State of Maine Department of Health and Human Services

Application for Health Insurance

Use this application to apply for MaineCare if you fit within any of the following groups:

- ✓ Families with Children
- ✓ Pregnant Women
- ✓ Former Foster Care Children (under age 26)
- ✓ You are seeking help with the following services: Family Planning, Reproductive and Sexual Health Care or Sexually Transmitted Infections

Return to:

REC'D

45th DAY

1. Person Filling Out The Application

Name (first, middle initial, last)			
Social Security Number (Optional if You Are Not Requesting Coverage)	**Birthdate** (month/day/year)	**Sex**	**Are you requesting Coverage?**

Check one ☐ **married** ☐ **widowed** ☐ **single** ☐ **divorced** ☐ **separated**

Maiden Name _____

2. Mailing Address

Street, PO Box or RR (include apartment number, in care of , etc.)				
City:	**State:**	**Zip code:**	**Home phone**	**Work phone:**
If different from your mailing address, write in the address where you actually live:				

3. Former Foster Child

Were you in foster care and enrolled in the MaineCare program through the State of Maine at age 18, and you are now less than 26 years of age? ☐ Yes ☐ No

If yes, you can skip the rest of this application. Just sign and date the last page and return this application to us.

4. Household Members (*List the people who live with you*) *If you are only applying for help with the family planning benefit, and do not want full MaineCare for yourself or any other household member, then answer the remaining questions just for yourself. You do not need to list information about other household members.

Last name	First name	Middle initial	Sex	Date of birth	Requesting Coverage?	Social Security Number (Optional if Not Requesting Coverage)	Relationship to you

5. Household Wages From Work *(You are not required to submit proof of your wages at this time, but you may be asked at a later date to provide paystubs or photocopies of paystubs for the last 4 weeks if electronic verification is not possible.)*

Name	Employer's name and phone	Amount you are paid (before any deductions)	How often you are paid	Hours worked each week

*Check here if your wages change a lot. [ ]

6. Self-Employment (*Attach a copy of your most recent tax return including all schedules*)

Name of person(s), if any, who is self-employed

	If you did not file a tax return, check here ☐
	If you did not file a tax return, check here ☐

7. Unearned Income (*You are not required to submit proof of your income at this time, but you may be asked to at a later date if electronic verification is not possible.*)

Note: You don't need to tell us about child support, veteran's payments, or Supplemental Security Income (SSI).

Name of person receiving income	Where is income from? (Social Security, Unemployment, etc.)	How often received? (monthly, weekly, etc.)	Amount before deductions

8. Health Insurance

Does anyone who is applying have health insurance, including health care coverage from the VA? ☐ Yes ☐ No

If yes, please answer the following questions for each individual:

Name of individual applying who has health insurance	Name of insurance company

List children in your household who lost health insurance (except for MaineCare) in the last 3 months and why they lost insurance:

List children in your household who can be added to a household member's State Employee health insurance:

9. Special Conditions

☐ Check here if any household member has a disability. Name of household member _____

☐ Check here if your child is a member of a Federally recognized American Indian tribe or Alaskan Native. (*No premium is required*.)
Name of tribe _____

[ ] Check here if English is not your first language. What language do you speak? _____

[ ] Check here if any child on this application has a parent living outside of the home.
If yes, you will be asked to cooperate with the agency that collects medical support from an absent parent. If you think that cooperating to collect medical support will harm you or your children, you can tell MaineCare and you may not have to cooperate.

[X] Check here if you are asking for help with medical bills incurred in the last 3 months.

[ ] Check here if you want to apply for Food Supplement benefits.

[ ] Check here if you or anyone in your household served in the US Military. If yes, please answer the following questions for each individual:

Question 1	Name of individual in household who served in the military	Branch of the military served	Dates of service (Start Date – End Date)

Question 2	Have you or anyone in your household ever applied for VA benefits? ☐ Yes ☐ No
	If no, would you like help from the Maine Veterans' Service to apply for VA benefits? ☐ Yes ☐ No
	If yes, please complete the attached Authorization to Release Information form and authorize DHHS to release information to "Maine Veterans' Service".

[ ] Check here if you want DHHS to tell you how much your deductible (spenddown) would be if we decide that your income is too high for the regular MaineCare program.

[ ] Check here if you and/or another household member is interested in a MaineCare benefit that provides limited coverage related only to family planning services if you or he/she is not eligible for full MaineCare benefits.

Name of other household member(s) interested in limited coverage related only to family planning services:

10. Citizenship

[ ] check here if someone applying for MaineCare is not a U.S. Citizen.

