

State of Maine
 Department of Health and Human Services (DHHS)
 Application For
**MaineCare and Food Stamp
 Benefits**

Return to:
 Department of human
 services
 396 Griffin Rd
 Bangor Me 04401

Application for: MaineCare – Full Benefits Medicare Buy-In Only
 Low Cost Drugs (DEL) / MaineRx Plus Food Stamps
 MaineCare Limited Benefits Program
 Do you have a physical or mental health condition that keeps you from working
 full or part time? Yes No

| | | | | |
|---|----------------|-------------------------------------|------------------------|-----|
| Your name (first, middle initial, last) | | Maiden Name | Social Security number | Sex |
| Birth date (month/day/year) | Place of birth | Your Medicare claim number (if any) | | |

Mailing address:

| | | | | |
|---|-------|----------|--|--|
| Street, PO Box, or RR (include apartment number, in care of, etc.) | | | Is this a safe delivery address? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| City | State | Zip Code | Phone | |
| If different from your mailing address, give the address where you actually live: | | | | |

You need to answer only the questions for the program(s) you are applying for.

For Food Stamps Only: To file this application now, we need your name (or that of an authorized representative), address and signature. If eligible, your benefits will begin from the date DHHS gets a signed application.

You may be eligible for Food Stamps benefits right away:

- does your monthly income and cash/money in a bank add up to less than your monthly living expense? _____
- is your monthly income less than \$150 and cash/money in a bank less than \$100? _____
- are you a migrant worker and your income has stopped? _____

Social Security numbers are used to do computer matches with I.R.S., BMV, IFW, the Social Security Administration, Department of Labor, other government agencies and private financial institutions. DHHS and federal officials may check with other sources to prove the information you give.

If you give wrong information, you may be charged with giving false information.

I understand the questions on this form. I certify, under penalty of perjury, that all my answers are correct and complete as far as I know, including those concerning citizenship and alien status for each person applying for benefits. I understand DHHS has the right to collect from other available insurance or from settlement(s) for accidents or injuries whenever MaineCare pays for Medical Expenses.

Signature of person applying _____ **Date** _____

Signature of person filling out this form _____ **Date** _____

If you have someone who knows your situation, and you want us to contact them to help with this application, please complete the following:

Name _____ **Address** _____
Telephone _____

| | |
|--|------------------------------|
| For office use only: | |
| Received _____ | 45 th day _____ - |
| Residency _____ | ID _____ |
| Food Stamp Expedite <input type="checkbox"/> Yes <input type="checkbox"/> No | |

For MaineCare and Food Stamps

| | |
|--|--|
| ARE YOU: <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated (Check only one box) | If you live with your spouse: Spouse's name _____ (first, middle initial, last) Date of birth _____ Sex _____ Able to work? <input type="checkbox"/> Yes <input type="checkbox"/> No (month /day/year) Place of birth _____ Maiden name _____ Spouse's Social Security number _____ Spouse's Medicare claim number _____ |
|--|--|

List other people who live with you:

| Last name | First name | Middle Initial | Sex | Birth - date | Social Security Number | Relationship to you |
|-----------|------------|----------------|-----|--------------|------------------------|---------------------|
| | | | | | | |
| | | | | | | |
| | | | | | | |

Is everyone you are applying for a U.S. citizen? Yes No
 If no, please list their names and Alien Registration Numbers.

Please list place of birth for each person for whom you are requesting assistance

| First Name | Place of Birth | First Name | Place of Birth | First Name | Place of Birth |
|------------|----------------|------------|----------------|------------|----------------|
| | | | | | |
| | | | | | |

List monthly household income below:

| Source | Yourself | Your spouse (who lives with you) | Other family members (please list amount and name of member) |
|---|----------|----------------------------------|--|
| Social Security | \$ | \$ | \$ |
| SSI | \$ | \$ | \$ |
| Other Income or Pensions (such as railroad retirement, interest, dividends, etc., please explain) | \$ | \$ | \$ |

List household earnings for yourself and your spouse (who lives with you): (please provide the last 4 pay stubs or copies of them)

| Name | Employer's name and phone number | Gross Amount earned | How often are you paid | Hours worked each week |
|------|----------------------------------|---------------------|------------------------|------------------------|
| | | | | |
| | | | | |
| | | | | |

Is anyone in your household self-employed? Yes No If YES, Who? _____
 Source? _____ How often? _____

Please provide a copy of your most recent tax return or business records.

List assets for yourself and your spouse (who lives with you), including jointly owned assets:

(If you are applying for Food Stamps, also list the assets of others in your household.)

- Checking or Savings Account • Credit Union Shares • IRA, 401K, Keogh • Certificate of Deposit
- Other Accounts
- Profit Sharing • Safety Deposit Box • Assets Owned with Others • Stocks • Annuities • Prepaid Burials
- Trusts

| Name(s) on account | Type of asset (see above) | Name of bank or institution | Account number | Current balance or value |
|--------------------|---------------------------|-----------------------------|----------------|--------------------------|
| | | | | |
| | | | | |
| | | | | |

List life insurance owned by yourself and/or your spouse (who lives with you):

| Owner | Company name and address | Face value | Cash value |
|-------|--------------------------|------------|------------|
| | | | |
| | | | |

Do you or anyone in your household own any land, buildings, time shares or jointly held real estate, including where you live? Yes No **If YES, list below:**

| Owner | Type of real estate |
|-------|---------------------|
| | |
| | |

Does anyone in your household own any cars, trucks, boats, campers, motorcycles, snowmobiles, ATV's, trailers, tractors, or other motorized vehicles? Yes No **If YES, list below:**

| Year | Make | Model | Owner | Used for | Amount owed |
|------|------|-------|-------|----------|-------------|
| | | | | | |
| | | | | | |
| | | | | | |

Did you give away anything in the last 3 months? Yes No

Does anyone who is applying have health insurance? Yes **Who?** _____; No

Are you requesting help with medical bills incurred within the last three months?

