MARYLAND DEPARTMENT of HUMAN RESOURCES
MARYLAND DEPARTMENT of HEALTH AND MENTAL HYGIENE
SSI RECIPIENT/COMMUNITY- ELIGIBLE
LONG-TERM CARE/WAIVER MEDICAL ASSISTANCE

Check List of Items Needed for Your Long- Term Care/Waiver Application

(Please keep this page for your records)

SEND PROOF If you do not already receive Long-Term Care Medical Assistance, we need the items listed below to process your application. Please send as many items as you can with this application. Please send copies, **do not send originals.** In some cases, we may need to request additional documents not listed below. If so, we will give you time to supply the additional documents.

DO NOT WAIT TO APPLY

The following items are needed from you and your spouse to determine if you are eligible for Long-Term Care Medical Assistance:

- ☐ Bank and Financial statements on all accounts owned and co-owned as of the first of the month
- ☐ Power of Attorney of Legal Guardianship Documents (if any)
- ☐ Long-Term Care Insurance Policies
- ☐ Current statement of retirement accounts
- ☐ Current statement of IRA or Keogh Accounts
- ☐ Current statements of:
  - ☐ Stock
  - ☐ Bonds
  - ☐ Money Market Funds
  - ☐ Mutual Funds, Treasury, or Other Notes
  - ☐ Certificates
- ☐ Current gross monthly income from all sources including:
  - ☐ VA Pensions
  - ☐ Railroad Retirement
  - ☐ Pensions
  - ☐ Annuities
- ☐ Face and cash value of Life Insurance policies (current annual statement)
- ☐ Current statement for burial accounts
- ☐ Burial Plot Deeds
- ☐ Life Estate Deeds
- ☐ Promissory Notes
- ☐ Mortgage Notes and Mortgage Deeds
- ☐ Trusts (including appendices, schedules, annual accountings, and amendments)
- ☐ Private Health Insurance Cards including Medicare (copy of both sides)
- ☐ Health Insurance premium amounts

If you want to find out if your spouse can keep some of your monthly income, please provide:

- ☐ Spouse's gross monthly income
- ☐ Condo fees
- ☐ Mortgage
- ☐ Lot Rent
- ☐ Property tax bill
- ☐ Rent
- ☐ Electric bill

Please continue by completely answering every question on the attached application. If you need more space to complete the application, please attach additional sheets.

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MARYLAND DEPARTMENT of HUMAN RESOURCES
MARYLAND DEPARTMENT of HEALTH AND MENTAL HYGIENE
SSI RECIPIENT/COMMUNITY ELIGIBLE
LONG TERM CARE/WAIVER MEDICAL ASSISTANCE
APPLICATION

Date Signed Application Received in Local Department MUST BE DATE STAMPED

Worker Name

Case Number

S

USE THIS FORM ONLY FOR SSI RECIPENT/COMMUNITY- ELIGIBLE

SECTION A – APPLICANT INFORMATION: Please tell us about yourself.

I am applying for:

☐ Long-Term Care Facility and/or ☐ Home and Community-Based Services Waiver

Last Name _____ First Name _____ Middle _____ Suffix _____ (Jr., Sr. etc) Maiden Name or Other Name _____

Social Security Number _____ Date of Birth: (Month,Day,Year) _____

What is your home address or the address of your nursing facility? Gender ☐ Male ☐ Female

Street _____ City _____ State _____ Zip _____

Telephone Number _____

Is this your mailing address? ☐ Yes ☐ No
*(If, no please provide your mailing address information in **Section P**)*

Previous Address:

Street _____ City _____ State _____ Zip _____

Did you or your spouse own this home?
☐ Yes ☐ No

Marital Status
☐ Single
☐ Married
☐ Divorced
☐ Separated
☐ Widowed

What is your primary language?

_____

Do you need an interpreter? ☐ Yes ☐ No

If you are not registered to vote, would you like to receive a voter registration form?
☐ Yes ☐ No ☐ Already registered to vote

SECTION B – BENEFIT STATUS:

Are you currently receiving Medicaid (Medical Assistance)? ☐ Yes ☐No

If yes, please provide your Medicaid (Medical Assistance) ID # _____

Are you a resident of Maryland? ☐ Yes ☐ No

Are you receiving Medicaid (Medical Assistance) benefits from another state? ☐ Yes ☐ No If yes, please list the state. _____

Do you need Medicaid (Medical Assistance) for medical bills incurred in the past 3 months?
If yes, you will need to provide copies of the bills to your case manager.
☐Yes ☐ No

SECTION C – SPOUSE INFORMATION: Tell us about your spouse.