Complete the following for any applicant who is not a U.S. Citizen

Name	Document Type	Document ID Number	Has he/she lived in US since 1996? Yes or No

11. Authorized Representative

[ ] check here if you would like to allow a person or organization to help you with applying for MaineCare. Please complete the attached "Appointment of Authorized Representative" form.

12. Signature

If you have to pay a premium, coverage can start either the month the Dept. of Health and Human Services receives this application, or the next month. Please write the name of the month you want coverage to start. _____

I understand and agree to provide documents to prove what I have stated. **I understand and agree that the information I have given may be verified by federal, state and local officials or other persons and organizations. 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 or alien status, are correct and complete for all persons applying for benefits.**

If anyone on this application is eligible for Medicaid, I am giving to the Medicaid agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving to the Medicaid agency rights to pursue and get medical support from a spouse or parent.

Signature of person filling out this form Date

MEDICAID APPLICATION SUPPLEMENT

COMPLETE THIS SUPPLEMENT FOR YOURSELF, YOUR SPOUSE/PARTNER AND CHILDREN WHO LIVE WITH YOU AND/OR ANYONE ON YOUR SAME FEDERAL INCOME TAX RETURN IF YOU FILE ONE. IF YOU DON'T FILE A TAX RETURN, REMEMBER TO STILL ADD FAMILY MEMBERS WHO LIVE WITH YOU.

APP LAST NAME:	**APP FIRST NAME:**	**MI:**

AMERICAN INDIANS AND ALASKA NATIVES

Names of those with Indian Health Service Coverage:
Does Not Receive Indian Health Service Coverage, but is eligible:

OTHER MEDICAL INSURANCE

(IF APPLICABLE, LIST THE HOUSEHOLD MEMBERS THAT CURRENTLY RECEIVE HEALTH COVERAGE)

Name:	Company:
Policy:	Type:

EMPLOYER INSURANCE

HOUSEHOLD MEMBERS RECEIVING, OR ELIGIBLE FOR, EMPLOYER SPONSORED HEALTH INSUARNCE (NOW OR IN THE NEXT THREE MONTHS)
PROVIDING THE SSN IS OPTIONAL FOR PERSONS WHO ARE NOT APPLYING FOR MEDICAL COVERAGE

Name:	SSN:	Minimal essential coverage?
Date when eligible to enroll:	Monthly premium for lowest-cost plan offered: $	
Employer Name:	Employer EIN:	
Employer Address:		
Employer Phone:	Employer Email:	
Employer Insurance Name:	Employee Contact Info:	

TAX INFORMATION, APPLICANT

(YOU CAN STILL BE ELIGIBLE FOR PROGRAMS EVEN IF YOU DON'T FILE FEDERAL INCOME TAX)

A. Will you file Income Tax Next Year (if yes, please answer questions A-C; if no, skip to question D:	
B. Will you file jointly with spouse:	Name of spouse:
C. Will you claim dependents on your tax return:	Name of dependent 1:
Name of dependent 2:	Name of dependent 3:
D. Will you be claimed as a dependent on someone's tax return:	Name of filer:

DEDUCTIONS, APPLICANT

ENTER AMOUNTS FOR ALL THAT APPLY

Alimony paid:	How often?	Student loan interest:	How often?
Other deductions:	How often?	Type:	

For American Indians and Alaskan Natives Only
Certain money received can be excluded from income; list any money received from these sources: per capita payments from a tribe that comes from natural resources, usage rights, leases or royalties: payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Dept. of Interior; and money from selling things that have cultural significance.

How much received? $ How often?

SIGNATURE

I'M SIGNING THIS APPLICATION UNDER PENALTY OF PERJURY WHICH MEANS I'VE PROVIDED TRUE ANSWERS TO ALL THE QUESTIONS ON THIS FORM TO THE BEST OF MY KNOWLEDGE. I KNOW THAT I MAY BE SUBJECT TO PENALTIES UNDER FEDERAL LAW IF I PROVIDE FALSE AND OR UNTRUE INFORMATION.

