



If you need help filling out this application or have questions, please contact us at 1-855-797-4357 or visit your local Department of Health and Human Services (DHHS) office – we can help!

How do I apply?

Fill out this application by answering as many questions as you can. We will accept your application if it is submitted with a name, address and signature. The date we get this information will establish a start date and begin your application.

What proof may I need to send to complete my application?

You may be asked to provide some or all of the information below:

- Copy of Power of Attorney, Conservator, or Guardianship documents
- Documentation of all income sources and amounts (with the exception of Social Security and SSI)
- Documentation of the value for property that is not the applicant's residence
- Copies of health insurance cards including Medicare
- Documentation of health insurance payments
- Copy of trust agreement where the applicant is a grantor or beneficiary
- Copy of annuity contract
- Copy of life insurance policies owned by the applicant and/or their spouse
- Copy of prepaid burial contracts or mortuary trust agreements
- Declaration of contents held in a safe deposit box
- Documentation of liquid assets owned currently by the applicant and/or spouse, or those that have their name on them. These include current statements on all savings and checking accounts, certificate of deposits, IRA or other investments
- Documentation of values and use of all assets cashed in, closed, sold, transferred or otherwise liquidated during the 60 months prior to application

Where do I return the application?

You can bring the application to your local DHHS office, send it by mail, or fax it to us. *Please do not send multiple copies of your application.*

Augusta Long Term Care

If the applicant lives in one of the following counties:

Androscoggin, Franklin, Kennebec, Knox, Lincoln, Oxford, Sagadahoc, Somerset, Waldo

Mail application to:

Office for Family Independence
State of Maine – DHHS
Attn: Long Term Care
35 Anthony Ave
11 State House Station
Augusta, ME 04333-0011

Or fax to: 207-624-8065

Machias Long Term Care

If the applicant lives in one of the following counties:

Aroostook, Hancock, Penobscot, Piscataquis, Washington

Mail application to:

Office for Family Independence
State of Maine – DHHS
Attention: Long Term Care
38 Prescott Drive
Machias, ME 04654-9984

Or fax to: 207-255-2078

Portland Long Term Care

If the applicant lives in one of the following counties:

Cumberland, York

Mail application to:

Office for Family Independence
State of Maine – DHHS
Attention: Long Term Care
151 Jetport Blvd
Portland, ME 04102-1946

Or fax to: 207-822-0350

What happens next?

When we get the application we will review the information and attempt to contact you for a phone interview. If we are not able to reach you by phone we will send you a letter telling you what other information we need.

Do not delay applying because something is not immediately available to you. This information can be obtained later in the interview process. Please tear off and keep this page for your records.

Long Term Care Programs

Nursing Facility Care

Assistance to help with the cost of services for individuals who expect to stay at least 30 days in a Nursing Facility. Nursing Facilities provide care or rehabilitative services for injured, disabled, or sick persons who are in need of daily care that can only be provided in a nursing facility. A third party will assess the medical need of the applicant to see if they medically qualify for this benefit.

Home and Community Benefits Waiver for the Elderly and for Adults with Disabilities (Section 19)

Assistance to help with the cost of in-home care and other services, designed as a package, to help eligible adults remain in their homes. To be eligible for this waiver, an applicant must meet nursing facility level-of-care requirements.

Residential Care Facility

Help with the cost of services for individuals who expect to stay at least 30 days in a Residential Care Facility. These facilities are for individuals that require less medical care than those in a Nursing Facility but still need services such as meals, homemaking, personal care, and/or medication administration.

Support Services Waiver for Members with Intellectual Disability or Autistic Disorders (Section 29)

Assistance to help with the cost of support services for adults with intellectual disabilities or Autistic Disorder (Section 29) who either live with their families or live on their own. To be eligible for this waiver, an applicant must require Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) level of care as set forth under the MaineCare Benefits Manual, Chapter II, Section 50.

Home and Community Benefits Waiver for Members with Intellectual Disabilities or Autistic Disorder (Section 21)

Assistance to help with the cost of support services for adults with intellectual disabilities or Autistic Disorder (Section 21) who live in their own home or in another home in the community. Assistance is provided in a community-based setting as an alternative for members who qualify to live in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). The assistance provides supplements, rather than replaces supportive, natural personal, family, work, and community relationships and complements.

