

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 Con	nmur	nity Benefi	its Waiver (Section 19	9)			
☐ Residential Care Facility								
☐ Support Services Waiver (Section	ion 2	9)						
☐ MR Waiver (Section 21)								
☐ Other Related Conditions Wais	ver (S	Section 20)					
☐ Adults with Brain Injury Waive	er (Se	ction 18)						
Information about you, the applic	cant.							
Your Name (First, Middle, Last, Su	ffix)							
Conial Consults Number		Data of D	٠			Dlaga	of Birth	
Social Security Number		Date of B	IFUTI			Place	OI BILLII	
Mailing Address								
City	Stat	te	Zip Code		Teleph	one Nu	ımber	
Home Address (where you actually	⊥ y live	, if differe	nt from abo	ve)				
	T a		o -		l			
City	Stat	te	Zip Code	Have you lived elsewhere in the last 5 years? If yes, provide mailing and home addresses.				
Gender: ☐ Male	/larita	al Status:	☐ Single ☐ Widow	☐ Marri ed, date o		Separa of your		orced
Are you a U.S. Citizen? ☐ Yes ☐] No	Have yo	u ever serv	ed in the U	J.S. Arm	ed Ford	ces? 🗆 Yes	□ No
If you are a Veteran, would you lik	ce ass	sistance fro	om the Mai	ne Bureau	of Vete	rans' S	ervices? 🗆 Y	es 🗆 No
Race (optional) $\ \square$ White			frican Ame			tive Ha	waiian or Pac	ific Islander
(Check all that apply) Asian		American	Indian or A	laskan Nat	tive	☐ Oth	er	
Information about your spouse.		6. 1						
Spouse's Name (First, Middle, Last	t, Suf	fix)						
Social Security Number		Date of B	irth			Place	of Birth	
Gender: ☐ Male ☐ Female D	oes v	our spous	e live with	/ou? □ Y	es 🗆 N	No If no,	provide mailing	and home addresses.
Spouse's Mailing Address		•		City			State	Zip Code
C /- 11 Add / 1 - 'f d'	rr		\				7' . C I.	
Spouse's Home Address (only if di	пеге	nt from ab	ove)	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? \Box Yes \Box No								
Race (optional)								

Income								
Do you or your spouse rece	ive any income?	□ Yes □ No	If yes, list	below. Exar	nples of i	ncome	types:	
Social Security Retirement ((SSA/SSR) P	ension		Alimony				
Social Security Disability (SS	•	∕Iilitary Retiren	•	S)	Dividend or Interest			
Supplemental Security Inco	• •	Civil Service Ann	•			f-Emplo	=	
Veterans (VA) Compensatio		Other Annuity P	•			•	rom a trust	
Veterans (VA) Aid and Atter		Railroad Retirer		_		rnings (• ,	
Veterans (VA) Pension	L	ong/Short Terr	n Disabilit				Compensation	
Your Income				Gross Amo	unt	How of	ten received?	
Example – Retirement Pens	ion			\$500		Bi-Wee	kly	
Your Spouse's Income				Gross Amo		How often received?		
Example – Social Security Re	etirement			\$800		Monthl	у	
Do you or your spouse rece Do you or your spouse rece	•	•	-					
Assets								
You will need to provide pro	oof of all assets yo	u and your spo	use own (or have an i	nterest in	. Examp	oles of assets:	
Cash	Resident Accoun	t at Facility	Stocks		Trus	t Funds		
Checking Account	Certificate of Dep	• •		Options	Annı	uities		
Savings Account	IRA, 401K, or 403	BB	Bonds			omissory Note		
Credit Union Account	Keogh Plan		Profit S	_		rect Express Account		
Money Market Account	Deferred Compe	1		eposit Box			cial Investments	
Name(s) on Account	Asset Type (see above)		lame of or Institut	ion	Acco Num		Current Balance or Value	
Example	Checking	Any Bank			12345		\$500	

