

Medicaid Eligibility Interview Guide

Date _____

Client's Name		Age	Client's Ability to Respond <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Unable	
Person Interviewed		Relationship to Client <input type="checkbox"/> Guardian <input type="checkbox"/> POA <input type="checkbox"/> Authorized Rep. <input type="checkbox"/> Estate <input type="checkbox"/> Durable <input type="checkbox"/> Medical <input type="checkbox"/> Executor <input type="checkbox"/> Person <input type="checkbox"/> Medical <input type="checkbox"/> Executor		
Address of Person Interviewed				
Home Telephone No.	Work Telephone No.	Driver's License	Type Interview <input type="checkbox"/> Face-to-Face <input type="checkbox"/> Telephone	

GROUNDWORK: Explain or Discuss

- Purpose of Interview
- Opportunity to Vote
- CBA
- Transfer Policy
- Tape Matches (especially IRS, and give opportunity to discuss financial area needs)
- Form H1200, Page 7 (liability for information)
- Medicaid Estate Recovery Program (MERP)
- Fair Hearings and Appeals
- If Spousal - SPRA, Diversions, SPRA Appeals, Transfers
- Data Broker

Client's Address (prior address if institutionalized)			Client intends to stay in Texas? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Living Arrangement (prior arrangement if institutionalized)		Who?	Household of Whose Home?	
<input type="checkbox"/> Rent	<input type="checkbox"/> Own Home	<input type="checkbox"/> With Someone: =>	<input type="checkbox"/> Another	=>
<input type="checkbox"/> Share Household Expenses	<input type="checkbox"/> Free Rent	<input type="checkbox"/> Live Alone	<input type="checkbox"/> Pays All of Own Shelter/Food Costs	
Date Left Home	Date Entered Hospital	Date Entered Institution	Is stay anticipated to be less than 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Prior Institutional Stay? => If yes, when?		Where =>		
<input type="checkbox"/> Yes <input type="checkbox"/> No				
Client Currently Receiving <input type="checkbox"/> SSI <input type="checkbox"/> Medicaid <input type="checkbox"/> Other (explain):				
Past Recip. =>	Date Rec'd	<input type="checkbox"/> Medicaid: =>	Date Rec'd	Specify/Give Date Rec'd
<input type="checkbox"/> SSI:		<input type="checkbox"/> Medicaid:	<input type="checkbox"/> Other:	
Alternate Care Considered <input type="checkbox"/> Family/Primary Home Care <input type="checkbox"/> Foster Care <input type="checkbox"/> Day Care <input type="checkbox"/> Other (explain):				
Alternate Care is: <input type="checkbox"/> Feasible <input type="checkbox"/> Not Feasible Reason Not Feasible <input type="checkbox"/> Needs 24-Hr Care <input type="checkbox"/> Needs Cannot be Met Outside Institution <input type="checkbox"/> Other (explain):				

BACKGROUND/BASIC INFORMATION

Place of Birth		Where Resided Most of Life		
Current Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced* <input type="checkbox"/> Separated <input type="checkbox"/> Never Married			Maiden Name	
Spouse's Name		If divorced/widowed, when? => Where? (county)		
Spouse's Address			Spouse's Telephone No.	
If widowed—inheritance? <input type="checkbox"/> Yes* <input type="checkbox"/> No => Will? <input type="checkbox"/> Yes <input type="checkbox"/> No => Probated? <input type="checkbox"/> Yes <input type="checkbox"/> No		Number of Other Heirs		
*Insurance/Divorce Settlements, Survivor Benefits, Inheritance—Explain:				
Child under 21; child of any age who is blind or permanently disabled by SSA standards; unmarried adult child residing in homestead:				
Child's Name		Date of Birth	Social Security No.	
Address			Does client have a will? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, who is executor of the will?		Address		

PRIOR MARRIAGES (attach additional page(s), if necessary)

Spouse's Name	How Marriage Ended	When	Where (county)

Inheritance Will Survivor Benefits Explain: _____

Military Service <input type="checkbox"/> Client <input type="checkbox"/> Spouse <input type="checkbox"/> Parents <input type="checkbox"/> Child Killed in Action <input type="checkbox"/> N/A	Name of Veteran	Service No.
Dates Served _____ to _____	Wartime? <input type="checkbox"/> Yes <input type="checkbox"/> No	Referred to VA or TVC? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> If no, explain: _____

Person's Name		Relationship					
Prefix/First /Last/Suffix		Indicate the Relationship of Each Person to the Primary Applicant	Verification of Relationship (Birth Certificate/ Marriage License, etc)	√ Indicate which criterion each person meets.			
				Able to Purchase and Prepare Food Together	If Yes, Physically Able to Purchase and Prepare Food Separately	Meets Parental Role	Provide Care for Other Person
1.		Primary Applicant					
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							

Person's Name		Education											
Prefix/First/Last/Suffix		High School (HS) Education Status					Higher Institution Education Status						
		HS Graduate√	Highest Grade	Graduation Date or Expected Date	School Name	Verification	Enrollment Status Full/Half N/A	Type of Institution	HS or GED Diploma Required	Training Program or Work Study	Weekly Hours Training Program or Work Study	Able to Work	Has Child Care
1.													
2.													
3.													
4.													
5.													
6.													
7.													
8.													
9.													
10.													

EMPLOYMENT HISTORY (attach additional page(s), if necessary)

Employer's Name	Address	Dates Employed	Potential Benefits*

*Pension plan (lump sum, monthly benefits), profit sharing, insurance.

FINANCIAL MANAGEMENT

Checks Received By		Cashed? <input type="checkbox"/> Yes <input type="checkbox"/> No ⇨ If yes, where?	Deposited? <input type="checkbox"/> Yes <input type="checkbox"/> No ⇨ If yes, where?
Direct Deposit? <input type="checkbox"/> Yes <input type="checkbox"/> No	Who handles finances?		Amount of Cash Held by Client
Amount of Client's Money Held by Others (who, why)			

Is the client listed on someone else's financial accounts/instruments (styling, signature cards, SSN)? Yes No

If yes, explain: _____

Was disapproval of ownership offered (Form H1299)?..... Yes No

RESOURCES

Financial Accounts/Instruments	Description
<input type="checkbox"/> Checking Account	
<input type="checkbox"/> Savings Account	
<input type="checkbox"/> CD/Money Market	
<input type="checkbox"/> IRA, Annuity, Retirement Plan	
<input type="checkbox"/> Bonds, Stocks	
<input type="checkbox"/> Promissory Note, Mortgages	
<input type="checkbox"/> Trust Fund in facility Other trust Supplemental or Special Needs Master Pooled Trust Qualified Income Trust (Miller)	Date established: Trust corpus amount: Name and address of trustee:
<input type="checkbox"/> Safe Deposit Box (list contents)	
<input type="checkbox"/> Other:	

Are all financial accounts/instruments owned by the client? Yes No

If any of the above items were **owned within the past 36 months**, describe and explain when and how disposed (attach additional page(s), if necessary):

REAL PROPERTY (check all that apply): **Never Owned**

<input type="checkbox"/> Currently Owned Homestead:	⇨ Intent to Return (Form H1245) signed <input type="checkbox"/> Rented or Income Producing	Person living in home: Name _____ Relationship <input type="checkbox"/>	Texas County _____	<input type="checkbox"/> Out-of-State <input type="checkbox"/> For Sale
<input type="checkbox"/> Currently Owned Other Property:	⇨ <input type="checkbox"/> Inherited/heir	<input type="checkbox"/> Rented or Income Producing	<input type="checkbox"/> Out-of-State	<input type="checkbox"/> For Sale
<input type="checkbox"/> Currently Owned Share Ownership:	⇨ Location _____	Name(s) of Co-Owner(s) _____	Amount of Land _____	% Ownership _____
<input type="checkbox"/> Previously Owned:	⇨ If previous Shared Ownership, list name(s) of co-owner(s)			
Disposition of Property (when and to whom)				
Location _____			Amount of Land _____	% Ownership _____
<input type="checkbox"/> Mineral Rights/Interest Retained	<input type="checkbox"/> Right to Income or Residency (life estate) Retained	<input type="checkbox"/> Promissory Note (explain):		
<input type="checkbox"/> Mineral Rights/Interest				
Location _____		Amt. % Owned _____	Leased? <input type="checkbox"/> Yes <input type="checkbox"/> No	Producing? <input type="checkbox"/> Yes <input type="checkbox"/> No
If leased or producing, explain income and source:				

- Vehicles (operational): _____
- Vehicles (non-operational): _____
- Work Equipment: _____
- Items of Unusual Value: _____
- Other: _____

Transfer of Assets (resources or income) Yes No If yes, explain (attach additional page(s), if necessary): _____

- Explain potential penalty for transfer of assets.
- Explain exceptions for transfer of homestead.

