DIVISION OF FAMILY AND CHILDREN SERVICES

MEDICALLY NEEDY OPTION STATEMENT

You have notified the Division of Family and Children Services that you owe a medical bill to _____in the amount of $_____.
(Name of medical provider)

You have the option to use unpaid Medical bills to meet your spend-down obligation for the month the bill was incurred or future months, otherwise Medicaid will pay the portion of the bill above your spend-down obligation.

If you wish to use the bill to meet future months spend-down you will remain responsible for paying the bill. If you choose to do so, please initial the statement below:

_____ (initial) I request that this bill be used to meet future month spend-down eligibility for Medicaid . I understand that by choosing this option, Medicaid will **not** pay this bill and I will remain responsible for the bill.

I would like to apply the bill, when possible, to the following months:

1) ___/___ 2) ___/___ 3) ___/___ 4) ___/___ 5) ___/___ 6) ___/___

Please note that your decision regarding this bill is <u>final</u>. Once a bill has been paid or used to meet spend-down for a month, it cannot be used again for any other Medicaid purpose.

_____ _____
Signature – Applicant/Recipient or Personal Representative Date

_____ _____
Applicant/Recipient Name (please print) Client ID #

_____ _____
Signature – Caseworker Date

_____ _____
Caseworker Name (please print) Caseload Number

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