Assets - Contir	nued										
Do you or your	spouse	have any Life	Insuran	ce Policies? 🗆 🗅	⁄es	\square No If yes,	list belo	w.			
Policy Owne	r Po	licy Number	Indiv	vidual(s) Covere	d	Insurance	e Compar	ıy	Face Va	lue	Cash Value
Do you or your	spouse	have a Funer	al Plan, I	Pre-Paid Burial, o	or Mo	rtuary Trust	:? □ Yes		No If yes,	, list l	below.
Date Set Up	Who is	it for?		Where are the	fund	s held?		ls it	irrevoca	ble?	Amount
									Yes \square	No	
									Yes \square	No	
									Yes \square	No	
Do you or your	spouse	own, or joint	y own, a	any vehicles?	Yes	□ No If y	es, list be	low.	Example	s of v	ehicles:
Cars	Boat	s R\	√ s	Motorcy	cles	AT\	/s	S	kidders		
Trucks	Trail	ers Ca	ampers	Snowmo	biles	Tra	ctors	C	ther mot	orize	d vehicles
Vehicle Type	Year	Make/Mod	el			Owner	Name(s)			Am	ount Owed
Do you or your	spouse	own, or joint	y own, a	any property?	Yes	□ No If	yes, list b	elow	Example	s of	property:
Land		Building	S	Tin	nesha	ire		C	amp		
Empty Lot		Life Esta	te	Но	use			R	ental Pro	perty	'
Property Type	Full A	ddress of Pro	perty		Ow	ner Name(s)			Am	ount Owed
Would you return to your residence if you no longer need care in a Nursing Facility or Residential Care Facility? \Box Yes \Box 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? \square Yes \square No If yes, explain:											
	Have you or your spouse recently received, or do either of you expect to receive, any retroactive government										
benefits, pay ra ☐ Yes ☐ No			ents, inh	eritances, lotter	y win	nings or cor	npensatio	on of	any othe	r kind	1.

Transfer of Assets							
	ouse, or anyone acting on your or ye last 60 months? \square Yes \square No	·	· ·	_	· · · · · -		
Personal Property Real Estate	Money Bank Accounts	Life I Stock	nsurance	Vehicles Foreign A	ssets		
Item Given Away		3,000	Value of Item		Gave Item Away		
item Given Away			value of item	Person wind	dave itelli Away		
	ouse, or anyone acting on your or y within the last 60 months?	•		y savings, check	ing, or any other		
Type of Account C	Closed		Date Closed	Reason for	Closure		
Expenses							
If you are in a hos	pital or nursing facility, does your spector spectors and samples of shelter expenses:	pouse live a	it home and pay sh	elter expenses?	⊓ Yes □ No		
Mortgage	Heat	Wate	er/Sewer	Homeowr	ners Insurance		
Rent	Electricity	Trash	n Collection	Renters Ir			
Property Taxes	Telephone/Cell Phone	Lot R	ent	Condo As	sociation 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 Ins	surance						
Do you have Medi	icare Coverage? ☐ Yes ☐ No	Medicare	Claim Number:				
Part A Effective Date: Part B Effective Date:							
	mount:	Part	B Premium Amoun	t:			
	have Medicare Coverage? Yes	□ No N	nedicare Claim Nur	nber:			
	ate:		art B Effective Date:				
Part A Premium A	mount:	Part	B Premium Amoun	t:			

Other Medica	I Insurance – Contin	ued						
Do you or you	r spouse have any ot	her me	edical insurance? Yes No	If yes,	list belov	w. Examp	les of	insurance:
Heath Insurance Dental Insurance Vision Insurance Medicare Supplement Plan							nt Plan	
Insurance Type	Name of Insure	ed	Name of Insurance Company	Policy	Number	Premi Amou	_	How Often Paid
Do you or you	r spouse have any Lo	ng Ter	m Care Insurance? \square Yes \square N	lo <i>If ye</i> s	s, list bei	low.		
Name of Insur	red		Name of Insurance Company			Policy No	umbe	er
	or have you in the pa o If yes, list below.	ast 90 d	lays been in a hospital, nursing fa	acility, o	r resider	itial care f	acilit	y?
Facility Name		Facilit	ty Address		Admissi	on Date	Disc	charge Date
Do you need help with any medical bills incurred within the past three months? \Box Yes \Box No If yes, which months? Note: You must send proof of income and assets for these months.								
Assistance wi	th Application							
Do you have a	power of attorney,	conserv	vator, or court-ordered guardian?	? 🗆 Yes	s 🗆 No) If yes, li	st be	low.
Person's Name: Type:								
Address: Phone:								
Please provide a copy of the court order or the power of attorney.								
		-	your financial situation, and who	m we m	ay conta	ict to help	with	this
	?							
Address:				Phone	e:			
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.					
	Δ.							

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 onl 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 other 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	
qualify for MaineCare Long Term Care, the State of Maine must 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 has at least one annuity. My spouse/I do not have any annuities. 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 onl 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 Understand and agree to provide documents to prove what I have stated. I understand and agree that federal, state and local officials or other 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	Acknowledgements
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 onl 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 other 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	qualify for MaineCare Long Term Care, the State of Maine must 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:
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I understand and agree to provide documents to prove what I have stated. I understand and agree that federal, state and local officials or other 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	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
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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.



