

GA-MP Application Form

Section 1-Providers MUST complete this section.					
Provider Name	Date Episode of Care Began	Application <input type="checkbox"/> New <input type="checkbox"/> Renewal	Source <input type="checkbox"/> ER <input type="checkbox"/> UC <input type="checkbox"/> IP <input type="checkbox"/> OP	Incident related to: <input type="checkbox"/> MVA <input type="checkbox"/> Personal Injury <input type="checkbox"/> Work <input type="checkbox"/> Illness	

Applicant Instructions: Print clearly. Use blue or black ink. Fill out the application completely. Answer all questions. There may be a delay in receiving GAMP benefits if this application is incomplete. Personal Identifiable Information is used solely for the administration of GAMP benefits.

Section 2-Applicant Information					
1. Social Security Number	2. Legal Name: Last Name	First Name	Middle Initial	Suffix (Jr/Sr)	3. Date of Birth (MM/DD/YY)
4. Sex M F	5. Race or Ethnic Background(optional-not used for eligibility) Black White Hispanic Asian/Pacific Islander American Indian/Eskimo SE Asian Other		6. Other Names you have used. (include Maiden Name)		
7. Have you ever been Married? No Yes	8. If yes, what is your current Marital Status? Married Separated Divorced Widowed			9. Date this Marital Status began.	
10. Address where you live. Street Address			11. Mailing Address (if different from where you live) Street Address or P.O. Box		
City	State	Zip Code	City	State	Zip Code
12. Phone Number (indicate type) () _____ <input type="checkbox"/> check here if this number is only for messages	13. How long have you continuously lived in Milwaukee County prior to this application date? Years _____ Months _____		14. If you have resided in Milwaukee County less than 180 days (6 months): Were you born in Milwaukee County? Yes No Live in Milwaukee County 365 days in the past? Yes No Move here to join a close relative? Yes No Move here to accept an offer of employment? Yes No		
15. Are you a US citizen? Yes No	16. If not a citizen, what is your Homeland Security (INS) status? _____	17. Date this status began. _____	18. Are you a Student? No FT PT School _____	19. Students, do you maintain residency in your parent's State/County? No Yes State/County _____	
20. Are you currently employed (include self-employment)? If yes, complete the section below. Yes No			21. Has your employment ended in the past 3 months? Yes No If yes, complete the section below.		
Current Employer Name			Past Employer Name		
Start Date	Hourly Rate	Hours/Week	Monthly Gross Income	Start Date	End Date
Applied for UC?		Monthly Gross Income			
Yes No					
Is this Job Considered Self Employment?		Insurance Offered?		Was this Job Considered Self Employment?	
A Seasonal Job?		No Yes Eff Date _____		A Seasonal Job?	
No Yes				No Yes	
No Yes				No Yes End Date _____	
22. Do you receive any other type of income? No Yes (circle all that apply and enter Monthly Gross amount below)					
Alimony	IDAP	Pension	Money from Friends or Relatives		
Annuities	SSI	Rental Income	Living off of savings		
Child Support	SSA-Retirement	Royalties	Other _____ \$ _____/ month		
Interest/Dividends	SSDi-Disability	Worker's Compensation (WC)			
W-2 Benefits	VA Benefits	Unemployment Compensation (UC)	Other _____		
23. Do any of these situations apply to you? (circle yes or no)					
Are you Pregnant?	No Yes	Receive Workers' Comp (WC)?	No Yes	Receiving Title 19 (T19, BadgerCare, Healthy Start, Medicaid, Medical Assistance, Forward Card)?	
Applied for Disability?	No Yes	Filed a WC claim in the past 5 years?	No Yes	Applied for Title 19 in last 90 days? No Yes	
Are you Legally Disabled?	No Yes	Honorably Discharged Vet?	No Yes	Claimed as a tax dependent by someone? No Yes	
Receiving Medicare Part A, B or D?	No Yes	Receiving VA services?	No Yes		
Are you a sponsored Alien?	No Yes	Active in the Military?	No Yes		
24. Do you have care and custody of child(ren) age 18 or younger?	Yes No	25. Are you ordered to pay support for any child(ren) age 18 or younger?	Yes No	26. Do you have children age 19 or older that you claim as a dependent?	Yes No
Yes No		Yes No		Yes No	
Yes No		Yes No		Yes No	

If you answered Yes to question 24, 25, 26 or 27, you will need to complete section 3. Otherwise go to section 4.

Section 3-Children and Dependents

Instructions: List any child age 18 or younger in your care and custody (including step children), or for whom you are required to pay child support.
List any person whom you claim as a dependent or that you sponsor through immigration.
All questions must be answered for this person, even if they are not applying for GAMP.

