

MAINE Rx PLUS Application

Including Low Cost Drugs for the Elderly or Disabled (DEL) Benefit

Return to:

Department of Human
Services
13 Prescott Drive
Machias, Maine
04654

Received _____

1. Person Applying

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

2. Mailing Address

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

3. Household Members

 List the people who live with you.

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

4. Citizenship

 Answer only for people applying.

Are all the people who are applying U.S. citizens? Yes <input type="checkbox"/> No <input type="checkbox"/>	
If no, list their names and Alien Registration Numbers. This is on the back of the I-94 card.	
Name	Alien Registration Number

5. Disability

Check here if anyone in your household has a disability. If yes, who _____

6. Health Insurance

Check here if you or anyone who is applying has health insurance. If yes, who _____

Name of insurance company _____ Policy# _____

Does this insurance cover prescription drugs? Yes No

7. Income

 Answer for you, your spouse and dependents living with you and any other person in your household who is applying.

Employer's name and phone number	Amount you earn	How often you are paid	Hours worked each week
----------------------------------	-----------------	------------------------	------------------------

(Income continued on other side.)

7. Income (continued)

List all gross income (before taxes). This includes income from wages and from other sources such as pensions, Social Security, Unemployment Compensation, interest income, Worker's Compensation, child support.

Name of person with income	Source of income (wages, Social Security, etc.)	How often received?	Gross amount received <small>(Add to your check amount the total taken out to pay for your Medicare Part B premium)</small>
1.			
2.			
3.			
4.			

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)

8. Assets Compare only if you are applying for yourself along with your children and teens age 18 and under.

A. Cashable Assets Type of asset	Name(s) on account	Account number and bank	Value or balance	
No need to fill out				
#8 (assets section)				
at this time.				
B. Real Estate (other than the home where you live) Owners	Type of real estate			
at this time.				
C. Vehicles Year	Make/model	Owners	Current value	Amount owed

9. Help with Applying

If you know someone who can answer the questions on this form and you would like us to ask them to help with this application, please tell us who this is:

Name _____ Telephone _____

Address _____

I understand the questions on this form. As far as I know all my answers are correct and complete. I know that if I give information that is not true I am breaking the law.

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 Human Services and federal officials may verify any information given.

The only benefit is help with paying for prescription drugs.

BFI REV HMP (R07/02)