Maryland Department of Health and Mental Hygiene

PAC
Maryland Primary Adult Care Program
Eligibility Application

The **Maryland Primary Adult Care Program** (PAC) covers primary health care, certain outpatient mental health services, and prescription drugs for certain low income eligible Maryland residents. Applicants must be 19 years of age or older, not eligible for Medicare, and a U.S. citizen or a qualified alien who meets all requirements for benefits.

If you qualify for the program, you will be required to join a managed care organization (MCO). There is no fee to enroll, no deductibles, no monthly premium, and no annual benefit limit. There are small co-payments for prescriptions.

Because income and asset limits are subject to change, please see our website, www.dhmh.state.md.us/mma/mmahome or call 1-800-226-2142 for the most current information. The Maryland Relay Service is available at 1-800-735-2258 for individuals with disabilities.

Important Application Information and General Instructions

- **Read** all the instructions for each part before filling it out.
- **Print** clearly. All information must be readable.
- You must **answer all questions**. Do not leave any blank spaces. Put a "**0**" or "**NA**" in each space that does not apply.
- You must include written documentation of all requested information such as Social Security number, citizenship or lawful immigration status, identity and work history.
- You must include written proof for all income and assets.
- Send copies of documentation only. Original documents will not be returned.
- If you have little income or assets, the person or agency providing your food and shelter must submit a supporting statement.
- Applications will NOT be accepted via email or fax.
- The process to determine eligibility takes up to 45 days. Notification of the eligibility determination will be sent by mail.
- If you are determined eligible for PAC, you must choose a managed care organization (MCO) or the State will choose an MCO for you.
- Attention women enrolled in the Maryland Family Planning Program: If you are approved for PAC, your Family Planning will be cancelled. You cannot be in both programs at the same time. PAC has more benefits including all family planning services except sterilization. If you have one scheduled, or plan to have one in the next few months, you should send in your application after you have that done.

When finished: Please remove instructions and mail the application page and required documentation to:

PAC Eligibility Services
P.O. Box 386
Baltimore, MD 21203-0386

Instructions for Completing the PAC Application

Important: Print with black or blue ink or type in the required information

A. Print your First Name, Middle Initial, Last Name, and Home Phone Number including area code.

B. Fill in your complete home address for where you live. **You must be a Maryland resident.** If you are homeless, please write "homeless" in the home address line and fill in the county and state. If you live in Baltimore City, enter "Baltimore City" for the county.

C. If you have a Post Office box to get mail, list it here. If you want a **representative** or someone else to get your mail, put that person's name and address in the mailing address box. You can include a message phone number in the message phone box. If you enter "homeless" in section B, you must enter a mailing address in section C.

D. Circle your current living arrangement.

E. If you are applying for PAC, do your parents intend to claim you as a dependant on the current year's income tax return? If they will not be claiming you, answer No on line E.

F. Circle your current marital status. Submit a copy of your separation or divorce decree, including any alimony and/or child support.

G. Write information for yourself, your spouse, and all of your children (under age 19) **living with you**. Do not list your spouse or child if they do not live with you. Children under 19 years old must be listed to determine family size, but are not eligible for PAC. If you need more space to list additional children under age 19, put all of their information on a separate sheet.

H. Write first name, middle initial and last name for yourself, your spouse, and children. Send in proof of identity for applicants only. This can be a valid Maryland Driver's License, MVA ID, or other government photo identity card.

I. Social Security numbers are used only to identify applicants and to help verify total household income. **Persons not applying for PAC benefits are not required to provide a Social Security number.**

J. Write the date of birth for yourself, your spouse, and children.

K. Write the relation of each person to you, such as spouse, son, daughter, stepchild or adopted child. Do **not** list grandchildren, foster children, other relatives, or others.