Child/Dependent 1 Check here if this person is applying for GAMP

1. Social Security Number		2. Legal Name: Last Name		First Name		Middle Initial	Suffix (Jr/Sr)	3. Date of Birth (MM/DD/YY)	
4. Sex M F		5. Relationship to Applicant		6. Does this person live with you? Yes No		7. Is this person claimed as a tax dependent? Yes No		8. Do you have Joint custody of this child? Yes No	
9. Does this person receive any type of income (Such as from a job, SSI, Child Support, Kinship care)? No Yes Source _____ Monthly Gross Amount \$ _____						10. Is this person covered by Insurance? No Yes			

Child/Dependent 2 Check here if this person is applying for GAMP

1. Social Security Number		2. Legal Name: Last Name		First Name		Middle Initial	Suffix (Jr/Sr)	3. Date of Birth (MM/DD/YY)	
4. Sex M F		5. Relationship to Applicant		6. Does this person live with you? Yes No		7. Is this person claimed as a tax dependent? Yes No		8. Do you have Joint custody of this child? Yes No	
9. Does this person receive any type of income (Such as from a job, SSI, Child Support, Kinship care)? No Yes Source _____ Monthly Gross Amount \$ _____						10. Is this person covered by Insurance? No Yes			

Child/Dependent 3 Check here if this person is applying for GAMP

1. Social Security Number		2. Legal Name: Last Name		First Name		Middle Initial	Suffix (Jr/Sr)	3. Date of Birth (MM/DD/YY)	
4. Sex M F		5. Relationship to Applicant		6. Does this person live with you? Yes No		7. Is this person claimed as a tax dependent? Yes No		8. Do you have Joint custody of this child? Yes No	
9. Does this person receive any type of income (Such as from a job, SSI, Child Support, Kinship care)? No Yes Source _____ Monthly Gross Amount \$ _____						10. Is this person covered by Insurance? No Yes			

Child/Dependent 4 Check here if this person is applying for GAMP

1. Social Security Number		2. Legal Name: Last Name		First Name		Middle Initial	Suffix (Jr/Sr)	3. Date of Birth (MM/DD/YY)	
4. Sex M F		5. Relationship to Applicant		6. Does this person live with you? Yes No		7. Is this person claimed as a tax dependent? Yes No		8. Do you have Joint custody of this child? Yes No	
9. Does this person receive any type of income (Such as from a job, SSI, Child Support, Kinship care)? No Yes Source _____ Monthly Gross Amount \$ _____						10. Is this person covered by Insurance? No Yes			

28. Does the other parent of any of these children live in the same household with you?

No Yes

This person is called a Co Parent. If you answered Yes, you will need complete Section 4 for this person or if you have a spouse.

Section 4--Spouse or Co Parent <input type="checkbox"/> Check here if this person is applying for GAMP								
Instructions: List your spouse or your child's parent. All questions must be answered for this person, even if they are not applying for GAMP.								
1. Social Security Number		2. Legal Name: Last Name		First Name		Middle Initial	Suffix (Jr/Sr)	3. Date of Birth (MM/DD/YY)
4. Sex	5. Race or Ethnic Background(optional-not used for eligibility)				6. Other Names you have used. (include Maiden Name)			
M F	Black	White	Hispanic	Asian/Pacific Islander				
	American Indian/Eskimo		SE Asian	Other				
7. Have you ever been Married?			8. If yes, what is your current Marital Status?			9. Date Marital Status began.		
No Yes			Married Separated Divorced Widowed					
10. Do you have any children with the applicant?		11. How long have you continuously lived in Milwaukee County prior to this application date?			12. If you have resided in Milwaukee County less than 180 days (6 months):			
No Yes		Years _____ Months _____			Were you born in Milwaukee County? Yes No			
					Live in Milwaukee County 365 days in the past? Yes No			
					Move here to join a close relative? Yes No			
					Move here to accept an offer of employment? Yes No			
13. Are you a US citizen?	14. If not a citizen, what is your Homeland Security (INS) status?		15. Date this status began.	16. Are you a Student?		17. Students, do you maintain residency in your parent's State/County?		
Yes No	_____		_____	No FT PT		No Yes		
				School _____		State/County _____		
18. Are you currently employed (include self-employment)? If yes, complete the section below				19. Has your employment ended in the past 3 months? If yes, complete the section below				
Yes No				Yes No				
Current Employer Name				Past Employer Name				
_____				_____				
Start Date	Hourly Rate	Hours/Week	Monthly Gross Income	Start Date	End Date	Applied for UC?	Monthly Gross Income	
						Yes No		
Is this Job Considered Self Employment?		Insurance Offered		Was this Job Considered Self Employment?		Insurance Offered?		
A Seasonal Job?		Eff Date _____		A Seasonal Job?		End Date _____		
No Yes	No Yes	No Yes	_____	No Yes	No Yes	No Yes	_____	
20. Do you receive any other type of income? No Yes (circle all that apply and enter Monthly Gross amount below)								
Alimony	IDAP	Pension	Money from Friends or Relatives					
Annuities	SSI	Rental Income	Living off of savings					
Child Support	SSA-Retirement	Royalties	Other _____ \$ _____/ month					
Interest/Dividends	SSDi-Disability	Worker's Compensation (WC)						
W-2 Benefits	VA Benefits	Unemployment Compensation (UC)	Other _____					
21. Do any of these situations apply to you? (circle yes or no)								
Are you Pregnant?	No Yes	Receive Workers' Comp (WC)?	No Yes	Receiving Title 19 (T19, BadgerCare, Healthy Start, Medicaid, Medical Assistance, Forward Card)?				
Applied for Disability?	No Yes	Filed a WC claim in the past 5 years?	No Yes	Assistance, Forward Card)? No Yes				
Are you Legally Disabled?	No Yes	Honorably Discharged Vet?	No Yes	Applied for Title 19 in last 90 days? No Yes				
Receiving Medicare Part A, B or D?	No Yes	Receiving VA services?	No Yes	Claimed as a tax dependent by someone? No Yes				
Are you a sponsored Alien?	No Yes	Active in the Military?	No Yes					