Last Name	First Name	Middle	Suffix	Maiden Name or Other Name
_____	_____	_____	_____ (Jr., Sr. etc)	_____

Spouse's Social Security Number

_____

Street _____ City _____ State _____ Zip _____

Telephone Number _____

Do you or your spouse own this home?
☐ Yes ☐ No

SECTION D – AUTHORIZED REPRESENTATIVE: Do you authorize someone to represent you **in this application**? If so, please tell us about your authorized representative.

Last Name _____ First Name _____ Middle _____ Suffix _____ (Jr., Sr. etc) Maiden Name or Other Name _____

Street _____ City _____ State _____ Zip _____

Telephone Number _____

What is the authorized representative's relationship to you? _____

SECTION E – VETERAN INFORMATION: If you are a veteran, a disabled widow (er), or a disabled child of a deceased veteran, fill in this section:

SEND PROOF *Please send a photocopy of the front and back of your military service card.*

Veteran's Name _____ Relationship to Veteran _____ Veteran's Status _____ Military Service Number _____

SECTION F – MEDICAL INSURANCE: If the applicant/recipient is insured, fill in this section: If you have more than one policy, place additional information in **Section P**.

SEND PROOF *Please send a photocopy of the front and back of your insurance card (s) and verification of the premium amounts you pay.*

Policy Number _____ Group Number _____ Policy Holder Name _____

Relationship to Policy Holder _____ Policy Effective Dates From: _____ To: _____

Policy Holder Address

Street _____ City _____ State _____ Zip _____

Telephone Number _____

Insurance Company

Insurance Company Name _____

Street _____ City _____ State _____ Zip _____

Telephone Number _____

SECTION G – BENEFITS AND OTHER INCOME OF APPLICANT OR SPOUSE: Please tell us about any income or benefits that you or your spouse are currently receiving, have applied for, or have been denied. Check all below that apply. If you check a benefit, fill in the details in the boxes below.

SEND PROOF *Please send current copies of statements that verify the gross amount of income you receive.*

☐ SSI (Supplemental Security Income) Please write your claim # _____
☐ SSI (Supplemental Security Income): **Spouse,** Please write the claim # _____
☐ Social Security Income: Please write your claim # _____
☐ Social Security Income: **Spouse,** Please write the claim # _____
☐ Railroad Retirement Benefit: Please write your claim # _____
☐ Railroad Retirement Benefit: **Spouse,** Please write the claim # _____
☐ Alimony
☐ Worker's Compensation
☐ Union Benefits
☐ Unemployment Benefits
☐ Business Income
☐ Rental Income
☐ Compensation from a Legal Settlement
☐ Lump Sum Cash Amount
☐ Black Lung Benefits
☐ Veteran's Pension/Benefits/Compensation/Aid and Attendance
☐ Pension or Retirement
☐ Disability/Sick Benefits
☐ Civil Service Annuity
☐ Other (Please Describe) _____

Type of Benefit or Income	Receiving Income or Benefits?	Person(s) Receiving Income or Benefits	Amount	Application Status	Application or Denial Date
	☐ Yes ☐ No	☐ Self ☐ Spouse	$ $	☐ Applied for ☐ Denied	
	☐ Yes ☐ No	☐ Self ☐ Spouse	$ $	☐ Applied for ☐ Denied	
	☐ Yes ☐ No	☐ Self ☐ Spouse	$ $	☐ Applied for ☐ Denied	
	☐ Yes ☐ No	☐ Self ☐ Spouse	$ $	☐ Applied for ☐ Denied	

SECTION H – INCOME FROM WORKING: Please tell us about any income you or your spouse are currently receiving from working, including any sick leave payments.

SEND PROOF *Please send copies of any proof of pay, such as a paystub. If you need additional space to complete this section, please use* ***Section P*** *or attach additional sheets.*

Employer Name _____	Type of Job _____
Employer Address Street _____ City _____ State _____ Zip _____ Telephone Number _____	

Date Job Began _____	Date Job Ended _____	Gross Wages per Pay Period, including tips and commissions. $ _____ per _____
Hours per Pay Period _____	How often do you get paid? ☐ Weekly ☐ Biweekly ☐ Monthly	If the job has ended, what is your last expected pay date? _____

SECTION I – ASSETS: Please tell us about your assets as of the first of the month. Please check all below that apply for each asset. List all assets owned by you or your spouse individually, jointly, or with other persons. If you have more than one asset of the same type, check the "Other" boxes below.