Home and Community Based Waiver Benefit for Adults Age 21 and Older with Other Related Conditions (Section 20)

Assistance to help with the cost of applicable services available to adults with Other Related Conditions (ORC) who are 21 or older, meet institutional level of care and choose to live in the community with the support of this waiver. This waiver is designed to maximize the opportunity for members to achieve the greatest degree of self-sufficiency and independence chosen by the applicant.

Home and Community Based Waiver Benefit for Adults with Brain Injury (Section 18)

Assistance to help with the cost of applicable services available adults with brain injury who are 18 or older, meet criteria for care in an intermediate care facility or nursing facility and who choose to live in the community with the support of this waiver. This waiver is designed to maximize the opportunity for members to achieve the greatest degree of self-sufficiency and independence chosen by the member.

What do you want to apply for?

- Nursing Facility Care
- In Home Nursing Care and Community Benefits Waiver (Section 19)
- Residential Care Facility
- Support Services Waiver (Section 29)
- MR Waiver (Section 21)
- Other Related Conditions Waiver (Section 20)
- Adults with Brain Injury Waiver (Section 18)

Information about you, the applicant.

Your Name (First, Middle, Last, Suffix)

Social Security Number	Date of Birth	Place of Birth
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Mailing Address

City	State	Zip Code	Telephone Number
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Home Address (where you actually live, if different from above)

City	State	Zip Code	Have you lived elsewhere in the last 5 years? <i>If yes, provide mailing and home addresses.</i>
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Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed, date of death of your spouse: _____
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Are you a U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever served in the U.S. Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No
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If you are a Veteran, would you like assistance from the Maine Bureau of Veterans' Services? <input type="checkbox"/> Yes <input type="checkbox"/> No

Race (optional) (Check all that apply)	<input type="checkbox"/> White	<input type="checkbox"/> Black or African American	<input type="checkbox"/> Native Hawaiian or Pacific Islander	<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Other _____
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Information about your spouse.

Spouse's Name (First, Middle, Last, Suffix)

Social Security Number	Date of Birth	Place of Birth
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Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Does your spouse live with you? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If no, provide mailing and home addresses.</i>
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Spouse's Mailing Address	City	State	Zip Code
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Spouse's Home Address (only if different from above)	City	State	Zip Code
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Is your Spouse a U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has your Spouse served in the U.S. Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No
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If your Spouse is a Veteran, would they like assistance from the Maine Bureau of Veterans' Services? <input type="checkbox"/> Yes <input type="checkbox"/> No

Race (optional) (Check all that apply)	<input type="checkbox"/> White	<input type="checkbox"/> Black or African American	<input type="checkbox"/> Native Hawaiian or Pacific Islander	<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Other _____
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Income

Do you or your spouse receive any income? Yes No *If yes, list below. Examples of income types:*

Social Security Retirement (SSA/SSR)	Pension	Alimony
Social Security Disability (SSDI)	Military Retirement (DFAS)	Dividend or Interest
Supplemental Security Income (SSI)	Civil Service Annuity	Self-Employment
Veterans (VA) Compensation	Other Annuity Payments	Payment from a trust
Veterans (VA) Aid and Attendance	Railroad Retirement	Earnings (wages)
Veterans (VA) Pension	Long/Short Term Disability Payments	Workers Compensation

Your Income	Gross Amount	How often received?
<i>Example – Retirement Pension</i>	<i>\$500</i>	<i>Bi-Weekly</i>

Your Spouse's Income	Gross Amount	How often received?
<i>Example – Social Security Retirement</i>	<i>\$800</i>	<i>Monthly</i>

Do you or your spouse receive rent monthly from property? Yes No

Do you or your spouse receive money from someone who pays room and board? Yes No

Do you or your spouse receive money from irregular income during the year? Yes No

Assets

You will need to provide proof of all assets you and your spouse own or have an interest in. **Examples of assets:**

Cash	Resident Account at Facility	Stocks	Trust Funds
Checking Account	Certificate of Deposit (CD)	Stock Options	Annuities
Savings Account	IRA, 401K, or 403B	Bonds	Promissory Note
Credit Union Account	Keogh Plan	Profit Sharing	Direct Express Account
Money Market Account	Deferred Compensation	Safe Deposit Box	Other Financial Investments

Name(s) on Account	Asset Type (see above)	Name of Bank or Institution	Account Number	Current Balance or Value
<i>Example</i>	<i>Checking</i>	<i>Any Bank</i>	<i>12345</i>	<i>\$500</i>

Assets - Continued

Do you or your spouse have any Life Insurance Policies? Yes No *If yes, list below.*