Signature of applicant:

Date:

TAX INFORMATION, NAME OF PERSON #1 WHO LIVES WITH YOU:

A. Will he/she file Income Tax Next Year (if yes, please answer questions A-C; if no, skip to question D:			
B. Will he/she file jointly with spouse:	Name of spouse:		
C. Will he/she claim dependents on your tax return:	Name of dependent 1:		
Name of dependent 2:	Name of dependent 3:		
D. Will he/she be claimed as a dependent on someone's tax return:	Name of filer:		
Total Income (list next year's total income for this person):			
DEDUCTIONS, PERSON#1 WHO LIVES WITH YOU - ENTER AMOUNTS FOR ALL THAT APPLY			
Alimony paid:	How often?	Student loan interest:	How often?
Other deductions:	How often?	Type:	
For American Indians and Alaskan Natives Only Certain money received can be excluded from income; list any money received from these sources: per capita payments from a tribe that comes from natural resources, usage rights, leases or royalties: payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Dept. of Interior; and money from selling things that have cultural significance. How much received? $ How often?			
TAX INFORMATION, NAME OF PERSON #2 WHO LIVES WITH YOU:			
A. Will he/she file Income Tax Next Year (if yes, please answer questions A-C; if no, skip to question D:			
B. Will he/she file jointly with spouse:	Name of spouse:		
C. Will he/she claim dependents on your tax return:	Name of dependent 1:		
Name of dependent 2:	Name of dependent 3:		
D. Will he/she be claimed as a dependent on someone's tax return:	Name of filer:		
Total Income (list next year's total income for this person):			
DEDUCTIONS, PERSON #2 WHO LIVES WITH YOU - ENTER AMOUNTS FOR ALL THAT APPLY			
Alimony paid:	How often?	Student loan interest:	How often?
Other deductions:	How often?	Type:	
For American Indians and Alaskan Natives Only Certain money received can be excluded from income; list any money received from these sources: per capita payments from a tribe that comes from natural resources, usage rights, leases or royalties: payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Dept. of Interior; and money from selling things that have cultural significance. How much received? $ How often?			
TAX INFORMATION, NAME OF PERSON #3 WHO LIVES WITH YOU:			
A. Will he/she file Income Tax Next Year (if yes, please answer questions A-C; if no, skip to question D:			
B. Will he/she file jointly with spouse:	Name of spouse:		
C. Will he/she claim dependents on your tax return:	Name of dependent 1:		
Name of dependent 2:	Name of dependent 3:		
D. Will he/she be claimed as a dependent on someone's tax return:	Name of filer:		
Total Income (list next year's total income for this person):			
DEDUCTIONS, PERSON #3 WHO LIVES WITH YOU -ENTER AMOUNTS FOR ALL THAT APPLY			
Alimony paid:	How often?	Student loan interest:	How often?
Other deductions:	How often?	Type:	
For American Indians and Alaskan Natives Only Certain money received can be excluded from income; list any money received from these sources: per capita payments from a tribe that comes from natural resources, usage rights, leases or royalties: payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Dept. of Interior; and money from selling things that have cultural significance. How much received? $ How often?			
TAX INFORMATION, NAME OF PERSON #4 WHO LIVES WITH YOU:			
A. Will he/she file Income Tax Next Year (if yes, please answer questions A-C; if no, skip to question D:			

B. Will he/she file jointly with spouse:	Name of spouse:
C. Will he/she claim dependents on your tax return:	Name of dependent 1:
Name of dependent 2:	Name of dependent 3:
D. Will he/she be claimed as a dependent on someone's tax return:	Name of filer:
Total Income (list next year's total income for this person):	

DEDUCTIONS, PERSON #4 WHO LIVES WITH YOU - ENTER AMOUNTS FOR ALL THAT APPLY

Alimony paid:	How often?	Student loan interest:	How often?
Other deductions:	How often?	Type:	

For American Indians and Alaskan Natives Only
Certain money received can be excluded from income; list any money received from these sources: per capita payments from a tribe that comes from natural resources, usage rights, leases or royalties: payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Dept. of Interior; and money from selling things that have cultural significance.

How much received? $ How often?

TAX INFORMATION, NAME OF PERSON #5 WHO LIVES WITH YOU:

A. Will he/she file Income Tax Next Year (if yes, please answer questions A-C; if no, skip to question D:	
B. Will he/she file jointly with spouse:	Name of spouse:
C. Will he/she claim dependents on your tax return:	Name of dependent 1:
Name of dependent 2:	Name of dependent 3:
D. Will he/she be claimed as a dependent on someone's tax return:	Name of filer:
Total Income (list next year's total income for this person):	

DEDUCTIONS, PERSON #5 WHO LIVES WITH YOU - ENTER AMOUNTS FOR ALL THAT APPLY

Alimony paid:	How often?	Student loan interest:	How often?
Other deductions:	How often?	Type:	

For American Indians and Alaskan Natives Only
Certain money received can be excluded from income; list any money received from these sources: per capita payments from a tribe that comes from natural resources, usage rights, leases or royalties: payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Dept. of Interior; and money from selling things that have cultural significance.

