APPLICATION FOR THE RESIDENTIAL CARE ASSISTANCE PROGRAM

State Form 37113 (R4 / 5-15) / BAIS 0050

Reset Form

COVER SHEET

Name of facility	
Name of contact person	E-mail address
Address of facility *(number and street, city, state, and ZIP code)*	
Name of new applicant	Date RCAP application e-mailed to DFR *(month, day, year)*
Has this resident been admitted to the RCAP facility? ☐ Yes ☐ No	If yes, what is the admit date? *(month, day, year)*

MEDICAID STATUS

Date of the Medicaid application *(month, day, year)*	Medicaid application confirmation number
Current Medicaid recipient number	Medicaid case number

FOR FSSA INTERNAL USE ONLY

Date DFR received application packet and corresponding documentation *(month, day, year)*		
MA application ☐ approval ☐ denial ☐ approved pending admission	Comments:	
Processed by		Date signed *(month, day, year)*
RCAP application ☐ approval ☐ denial ☐ approved pending admission	Comments:	
DA ☐ approval ☐ denial ☐ approved pending admission	Comments:	
Processed by		Date signed *(month, day, year)*
Administrative Services processed by		Date signed *(month, day, year)*
Comments:		

APPLICATION FOR THE RESIDENTIAL CARE ASSISTANCE PROGRAM

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C O N F I D E N T I A L

CONFIDENTIALITY STATEMENT

The personal information requested on this form will be used in the determination of your entitlement to or continued receipt of Division of Aging. Disclosure of the information requested is mandatory pursuant to the provisions of IC 12-10-6. Non-disclosure of the information requested will hamper and possibly prevent the delivery of assistance to you. All personal information collected on this form will be treated as confidential pursuant to applicable laws and regulations.

SOCIAL SECURITY NUMBER

* Your Social Security number is being requested by this state agency pursuant to the provisions of IC 4-1-8-1.

FOR USE BY THE DIVISION OF FAMILY RESOURCES

CASE NUMBER (ICES)	CASE NUMBER (CMS)
Date of RCAP application *(month, day, year)*	
Received by: *(name of person completing this box)*	
Date application e-mailed to DA *(month, day, year)*	
Other copy to be filed in case folder.	

To the Division of Family Resources County: _____

1. I wish to apply for Residential Care Assistance ☐ RBA ☐ ARCH	2. I am: *(check all that apply)* ☐ 65 years of age or over ☐ Blind ☐ Disabled		2a. Race
3. My full name is: ☐ Mr. ☐ Mrs. ☐ Ms. First	Middle	Last	Maiden name *(if applicable)*
4. I will live at or will be entering: *(name of facility)*		Date entered facility *(month, day, year)*	County
Address *(number and street, city, state, and ZIP code)*			
5. My mailing address is: ☐ the same as above; or ☐ different and is			
Address *(number and street, city, state, and ZIP code)*			Telephone number ( )
6. Social Security number *	Medicare claim number	Railroad retirement number	Veterans claim number	RFD number

7. Date of birth *(month, day, year)*

Place of birth *(city or county)*

Place of birth *(state or country)*

United States citizen? ☐ Yes ☐ No

Lawfully admitted for permanent residence? ☐ Yes ☐ No

8. I have given away, sold, deeded, or transferred any items of value, such as money, land, buildings, shares of insurance, or bank accounts within the last five (5) years. ☐ Yes ☐ No

9. Blind Applicants Only:
I am blind within the meaning of the definition set forth in IC 12-7-2-21. ☐ Yes ☐ No

10. Disabled Applicants Only:
I have a disability which has lasted or is expected to last twelve (12) months. ☐ Yes ☐ No

11. I own personal property. ☐ Yes ☐ No If Yes, complete below:

Type	Make	Model	Year

12. MEDICAL INFORMATION
I have health coverage that meets all or part of my medical needs.
☐ Yes ☐ No If Yes, complete below:

☐ Medicare Part A ☐ CHAMPUS
☐ Medicare Part B ☐ CHAMPVA
☐ Workman's Compensation ☐ Veterans Administration
☐ Other *(describe)* _____

HEALTH INSURANCE

Name of Company:

Policy Number:

