



State of Maine Department of Health and Human Services

Application For MaineCare Limited Benefits

Return to:

Attention: MaineCare
 Limited Benefits
 DHHS-OIA&S
 SHS#11
 268 Whitten Road
 Augusta, ME. 04333

1. Person Applying

Your name (first, middle initial, last)		
Social Security Number	Birthdate (month/day/year)	Sex

Received _____

2. Mailing Address

Street, PO Box, or RR (include apartment number, in care of, etc.)			
City	State	Zip Code	Phone
If different from your mailing address, give the address where you actually live:			

3. Household Members *List the people who live with you*

Last name	First name	Sex	Birthdate	Relationship to you	Is this person applying for benefits?	Social Security number for those applying

4. Income (Part A) Attach paystubs or photocopies of paystubs for the last 4 weeks

A. Self-Employment

Name of person who is self-employed:	Name of business:
List business income from the most recent federal tax return: Form 1040, line 12 _____	
If you did not file a tax return, what is your yearly income from self-employment (minus business expenses) _____	

4. Income (Part B) Answer only for people applying

B. List all gross income (before taxes) received. This includes income from wages and from other sources such as child support, Unemployment Compensation, interest income, Social Security, Workers Compensation.

Name of person with income	Source of income (Employment, child support, etc.)	How often received? (Weekly, bi-weekly, monthly, bi-monthly, etc.)	Amount Received
1.			
2.			
3.			
4.			

5. Citizenship Answer only for people applying

Are all the people who are applying U.S. citizens? Yes No

If no, list their names and Alien Registration Numbers. This is on the back of the I-94 card.

Name	Alien Registration Number

6. Help with Applying

If you have a guardian, conservator or someone who knows your situation, and you would like us to contact them to help with this application, please complete the following:

Name _____ Telephone _____

Address _____

I understand the questions on this form and that this application is voluntary. I certify, under penalty of perjury, that all my answers are correct and complete as far as I know.

Signature of person applying _____ Date _____

Signature of person filling out this form _____ Date _____

Social Security numbers are used to do computer matches with I.R.S., the Social Security Administration, Department of Labor, other government agencies and private financial institutions. The Department of Health and Human Services and federal officials may verify any information given.

D.O. Code _____

THIRD PARTY RESOURCE INFORMATION REQUEST

New App Review Change/Cancellation TANF Medicaid

Case Name: _____ Case ID# _____ Tel.# _____

Household Members	Medicaid ID#	DOB	Sex
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

1. Are you or anyone in the household covered by any health insurance other than Medicare or Medicaid? Yes ___ No ___

*******IF YES, THE FOLLOWING MUST BE COMPLETED*******
PLEASE ENCLOSE A COPY OF YOUR INSURANCE CARD (FRONT AND BACK)

2. Name of Policyholder/Employee: _____ SS# _____

Employer's name: _____ Tel# _____
Address _____

Name of insurance company(s) _____
Address _____ Tel# _____

Date policy began: _____ Date ended: _____

Group # _____ Certificate/Policy # _____

Name and address of prescription card company, if any _____
Group# _____ Policy# _____

Name and address of dental insurance company, if any _____
Group# _____ Policy# _____

Name and address of vision insurance company, if any _____
Group# _____ Policy# _____

3. Is insurance listed above provided by an absent parent? Yes ___ No ___

If yes, absent parent name _____ SS# _____
Address _____ Tel # _____

ACCIDENT INFORMATION (if applicable)

Name of injured person: _____

Date of accident: _____ Nature of injury _____

Attorney/insurance company name: _____

RIGHTS AND RESPONSIBILITIES ON REVERSE SIDE

Signature _____ Date _____

NOTICE

Tell your worker at the Department if you or the children in your household:

- have other health or accident insurance,
- get money from workmen's compensation or anyone else to pay for health care bills.

Tell your worker at the Department if the children in your household:

- have a legal parent or guardian who pays for health insurance,
- get money from a legal parent or guardian to pay for health care bills.

If you do not tell your worker about the things listed above, you or the children in your household may lose any health care coverage the Department provides.

I understand the Department has the right to collect from other available insurance or from settlement(s) for accidents or injuries whenever the medical card was used.

I agree to let the Department talk or write to my employer, other insurance companies or others such as doctors, hospitals, or other health care people to get the information it needs to run its programs correctly.

I have read and I understand the above. The information I have given on the front side of this form is true as far as I know.



MaineCare Benefit For People Living With HIV/AIDS
Informed Consent Form

To get the MaineCare Benefit for People Living with HIV/AIDS, you must read this form carefully and sign it. This form tells you what you must know about this Benefit. By reading and signing this form, you let us know that you understand and want to get this Benefit.

1. No one is making me participate. This is something I want to do. In order to get services under this Benefit I must:
 - a. be medically and financially eligible;
 - b. follow the treatment plan recommended by my doctor;
 - c. take the medications the doctor has prescribed;
 - d. keep my appointments with the doctor and the laboratory; and
 - e. pay any monthly premiums and the Benefit co-payments. The amount of the premium will change over time.
2. I know there is a limit to the number of people who can get this Benefit. If the limit is reached, I will be put on a waiting list. Names will be listed on a first come, first served basis. I will get a letter when there is an opening.

Other things I need to know:

The MaineCare Benefit for People Living with HIV/AIDS is not the same as MaineCare Full Benefits.

On the next page, there is a list of services this MaineCare Benefit For People Living With HIV/AIDS will cover and services it will not cover.

If you become eligible for MaineCare Full Benefits while getting the MaineCare Benefit for People Living with HIV/AIDS, we will add those benefits to your care coverage.

Signed,

Signature

Printed Name

Date

Please sign and return this page to the Bureau of Family Independence in the envelope provided.

If you have questions about this form please call 1-866-796-2463.

You may keep the list of covered and non-covered services for your records.

**CONSENT TO DISCLOSURE OF HIV TEST RESULTS TO
THE DEPARTMENT OF HUMAN SERVICES**

I, _____ authorize
(test subject)

(person or office making the disclosure)

to disclose the results of an HIV test done on me to:

The Department of Human Services, including the Bureau of Health, Bureau of Medical Services and the Bureau of Family Independence, including but not limited to, all employees who are caseworkers or supervisors, and who work in regional administration, quality control, the Department's central office, audit office, and hearing's unit. In addition, test results may be disclosed to employees of the Federal Department of Health and Human Services who perform audit and review functions for the federally funded benefit programs.

Disclosure to those listed in the above paragraph, of the results of the HIV test performed on me is specifically limited to the purpose of determining my eligibility for any or all of the following benefits: Temporary Assistance to Needy Families (TANF); Medicaid, including HIV Waiver programs; Food Stamps; Emergency Assistance; ASPIRE; or Family Services.

DATE _____

SIGNATURE _____

SIGNATURE OF PARENT OR GUARDIAN (where required):

SIGNATURE OF AUTHORIZED PERSON (where required):

This consent can be revoked, in writing, showing authorized signature and the date, at any time except to the extent that the person or office disclosing test results has already taken action in reliance upon this consent. If not previously revoked, this consent will expire one year after it's execution.