Case Name:
Case Number:
Date:
DHS Office:

Specialist / ID:
Phone:
Fax:
Individual ID:

If you do not understand this, call a DHS office in your area.
DHS employees are prohibited by law from providing legal advice.
Si ústed no entiende esto, llame a una oficina de DHS en su área.
La ley prohibe a los empleados de DHS proporcionar asesoria legal.
إذا واجهت صعوبة في فهم هذا الطلب، فاتصل بمكتب DHS الموجود في منطقتك.
يحرّم القانون على موظفي DHS إعطاء النصيحة القانونية.

STATE OF MICHIGAN
Department of Human Services

HEALTH CARE COVERAGE SUPPLEMENTAL QUESTIONNAIRE

Due Date:

Why Are You Getting This Notice? We need some additional information to find the most beneficial health care coverage for you or a member of your family.

- **What Steps Should You Take?**
  - You must complete, sign, and date this form, and return it by the due date.
  - Include a copy of all proofs that are listed in each section of this form.
    - Original documents which are received as proof may not be returned.
  - The completed form and a copy of all proofs must be returned by the due date listed above. Please make sure your name is on all proofs.
- **What Happens If You Do Not Return the Completed Form and Required Proofs by the Due Date?**
  - For new applicants: If you do NOT return this form **and** all of the required proofs by the due date, your request for health care coverage may be denied.
  - For existing Medicaid recipients: Your benefits will continue at the current level.
  - If you receive Medicare: A determination for the Medicare Savings Program may not be made.

- If you do not understand this form and need help completing it, contact the specialist listed above before the due date.
- Complete this form to allow us to determine the most beneficial health care coverage. If you need additional space to provide your answers, use Client Comments Section on page 3.
- To apply for additional programs, please visit www.michigan.gov/mibridges, or contact the DHS office in your area.
- **If you have questions or problems getting the proofs before the due date, please contact the specialist listed above. If you ask for help getting your proofs, your specialist may be able to assist you.**

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Case Name	Case Number	Specialist

MEMBERS OF HOUSEHOLD – Below are the names of people we show living in your household. Cross out incorrect information and write the correct information in the space provided. Add names and information about people living with you who do not appear on this form. Complete all columns. If more space is needed, report additional information in Client Comment Section on page 3.

Name	Date of Birth	Relationship to you	Social Security Number	Gender (please circle)	U.S. Citizen? Yes/No	Pregnant now/in last 3 months? Yes/No	If Pregnant, Expected Due Date
		SELF					

FACILITY – List any person in your household who lives in a facility.

Patient's Name	Name of Facility	Date of Facility Admission	Address Where You Lived Before You Entered the Facility
a			

	Yes	No	Amount	How Often Paid
Do you and/or your spouse have a rent, mortgage or other shelter expense?	☐	☐		

DISABILITY – List any person in your home who is blind or has a disability.

Name	Medical Condition	Is this person able to work?	
		☐Yes	☐ No
		☐Yes	☐ No
		☐Yes	☐No

INCOME SOURCE - Report all sources of earned and unearned income. **Send proof** of **all** income your household received. Send proof of the last 30 days for employment, unemployment, social security benefits, pension, etc. Send proof of the last 90 days for child support and self-employment income/expenses records. Examples of proof include check stubs, a statement from source of income.

Recipient's Name	Income Source	Gross Amount (Before deductions)	*Number of Expected Hours of Work Per Pay Period	Frequency (Weekly, Bi-weekly, Monthly)	Start/End/ Change Date

Case Name	Case Number	Specialist

EXPENSES YOU OR YOUR SPOUSE ARE RESPONSIBLE TO PAY - Send proof of all expenses with your name on it.

Type of expense to report	Name of Person Who Incurred the Expense	Type of Expense	Amount of Expense	Amount You are Responsible to Pay
• Guardian • Conservator • Child Support - court-ordered • Care for Adult with Disabilities • Employment-related • Dependent Care Expenses • Medical				

ASSETS – Report **all** assets. This may include: bank accounts, land, cars, other vehicles, boats, life insurance, Long Term Care Partnership Policy (LTCP), investments, lawsuit settlements, trusts, annuities or any other property (including in trust). Report if anyone bought, sold, transferred, gave away or received any asset in the last 60 months. **Provide proof with your name on it.** If more space is needed, use the Client Comment Section below.

Has anyone in your household received a federal tax refund in the last 12 months? ☐Yes ☐No

If yes, Who? _______________ Date? ___________ How much? __________

	Name of Owner	Financial Institution	Account Number	Balance	New/Change Date
Savings					
Checking					
Other					

PENALTY WARNING

"Under penalties of perjury, I swear or affirm that this application has been examined by or read to me, and, to the best of my knowledge, the facts are true and complete. If I am a third party applying on behalf of another person, I swear or affirm that this application has been examined by or read to the applicant, and, to the best of his/her knowledge, the facts are true and complete."

I certify, under penalty of perjury, that all the information I have written on this form or told to my DHS specialist or my representative is true. I understand I can be prosecuted for perjury if I have intentionally given false or misleading information, misrepresented, hidden or withheld facts which caused me to receive assistance I should not have received or more assistance than I should have received. I can be prosecuted for fraud and/or required to repay the amount wrongfully received. I understand I may be asked to show proof of any information I have given.

Signature of Client or Authorized Representative / Date	Telephone Number	Signature of Department Witness / Date
	( )	

Telephone Number where you can be reached or where we can leave a message

( )

CLIENT COMMENTS (may also report additional information here)

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Michigan Department of Health and Human Services (MDHHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to an MDHHS office in your area.