Date Coverage Effective *(month, day, year):*

Hospitalization? ☐ Yes ☐ No

Major Medical? ☐ Yes ☐ No

Cancer Policy Only? ☐ Yes ☐ No

CONFIDENTIAL

13. INCOME INFORMATION

I receive money. ☐ Yes ☐ No If Yes, the money comes from:

A. Supplemental Security Income
B. Social Security
C. Medical Assistance or Medicaid
D. Veterans Benefits
E. Railroad Retirement
F. Pension
G. Military Allotment
H. Unemployment Compensation
I. Support Payments
J. Union Benefits
K. Sick Benefits
L. Rental of Property
M. Regular money from relatives
N. Other *(describe)* _____

Type of income	Amount	How Often?
	$	
	$	
	$	
	$	

14. EMPLOYMENT INFORMATION

Employed? ☐ Yes ☐ No If Yes, complete below:

Name of employer

Address of employer *(number and street, city, state, and ZIP code)*

If self-employed, state occupation

How long employed? | Regular working hours From To

Earnings before deduction each pay period
$

How often payed? ☐ Daily ☐ Every Other Week ☐ Monthly ☐ Weekly ☐ Twice a Month ☐ Other _____

Number of days worked each week | Hourly wage $

Payroll deductions ☐ Social Security ☐ Income Taxes ☐ Union Dues ☐ Other _____

Employment Expenses Per Week: | Transportation costs:

☐ Drives a car to work one-way, _____ miles
☐ Rides With Someone ☐ Bus ☐ Other _____

Other employment expenses *(uniforms, etc.)*
$

Describe

15. I have:

A. Savings Account in Bank
B. Checking Account in Bank
C. U.S. Savings Bonds
D. Stocks and Bonds
E. Savings and Loan Association
F. Credit Union Shares
G. Other money in burial account in bank, with funeral director, or with others *(specify)* _____
H. Other *(describe)* _____

TYPE	AMOUNT	OWNED BY		LOCATION
		Myself	Owned Jointly With Others	
	$			
	$			
	$			
	$			
	$			

16. LIFE INSURANCE

I am insured. ☐ Yes ☐ No If Yes, complete below:

Name of Company:

Policy Number:

Date Issued *(month, day, year):*

Face Value:

Cash Value:

Owner of Policy:

17. I own real property (land or buildings) in which I am not living. ☐ Yes ☐ No

Address *(number and street, city, state, and ZIP code)*

Amount of taxes $ | Insurance $ | Monthly payment $

Monthly income $ | Balance owed $

Additional comments:

18. EACH APPLICANT MUST READ THE FOLLOWING POINTS AND PUT AN "X" IN EACH BOX TO SHOW THESE STATEMENTS ARE UNDERSTOOD AND AGREES TO THEIR PROVISIONS.

☐ I understand that I will be asked to provide proof of the information which I have given and I agree to help the Division of Family Resources obtain the necessary verifications. I also understand that a person who receives assistance by giving false information may be criminally prosecuted under applicable State law.

☐ I agree to let the Division of Family Resources know within five (5) days of any change in my income or resources and any other changes that might affect my eligibility for assistance.

☐ I agree to any examinations necessary to establish my eligibility for Room and Board Assistance or Assistance to Residents in County Homes. I authorize any physician, hospital, or other provider of care to release any medical information about me, if requested by the Division of Family Resources.

☐ I agree to file for any benefits for which I may be eligible.

☐ I agree to contribute my personal income, minus the personal needs amount, toward my room and board.

☐ I authorize the release of medical or other information acquired by the Medicare Carrier and/or Intermediary under the Title XVIII Program (Medicare) to the extent necessary to process any current or future Medicaid claim.

☐ I understand and acknowledge that any assistance granted me becomes a lien against any real property I now own or subsequently acquire, that a notice of said lien will be filed in the office of the County Recorder, and that such assistance becomes a preferred claim against my estate.

Signature of applicant, legal guardian, or interested person | Date signed *(month, day, year)*

Signature of witness *(if signature is by "X")* | Date signed *(month, day, year)*

Address *(number and street, city, state, and ZIP code)*

Signature of witness *(if signature is by "X")* | Date signed *(month, day, year)*

Address *(number and street, city, state, and ZIP code)*