Family Independence
An Office of the
Department of Health and Human Services

Application for Long Term Care MaineCare

OFI NHW01 (R6/17)

If you need help filling out this application or have questions, please contact us at 1-855-797-4357 or visit your local Department of Health and Human Services (DHHS) office – we can help!

How do I apply?
Fill out this application by answering as many questions as you can. We will accept your application if it is submitted with a name, address and signature. The date we get this information will establish a start date and begin your application.

What proof may I need to send to complete my application?
You may be asked to provide some or all of the information below:

- Copy of Power of Attorney, Conservator, or Guardianship documents
- Documentation of all income sources and amounts (with the exception of Social Security and SSI)
- Documentation of the value for property that is not the applicant's residence
- Copies of health insurance cards including Medicare
- Documentation of health insurance payments
- Copy of trust agreement where the applicant is a grantor or beneficiary
- Copy of annuity contract
- Copy of life insurance policies owned by the applicant and/or their spouse
- Copy of prepaid burial contracts or mortuary trust agreements
- Declaration of contents held in a safe deposit box
- Documentation of liquid assets owned currently by the applicant and/or spouse, or those that have their name on them. These include current statements on all savings and checking accounts, certificate of deposits, IRA or other investments
- Documentation of values and use of all assets cashed in, closed, sold, transferred or otherwise liquidated during the 60 months prior to application

Where do I return the application?
You can bring the application to your local DHHS office, send it by mail, or fax it to us. *Please do not send multiple copies of your application.*

Augusta Long Term Care

If the applicant lives in one of the following counties:
Androscoggin, Franklin, Kennebec, Knox, Lincoln, Oxford, Sagadahoc, Somerset, Waldo

Mail application to:
Office for Family Independence
State of Maine – DHHS
Attn: Long Term Care
35 Anthony Ave
11 State House Station
Augusta, ME 04333-0011

Or fax to: 207-624-8065

Machias Long Term Care

If the applicant lives in one of the following counties:
Aroostook, Hancock, Penobscot, Piscataquis, Washington

Mail application to:
Office for Family Independence
State of Maine – DHHS
Attention: Long Term Care
38 Prescott Drive
Machias, ME 04654-9984

Or fax to: 207-255-2078

Portland Long Term Care

If the applicant lives in one of the following counties:
Cumberland, York

Mail application to:
Office for Family Independence
State of Maine – DHHS
Attention: Long Term Care
151 Jetport Blvd
Portland, ME 04102-1946

Or fax to: 207-822-0350

What happens next?
When we get the application we will review the information and attempt to contact you for a phone interview. If we are not able to reach you by phone we will send you a letter telling you what other information we need.

Do not delay applying because something is not immediately available to you. This information can be obtained later in the interview process. Please tear off and keep this page for your records.

Long-Term Care Programs

Nursing Facility Care
Assistance to help with the cost of services for individuals who expect to stay at least 30 days in a Nursing Facility. Nursing Facilities provide care or rehabilitative services for injured, disabled, or sick persons who are in need of daily care that can only be provided in a nursing facility. A third party will assess the medical need of the applicant to see if they medically qualify for this benefit.

Home and Community Benefits Waiver for the Elderly and for Adults with Disabilities (Section 19)
Assistance to help with the cost of in-home care and other services, designed as a package, to help eligible adults remain in their homes. To be eligible for this waiver, an applicant must meet nursing facility level-of-care requirements.

Residential Care Facility
Help with the cost of services for individuals who expect to stay at least 30 days in a Residential Care Facility. These facilities are for individuals that require less medical care than those in a Nursing Facility but still need services such as meals, homemaking, personal care, and/or medication administration.

Support Services Waiver for Members with Intellectual Disability or Autistic Disorders (Section 29)
Assistance to help with the cost of support services for adults with intellectual disabilities or Autistic Disorder (Section 29) who either live with their families or live on their own. To be eligible for this waiver, an applicant must require Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) level of care as set forth under the MaineCare Benefits Manual, Chapter II, Section 50.

