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

Application for Benefits

Do you want help filling out this application? Do you have questions? Call 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. If you are applying for Food Supplement, we encourage you to fill out as much of the application as possible. 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 for benefits and begin your application. You may keep this page of the application for your information.

Apply faster online.

Visit www.maine.gov/mymaineconnection to apply online. Save your confirmation number!

Who can complete the application?

The application should be filled out by you or an adult member of your household, or a relative, friend or authorized representative who knows the financial situation of all household members. If you would like to appoint an authorized representative to act on behalf of the household you may do so by filling out an Appointment of Representative form.

What other information may I need?

You may need to give us proof of much of the information you list on your application. You can find a list of things you may need to provide as proof on page 2.

Do I need an interview?

Food Supplement and TANF both require an interview before we can determine if you are eligible for assistance. If you mail the application to us, we will schedule an interview for you.

Where do I return the application?

You can bring it in to a local DHHS office, mail, or fax it to us.

Mail: Office for Family Independence
State of Maine – DHHS
114 Corn Shop Lane
Farmington, ME 04938

Fax: 1-207-778-8429

Programs

Food Supplement

Helps low-income households buy food.

MaineCare

Helps people with medical bills such as bills for doctors, hospitals, and medicines.

Temporary Assistance for Needy Families (TANF) or Alternative Aid (AA)

Provides cash assistance for a limited number of months, to families with children in need of support.

Emergency Assistance (EA)

Help for families with children who are facing destitution or homelessness because of an emergency situation.

Child Care Subsidy Program

Helps families to pay for child care so they can work, go to school or participate in a job training program.

State Supplement

Provides cash payment to aged, blind, or disabled people who get SSI, or would be eligible for SSI except for income or due to citizenship rules.

Katie Beckett

Offers MaineCare eligibility for children under age 19 with severe health conditions who are not in a medical facility but need the level of care of a facility.

Medicare Savings Program (Buy-In)

Pays Medicare deductibles, co-pays, co-insurance and premiums for low-income Medicare members.

Family Planning Services (MaineCare)

Helps with the following services: Family Planning, Reproductive and Sexual Health Care or Sexually Transmitted Infections.

Please tear off and keep this page for your records.

What proof may I need to send to complete my application?
The proof we may need depends on the programs you are applying for. Below is a list of items you may need to verify along with examples.

Identity/Citizenship
- ✓ Driver's license or state identification card
- ✓ Birth certificate
- ✓ Passport
- ✓ Immigration or naturalization documents

Earned Income
- ✓ Pay stubs (most recent 4 weeks)
- ✓ Employer statement verifying gross wages
- ✓ Federal income tax return (if self-employed)
- ✓ Self-employment business records (for 3 months)
- ✓ Statements from roomer/boarder
- ✓ Verification of Income ending if in last 60 days

Assets
- ✓ Bank Statements
- ✓ Certificates of Deposit
- ✓ Retirement Funds (IRA/Keogh/401K)
- ✓ Life Insurance Policies
- ✓ Burial funds
- ✓ Stocks/bonds/mutual funds

Other Documents Which May be Required
- ✓ Copies of medical insurance cards
- ✓ Student loan interest statement

Residence
- ✓ Rental agreement or mortgage statement
- ✓ Utility bills such as electric, gas and water

Unearned Income
- ✓ Social Security Award Letter
- ✓ Pension/Retirement statement
- ✓ Alimony
- ✓ Child support court order
- ✓ Unemployment/workers' compensation benefits
- ✓ Interest/dividend statements
- ✓ Financial aid award letter
- ✓ Veteran/military benefits

Expenses
- ✓ Lease or rental agreement
- ✓ Homeowner's insurance policy
- ✓ Utility bills
- ✓ Property tax/mortgage bills

Medical Expense Deductions (age 60 or older; disabled)
- ✓ Billing statements
- ✓ Itemized receipts for medical expenses

Child Care Expenses
- ✓ Receipts/statement from the provider

Do I Need To Give A Social Security Number When I Apply?
Applicants are required to provide their social security number if they have one. If there are members of the household who do not wish to receive benefits, they must be listed as household members on the application. They do not need to provide their social security number.

What Are Some of My Rights?
In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, religion, political beliefs, age or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1)mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; (2)fax: (202) 690-7442; or (3)email: program.intake@usda.gov.