SEND PROOF *Please send copies of statements that verify the value of the assets.*

☐ Cash on Hand ☐ Checking Account ☐ Savings Account ☐ Credit Union Account ☐ Trust Account
☐ IRA or Keogh Account ☐ Other Retirement Account ☐ Stocks and Bonds ☐ Treasury or Other Notes ☐ Annuity
☐ Ownership in Company ☐ Patient Fund Account ☐Other _____ ☐Other _____

Asset Type	Owner	Amount	Account Number	Institution Name
_____	_____	$ _____	_____	_____
_____	_____	$ _____	_____	_____
_____	_____	$ _____	_____	_____

SECTION J – OTHER ASSETS: Please tell us about any other assets you own and assets jointly owned with other individuals. This could include livestock, recreational vehicles, or any other property of value such as collections of antiques, coins, jewelry, or stamps.

SEND PROOF *Please send copies of current statements or documents that establish the fair market value of the asset (s) as well as the amount owed.*

Asset Type	Current Fair Market Value	Current Amount Owed	Owners (s)
	$	$	
	$	$	

SECTION K – POTENTIAL ASSET OR INCOME: Please tell us about any accident settlement, trust fund, inheritance, or any other money, property, or assistance you expect to receive.

SEND PROOF *Please send copies of current statements or documents that describe the nature, amount, and payment schedule of the asset.*

Asset Type _____	Lawyer Name _____
Explanation _____	Lawyer Telephone Number _____
Anticipated Date of Receipt _____	

SECTION L – TRANSFER OF ASSETS: Please tell us about any assets that you sold, traded, gifted, or disposed of as of the first of the month. This could include personal and real property, motor vehicles, stocks, bonds, cash or other assets.

SEND PROOF *Please send copies of current statements or documents that verify the date the asset was transferred, the value of the asset at the time of the transfer, and the amount you received for the transferred asset. If you need additional space to complete this section, please use* ***Section P*** *or attach additional sheets.*

Transfer Date	Type of Asset	Value of the Asset at the Time of the Transfer	Who Received the Asset and the Reason for the Transfer	Amount Received
				$
				$

SECTION M – LIFE INSURANCE, LONG-TERM CARE INSURANCE AND FUNERAL PLANS: Please tell us about any life insurance, Long-Term Care (LTC) insurance or pre-paid burial plans or funds that you own. Please list all policies and funds, no matter who pays for them.

SEND PROOF *Please send a copy of the declaration page of each policy. Please also send copies of current statements to verify the cash value of each policy, if applicable.*

Original Face Value or Value of Plan	Cash Value	Type of Plan	Policy Number or Account Number	Policy Owner	Company, Funeral Home, or Bank Name
$	$	☐ Life Insurance ☐ LTC Insurance ☐ Burial Plan			
$	$	☐ Life Insurance ☐ LTC Insurance ☐ Burial Plan			

SECTION N – SPOUSAL IMPOVERISHMENT: If you have a living spouse, fill in this section. List all assets owned in the month the applicant was admitted to a Long-Term Care Facility. Include all assets owned individually or jointly by the applicant, or owned individually or jointly by your spouse.

SEND PROOF *Please send copies of statements that verify the value of the assets.*

☐ Cash on Hand ☐ Checking Account ☐ Savings Account ☐ Credit Union Account ☐ Trust Fund
☐ IRA or Keogh Account ☐ Other Retirement Accounts ☐ Stocks and Bonds ☐ Treasury or Other Notes
☐ Annuity ☐ Ownership in a Company ☐ Patient Fund Account ☐ Other

Asset Type	Owner	Amount	Account Number	Institution Name
		$		
		$		
		$		
		$		
		$		
		$		

SECTION O – RESIDENTIAL, SPOUSAL, OR DEPENDENT ALLOWANCE:

Have you or your spouse been in an Institution/Long-Term Care Facility in the past? ☐ Yes ☐ No
If yes, please provide the following:

Date Entered Institution/Long-Term Care Facility _____ Name of the Facility_____

Is there a spouse, child under 21, or any other dependent relatives at home? ☐ Yes ☐ No

If yes, fill in the section below. If you need additional space for assets for dependent children and relatives at home, please use **Section P** or attach additional sheets.