Policy Owner	Policy Number	Individual(s) Covered	Insurance Company	Face Value	Cash Value

Do you or your spouse have a Funeral Plan, Pre-Paid Burial, or Mortuary Trust? Yes No *If yes, list below.*

Date Set Up	Who is it for?	Where are the funds held?	Is it irrevocable?	Amount
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	

Do you or your spouse own, or jointly own, any vehicles? Yes No *If yes, list below. Examples of vehicles:*

Cars Boats RVs Motorcycles ATVs Skidders
 Trucks Trailers Campers Snowmobiles Tractors Other motorized vehicles

Vehicle Type	Year	Make/Model	Owner Name(s)	Amount Owed

Do you or your spouse own, or jointly own, any property? Yes No *If yes, list below. Examples of property:*

Land Buildings Timeshare Camp
 Empty Lot Life Estate House Rental Property

Property Type	Full Address of Property	Owner Name(s)	Amount Owed

Would you return to your residence if you no longer need care in a Nursing Facility or Residential Care Facility?
 Yes No

Does your name or your spouse's name appear on anyone else's assets, financial accounts, or any type of property other than those already listed? Yes No *If yes, explain:*

Have you or your spouse recently received, or do either of you expect to receive, any retroactive government benefits, pay raises, lawsuit settlements, inheritances, lottery winnings or compensation of any other kind?
 Yes No *If yes, explain:*

Transfer of Assets

Have you, your spouse, or anyone acting on your or your spouse's behalf disposed of, sold, or given away anything of value within the last 60 months? Yes No *If yes, list below. Examples of things you may have owned:*

Personal Property
Real Estate

Money
Bank Accounts

Life Insurance
Stocks

Vehicles
Foreign Assets

Item Given Away	Value of Item	Person Who Gave Item Away

Have you, your spouse, or anyone acting on your or your spouse's behalf closed any savings, checking, or any other financial accounts within the last 60 months? Yes No *If yes, list below.*

Type of Account Closed	Date Closed	Reason for Closure

Expenses

If you are in a hospital or nursing facility, does your spouse live at home and pay shelter expenses? Yes No *If yes, list below. Examples of shelter expenses:*

Mortgage

Heat

Water/Sewer

Homeowners Insurance

Rent

Electricity

Trash Collection

Renters Insurance

Property Taxes

Telephone/Cell Phone

Lot Rent

Condo Association Fees

Type of Expense	Who Pays this Expense	Who is it paid to	Amount	How Often Paid

Is your heating cost included in your rent? Yes No

Does your mortgage payment include taxes and insurance? Yes No

Does anyone else live in the household of your spouse? Yes No

Other Medical Insurance

Do you have Medicare Coverage? Yes No Medicare Claim Number: _____

Part A Effective Date: _____ Part B Effective Date: _____

Part A Premium Amount: _____ Part B Premium Amount: _____

Does your Spouse have Medicare Coverage? Yes No Medicare Claim Number: _____

Part A Effective Date: _____ Part B Effective Date: _____

Part A Premium Amount: _____ Part B Premium Amount: _____

Other Medical Insurance – Continued

Do you or your spouse have any other medical insurance? Yes No *If yes, list below. Examples of insurance:*

Health Insurance Dental Insurance Vision Insurance Medicare Supplement Plan

Insurance Type	Name of Insured	Name of Insurance Company	Policy Number	Premium Amount	How Often Paid

Do you or your spouse have any Long Term Care Insurance? Yes No *If yes, list below.*

Name of Insured	Name of Insurance Company	Policy Number

Are you now, or have you in the past 90 days been in a hospital, nursing facility, or residential care facility?

Yes No *If yes, list below.*

Facility Name	Facility Address	Admission Date	Discharge Date

Do you need help with any medical bills incurred within the past three months? Yes No

If yes, which months? _____ Note: You must send proof of income and assets for these months.

Assistance with Application

Do you have a power of attorney, conservator, or court-ordered guardian? Yes No *If yes, list below.*

Person’s Name: _____ Type: _____

Address: _____ Phone: _____

Please provide a copy of the court order or the power of attorney.

Is there someone else who knows about your financial situation, and whom we may contact to help with this application? Yes No *If yes, list below.*

Person’s Name: _____ Type: _____

Address: _____ Phone: _____

Please fill out the Appointment of an Authorized Representative Form and Authorization to Release Form on page 7-10 of this application.