How much received? $ How often?

TAX INFORMATION, NAME OF PERSON #6 WHO LIVES WITH YOU:

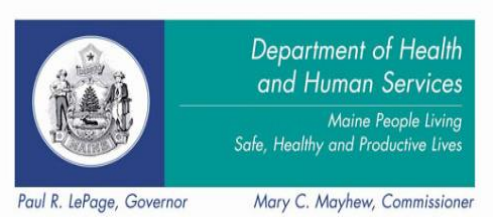
A. Will he/she file Income Tax Next Year (if yes, please answer questions A-C; if no, skip to question D:	
B. Will he/she file jointly with spouse:	Name of spouse:
C. Will he/she claim dependents on your tax return:	Name of dependent 1:
Name of dependent 2:	Name of dependent 3:
D. Will he/she be claimed as a dependent on someone's tax return:	Name of filer:
Total Income (list next year's total income for this person):	

DEDUCTIONS, PERSON #6 WHO LIVES WITH YOU - ENTER AMOUNTS FOR ALL THAT APPLY

Alimony paid:	How often?	Student loan interest:	How often?
Other deductions:	How often?	Type:	

For American Indians and Alaskan Natives Only
Certain money received can be excluded from income; list any money received from these sources: per capita payments from a tribe that comes from natural resources, usage rights, leases or royalties: payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Dept. of Interior; and money from selling things that have cultural significance.

How much received? $ How often?



Appointment of an Authorized Representative

You have the right to appoint an authorized representative to act on your behalf with the Department. If you want to name a person or organization as your authorized representative, use this form.

We are committed to the privacy of your health information. Please read this form carefully.

Individual's Name:_____

Individual's Date of Birth:_____

Individual's Social Security Number:_____

Individual's Address:_____

I (individual named above) hereby appoint the following individual/organization to act as Authorized Representative for me.

Authorized Representative's Name:_____

Address:_____

Telephone number:_____

Email address:_____

Existing legal authority (if any) for individual/organization to act on my behalf (check all that apply and attach copy of documentation):

_____*Guardianship*

_____*Power of Attorney*

_____*Advance Healthcare Directive*

_____*Other:*_____

By making this appointment, I want my Authorized Representative to (check all that apply):

_____Sign and submit an application on my behalf (including an electronic application)

_____Sign and submit a recertification form on my behalf (including an electronic recertification)

_____Receive copies of Notices of Decision and all other written communications from the Department; I'm aware I may also need to complete an Authorization to Release Information form

_____Obtain Food Supplement benefits on behalf of my household

_____Represent me at a fair hearing; I'm aware that I may also need to complete an Authorization to Release Information form

_____Other (please describe) _____

_____Act on my behalf in all other matters with the Department of Health and Human Services; I'm aware I may also need to complete an Authorization to Release Information form

- My authorized representative's authority is limited to the task or tasks I have delegated, above.
- This appointment is valid until:
    - I change this appointment in writing by notifying the Department that this Authorized Representative is no longer authorized to act on my behalf; or
    - My Authorized Representative informs the Department in writing that he/she is no longer acting as my Authorized Representative.
- I understand that taking back this appointment does not apply to any documents signed by or sent to my Authorized Representative before I took back the appointment.
- I understand that if I want my Authorized Representative to receive copies of the Notices of Decision and all other written communications from the Department, the information shared will be for all programs in which I participate that are administered by the Department.
- I understand that an appointment of a representative for the TANF or Food Supplement programs is a representative for both me and my household and that my household will be liable for any overissuance of Food Supplement or TANF benefits that results from erroneous information given by the authorized representative.

I am signing this form voluntarily, and I have the right to a signed copy of this form if I request one.

Signature of the Individual: _____ Date:_____

For the Authorized Representative

I (Individual or Organization Named as Authorized Representative) hereby agree to:

- Fulfill all above-designated responsibilities on behalf of the individual who appointed me as his/her Authorized Representative;
- Maintain the confidentiality of any information regarding the individual who appointed me as his/her Authorized Representative;
- Adhere to the regulations 42 C.F.R. § 431(F) and at 45 CFR § 155.260(f) (relating to confidentiality of information), 42 C.F.R. § 447.10 (relating to the prohibition against reassignment of provider claims as appropriate for a facility or an organization acting on the facility's behalf), as well as all other applicable state and federal laws concerning conflicts of interest and confidentiality of information.

Signature of the Authorized Representative: _____ Date:_____