

**MEDICAL ASSISTANCE QUESTIONNAIRE
- RESPONSIBLE RELATIVE -**

NEW YORK STATE

DEPARTMENT OF HEALTH

CASE NUMBER	AGE	DATE SENT
APPLICANT'S NAME		
FAMILY MEMBERS		

NAME AND ADDRESS OF LEGALLY RESPONSIBLE RELATIVE

- An application for Medical Assistance (Medicaid) has been submitted by or on behalf of the above person or family household.
- The New York State program for Medical Assistance will cover that part of a recipient's care for which he and/or his legally responsible relatives are unable to pay.
- Legally responsible relatives are: husband for wife; wife for husband; parent(s) for children under 21.
- The following information is needed to determine the amount of income or resources which you may have available to contribute toward the cost of medical care.

PLEASE COMPLETE THIS QUESTIONNAIRE AND RETURN IT IN THE ENCLOSED ENVELOPE WITHIN 10 DAYS.

IF ADDITIONAL SPACE IS NEEDED FOR ANY SECTION, USE SECTION IX.

IF YOU HAVE ANY QUESTIONS, YOU MAY CONTACT:

SECTION I - DEPENDENTS

Do you have other persons dependent on you for support? Yes No

If yes, enter name(s).



NAME OF PERSON	AGE	RELATIONSHIP

SECTION II – SALARY OR WAGE

Do you or your dependents receive a salary or wage, or are you or any of your dependents self-employed?

Yes No

If yes, enter name(s) below and complete lines.

FIRST NAME	EMPLOYER'S NAME (Indicate if Self-Emp)	GROSS WAGES	HEALTH INSURANCE	COURT ORDERED PAY*
		Amount/Person	Amount/Person	Amount/Person
Self				

NOTICE: You are requested to furnish proof of your income from wages. Please submit paycheck stubs or a statement from your employer showing gross wages, and deductions for income taxes and health insurance for the last 4 weeks. These documents will be returned to you promptly. If you cannot secure such proof, give reason in Section IX.

*List only payments for support of dependents. Give name of court _____.

1. If you have incapacitated adult/child care expenses, indicate name and address of incapacitated adult/child caring person or agency, and amount paid. _____

2. Health insurance premium(s) not deducted from salary or wages _____.

SECTION III – OTHER INCOME

Are you or your dependents receiving any of the following?

TYPE OF BENEFIT	YES	NO	IF YES, NAME OF PERSON RECEIVING INCOME	AMOUNT	WEEKLY MONTHLY YEARLY
Unemployment Insurance					
Worker's Compensation					
Veteran's Benefits or Pension					
Social Security/Railroad Retirement					
Union Benefits					
Disability Benefits, SSI, Employment, etc. (Please Specify)					
Court Order/Support Payments					
Income From: Rent, Produce of Farm, Roomers, Boarders, Mortgages, etc.					
G.I. Dependency Allotment					
Income from Relative or Friend (Give Name)					
Income from a Trust					
Pension(s)					
Dividends or Interest from Stocks, Bonds, Life Insurance, Bank Accounts, Annuities, or Mutual Funds (Please Specify)					
IRA, KEOGH, 401K, Deferred Compensation					
G.I. Bill					
Income from Training Program					
Other Income					

If you are receiving Public Assistance, give the name and address of the Office where you applied.

NAME and ADDRESS

SECTION IV – RESOURCES

Do you or your dependents have any of the following?

TYPE OF RESOURCE	YES	NO	IF YES, NAME OF PERSON OWNING RESOURCE				VALUE OF RESOURCE
Cash on Hand							
Saving Account(s) (Checking, Savings, Certificate of Deposit in Bank, Credit Union) 1					NAME AND ADDRESS OF BANK	ACCOUNT NO.	
2							
Pending Lawsuit Which May Result in Cash Award					NAME AND ADDRESS OF LAWYER		
Stocks, Bonds							
Trust Fund							
Annuity							
Safe Deposit Box							
Union Benefits							
Pension Funds (e.g. IRA, KEOGH)							
Other Pension or Retirement Account					NAME AND ADDRESS	ACCOUNT NO.	
Other, Specify							
Life Insurance 1			INSURED	INSURANCE CO.	POLICY NO.	FACE VALUE	CASH VALUE
			TYPE OF INS.	BENEFICIARY	DATE OF ISSUE	PREMIUM	PERIOD
2			INSURED	INSURANCE CO.	POLICY NO.	FACE VALUE	CASH VALUE
			TYPE OF INS.	BENEFICIARY	DATE OF ISSUE	PREMIUM	PERIOD
Burial Fund			NAME OF PERSON OWNING RESOURCE			VALUE OF RESOURCE	

SECTION V – REAL ESTATE

Do you or your dependents own property other than that which you use for your home? Yes No

DESCRIPTION OF PROPERTY		VALUE OF PROPERTY
LOCATION OF PROPERTY		Do you receive rent? <input type="checkbox"/> Yes <input type="checkbox"/> No
		Amount _____ per _____
IF YOU RECEIVE RENT, ENTER THE APPLICABLE EXPENSES:		
Taxes (School & Property) Amt. _____ per _____	Fire Insurance Amt. _____ per _____	
Mortgage Interest _____ per _____	Water and Sewer _____ per _____	
Mortgage Principal _____ per _____	Maintenance Expenses _____ per _____	

SECTION VI – VETERAN STATUS

Are you or any of your dependents a veteran or a widow(er) of a veteran? Yes No

If yes, Enter name(s) And complete Line(s).

FIRST NAME	NAME OF VETERAN, IF A RELATIVE	RELATIONSHIP	ARMED FORCES SERIAL NUMBER	VA CLAIM NUMBER
Self				