BURIAL ARRANGEMENTS

<input type="checkbox"/> Life Insurance:	Name(s) of Company(ies) _____	<input type="checkbox"/> Term	<input type="checkbox"/> Burial	<input type="checkbox"/> Whole	<input type="checkbox"/> Life
<input type="checkbox"/> Other Irrevocable Arrangement:	Name of Owner _____				
<input type="checkbox"/> Insurance Others Own (client is beneficiary/insured):	Whose funds used? _____	Fully Paid? <input type="checkbox"/> Yes <input type="checkbox"/> No	Available to Client? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Insurance Client Owns (someone else is beneficiary/insured):					
<input type="checkbox"/> Mutual Aid/Benefit Policy, Fraternal Organization:					
<input type="checkbox"/> Prepaid Contract:	Owner _____	Whose funds used? _____	Available to Client? <input type="checkbox"/> Yes <input type="checkbox"/> No	Fully Paid? <input type="checkbox"/> Yes <input type="checkbox"/> No	Irrevocable? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Funds Set Aside:	Who holds the funds? _____				
<input type="checkbox"/> Burial Site:	Location _____				Owner of Grave Site _____
<input type="checkbox"/> Heir to family-owned site?	No. Spaces	No. Occupied	Fully Paid? <input type="checkbox"/> Yes <input type="checkbox"/> No	Remaining Designated (name/relationship)	

INCOME	Client	Spouse		Client	Spouse		Client	Spouse
<input type="checkbox"/> SSI			<input type="checkbox"/> CSA/FERS			<input type="checkbox"/> Rental/Lease		
<input type="checkbox"/> RSDI			<input type="checkbox"/> Other Govt. Pension			<input type="checkbox"/> Interest/Dividends		
<input type="checkbox"/> VA			<input type="checkbox"/> Private Pension			<input type="checkbox"/> Prom. Note/Mort.		
<input type="checkbox"/> RR Retirement			<input type="checkbox"/> Trust Income					
<input type="checkbox"/> Gifts/Contributions			Source _____					
<input type="checkbox"/> Earned			Employer _____					
<input type="checkbox"/> Other			Source _____					
Any increases/decreases? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain: _____								
Any income rec'd previously not rec'd now? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what was source? _____ When stopped? _____ Why stopped? _____								
Have support and maintenance been explored? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Informed to Apply for Potential Benefits								

Comments: _____

THIRD PARTY RESOURCES (including insurance paid by someone else)

Covered? <input type="checkbox"/> Yes <input type="checkbox"/> No	Who pays Medicare premiums? <input type="checkbox"/> Client <input type="checkbox"/> Other (explain):
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Give the following information about any insurance policies covering the client:

POLICY 1 –Company Name		Policy No.	Type Coverage
Address for Claims			
Premium Amount	How often paid?	Whose funds are used to pay the premiums?	Does client plan to keep insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No ⇒ If no, date it will end:

POLICY 2 –Company Name		Policy No.	Type Coverage
Address for Claims			
Premium Amount	How often paid?	Whose funds are used to pay the premiums?	Does client plan to keep insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No ⇒ If no, date it will end:

Does the client have other allowable incurred medical expenses? Yes No

If yes, document: _____

Does the client have Three Months Prior medical bills? Yes No

If yes, document: _____

REMINDERS/GENERAL INFORMATION

Eligible for deduction for home maintenance (if yes, document):

- | | | |
|--|---|---|
| <input type="checkbox"/> Possible 3 months prior SLMB or QI-1. | <input type="checkbox"/> Home/car insurance–Company: | <input type="checkbox"/> Medical Necessity/Level of Care. |
| <input type="checkbox"/> QIT discussed (if needed). | <input type="checkbox"/> Form H1260, Par. Status/Inheritance (if needed). | <input type="checkbox"/> Explain appeal/fair hearing. |
| <input type="checkbox"/> Check for possible TP 03. | <input type="checkbox"/> Form H1350/H0025. | <input type="checkbox"/> Resource/income limits. |
| <input type="checkbox"/> Alien verification (if needed). | <input type="checkbox"/> Bed hold charges/therapeutic home visits. | <input type="checkbox"/> Repeat explanation of tape matches. |
| <input type="checkbox"/> Explain applied income calculation: TPR premiums, other incurred medical reconciliation of variable income (if needed). | <input type="checkbox"/> Emphasize need to report all changes within 10 days: Income, Resources, Status of Homestead (if applicable). | <input type="checkbox"/> Explain liability for not reporting (or for untimely reporting) of information, or intentionally giving false information. |
| <input type="checkbox"/> Gift income/deposits to accounts. | <input type="checkbox"/> Explain Medicaid Estate Recovery Program. | <input type="checkbox"/> Medical Necessity/Level of Care. |

INTERVIEWED BY: _____

Signature

Date

Comments: _____