Yes No **Which months?** _____

Did you or anyone in your household serve in the U. S. military? Yes No

In which branch of the military did you serve? _____

When did you serve? (dates) _____ to _____

Did you serve on foreign soil? Yes No

Are you receiving VA benefits that include payment of prescription drugs? Yes No

Estate Recovery:

If you receive benefits from MaineCare after age 55, and certain conditions exist, the Estate Recovery Program will make a claim against the assets of your estate to recover money MaineCare has paid for your care. Estate assets can include real property, including jointly owned property, insurance payments, annuities, any property left to an heir, survivor or assignee. No claim will be made if the only service you receive is the Medicare Buy-In. For more information about the Estate Recovery Program, call 1-800-572-3839.

| Please complete a section for each adult applying for benefits. This information is Voluntary. Your benefits <u>will not</u> be affected if you do not answer. | Applicant | Second Adult |
|---|--|--|
| Are you Hispanic or Latino? | No <input type="checkbox"/> Yes <input type="checkbox"/> | No <input type="checkbox"/> Yes <input type="checkbox"/> |
| Are you an American Indian or Alaskan Native? Circle the tribe you belong to: 1. Houlton Maliseet 2. Peter Dana Pt. Passamaquoddy 3. Pleasant Point Passamaquoddy 4. Penobscot 5. Aroostook Micmac 6. Other | No <input type="checkbox"/> Yes <input type="checkbox"/> | No <input type="checkbox"/> Yes <input type="checkbox"/> |
| Do you live on your tribe's reservation? | No <input type="checkbox"/> Yes <input type="checkbox"/> | No <input type="checkbox"/> Yes <input type="checkbox"/> |
| Are you Asian? | No <input type="checkbox"/> Yes <input type="checkbox"/> | No <input type="checkbox"/> Yes <input type="checkbox"/> |
| Are you Black or African American? | No <input type="checkbox"/> Yes <input type="checkbox"/> | No <input type="checkbox"/> Yes <input type="checkbox"/> |
| Are you Native Hawaiian or Pacific Islander? | No <input type="checkbox"/> Yes <input type="checkbox"/> | No <input type="checkbox"/> Yes <input type="checkbox"/> |
| Are you White? | No <input type="checkbox"/> Yes <input type="checkbox"/> | No <input type="checkbox"/> Yes <input type="checkbox"/> |

Fill out the rest of this form only if you are applying for Food Stamps

Please list your shelter costs (do not list past due amounts or security deposits).

| | | | |
|-----------------------|-----------------|-------------------------|-----------------|
| Rent _____ | How often _____ | Electricity _____ | How often _____ |
| Mortgage _____ | How often _____ | Telephone (basic) _____ | How often _____ |
| Property taxes _____ | How often _____ | Cooking fuel _____ | How often _____ |
| House insurance _____ | How often _____ | Water _____ | How often _____ |
| Condo fees _____ | How often _____ | Sewer _____ | How often _____ |
| Heat _____ | How often _____ | Trash collection _____ | How often _____ |

If you rent, is your heat included in your rent? Yes No

If you pay a mortgage, are taxes and insurance included in your payment? Yes No

Has anyone received HEAP fuel assistance since last October? Yes No

Have you moved since last October? Yes No

Have you received help with these expenses from the town or city in the last 6 months? Yes No

Does anyone else help pay part or all of these bills? Yes No

If yes, who has helped you? _____

How many people, including yourself, live in your home and purchase and prepare meals with you? _____

Is anyone in your household a migrant or seasonal farm worker? Yes No

If anyone in your household is 60 or older or receiving disability benefits, do they pay over \$35/month for their medical expenses, such as health insurance (including Medicare), over the counter or prescription medicines, doctor or dentist bills, hearing aids, eye care, transportation and other medical services? Yes No If yes, please list and provide proof of these expenses.

Is anyone you are applying for a foster child, in state custody or a boarder Yes No If yes, who? _____

Are you paying someone to care for a child or disabled adult? Yes No

Who do you pay? _____ How much do you pay? _____ How often? _____

Is anyone on strike? Yes No Who? _____

Has anyone committed an Intentional Program Violation for Food Stamps Yes No Who? _____

Has anyone quit a job in the last 60 days? Yes No Who? _____

Does anyone pay child support? Yes No Who? _____ How much? _____

How often? _____ To whom? _____ For whom? _____

Is any household member fleeing to avoid prosecution or jail for a felony or violation of probation or parole? Yes No

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, religion, political belief, sexual orientation or disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326 – W, Whitten Building, 1400 Independence Avenue, S. W. Washington D.C. 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.