Section 5: Comments

Comments: This space is for further information or explanations. If no income is listed, you must explain how you are meeting your day-to-day needs. Any special situations or circumstances should be explained in this area. You do not need to disclose any medical information, your medical condition is not used to determine your eligibility.

Section 6-Certification

1. Clinic Selection

Each household must choose a Primary Care Clinic. Please indicate your choice below.
I also understand that this will be my clinic for the duration of my eligibility segment and that I can not change clinics during the eligibility segment. Your clinic will provide your primary care and process any referrals to specialists or hospitals within their network.
Failure to choose a clinic may delay the processing of your application.
My initials here indicate that I have chosen these clinics from a list of available GAMP Providers.

1st Choice _____ 2nd Choice _____ Initials _____

2. Did someone assist you in completing this application form?

No Yes Name _____ Agency _____
(If applicable)

3. Authorized Representative

I authorize the following person to contact GAMP on my behalf. As Representative, this person can request and provide information regarding my eligibility and services in accordance with the laws and policies the govern Milwaukee County. I understand that I am responsible for any information provided by my representative.
This authorization will last for the duration of my eligibility period and may be rescinded in writing at any time during that period by me.

Name _____ Relationship _____

4. Please read this section carefully before signing this application. This section contains information about your rights and responsibilities.

- * I certify, under penalty of false swearing, that the information provided is correct and complete to the best of my knowledge.
- * I understand and agree to provide documents to prove that what I have said is true.
- * I understand that the penalties for giving false information include denial of benefits, sanction, criminal prosecution, and repayment for any medical benefit payments made by Milwaukee County General Assistance Medical Program (GA-MP).
- * I also certify that I am not covered by or eligible to be covered by any healthcare program or insurance.
- * I authorize the Milwaukee County GA-MP to verify the information I have provided.
- * I understand that my Protected Health Information will be used for the administration and verification of GA-MP benefits
- * I authorize Milwaukee County to contact other persons or organizations to obtain the necessary proof of my eligibility and level of benefits.
- * I acknowledge and agree that facts as stated in this application may be subject to private investigations for verity.
- * I understand that completing this application does not guarantee that medical bills will be covered and that I am responsible for any co-payments or non-covered/unauthorized services.
- * I understand that I am required to pay any applicable processing fees to be certified as a GA-MP recipient.
- * I also understand that if this application is approved I will be designated as medically indigent according to state statute and county ordinance.
- * I authorize the Milwaukee County GA-MP to access, review, and collect information regarding the medical services I have received in order to verify cost or quality of service by a medical provider or to address other management and/or payment issues as may be determined to be in the best interest of the county.
- * Furthermore, I understand and consent to the sharing of this information with other County, State or Federal entities or authorized service/medical providers in order to coordinate service delivery.
- * I understand that any co-payment or repayment owed will be pursued for full collection.
- * I understand that Milwaukee County may attach my property and/or garnish my income or assets that it is legally entitled to attach and garnish.

5. Signature

A GAMP Healthcare Specialist will determine your eligibility for this program within 15 business days of our office receiving this application.

Do not sign a blank application

Date Applicant Signature (required) Spouse's Signature (required only if spouse is applying)

Date Witness Signature Print witness name

Hospital or Clinic witnessing this application

For Office use only--Leave Blank

GAMP Application Form Supplemental Page

Instructions: As of February 1, 2008, this page must be completed and accompany all applications for GAMP benefits.

1. Applicant Name

2. Do you or your spouse have minor children (age 18 or younger)?

No

Yes

If you answered Yes, your children MUST also be entered in Section 3 of the GAMP application.
If you answered No, please go to Question 3.

Who do your children live with?

Name _____ Relationship to children _____

Address _____

What is your custody arrangement?

Are your children in Foster Care or placed with Kinship Care?

No

Yes

Is there a court order?

Are you ordered to pay Child Support?

No

Yes

Order # _____

No

Yes

Amount \$ _____

3. Do someone else's children reside with you?

No

Yes

If you answered Yes, the children MUST be entered in Section 3 of the GAMP application.
If you answered No, you have completed this page.

Are you or your spouse the caretaker of the child(ren)?

No

Yes

Relationship to Child(ren) _____

Is there a Court Order for their placement in Foster care or Kinship Care?

No

Yes

Order # _____

Additional Comments:

For Office use only-Leave Blank