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.

maividual's Name:
Individual's Date of Birth:
Individual's Social Security Number:
Individual's Address:
I <u>(individual named above)</u> 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
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 Re	epresentative
 I (Individual or Organization Named as Authorized Repre Fulfill all above-designated responsibilities on behis/her Authorized Representative; Maintain the confidentiality of any information his/her Authorized Representative; Adhere to the regulations 42 C.F.R. § 431(F) and confidentiality of information), 42 C.F.R. § 447.1 reassignment of provider claims as appropriate facility's behalf), as well as all other applicable sinterest and confidentiality of information. 	regarding the individual who appointed me as at 45 CFR § 155.260(f) (relating to 0 (relating to the prohibition against for a facility or an organization acting on the

Signature of the Authorized Representative: ______ Date:_____ Date:_____



Authorization to Release Information

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

☐Office of MaineCare Services	☐ Substance Abuse and M	Iental Health Servio	ces
☐Office for Family Independence including Medical Review Team	Office of Child and Far	nily Services	
☐ Maine Centers for Disease Control and Prevention	☐ Office of Aging and Di	sability Services	
☐ Dorothea Dix Psychiatric Center	☐ Office of Administrativ	e Hearings	
☐ Riverview Psychiatric Center	☐ Other:		
Individual's Name:	Individual's Date of Bir	th:	
	Individual's Social Secu	arity Number:	
		Ž	
Individual's Address:			
Street	Town/City	State	Zip Code
Succi	Town/City	State	Zip Code
D	1		
Records to be released, including written, electronic and verb	oal communication:		
— AN XX 14			
□All Healthcare, including treatment, services, supplies and med	dicines		
	.,		
☐ Claims Information ☐ Billing, payment, income, banking		information regai	ding
eligibility for DHHS program ben	efits such as MaineCare		
□Other:			
\square Limit to the following date(s) or type(s) of information:			
(e.g. "lab test dated June 2, 2013" or "hospital records from 1/1/1	4 - 1/15/14")		
	,		
I authorize the DHHS office(s) checked above to: □Release	e my information to: \Box	Obtain my inform	nation from:
Name:			
rume.			
Address:			
	own/City	State	Zip Code
Succi	DWII/City	State	Zip Code
E N	La da assista Danais da GE-		
Fax No., where applicable:Phone N	lo. to verify Receipt of Fa	X	
			1
If requesting that electronic information be transmitted by email	l, please clearly print the o	email address bel	ow:
☐ I understand that DHHS systems may not be able to send my	information securely thre	ough email Lund	erstand that
email and the internet have risks that DHHS cannot control and			
			i oy a umu
party. I accept those risks and still request that DHHS send my	<u>-</u>		
Please allow the office(s) named above to disclose my information	on for the following purpo	ose(s):	
☐ For a legal matter, including an administrative hearing ☐ To	see if I qualify for insura	nce coverage or b	enefits

☐ For	coordination of my care A Personal Request Other (note here):
impli	aling below, I agree to disclose the following types of records: Mental health treatment provider or program Substance/alcohol/drug Abuse treatment provider or program HIV infection status or test results: Maine law requires us to tell you that releasing this information may have cations. Positive implications may include giving you more complete care, and negative implications may include amination if the data is misused. DHHS will protect your HIV data, and all your records, as the law requires.
	dual/personal representative of individual) permit DHHS to release and/or obtain my records as written on Page 1 orm. I understand and agree to the following:
•	This form will expire one year from the date I sign below, unless I revoke (take back) my permission sooner by completing, signing and sending in the Revocation Form found on the DHHS website at http://www.maine.gov/dhhs/privacy/index.shtml . I may call DHHS at 207-287-3707 and ask for the office where I receive services if I need help revoking this form.
•	I understand that taking back my permission to release my information does not apply to the information that was already shared after I signed this form.
•	If I take back my permission to release my information, or if I refuse to release some or all of my healthcare or insurance information, that may result in improper diagnosis or treatment, denial of insurance coverage or a claim for health benefits, or other adverse consequences.
•	This form permits the people or offices listed on Page 1 to speak to each other for the purpose(s) on this form.
•	If I am disclosing healthcare information, I agree that records of other providers (such as doctors, hospitals, and counselors) in my file are included in this release.
•	Unless I am applying for benefits, DHHS will not condition my treatment, payment for services, or benefits on whether I sign this form.
•	I have the right to make a written request to review my records. If I wish to receive a copy of my healthcare or billing information, a fee may be charged as permitted by law.
•	If I want to review my mental health program or provider records before they are released, I must check THIS BOX . I understand that the review will be supervised.
•	DHHS offices will keep my information confidential as required by law. If I give my permission to share my records with people who are not required by law to keep them private, they may no longer be protected by federal confidentiality laws.
•	If alcohol or drug treatment or program records are included in this release, federal law requires the person sharing those records to include a notice saying that such information may not be re-released or shared without my written permission, unless required or permitted by law.
•	I am signing this form voluntarily, and I have the right to a signed copy of this form if I request one.
Date:	Signature

Personal Representative's authority to sign: