting to work in the next three months? ☐ Yes ☐ No
If yes, please complete the information below and **provide proof**:

Name of person working	Employer	Number of Hours Per Week (If hours vary, list average.)	Gross Amount Paid	How Often Paid (weekly, etc.)

b. Are you or any family member self-employed? ☐ Yes ☐ No

If self-employed, what is your gross monthly income? _____

c. If self-employed, has adjusted gross income from last Federal Tax Return changed? ☐ Yes ☐ No

d. If you are not working, when did you last work?
Name of person: _____ Month: _____ Year:_____

Name of person:_____ Month:_____ Year:_____

9. Do you or any family member receive any of the following items free (F) or in exchange for work (W)? ☐ Yes ☐ No
If yes, what do you receive?
☐F ☐W Rent or housing ☐F ☐W Utilities ☐F ☐W Food ☐F ☐W Clothing

10. How much do you or any family member pay each month for rent/mortgage? $ _____ utilities: $ _____

COUNTY USE ONLY

☐ UIB/SDI referral
☐ LDW:_____
☐ LDP: _____
☐ Tax return
☐ P and Ls
☐ Last employer
☐ Unearned
☐ Earned

11. Have you or any family member applied for, received, or expect to receive any of the following benefits or payments? (Check (☐) and if yes, provide proof.)

Yes	No	**Name of person:** _____
☐	☐	Social security disability or retirement benefits
☐	☐	SSI/SSP
☐	☐	Unemployment insurance
☐	☐	State/private disability insurance
☐	☐	Veterans benefits
☐	☐	Child support/alimony
☐	☐	Workers Compensation
☐	☐	Money from an insurance settlement or a lawsuit
☐	☐	Scholarships, loans, grants
☐	☐	General assistance/general relief
☐	☐	Loans or Gifts
☐	☐	Do you have any other income?
		If yes, what kind: _____

Total amount expected for this month: $ _____

Yes	No	**Name of person:** _____
☐	☐	Social security disability or retirement benefits
☐	☐	SSI/SSP
☐	☐	Unemployment insurance
☐	☐	State/private disability insurance
☐	☐	Veterans benefits
☐	☐	Child support/alimony
☐	☐	Workers Compensation
☐	☐	Money from an insurance settlement or a lawsuit
☐	☐	Scholarships, loans, grants
☐	☐	General assistance/general relief
☐	☐	Loans or Gifts
☐	☐	Do you have any other income?
		If yes, what kind: _____

Total amount expected for this month: $ _____

12. Have you or any immediate family member ever been in the U.S. military service? ☐ Yes ☐ No
If yes, name of person: _____

If yes, relationship of that person to you:

13. Are you or any family member the owner of any life insurance, burial insurance, or burial trust? ☐ Yes ☐ No
If yes, please complete the following:

Name of person	Company name and address	Type (Burial, Whole or Term life Insurance)	Face Value	Cash Surrender Value
			$	$
			$	$

14. Do you and any immediate family members have liquid resources, such as cash, checking and savings accounts, stocks, bonds, retirement accounts, certificates of deposit, IRAs, 401Ks, mutual funds, trust accounts, etc.? ☐ Yes ☐ No

Name of person	Type of account	Bank	Account Number	Balance

15. Do you or any family member have any cars or other motor vehicles, motorcycles, boats, campers, trailers? ☐ Yes ☐ No

Name of person	Year	Make	Model	Type of Vehicle (car, truck,etc)	Amount Owed
					$
					$
					$
					$

16. a. Are you or any family member purchasing or do you own a home? ☐ Yes ☐ No
If yes, name of person: _____

b. Are you or any family member purchasing or do you own other real property? ☐ Yes ☐ No
If yes, name of person: _____

If yes, address (number, street) of home and/or other real property	City	State	ZIP code

17. Do you or any family member own jewelry items worth more than $100 each or any other personal property, other than household items? ☐ Yes ☐ No

If yes, please list the items and name of person: _____

18. Have you or any family member sold, transferred, or given away any personal or real property in the past two months? ☐ Yes ☐ No

If yes, please list the items and name of person: _____

_____

19. Do you or any family member pay child support, alimony, or child care? If yes, provide proof. ☐ Yes ☐ No

Amount	Name of person who pays:	To whom:
$		

20. Are you or any family member fleeing to avoid prosecution, custody or confinement after conviction for a crime, which is a felony under the law of the place from which he/she flees, or violating a condition of probation or parole (for a felony) imposed under Federal or State Law? ☐ Yes ☐ No
If yes, name of person: _____

Be sure you have read every item and answered all the questions. Read the following carefully before signing.

- I understand that I am applying for the Path2Health/County Medical Services Program.
- I understand that the county may review my eligibility for other federal, state and local programs.
- I declare under penalty of perjury that the answers I have given are correct and true to the best of my knowledge.
- I agree to meet all the responsibilities explained in the "Path2Health/County Medical Services Program Rights, Responsibilities, and Other Information" form that I have received.
- I understand that I may be asked to prove my statements and that my eligibility may be subject to a quality control review.
- I understand that the county is required by law to keep all information I provide confidential.

I realize that if I deliberately make false statements or withhold information, I (or the person on whose behalf I am acting) may lose my Path2Health/CMSP eligibility and/or I can be prosecuted for fraud.

Signature of applicant			Date
Signature of witness (if applicant signed with mark) or person acting for or helping applicant	**Relationship**	**Phone number**	**Date**
		( )	