Home and Community Benefits Waiver for Members with Intellectual Disabilities or Autistic Disorder (Section 21)
Assistance to help with the cost of support services for adults with intellectual disabilities or Autistic Disorder (Section 21) who live in their own home or in another home in the community. Assistance is provided in a community-based setting as an alternative for members who qualify to live in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). The assistance provides supplements, rather than replaces supportive, natural personal, family, work, and community relationships and complements.

Home and Community Based Waiver Benefit for Adults Age 21 and Older with Other Related Conditions (Section 20)
Assistance to help with the cost of applicable services available to adults with Other Related Conditions (ORC) who are 21 or older, meet institutional level of care and choose to live in the community with the support of this waiver. This waiver is designed to maximize the opportunity for members to achieve the greatest degree of self-sufficiency and independence chosen by the applicant.

Home and Community Based Waiver Benefit for Adults with Brain Injury (Section 18)
Assistance to help with the cost of applicable services available adults with brain injury who are 18 or older, meet criteria for care in an intermediate care facility or nursing facility and who choose to live in the community with the support of this waiver. This waiver is designed to maximize the opportunity for members to achieve the greatest degree of self-sufficiency and independence chosen by the member.

What do you want to apply for?

☐ **Nursing Facility Care**

☐ **In Home Nursing Care and Community Benefits Waiver (Section 19)**

☐ **Residential Care Facility**

☐ **Support Services Waiver (Section 29)**

☐ **MR Waiver (Section 21)**

☐ **Other Related Conditions Waiver (Section 20)**

☐ **Adults with Brain Injury Waiver (Section 18)**

Information about you, the applicant

Your Name (First, Middle, Last, Suffix)

Social Security Number	Date of Birth	Place of Birth

Mailing Address

City	State	Zip Code	Telephone Number

Home Address (where you actually live, if different from above)

City	State	Zip Code	Have you lived elsewhere in the last 5 years? *If yes, provide mailing and home addresses.*

Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed, date of death of your spouse: _____

Are you a U.S. Citizen? ☐ Yes ☐ No

Have you ever served in the U.S. Armed Forces? ☐ Yes ☐ No

If you are a Veteran, would you like assistance from the Maine Bureau of Veterans' Services? ☐ Yes ☐ No

Race (optional) (Check all that apply) ☐ White ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ Asian ☐ American Indian or Alaskan Native ☐ Other _____

Information about your spouse

Spouse's Name (First, Middle, Last, Suffix)

Social Security Number	Date of Birth	Place of Birth

Gender: ☐ Male ☐ Female

Does your spouse live with you? ☐ Yes ☐ No *If no, provide mailing and home addresses.*

Spouse's Mailing Address	City	State	Zip Code

Spouse's Home Address (only if different from above)	City	State	Zip Code

Is your Spouse a U.S. Citizen? ☐ Yes ☐ No

Has your Spouse served in the U.S. Armed Forces? ☐ Yes ☐ No

If your Spouse is a Veteran, would they like assistance from the Maine Bureau of Veterans' Services? ☐ Yes ☐ No

Race (optional) (Check all that apply) ☐ White ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ Asian ☐ American Indian or Alaskan Native ☐ Other _____

Income

Do you or your spouse receive any income? ☐ Yes ☐ No *If yes, list below.* **Examples of income types:**

Social Security Retirement (SSA/SSR)	Pension	Alimony
Social Security Disability (SSDI)	Military Retirement (DFAS)	Dividend or Interest
Supplemental Security Income (SSI)	Civil Service Annuity	Self-Employment
Veterans (VA) Compensation	Other Annuity Payments	Payment from a trust
Veterans (VA) Aid and Attendance	Railroad Retirement	Earnings (wages)
Veterans (VA) Pension	Long/Short Term Disability Payments	Workers Compensation

Your Income	**Gross Amount**	**How often received?**
Example – Retirement Pension	*$500*	*Bi-Weekly*