USDA and this institution are equal opportunity providers and employers.

Check the kinds of help you want to apply for. You must check at least one box.

☐ **Food Supplement**	☐ **MaineCare (including Maine Rx / Low Cost Drugs for the Elderly)**
☐ **TANF (including Alternative Aid)**	☐ **Medicare Savings Program (Buy-in)**
☐ **Emergency Assistance**	☐ **Katie Beckett**
☐ **Child Care Subsidy Program**	☐ **State Supplement (State SSI cash assistance)**

Signature – This application cannot be accepted without a signature.

I understand and agree to provide documents to prove what I have stated on the pages below. 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 benefits.

Your signature or your representative's signature **Date**

MaineCare Applicants

• Do you need help with any medical bills incurred within the past three months? If yes, which months? _____	☐ Yes ☐ No
• Were any applicants under the age of 26 previously enrolled in the Maine foster care system at the age of 18? If yes, who? _____	☐ Yes ☐ No
• If you are over the income limit for MaineCare, would you like to be quoted a six month deductible?	☐ Yes ☐ No
• If ineligible for full MaineCare benefits, would you like to be considered for either of the limited MaineCare coverage options listed below?	☐ Yes ☐ No
☐ **Special Benefits Waiver (HIV/AIDS)** Does anyone in your household have HIV/AIDS?	☐ Yes ☐ No If yes, who? _____
☐ **Family Planning Services** Does anyone want Family Planning benefits if you cannot get full MaineCare?	☐ Yes ☐ No If yes, who? _____

☐ **Long Term Care Services**

There are special programs in MaineCare that require a Long Term Care application to be completed instead of this application. Some examples of these programs are nursing facility care, receiving nursing care in your home, residential care facilities, and assistance to help with the cost of support services for adults with intellectual disabilities or Autistic Disorder. Ask your eligibility specialist to help you determine if one of these special programs is right for you.

Food Supplement Applicants

If the answer to any of these 3 questions is yes, you may be able to get Food Supplement benefits right away.

1. Does your household have $100 or less in available cash/bank accounts and expect to receive less than $150 in income this month?	☐ Yes ☐ No
2. Is your monthly income and any other money available to you in cash or in bank accounts less than the amount of money you need to pay your rent/mortgage and utility bills for this month?	☐ Yes ☐ No
3. Are you a migrant or seasonal farm worker?	☐ Yes ☐ No

**** If you only want MaineCare Family Planning benefits, then you only need to fill out this application for yourself and need not include other household members. ****

About Person 1, you, the applicant. If you are a minor, we may need to contact an adult/parent/caretaker.

Your Name: First, Middle, Last, Suffix	Social Security Number	Date of Birth

Gender: ☐Male ☐ Female | Marital Status ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

Home Address

City	State	Zip Code	Telephone Number

Mailing Address, if different from where you actually live:

Are you a U.S. Citizen? ☐ Yes ☐ No

If you are not a U.S. Citizen, and want benefits for yourself, then answer the following questions	What is your immigration status?	Document Type	Document ID
	Date of entry to U.S.? _____	Do you have a sponsor? ☐ Yes ☐ No	

Ethnicity (Optional) ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

Race (Optional) ☐ White ☐ Black or African American ☐ Native Hawaiian or Pacific Islander

(Check all that apply) ☐ Asian ☐ American Indian or Alaskan Native ☐ Other _____

If applicable, which tribe do you belong to? _____ Do you live on tribal land? ☐ Yes ☐ No

Are you in school? ☐ Yes ☐ No	If yes, what grade? _____	Name of school _____	Full time student? ☐ Yes ☐ No

**** If you are a former foster child and aged out of the Maine Foster Care system and only want MaineCare benefits, then just sign and mail this to us. You do not need to complete the rest of this application.****

Household Relationships – Please answer both questions if there are 2 or more people in your household.

How are you related to the other household members?

Please explain the relationship of the other members in your household to each other.

About Person 2

Name: First, Middle, Last, Suffix	Social Security Number	Date of Birth

Gender: ☐Male ☐ Female | Marital Status ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

Is this person a U.S. Citizen? ☐ Yes ☐ No

If this person is not a U.S. Citizen, answer the following questions	Do they have an eligible immigration status? ☐ Yes ☐ No	Document Type	Document ID
	Date of entry to U.S.? _____	Do they have a sponsor? ☐ Yes ☐ No	

Ethnicity (Optional) ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

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

If applicable, which tribe do they belong to? _____ Do they live on tribal land? ☐ Yes ☐ No

Are they in school? ☐ Yes ☐ No	If yes, what grade? _____	Name of school _____	Full time student? ☐ Yes ☐ No

About Person 3

Name: First, Middle, Last, Suffix	Social Security Number	Date of Birth

Gender: ☐Male ☐ Female | Marital Status ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

Is this person a U.S. Citizen? ☐ Yes ☐ No

If this person is not a U.S. Citizen, answer the following questions	Do they have an eligible immigration status? ☐ Yes ☐ No	Document Type	Document ID
	Date of entry to U.S? _____	Do they have a sponsor? ☐ Yes ☐ No	

Ethnicity (Optional) ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

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

If applicable, which tribe do they belong to? _____ Do they live on tribal land? ☐ Yes ☐ No

Are they in school? ☐ Yes ☐ No	If yes, what grade? _____	Name of school _____	Full time student? ☐ Yes ☐ No

About Person 4

Name: First, Middle, Last, Suffix	Social Security Number	Date of Birth

Gender: ☐Male ☐ Female | Marital Status ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

Is this person a U.S. Citizen? ☐ Yes ☐ No

If this person is not a U.S. Citizen, answer the following questions	Do they have an eligible immigration status? ☐ Yes ☐ No	Document Type	Document ID
	Date of entry to U.S? _____	Do they have a sponsor? ☐ Yes ☐ No	

Ethnicity (Optional) ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

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

If applicable, which tribe do they belong to? _____ Do they live on tribal land? ☐ Yes ☐ No

Are they in school? ☐ Yes ☐ No	If yes, what grade? _____	Name of school _____	Full time student? ☐ Yes ☐ No

About Person 5

Name: First, Middle, Last, Suffix	Social Security Number	Date of Birth

Gender: ☐Male ☐ Female | Marital Status ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

Is this person a U.S. Citizen? ☐ Yes ☐ No

If this person is not a U.S. Citizen, answer the following questions	Do they have an eligible immigration status? ☐ Yes ☐ No	Document Type	Document ID
	Date of entry to U.S? _____	Do they have a sponsor? ☐ Yes ☐ No	

Ethnicity (Optional) ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

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

If applicable, which tribe do they belong to? _____ Do they live on tribal land? ☐ Yes ☐ No

Are they in school? ☐ Yes ☐ No	If yes, what grade? _____	Name of school _____	Full time student? ☐ Yes ☐ No

About Person 6

Name: First, Middle, Last, Suffix	Social Security Number	Date of Birth

Gender: ☐Male ☐ Female | Marital Status ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

Is this person a U.S. Citizen? ☐ Yes ☐ No

If this person is not a U.S. Citizen, answer the following questions	Do they have an eligible immigration status? ☐ Yes ☐ No	Document Type	Document ID
	Date of entry to U.S? _____	Do they have a sponsor? ☐ Yes ☐ No	

Ethnicity (Optional) ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

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

If applicable, which tribe do they belong to? _____ Do they live on tribal land? ☐ Yes ☐ No

Are they in school? ☐ Yes ☐ No	If yes, what grade? _____	Name of school _____	Full time student? ☐ Yes ☐ No

If there are more than six people in the household, you can include additional pages with your application.

More about your household

If anyone you are applying for has served in the military, answer the following questions for each member.

Military Service Members	Name: _____	Name: _____
In which branch did you serve?		
When did you serve? (dates)		
Has this person applied for VA benefits?	☐Yes ☐No	☐Yes ☐No
If no, would you like help from the Maine Veterans' Service to apply for VA benefits?	☐Yes ☐No	☐Yes ☐No

If you would like help, please be sure to complete the Authorization to Release Information form and authorize DHHS to release information to "Maine Veterans' Service".

