Name of Applicant:	





Application for Health Coverage and Help Paying Costs APPENDIX E (Medically Needy Spenddown)

Complete Appendix E if you have applied for Health care Coverage for someone who is medically needy (has income greater than the Medicaid limit and would like to be evaluated based on income, resources and medical expenses). LIFC (low income families with children) applicants cannot be evaluated as medically needy.

Appendix E is not a full application for benefits. Submit at LDSS request after filing The Application for Health Coverage and Help Paying Costs.

SECTION 1 Resources and Assets

Answer for the applicant and his or her husband, wife and/or parents and siblings (if applicant is a child). Include any resources anyone owns, or that are jointly owned with someone else, even if that person does not live with you. List the names of all joint owners.

Do you or anyone who lives with you have any of the following resources or assets?						
Yes	No	Yes No	Yes No			
	Cash \$	Motor Vehic	cles Stocks or E	sonds		
	Checking, Savings	Real Propert	ty Annuities			
	Credit Union	Life Insuranc	ce Deeds of T	rust		
	Money Market Funds	Burial Arran	gements Trust Fund	S		
	Certificate of Deposit (CD)	Retirement A	Accounts Other			
	Self Sufficiency Account	Pension Plan	n			

IMPORTANT: If you have **any of the above** resources, please provide the following information and return documents, such as bank statements, life insurance policies, or a letter from the bank or company documenting the **cash value of the resource**. Verify any liens which reduce cash value. Use additional pages to list additional resources. Complete the following section for any **"Yes"** answers

a. Owner Name (first, middle initial, las-	Co-owner Name (first, middle initial, last)			
Name of Bank, Institution or Company	Resource Type	Identifying Number	Balance or Value \$	
Address of Bank, Institution or Compan	y (if applicable)	,		
b. Owner Name (first, middle initial, last)		Co-owner Name (first, middle initial, last)		
b. Owner Name (mst, madic initial, las	c)	co owner warne (ms	i, middle mitial, last)	
Name of Bank, Institution or Company	Resource Type	Identifying Number	Balance or Value	

If you are visually impaired and need large print or other assistance to access this document, please contact us at 1-855-242-8282 (TTY: 1-888-221-1590).

c. Owner Name (last, first, middle initial)				Co-owner Nam	Co-owner Name (last, first, middle initial)			
Name of Bank, Institution or Com	pany	Reso	urce Type	Identifying Nur	nber	Bala \$	nce or Value	
Address of Bank, Institution or Company (if applicable)								
d. Owner Name (last, first, middle initial)				Co-owner Nam	Co-owner Name (last, first, middle initial)			
Name of Bank, Institution or Com	pany	Reso	urce Type	Identifying Nur	nber	Bala \$	nce or Value	
Address of Bank, Institution or Co	mpany	(if ap	pplicable)	<u>'</u>				
SECTION 2 Ad	lditio	nal	Income					
Do you or anyone who lives with	ı you (i	nclud	ling children) ro	eceive or expect to r	eceive	any c	of the following?	
Yes No	Yes	No		Yes No				
Worker's Compensation Child Support	1		VA Benefits Lump Sums				Gifts, Life ds, Inheritances)	
IMPORTANT: If you answered "yes" above, please provide the following information and return documents, such as a letter from the source documenting the monthly gross amount of income . Use additional pages if needed to list additional income sources. Complete the following section for any "Yes" answers								
Name of Person	Amou \$	nt	٦	Гуре of Money or He	elp	How	Often Received?	
Name of Person b.	Amou	nt	٦	Type of Money or He	elp	How	Often Received?	
Name of Person	Amou \$	nt	-	Type of Money or He	elp	How Often Received?		
Name of Person d.	Amou \$	nt	7	Гуре of Money or He	elp	How	Often Received?	
Does anyone have a day care expense for a child, an elderly person, or an adult with a disability? ☐ Yes ☐ No — If yes, give name of person being cared for, name of person providing care, monthly cost and attach verification.								
Name of Person Being Cared For			Name of Perso	n Providing Care			Monthly Cost \$	
Sign the Form								
I am signing this appendix under penalty of perjury which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false or untrue information.								
Signature	1	Relationship to Applicant Date (mm/dd/yyyy)			dd/yyyy)			