Did someone help you fill out this form? Yes No *If yes, list below.*

Person’s Name: _____ Phone: _____

Acknowledgements

Annuity Disclosure: You need to tell us about any annuity that you or your spouse have an interest in. In order to qualify for MaineCare Long Term Care, the State of Maine must be made a remainder beneficiary on an annuity if you have purchased or taken action on this annuity on or after February 8, 2006. The State of Maine may get any benefits remaining in the annuity after your death or the death of your spouse or disabled or minor child, up to the amount of MaineCare benefits paid. Please check and initial any that apply:

- I have at least one annuity. _____
- My spouse has at least one annuity. _____
- My spouse/I do not have any annuities. _____

Assignment of Rights to Medical Payments: If MaineCare pays a bill for you; then MaineCare has the right to collect for that bill from other medical support or medical insurance you may have.

Estate Recovery: If you are age 55 or older and receive MaineCare (Maine Medicaid) to pay for nursing facility services or home and community-based services, the State may make a claim on the assets of your estate (upon your death) to recover the money that MaineCare has paid for these services as well as for any hospital and prescription drug services related to these nursing facility or home and community-based services. No claim will be made if the only benefit you get is Medicare Savings Program (Buy-in). For more information about estate recovery call 1-800-977-6740.

Signature

I understand and agree to provide documents to prove what I have stated. **I understand and agree that federal, state and local officials or other persons and organizations may verify the information I have given.** If I have given incorrect information, my application may be denied and I may be charged with giving false information. I understand the questions on this application and the penalty for hiding or giving false information or breaking any of the rules in the penalty warning. I certify under penalty of perjury that my answers, including those concerning citizenship, alien status, or a conviction of a drug related felony are correct and complete for all persons applying for benefits.

Your signature or your representative's signature

Date

Please note: This application will not be accepted and cannot be processed without a signature.

Although an application with missing information will be accepted, please be aware that incomplete applications will increase the length of time it takes to make an eligibility decision.



Appointment of an Authorized Representative

You have the right to appoint an authorized representative to act on your behalf with the Department. If you want to name a person or organization as your authorized representative, use this form. We are committed to the privacy of your health information. Please read this form carefully.

Individual's Name: _____

Individual's Date of Birth: _____

Individual's Social Security Number: _____

Individual's Address: _____

I (individual named above) hereby appoint the following individual/organization to act as Authorized Representative for me.

Authorized Representative's Name: _____

Address: _____

Telephone number: _____

Email address: _____

Existing legal authority (if any) for individual/organization to act on my behalf (check all that apply and attach copy of documentation):

____ *Guardianship*

____ *Power of Attorney*

____ *Advance Healthcare Directive*

____ *Other:* _____

By making this appointment, I want my Authorized Representative to (check all that apply):

____ Sign and submit an application on my behalf (including an electronic application)

____ Sign and submit a recertification form on my behalf (including an electronic recertification)

____ Receive copies of Notices of Decision and all other written communications from the Department; I'm aware I may also need to complete an Authorization to Release Information form

____ Obtain Food Supplement benefits on behalf of my household

____ Act on my behalf in all other matters with the Department of Health and Human Services; I'm aware I may also need to complete an Authorization to Release Information form

- My authorized representative’s authority is limited to the task or tasks I have delegated, above.
- This appointment is valid until:
 - I change this appointment in writing by notifying the Department that this Authorized Representative is no longer authorized to act on my behalf; or
 - My Authorized Representative informs the Department in writing that he/she is no longer acting as my Authorized Representative.
- I understand that taking back this appointment does not apply to any documents signed by or sent to my Authorized Representative before I took back the appointment.
- I understand that if I want my Authorized Representative to receive copies of the Notices of Decision and all other written communications from the Department, the information shared will be for all programs in which I participate that are administered by the Department.
- I understand that an appointment of a representative for the TANF or Food Supplement programs is a representative for both me and my household and that my household will be liable for any over issuance of Food Supplement or TANF benefits that results from erroneous information given by the authorized representative.

I am signing this form voluntarily, and I have the right to a signed copy of this form if I request one.

Signature of the Individual: _____ Date: _____

For the Authorized Representative

I (Individual or Organization Named as Authorized Representative) hereby agree to:

- Fulfill all above-designated responsibilities on behalf of the individual who appointed me as his/her Authorized Representative;
- Maintain the confidentiality of any information regarding the individual who appointed me as his/her Authorized Representative;
- Adhere to the regulations 42 C.F.R. § 431(F) and at 45 CFR § 155.260(f) (relating to confidentiality of information), 42 C.F.R. § 447.10 (relating to the prohibition against reassignment of provider claims as appropriate for a facility or an organization acting on the facility’s behalf), as well as all other applicable state and federal laws concerning conflicts of interest and confidentiality of information.

