MARYLAND DEPARTMENT OF HUMAN RESOURCES
Family Investment Administration
Long Term Care Medical Assistance
Request for Information to Verify Eligibility

Local Department:	**Date:**
Address:	**Case Name**: **Address:**
	CID#: **(Please use this number on all correspondence)**
	Case Manager:
	Telephone Number:

Ms./Mr:_____ **for:**_____

After you give us a signed application, we have 30 days to make a decision about eligibility for Long Term Care Medical Assistance. To make that decision, we must have the verifications checked NEED.
Please mail or bring them to our office at the address above by _____. Please keep copies of all information that you supply.
Questions? Would you like an in-person meeting? Call your case manager at the number above.

Key: N/A - Not Applicable **OK - Already have or do not need** **NEED - Please Provide**

I. BASIC REQUIREMENTS

N/A	OK	NEED	
☐	☐	☐	**Signed, dated application** (DHR/FIA CARES 9709)
☐	☐	☐	**Consent to Release Information** - Nursing home to DSS worker (DES 2002 form)
☐	☐	☐	**Consent to Release Information** - DSS worker to nursing home (DES 2005 form)
☐	☐	☐	**DHMH 257** (Medical certification initiated by Nursing Facility)

II. DEMOGRAPHIC DATA

N/A	OK	NEED	
☐	☐	☐	**Proof of Social Security Number** (SSA 1099, SSA letter, or other SSA verification)
☐	☐	☐	**Medicare Card** (front and back of the card)
☐	☐	☐	**Alien status**
☐	☐	☐	**Proof of disability** (DHR/FIA 700, DHR/FIA 827, DHR/FIA 3368, if applicable and verification that the applicant has a pending SSA claim)
☐	☐	☐	**Marriage Certificate/Divorce Decree**
☐	☐	☐	**Spouse's Death Certificate**

III. INCOME VERIFICATION

N/A	OK	NEED	
☐	☐	☐	**Income Tax Returns** (IRS, 1-800-908-9946) for the tax year(s) specified_____
☐	☐	☐	**Social Security Benefits** (award letter, SSA 1-800-772-1213) For_____
☐	☐	☐	**Private Pension** (gross benefit/deductions, if any) For_____
☐	☐	☐	**Application for any private public benefit** to which the applicant may be entitled
☐	☐	☐	**Other** (annuities, alimony, royalties, income from loans, LTC insurance, etc.)_____

IV. ASSETS

Checking, Savings, Certificates of Deposit, Stocks, Bonds, Mutual Funds, etc.
(for the month of application and any additional statements specified)

N/A	OK	NEED	NAME	ACCT. #	COMMENTS (which months, etc.)	FOR:
☐	☐	☐	_____	_____	_____	_____
☐	☐	☐	_____	_____	_____	_____
☐	☐	☐	_____	_____	_____	_____
☐	☐	☐	_____	_____	_____	_____
☐	☐	☐	_____	_____	_____	_____
☐	☐	☐	_____	_____	_____	_____

(PLEASE GO TO PAGE 2)

Original: Representative Yellow: Long Term Care Facility Pink: Case Record

Case Name:	CID #:

Closed Accounts - final statement (accounts which were active/open at any time in the past 60 months)

N/A	OK	NEED	NAME	ACCT. #	COMMENTS (which months, etc)	FOR:
☐	☐	☐	_____	_____	_____	_____
☐	☐	☐	_____	_____	_____	_____
☐	☐	☐	_____	_____	_____	_____
☐	☐	☐	_____	_____	_____	_____

Life Insurance - Form DES 2001, letter from the Insurance Company (stating original face value, current cash value, dividend value and loans against policy)

N/A	OK	NEED	Company Name	Policy Number	For:
☐	☐	☐	_____	_____	_____
☐	☐	☐	_____	_____	_____
☐	☐	☐	_____	_____	_____
☐	☐	☐	_____	_____	_____

Home Property/Other

N/A	OK	NEED	Primary/other:_____/other: _____ for: _____		
☐	☐	☐	☐ Mortgage Statement	☐ DHMH 4245 Physician's Report	☐ Deed (s)
☐	☐	☐	☐ State Property Tax Assessment	☐ DHMH 4255 Statement of Intent	

N/A	OK	NEED	Primary/other:_____/other: _____ for: _____		
☐	☐	☐	☐ Mortgage Statement	☐ DHMH 4245 Physician's Report	☐ Deed (s)
☐	☐	☐	☐ State Property Tax Assessment	☐ DHMH 4255 Statement of Intent	

Funeral Arrangements

N/A	OK	NEED	Bank Account Statements, Revocable, Irrevocable and Itemized Contracts:	For:
☐	☐	☐	_____	_____
☐	☐	☐	_____	_____
☐	☐	☐	_____	_____

V. ALLOWANCES

Health Insurance

N/A	OK	NEED	
☐	☐	☐	Other Health Insurance (ID Card - front and back, actual bill premium or canceled check)

Residential Allowance

N/A	OK	NEED	
☐	☐	☐	DHMH 4245 Physician's Report

Spousal Allowance

N/A	OK	NEED	
☐	☐	☐	Income Expense Reporting Form for Community Spouse (DES 2003)
☐	☐	☐	Other _____

☐ **ADDITIONAL INFORMATION NEEDED**_____

_____

_____

_____

You must provide the information and verifications checked on this form. You may also receive a request to provide additional documentation after the review of the materials you provide. The application you submitted is good for only six (6) months from the date you applied and a new application will be required if you do not provide all the required verification within six (6) months from the date of the application.