Name	Relationship	Age	Gross Monthly Income **SEND PROOF**	Type of Income	Value of Asset **SEND PROOF**	Asset Type
			$			
			$			
			$			

If the applicant/recipient intends to return home within six months and if there is no spouse, child under 21, or other dependent relatives, fill in the section below:

Rent/Mortgage	Utilities	Heat (If separate from utilities)	Property Taxes
$ _____	$ _____	$ _____	$ _____

Home Owners Insurance	Condo Fees	Other Shelter Costs (Specify)	Other Shelter Costs (Specify)
$ _____	$ _____	$ _____	$ _____

SECTION P – ADDITIONAL INFORMATION: Please use this area for any information that would not fit in the space provided. Identify the section(s) the provided information pertains to in this application.

SECTION Q – PRE-ELIGIBILITY MEDICAL EXPENSES (NON-COVERED SERVICES): Please tell us about any unpaid medical bills that you incurred in the last three months. You may be eligible for deductions from your income.

Do you have any unpaid medical bills that you incurred in the last three months? ☐ Yes ☐ No

SEND PROOF If you answered yes, provide a newly dated, itemized, unpaid medical bill(s) that you incurred up to three months prior to this application. The bill must contain a service date, charge, and a detailed description of the service(s) provided. Attach copies of the bill(s) to the form and submit them with your Long-Term Care Medical Assistance application. If you do not have the bills at the time you submit the application, the bills may be submitted at a later date during this application process.

Please check **one** of the Yes or No choices below and sign where you have indicated your choice:

☐ Yes, I HAVE unpaid medical bills from the last three months.
- ☐ I am sending copies of my bills with this application.
- ☐ I will send copies of my bills at a later date during this application process.

Signature: _____ (Applicant)

Date: _____

Signature: _____ (Authorized Representative)

Date: _____

☐ No, I DO NOT HAVE unpaid medical bills at the time.

Signature: _____ (Applicant)

Date: _____

Signature: _____ (Authorized Representative)

Date: _____

RIGHTS AND RESPONSIBILITIES

I UNDERSTAND I HAVE THE FOLLOWING RIGHTS:

▪**The Department cannot discriminate against me.** Federal and State law prohibit the Department from discriminating against me because of race, color, national origin, sex, age, or disability. If I think the Department has discriminated against me, I may contact the U.S. Department of Health and Human Services at: HHS, Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or by calling 202-619-0403 (voice) or 202-619-3257 (TDD).

▪**I have the right to privacy of my personal information.** I am providing personal information (that includes, but is not limited to: name, address, date of birth, Social Security number, income history, employment history, medical history) in this application for Medical Assistance. The purpose of requesting this personal information is to determine my eligibility for Medical Assistance. If I do not provide this information, the Department may deny my application for benefits. I have a right to inspect, amend, or correct this personal information. The Department will not permit inspection of my personal information, or make it available to others, except as permitted by Federal and State law. I understand, however, that the Department may deny my application for Medical Assistance if I do not provide this information.

▪**If my case is approved, the Department will provide me with a written notice explaining my benefits.**
The Department must give me written notice when it changes my benefits or, determines that I am ineligible for Medical Assistance. I have 90 days from the date of the notice to request a hearing. If I am already receiving benefits and request a hearing within 10 days from the date of the notice, I may continue to receive benefits while I wait for the hearing. Any erroneous benefits I receive from the Department must be repaid to the Department.

▪**I have the right to appeal certain actions taken by the Department.** I can request a hearing if: my application for Medical Assistance eligibility is denied; I assert the Department's decision about Medical Assistance services was erroneous; or, there was a delay in the Department's action(s) related to my application. I may call the Department at 1-800-332-6347 for help requesting a hearing. I am responsible for providing the reason for requesting a hearing. At the hearing, I may speak for myself or I may be accompanied by a lawyer, friend, or relative to speak on my behalf.

IF I ACCEPT MEDICAL ASSISTANCE, I UNDERSTAND BY SIGNING THIS APPLICATION:

▪**Payment Authorization** - I authorize payment under Medicare Part B to be made directly to health care providers and medical suppliers.

▪**Assignment of Health Insurance/Third Party Payments** - I assign all rights, title, and interest of health Insurance payments I may have to the Department and give the Department the right to seek payment from private or public health insurance and any liable third party for the costs the Department incurs for the benefits I receive under Medical Assistance. The Department may seek payment without legal action, providing it does not keep more than the amount Medical Assistance paid. I agree to promptly forward, to the Department, any health insurance payments I receive, including payments received as a settlement from an accident.

▪**Access to Records** - I give the Department the right to inspect, review, and copy all relevant portions of my Medical records for purposes of determining my eligibility for, and for determining the appropriateness of the Services received through, the Medical Assistance program.

▪**Quality Review Cooperation** - I understand that the Department may select my case for a random check or audit for quality control purposes. I agree to allow any representative from the Department to visit me where I reside. I will fully assist the Department in retrieving all proof needed from any source.