Your Spouse's Income	**Gross Amount**	**How often received?**
Example – Social Security Retirement	*$800*	*Monthly*

Do you or your spouse receive rent monthly from property? ☐ Yes ☐ No

Do you or your spouse receive money from someone who pays room and board? ☐ Yes ☐ No

Do you or your spouse receive money from irregular income during the year? ☐ Yes ☐ No

Assets

You will need to provide proof of all assets you and your spouse own or have an interest in. **Examples of assets:**

Cash	Resident Account at Facility	Stocks	Trust Funds
Checking Account	Certificate of Deposit (CD)	Stock Options	Annuities
Savings Account	IRA, 401K, or 403B	Bonds	Promissory Note
Credit Union Account	Keogh Plan	Profit Sharing	Direct Express Account
Money Market Account	Deferred Compensation	Safe Deposit Box	Other Financial Investments

Name(s) on Account	**Asset Type (see above)**	**Name of Bank or Institution**	**Account Number**	**Current Balance or Value**
Example	*Checking*	*Any Bank*	*12345*	*$500*

Assets - Continued

Do you or your spouse have any Life Insurance Policies? ☐ Yes ☐ No *If yes, list below.*

Policy Owner	Policy Number	Individual(s) Covered	Insurance Company	Face Value	Cash Value

Do you or your spouse have a Funeral Plan, Pre-Paid Burial, or Mortuary Trust? ☐ Yes ☐ No *If yes, list below.*

Date Set Up	Who is it for?	Where are the funds held?	Is it irrevocable?	Amount
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	

Do you or your spouse own, or jointly own, any vehicles? ☐ Yes ☐ No *If yes, list below.* **Examples of vehicles:**

Cars Boats RVs Motorcycles ATVs Skidders
Trucks Trailers Campers Snowmobiles Tractors Other motorized vehicles

Vehicle Type	Year	Make/Model	Owner Name(s)	Amount Owed

Do you or your spouse own, or jointly own, any property? ☐ Yes ☐ No *If yes, list below.* **Examples of property:**

Land Buildings Timeshare Camp
Empty Lot Life Estate House Rental Property

Property Type	Full Address of Property	Owner Name(s)	Amount Owed

Would you return to your residence if you no longer need care in a Nursing Facility or Residential Care Facility?
☐ Yes ☐ No

Does your name or your spouse's name appear on anyone else's assets, financial accounts, or any type of property other than those already listed? ☐ Yes ☐ No *If yes, explain:*

Have you or your spouse recently received, or do either of you expect to receive, any retroactive government benefits, pay raises, lawsuit settlements, inheritances, lottery winnings or compensation of any other kind?
☐ Yes ☐ No *If yes, explain:*

Transfer of Assets

Have you, your spouse, or anyone acting on your or your spouse's behalf disposed of, sold, or given away anything of value within the last 60 months? ☐ Yes ☐ No *If yes, list below.* **Examples of things you may have owned:**

Personal Property	Money	Life Insurance	Vehicles
Real Estate	Bank Accounts	Stocks	Foreign Assets

Item Given Away	Value of Item	Person Who Gave Item Away

Have you, your spouse, or anyone acting on your or your spouse's behalf closed any savings, checking, or any other financial accounts within the last 60 months? ☐ Yes ☐ No *If yes, list below.*

Type of Account Closed	Date Closed	Reason for Closure

Expenses

If you are in a hospital or nursing facility, does your spouse live at home and pay shelter expenses? ☐ Yes ☐ No *If yes, list below.* **Examples of shelter expenses:**

Mortgage	Heat	Water/Sewer	Homeowners Insurance
Rent	Electricity	Trash Collection	Renters Insurance
Property Taxes	Telephone/Cell Phone	Lot Rent	Condo Association Fees

Type of Expense	Who Pays this Expense	Who is it paid to	Amount	How Often Paid

Is your heating cost included in your rent? ☐ Yes ☐ No
Does your mortgage payment include taxes and insurance? ☐ Yes ☐ No
Does anyone else live in the household of your spouse? ☐ Yes ☐ No

