Combined Application
For State and County Medical Assistance

Affordable Care Act
Health Coverage Assistance

- AABD
- MAGI
- APTC
- Aged
- Medicaid Coverage
- Advance Payment of Tax
- Disabled
- Pregnant Women
- Adults with Children
- E-Med Exchange
- Modified Adjusted Gross Income
Combined Application Unit

Hospital

County

CAU Unit

Application

- Combined Application Form will be used for County Indigent applications.
- Fax coversheet is required.
- Combined Application must be completed entirely and have a valid signature.
- Application can be mailed or faxed using the following contact information.

Health and Welfare
PO Box 83720
Boise, ID 83720-0026
Fax: (208) 528-3771
IDAH0 DEPARTMENT OF
HEALTH & WELFARE

Key Areas of the Application

1. Patients Name & Dates of Service
2. Hospital Contact Information
3. County Contact Information

FAX COVER SHEET
Request for Medicaid Eligibility Determination

Patient's Name: ____________________________
Hospital Name: ____________________________
Hospital Contact Information: 
Hospital Name: ____________________________
Address: ____________________________
Phone: ____________________________
Fax: ____________________________
Email: ____________________________

Hospital Contact Information: 
Name: ____________________________
Address: ____________________________
Phone: ____________________________
Fax: ____________________________
Email: ____________________________

County Contact Information: 
Name: ____________________________
Address: ____________________________
Phone: ____________________________
Fax: ____________________________
Email: ____________________________

By signing below, I acknowledge that by completing this application form, it will be used to determine my eligibility for Medicaid or Managed Care Medical Assistance and that the information provided is true and correct. I authorize Idaho Department of Health and Welfare to verify the information provided and to release any necessary test results necessary to determine eligibility. I understand that the information provided may be used by the Idaho Department of Health and Welfare to determine whether I qualify for Medicaid or Managed Care Medical Assistance and to verify any information provided.

Type of Application & Signature: ____________________________

IDAH0 DEPARTMENT OF
HEALTH & WELFARE

Key Areas of the Application

1. Type of Application & Signature
2. Alternate Contact Person
3. Diagnosis/Request
4. Dates of Service

COMBINED APPLICATION FOR STATE AND COUNTY MEDICAL ASSISTANCE

Understanding: If you need any of the following assistance, please ask. These services are free:

- Language Assistance: Please provide assistance in Spanish, French, Chinese, or other languages.
- Accommodation for Individuals with Disabilities: If you require assistance in a language other than English, please contact the Department of Health and Welfare.

By signing below, I acknowledge that by completing this application form, it will be used to determine my eligibility for Medicaid or Managed Care Medical Assistance and that the information provided is true and correct. I authorize Idaho Department of Health and Welfare to verify the information provided and to release any necessary test results necessary to determine eligibility. I understand that the information provided may be used by the Idaho Department of Health and Welfare to determine whether I qualify for Medicaid or Managed Care Medical Assistance and to verify any information provided.

Type of Application & Signature: ____________________________

CALLS MADE TO MANAGED CARE OR MEDICAL AIDS PROVIDERS WILL BE INFRASTRUCTURE TO THE PROVIDER TO PROVIDE THE APPLICATION TO MEDICAID.

IDAH0 DEPARTMENT OF
HEALTH & WELFARE

Key Areas of the Application

1. Type of Application & Signature
2. Alternate Contact Person
3. Diagnosis/Request
4. Dates of Service
Key Areas of the Application

1. Client Applying for Coverage

2. Tax Filing Information

3. All Other Household Members

IDAH0 DEPARTMENT OF HEALTH & WELFARE

Tell Us Who You Are

- If you need to provide more information, please ask any one.

**ATTENTION**
- This is an application to determine your eligibility. Complete the application as accurately and provide all information from which is involved.
- List every person living in your home.

1. Has a Disability or Applying with SSA

2. Medical Assistance

3. Lives in a Medical care Facility
**Key Areas of the Application**

1. Health Insurance and Legal Information

   - All Household Earned Income
   - Gross Annual Income (APTC)
   - Self-Employment
Key Areas of the Application

1. All Household Unearned Income

2. Assets

Patient Rights and Responsibilities for State and County Assistance

For State Assistance:

- The individual or representative of the individual must sign the application.
- The Department may ask the individual to provide proof of identity and/or eligibility.
- The Department must provide the individual with written notification of the decision and the reasons for the decision.
- The individual has the right to request a hearing if the decision is not to their advantage.

For County Assistance:

- The individual or representative of the individual must sign the application.
- The Department may ask the individual to provide proof of identity and/or eligibility.
- The Department must provide the individual with written notification of the decision and the reasons for the decision.
- The individual has the right to request a hearing if the decision is not to their advantage.

1. Signatures are Required
1. Signatures for Release of Information

Disability Determination Packet

Disability is permanent. Disability has been present for 12 months. Will the disability continue after the 12 months.

Must be filled out by the client or member who has Power of Attorney.

Medical Records are required to support the disability determination. The SSA release of information form must be signed.

For deceased applicants the death certificate is required.

Disability Determination Packets can only be submitted twice to SSA.
Disability Determination

Disability Report

Vocational Report for Disability Determination

Authorization to Disclose Information to the Social Security Administration

E-Med

Must meet all eligibility requirements with the exception of citizenship.

Application must be received after services provided. Three months retro available.

Provide medical records to support the emergency and services received.
**Additional Requests**

To submit a request for Additional Services for the same diagnosis the Combined Application Unit needs to receive the Cover sheet, Pages 1, and 2.

Note: The combined Application Unit only determines eligibility and does not determine if services provided were related to the original diagnosis that is the responsibility of the County.
CAU Unit Information

- 208-528-3770
- 208-528-3771
- CntyhospApp@dhw.idaho.gov

Questions & Answers