L. Check race. You may check more than one race for each person. Race information is optional.

M. Check whether ethnicity is Hispanic or Latino. Ethnicity information is optional.

N. Check male or female.

O. Check U.S. Citizenship status. If you check "YES", send proof of citizenship (such as a birth certificate or naturalization approval). If you check "NO", send proof of alien status from the Immigration and Naturalization Services (INS) that includes the date the applicant became a permanent alien resident and the alien registration number. **You are not required to provide this information for persons not applying for PAC benefits.**

P. Please check "YES" or "NO" to let us know who is applying for PAC.

Q. Primary language is included to help provide an interpreter if needed. Language information is optional.

R. **Persons eligible to apply for Medicare are not eligible for PAC.** However, a non-Medicare spouse may be eligible for PAC. If you are 65 or over, and do not have Medicare, you must send proof that you applied for Medicare from the Social Security Administration.

S. Check sections for visually or hearing impaired if they apply to you.

This space is for PAC office use only. Do not write or mark on or near the bar code or obscure it in any way. Do not photocopy.

UIIN:_____

PAC Application

A	First Name	MI	Last Name		Home Phone ( )	
B	Home Street Address (Include Apt)		City	ST	Zip	County
C	Mailing Name & Street Address or P.O. Box (If different or for a representative)					
	City	ST	Zip	Message Phone( )		
D	**Living Arrangement** (*Circle One*)	At Home Nursing Home/Long Term Care Facility Assisted Living Homeless Correctional Facility Migrant Camp Other: _____				
E	**Dependent Adult** (*Circle One*)	Do your parents intend to claim you as a dependant for the current year's income tax return? Yes No				
F	**Marital Status** (*Circle One*)	Never Married Married Separated Divorced Widowed				

Please read the instructions for sections G – P before completing for yourself and your family living with you

		Self	**Your Spouse**	**Your Child**	**Your Child**
G					
H	First Name and Middle Initial				
	Last Name				
I	Social Security No.				
J	Date of Birth				
K	Relation to applicant	SELF	SPOUSE		
L	Race	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ White	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ White	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ White	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ White
M	Hispanic/ Latino	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
N	Sex	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
O	U.S. Citizen?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
P	Applicant?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Q	Family's Primary Language:	Do you need an interpreter? ☐ Yes ☐ No
R	If you and/or your spouse have Medicare, write your and/or your spouse's complete Medicare claim number(s) as it appears on your Medicare card(s) on the lines below. Medicare Claim Number(s): (Self)_____(Spouse)_____	
S	Are you or any other household member visually impaired? ☐ Yes ☐ No If yes, do you want large print notices? ☐ Yes ☐ No Are you hearing impaired? ☐ Yes ☐ No If Yes, do you need an interpreter? ☐ Yes ☐ No	

Please Turn Page and Complete The Other Side

PAC FINANCIAL INFORMATION

Income	Self	How Often	Spouse	How Often	All Children	How Often
Social Security	$		$		$	
Widow's Pension	$		$		$	
SSI or SSDI	$		$		$	
Railroad Retirement	$		$		$	
Black Lung Benefit	$		$		$	
Federal Civil Service	$		$		$	
Pension / Retirement	$		$		$	
Veteran's Benefit	$		$		$	
Unemployment	$		$		$	
Workers Compensation	$		$		$	
Insurance Benefit	$		$		$	
Interest / Dividends	$		$		$	
Trust /Annuity	$		$		$	
Wages	$		$		$	
Self Employment	$		$		$	
Other Income	$		$		$	

Assets	Self	Spouse	Children
Checking	$	$	$
Savings / CD	$	$	$
IRA / Keogh	$	$	$
Stocks / Bonds	$	$	$
Real Property	$	$	$
Trust Fund	$	$	$
Other	$	$	$

Do you have other insurance, including **Medicaid** that pays for health care? □ Yes □ No
If yes, please write the name of the insurance company or program and your ID/ policy number.

Are you suing or have you won a lawsuit to recover medical care costs? □ Yes □ No

I have read and agree to the rights and responsibilities listed elsewhere in this application packet. I swear and affirm under penalty of perjury that all the information I gave is true, correct, and complete to the best of my ability, belief, and knowledge.

Applicant's Signature: **Date:**

Spouse's Signature: **Date:**

Representative's Signature (if applicable): **Date :**

Internal Use Only

INSTRUCTIONS FOR COMPLETING FINANCIAL SECTION INCOME

YOU MUST ANSWER ALL QUESTIONS. DO NOT LEAVE ANY BLANK SPACES. PUT A "0" OR "NA" IN EACH SPACE THAT DOES NOT APPLY.