▪**Estate Recovery** - I understand that the Department may recover, from the estate of a deceased Medical Assistance recipient, Medical Assistance payments made on his or her behalf on or after the person attained age 55.The Department may recover only if there is no surviving spouse, unmarried child younger than 21, or blind or disabled child (married or unmarried) of any age.

▪ **Accurate and Confidential Application Information** - I acknowledge that I must provide true, correct, and complete information and provide proof of this information.

▪**Social Security Number(s)** - I must provide my (and my spouse's) Social Security number as an applicant for Medical Assistance. The Department will use the Social Security number(s) and other information I provide to verify the information I provide for program reviews. The Department will do this to make sure I am eligible. The Department may also verify my information by contacting my employer, bank, or other parties; and/or, the Department may contact local, State, or Federal agencies to make sure the information I provide is correct. If I do not have a Social Security number, I must apply for one and the Department can provide assistance in applying for a number.

▪**Accurate Financial Reporting** - I understand that I am responsible for reporting true, correct, and complete financial information. This includes, but is not limited to information about: all my assets; potential assets; transfer of assets within the last 5 years of my initial application; transfer of assets within the last 12 months of the date of the annual redetermination of my eligibility; income; insurance; real property; annuities; and all other benefits I may be receiving. I understand that Federal law requires that, as a condition of receiving long-term care services, the Department must be named, in my annuity, as the primary remainder beneficiary.

▪**Report Changes** - I am responsible for reporting changes in my situation. I must report changes within 10 days. The best way for me to report changes is in writing. Examples of changes in my situation are changes in my income, assets, address, health insurance premiums, or persons living in my home. My representative (person acting on my behalf who may file my application) is responsible for reporting such changes. Changes must be reported to the appropriate Local Department of Social Services or the Bureau of Long-Term Care Eligibility.

▪**Medical Assistance Card Misuse** - If I become eligible for Medical Assistance, I must use my Medical Assistance card properly. It is against the law to allow another person to use my card.

▪**Medical Assistance Fraud** - If I do not report true, correct, and complete information, or report changes, the Department may deny, stop, or reduce my benefits. A judge may fine me and/or imprison me if I intentionally do not give correct information or report changes.

SIGNATURES:

I swear or affirm that I have read or had read to me this entire application. I also swear or affirm, under penalty of perjury, that all the information I have given is true, correct, and complete to the best of my ability, knowledge and belief. I have received a copy of my rights and responsibilities. I authorize any person, partnership, corporation, association, or governmental agency which knows the facts relevant to determining my eligibility to release that information to the Department. I also authorize the Department to contact any person, partnership, corporation, association, or governmental agency that has provided information relevant to my eligibility for benefits. I certify, under penalty of perjury, by signing my name below, that the person for whom I am applying is a U.S. citizen or lawfully admitted immigrant.

Signature of Applicant/Recipient _____ Date _____

Signature of Witness (If you Signed an X) _____ Date _____

Signature of Spouse (If applicable) _____ Date _____

Signature of Authorized Representative (if applicable) _____ Date _____

☐ I withdraw my application for Medical Assistance

_____ _____

Signature of Applicant, Recipient, or Authorized Representative Date

Signature of Case Manager	Date

DECLARATION

I swear or affirm, under penalty of perjury, that all information, including financial information, I have provided on this application is true, correct, and complete to the best of my knowledge. The requirement to report true, correct, and complete information includes the requirement to report financial changes that may affect my eligibility for benefits. Federal and State law requires that I disclose all transfers or gifting of assets within the 60 month (5 year) period prior to the month of application.

I understand that if I knowingly do not tell the truth, hide information, pretend to be someone else, or withhold information about myself (and my spouse, if any) or about the person for whom I am applying (and that person's spouse, if any), I may be breaking the law. Information provided on the application may be verified or investigated by Federal, State, and local officials including Federal and State Quality Control staff.

The consequences of not complying with the law are: my benefits may be denied; I may be required to pay back the State for benefits received; my case may be investigated for suspected fraud; and I may be prosecuted for perjury, larceny, and/or Federal healthcare fraud [not limited to Statute 42 U.S.C. sec. 1320a-7b(a)(ii)], which may involve a fine up to $10,000 per offense and/or federal imprisonment.

Signature of Applicant/Recipient _____ Date _____

Signature of Witness (If you Signed an X) _____ Date _____

Signature of Spouse (If applicable) _____ Date _____

Signature of Authorized Representative (if applicable) _____ Date _____