Other Medical Insurance

Do you have Medicare Coverage? ☐ Yes ☐ No Medicare Claim Number: _____

Part A Effective Date: _____ Part B Effective Date: _____

Part A Premium Amount: _____ Part B Premium Amount: _____

Does your Spouse have Medicare Coverage? ☐ Yes ☐ No Medicare Claim Number: _____

Part A Effective Date: _____ Part B Effective Date: _____

Part A Premium Amount: _____ Part B Premium Amount: _____

Other Medical Insurance – Continued

Do you or your spouse have any other medical insurance? ☐ Yes ☐ No *If yes, list below.* **Examples of insurance:**

Heath Insurance Dental Insurance Vision Insurance Medicare Supplement Plan

Insurance Type	Name of Insured	Name of Insurance Company	Policy Number	Premium Amount	How Often Paid

Do you or your spouse have any Long Term Care Insurance? ☐ Yes ☐ No *If yes, list below.*

Name of Insured	Name of Insurance Company	Policy Number

Are you now, or have you in the past 90 days been in a hospital, nursing facility, or residential care facility?
☐ Yes ☐ No *If yes, list below.*

Facility Name	Facility Address	Admission Date	Discharge Date

Do you need help with any medical bills incurred within the past three months? ☐ Yes ☐ No
If yes, which months? _____ *Note: You must send proof of income and assets for these months.*

Assistance with Application

Do you have a power of attorney, conservator, or court-ordered guardian? ☐ Yes ☐ No *If yes, list below.*
Person's Name: _____ Type: _____
Address: _____ Phone: _____

Please provide a copy of the court order or the power of attorney.

Is there someone else who knows about your financial situation, and whom we may contact to help with this application? ☐ Yes ☐ No *If yes, list below.*
Person's Name: _____ Type: _____
Address: _____ Phone: _____

Please fill out the Appointment of an Authorized Representative Form and Authorization to Release Form on page 7-10 of this application.

Did someone help you fill out this form? ☐ Yes ☐ No *If yes, list below.*
Person's Name: _____ Phone: _____

Acknowledgement

Annuity Disclosure: You need to tell us about any annuity that you or your spouse have an interest in. In order to qualify for MaineCare Long Term Care, the State of Maine may need to be made a remainder beneficiary on an annuity if you have purchased or taken action on this annuity on or after February 8, 2006. The State of Maine may get any benefits remaining in the annuity after your death or the death of your spouse or disabled or minor child, up to the amount of MaineCare benefits paid. Please check and initial any that apply:

☐ I have at least one annuity. ____
☐ My spouse has at least one annuity. ___
☐ My spouse/I do not have any annuities. ___

Assignment of Rights to Medical Payments: If MaineCare pays a bill for you; then MaineCare has the right to collect for that bill from other medical support or medical Insurance you may have.

Estate Recovery: If you receive MaineCare benefits and are age **55 or older**, the State may make a claim on the assets of your estate to recover the money that MaineCare has paid for your care. **No claim will be made if the only service you receive is the Medicare Buy-In**. For more information about the Estate Recovery Program, please call MaineCare Member Services at 1-800-977-6740.

Signature

I understand and agree to provide documents to prove what I have stated. **I understand and agree that federal, state and local officials or o her persons and organizations may verify the information I have given.** If I have given incorrect information, my application may be denied and I may be charged with giving false information. I understand the questions on this application and the penalty for hiding or giving false information or breaking any of the rules in the penalty warning. I certify under penalty of perjury that my answers, including those concerning citizenship, alien status, or a conviction of a drug related felony are correct and complete for all persons applying for benefits.

Your signature or your representative's signature Date

Please note: This application will not be accepted and cannot be processed without a signature.

Although an application with missing information will be accepted, please be aware that incomplete applications will increase the length of time it takes to make an eligibility decision.