

**AUXILIARY GRANT SUPPLEMENTAL RENEWAL APPLICATION**

Name: \_\_\_\_\_ Case Number \_\_\_\_\_ Date Received \_\_\_\_\_

**Note: This form must be completed in addition to the Renewal Application Form (032-03-729A).**

**This supplemental application may be used for the renewal of Medical Assistance programs for persons receiving Auxiliary Grant benefits. The following questions will help determine Medicaid eligibility through the Department of Social Services. If you are not eligible for Medicaid at renewal and you do not have Medicare, your information will be used for possible eligibility for Advanced Premium Tax Credits (APTC) for private health insurance through the Federal Marketplace (Healthcare.gov).**

YES  NO 1. Do you own any household goods or personal effects worth more than \$500? If **YES**, list the items and their value here. \_\_\_\_\_

YES  NO 2. Has anyone made any third party payments to an Assisted Living Facility on your behalf? If **YES**, who made the payments? \_\_\_\_\_

How much was paid on your behalf? \_\_\_\_\_

YES  NO 3. Does anyone own any personal property, such as campers/trailers, non-motorized boats, utility trailers, tools, equipment, supplies, or livestock?

Owner(s)	Type	Is this property used in your business or trade, including farming?	Value	Amount Owed	Date Acquired
		YES ( ) NO ( )			

YES  NO 4. Does anyone own any real property, including life estates, inherited property, land, buildings, or mobile homes? If **YES**, do you live there? Check (✓):  YES  NO

Owner(s)	Type	YES ( ) NO ( ) Currently rented?	Value	Amount Owed	Date Acquired
		YES ( ) NO ( ) Income-producing?	\$	\$	
		YES ( ) NO ( ) Currently for sale?			

YES  NO 5. Does anyone own vehicles, such as cars, trucks, vans, motorboats, motor homes, recreational vehicles, or motorcycles/mopeds?

Owner(s)	Type, Make, Model, Year	Currently Licensed?	Vehicle ID# License #	Value Amount Owed	How Used	Date Acquired
		<input type="checkbox"/> YES <input type="checkbox"/> NO	#	\$		
			#	\$		

YES  NO 6. Does anyone have health insurance?

Policy Holder	Company Name, Address, Phone	Begin Date End Date	ID Number Premium Amount	Coverage Type	Person(s) Insured
			#		
			\$		

YES  NO 7. Does anyone have Medicare?

Person Insured	Claim Number	Coverage			
		<input type="checkbox"/> Part A <input type="checkbox"/> Part B			
		<input type="checkbox"/> Part A <input type="checkbox"/> Part B			

YES  NO 8. Does anyone have life insurance, retirement insurance, or other related types of insurance policies?

Owner(s)	Person(s) Insured	Company Name, Address, Phone,	Type of Policy	Policy Number	Face Value Cash Value	Date Acquired

9) List the names of everyone expected to be included on the same tax return as you for this year, whether or not they live in the same home as you. For anyone in the home that does not file taxes and does not expect to be on anyone else's tax return, list those names under "Non-filer(s)".

Tax Filer:	
Joint Taxpayer:	
Tax Dependent(s):	
Non-filer(s):	

**BY MY SIGNATURE BELOW, I DECLARE, UNDER PENALTY OF PERJURY, THAT THE INFORMATION PRESENTED HERE IS CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.**

I understand:

- All of my responsibilities, including my responsibility to report required changes on time.
- If I give false, incorrect, or incomplete information, or do not report required changes on time, I may be breaking the law and could be prosecuted.
- If I helped someone complete this form so as to get benefits he or she is not entitled to, I may be breaking the law and could be prosecuted.
- If I refuse to cooperate with any review of my eligibility, including reviews by Quality Assurance, my benefits may be denied until I cooperate.
- I understand that if I do not qualify for Medical Assistance my local department of social services will check to see if I qualify for other kinds of health coverage. My local department of social services may send my information to another program so they can see if I qualify.

My signature authorizes the release to this agency of all information necessary to both determine and review my eligibility This authorization is valid for one year from the date of my signature below. I understand that this time limit does not apply to investigations regarding possible fraud.

I filled in this application myself:  YES  NO If NO, it was read back to me when complete:  YES  NO

\_\_\_\_\_  
Your Signature or Authorized Representative's Signature or Mark

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness to Mark or Interpreter

\_\_\_\_\_  
Date

Complete this section if this application was completed for the applicant by someone else.

\_\_\_\_\_  
Name of person completing application

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to applicant

Primary Telephone Number \_\_\_\_\_

Alternate Telephone Number \_\_\_\_\_

AUXILIARY GRANT (AG), SUPPLEMENTAL RENEWAL APPLICATION

FORM NUMBER - 032-03-729C

PURPOSE OF FORM – To collect additional information to renew eligibility for AG and persons receiving Medicaid with AG benefits.

USE OF FORM – This supplemental application is limited to renewal of AG. This application may not be used in lieu of an application to apply for initial benefits, or to protect the date of application. This supplemental application must be accompanied by the Renewal Application for Auxiliary Grant (AG), Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance For Needy Families (TANF) (032-03-729A) to be a valid application. This form also allows for the renewal of Medical Assistance (MA) programs for individuals receiving the Auxiliary Grant benefit.

NUMBER OF COPIES - One.

DISPOSITION OF FORM – This application must be completed at the time of the eligibility review for AG. The completed application must be filed in the AG case record.

INSTRUCTIONS FOR PREPARATION OF FORM – The supplemental renewal application must be completed in its entirety.