State of Maine
Department of Health and Human Services (DHHS)
Application For

MaineCare and Food Supplement Benefits

Return to:

Application for:

☐ MaineCare – Full Benefits
☐ Low Cost Drugs (DEL) / MaineRx Plus
☐ MaineCare Limited Benefits Program
☐ Medicare Savings Program Only (Buy In)
☐ Food Supplement Benefits

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?** ☐**Yes** ☐**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 Supplement Benefits 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 Supplement 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 _____ **45th day** _____-
Residency _____ **ID** _____
Food Supplement Benefit Expedite ☐Yes ☐No

For MaineCare and Food Supplement Benefits

ARE YOU:
- ☐ Married
- ☐ Widowed
- ☐ Single
- ☐ Divorced
- ☐ 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? ☐Yes ☐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 and their grade in school if applicable:

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

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 Supplement Benefits, 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 MaineCare Member Services at 1-800-977-6740.

Please complete a section for each adult applying for benefits. This information is Voluntary. Your benefits will not be affected if you do not answer.	Applicant	Second Adult
Are you Hispanic or Latino?	No☐ Yes☐	No☐ Yes☐
Are you an American Indian or Alaskan Native?	No☐ Yes☐	No☐ Yes☐
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		
Do you live on your tribe's reservation?	No☐ Yes☐	No☐ Yes☐
Are you Asian?	No☐ Yes☐	No☐ Yes☐
Are you Black or African American?	No☐ Yes☐	No☐ Yes☐
Are you Native Hawaiian or Pacific Islander?	No☐ Yes☐	No☐ Yes☐
Are you White?	No☐ Yes☐	No☐ Yes☐

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

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 Supplement Benefits ☐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