INCOME

1. List the **GROSS** amount (**before any deductions**) and frequency of **all** income received by you, your spouse, and your children younger than 19 years old, if they live with you.
2. You must submit a copy of a **current benefit statement** from the agency or company that sends you the money.
3. If you receive more than one Social Security benefit you must list both.
4. If you receive **SSI** or **SSDI**, please **circle** which one(s) you receive. We count these incomes differently.
5. You must submit **the most current statement** of payments of dividends, trusts, annuities, and all other incomes listed.
6. If you are working, you must submit **complete** copies of four (4) most recent and consecutive pay stubs or a signed statement, on letterhead, from your employer giving this same information or expected earnings for the next six (6) months. Wages include all money you get for a job, tips, and commissions. Failure to do this will result in a delay in your application.
7. If you are **not** currently working, but have worked in the **last six (6) months**, you must **submit a statement** from your former employer giving your last day worked, **or** proof that you have applied for unemployment.
8. If you are **self-employed**, you must submit a **signed copy** of your latest **tax return and schedule C** showing business profit or loss.
9. **Other Income** includes things like alimony, child support, rent paid to you, money received on a regular basis, etc. Please list the type of income as well as the amount and frequency. You must submit supporting documentation such as receipts, child support enforcement forms, or a letter from the person giving you the money.
10. If you have little or no income, the person or agency providing your food and shelter must submit a supporting statement.

ASSETS

1. List the value **as of the 1st day of this month** for all assets owned by you, your spouse, and your children younger than 19 years old living with you. You must submit a current statement from your bank or other institution showing the amount and ownership of the asset.
2. Do not list the home you live in. Submit the property tax statement of any other real property you own, either by yourself or with others.
3. Cash that you have on hand is an asset. **Checking, CDs, IRAs, Keoghs**, and other **savings** accounts are assets and must be listed and proof must be sent. This includes any direct deposit accounts.
4. Trust funds are counted as an asset, unless you submit proof that you do not have access to it.

PLEASE REMEMBER TO SIGN AND DATE YOUR APPLICATION. AN UNSIGNED APPLICATION IS NOT VALID AND WILL BE RETURNED. A REPRESENTATIVE MAY SIGN ONLY IF THE APPLICANT IS PRESENT AND UNABLE TO SIGN.

Revised 12/2006. Previous editions are obsolete.

PAC RIGHTS AND RESPONSIBILITIES

Please read and save these rights and responsibilities for your records.

I understand and agree to the following:

1. This application constitutes a request for the Primary Adult Care Program only.

2. If I am determined eligible for PAC, I understand that I will be required to choose a managed care organization (MCO) or the State will choose one for me.

3. My Social Security number will be used to verify identity and eligibility. My Social Security number may also be used to cross-match information in federal, state, and local government files.

4. The Department may conduct independent verification of the statements made by me on this application.

5. I must notify the Department within 10 business days of any changes in the household income or assets. I must also notify the Department of a change of address or living arrangements.

6. I understand that the information given on this form is confidential and will only be used for the purpose of program administration.

7. I have the right to appeal any decision made concerning my eligibility or benefits.

8. I am required by law to assign to the State all third party payments and to cooperate with the State in securing such payments.

9. I certify that everyone requesting benefits is a U.S. citizen or qualified alien.

10. The State may recover monies spent on the cost of care from the estate of individuals over 55 years old who received program benefits and who do not have a living spouse or a surviving child who is under 21 or blind or disabled.

11. I agree to the release of personal and financial information from any financial institution, insurance company, present or past employer, federal, state or local governmental agency, private or public organization to the Department for eligibility determination.

12. PAC will not permit inspection of your personal information, or make it available to others, except as permitted by federal and State law.

YOUR APPLICATION MUST BE COMPLETE AND SIGNED OR THE DECISION IN YOUR CASE WILL BE DELAYED. IF YOU HAVE QUESTIONS, CALL OUR OFFICE AT 1-800-226-2142 BEFORE YOU SEND YOUR APPLICATION.