Signature of the Authorized Representative: _____ Date: _____



Authorization to Release Information

We are committed to the privacy of your health information. Please read this form carefully.

<input type="checkbox"/> Office of MaineCare Services	<input type="checkbox"/> Substance Abuse and Mental Health Services
<input type="checkbox"/> Office for Family Independence including Medical Review Team	<input type="checkbox"/> Office of Child and Family Services
<input type="checkbox"/> Maine Centers for Disease Control and Prevention	<input type="checkbox"/> Office of Aging and Disability Services
<input type="checkbox"/> Dorothea Dix Psychiatric Center	<input type="checkbox"/> Office of Administrative Hearings
<input type="checkbox"/> Riverview Psychiatric Center	<input type="checkbox"/> Other:

Individual's Name:	Individual's Date of Birth:
	Individual's Social Security Number:

Individual's Address:

Street	Town/City	State	Zip Code
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Records to be released, including written, electronic and verbal communication:

All Healthcare, including treatment, services, supplies and medicines

Claims Information Billing, payment, income, banking, tax, asset, and/or other information regarding eligibility for DHHS program benefits such as MaineCare

Other: _____

Limit to the following date(s) or type(s) of information:
(e.g. "lab test dated June 2, 2013" or "hospital records from 1/1/14 - 1/15/14")

I authorize the DHHS office(s) checked above to: Release my information to: Obtain my information from:

Name: _____

Address: _____

Street	Town/City	State	Zip Code
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Fax No., where applicable: _____ Phone No. to verify Receipt of Fax _____

If requesting that electronic information be transmitted by email, please clearly print the email address below:

I understand that DHHS systems may not be able to send my information securely through email. I understand that email and the internet have risks that DHHS cannot control and that the information possibly could be read by a third party. I accept those risks and still request that DHHS send my information by email. Initials _____

Please allow the office(s) named above to disclose my information for the following purpose(s):

For a legal matter, including an administrative hearing To see if I qualify for insurance coverage or benefits

By initialing below, I agree to disclose the following types of records:

_____ **Mental health treatment provider or program**

_____ **Substance/alcohol/drug Abuse treatment provider or program**

_____ **HIV infection status or test results:** Maine law requires us to tell you that releasing this information may have implications. Positive implications may include giving you more complete care, and negative implications may include discrimination if the data is misused. DHHS will protect your HIV data, and all your records, as the law requires.

I (individual/personal representative of individual) permit DHHS to release and/or obtain my records as written on Page 1 of this form. I understand and agree to the following:

- This form will expire one year from the date I sign below, unless I revoke (take back) my permission sooner by completing, signing and sending in the Revocation Form found on the DHHS website at <http://www.maine.gov/dhhs/privacy/index.shtml>. I may call DHHS at 207-287-3707 and ask for the office where I receive services if I need help revoking this form.
- I understand that taking back my permission to release my information does not apply to the information that was already shared after I signed this form.
- If I take back my permission to release my information, or if I refuse to release some or all of my healthcare or insurance information, that may result in improper diagnosis or treatment, denial of insurance coverage or a claim for health benefits, or other adverse consequences.
- This form permits the people or offices listed on Page 1 to speak to each other for the purpose(s) on this form.
- If I am disclosing healthcare information, I agree that records of other providers (such as doctors, hospitals, and counselors) in my file are included in this release.
- Unless I am applying for benefits, DHHS will not condition my treatment, payment for services, or benefits on whether I sign this form.
- I have the right to make a written request to review my records. If I wish to receive a copy of my healthcare or billing information, a fee may be charged as permitted by law.
- If I want to review my mental health program or provider records before they are released, I must check **THIS BOX**. I understand that the review will be supervised.
- DHHS offices will keep my information confidential as required by law. If I give my permission to share my records with people who are not required by law to keep them private, they may no longer be protected by federal confidentiality laws.
- If alcohol or drug treatment or program records are included in this release, federal law requires the person sharing those records to include a notice saying that such information may not be re-released or shared without my written permission, unless required or permitted by law.
- I am signing this form voluntarily, and I have the right to a signed copy of this form if I request one.

Date: _____ Signature _____

Personal Representative's authority to sign: _____