More about your household – Continued

Does anyone in your household have an injury, illness, or disability that has lasted or is expected to last for at least 12 months? ☐ Yes ☐ No If yes, who? _____

Is anyone in your household pregnant? ☐ Yes ☐ No If yes, who? _____
What is the expected due date? _____ How many babies are expected? _____

Of the individuals listed on the application, are any of them foster children, in state custody or boarders?
☐ Yes ☐ No If yes, who? _____
Please explain:

Are you or anyone for whom you are applying in violation of parole or probation or fleeing to avoid prosecution or confinement for a felony? If yes, who? _____ ☐ Yes ☐ No

Have you or anyone for whom you are applying ever been convicted of making false or misleading statements about your identity or address to get Food Supplement, Medicaid, or TANF in two or more states at the same time? If yes, who? _____ ☐ Yes ☐ No

If someone is 18 to 50 years old, did they get Food Supplement in another state in the past three years? If yes, who? _____ Which state(s)? _____ ☐ Yes ☐ No

Does anyone in the household pay any of the following types of expenses?

Pre-Tax Deductions from a paycheck, Alimony or Student Loan Interest.

Type and Description	Who pays?	How much?	How often?

If you are paying someone to take care of your children or disabled adults, complete the following.

Name of person being paid_____
Address_____
_____Phone #_____
How much help do you get with
child care expenses $_____ How often_____
Amount paid $ _____ How often _____
For whom: _____ Type of Provider:_____

Name of person being paid_____
Address_____
_____Phone #_____
How much help do you get with
child care expenses $_____ How often_____
Amount paid $ _____ How often _____
For whom: _____ Type of Provider:_____

Does anyone in your household get benefits from another state?

Members Covered	Program Type	State Providing Assistance	Date Assistance Started	Date Assistance Ended	Months on TANF in Other States

For American Indians and Alaskan Natives Only

Names of those with Indian Health Service Coverage:

Does Not Receive Indian Health Service Coverage, but is eligible:

Please answer if you are applying for Food Supplement benefits

Do you have an EBT Food Supplement Card? ☐Yes ☐No

How many people, including yourself, live in your home and purchase and prepare meals with you?

If someone is 18 to 50 years old, did they get Food Supplement in another state in the past three years?
☐ Yes ☐ No If yes, who? _____ Which state(s)? _____

Is anyone in your household on strike? ☐ Yes ☐ No If yes, who? _____

Has anyone in your household left a job in the last 60 days?
☐ Yes ☐ No If yes, who? _____
Please explain:

Employment

Proof of income is required. Please give us a copy of the last 4 weeks' wage stubs or a statement of earnings from all employers. If you or anyone you are applying for, including children, has income from employment, complete this section.

Household Member	Currently Employed	Current or Last Employer	Weekly Hours	Hourly Pay or Salary	How Often Paid
	☐ Yes ☐ No				
	☐ Yes ☐ No				
	☐ Yes ☐ No				
	☐ Yes ☐ No				

Self-Employment

You must provide a copy of the most recent tax return or current business income and expense records.

Name of person who is self-employed:	
Is this a partnership or corporation? ☐ Yes ☐ No	
Name of Business:	
Type of Business:	
Hours worked weekly:	Monthly Net Income (after expenses):

Unearned Income

Examples of unearned income include:

Social Security Benefits	Unemployment	Railroad Retirement	Rental Income
SSI	Child Support	Workers' Comp	Pensions
Veterans Benefits	Grants, Loans	Military Allotments	Alimony
Annuities	Scholarships	Interest/Dividends	Other Unearned Income

Household Member Name	Unearned Income Type	Source	Gross Amount Received (before any deductions)	How Often Paid

Other Income Questions

Do you receive an Earned Income Tax Credit (EITC) in your normal paycheck? ☐ Yes ☐ No

Do you receive a yearly EITC? ☐ Yes ☐ No If yes, when? _____ For how much? _____

Does anyone give any money or assistance to anyone in your household? ☐ Yes ☐ No

Do you expect any change in income? ☐ Yes ☐ No If yes, explain:

Has anyone recently received, or does anyone expect to receive in the near future, any payments such as retroactive government benefits, compensation, pay raises, lawsuit settlements, inheritance, lottery winnings, etc.?
☐ Yes ☐ No If yes, explain:

Assets

If additional space is needed, please attach a separate sheet of paper. Examples of assets include:

Cash	Trust Accounts	Profit Sharing	Prepaid Burial
Savings Accounts	Stocks or Bonds	Life Insurance	Separate Identifiable Accounts
Checking Accounts	Christmas Clubs	IRA, 401K	Family Development Accounts
Credit Union Accounts	Annuities	Keogh Plan	Certificate of Deposits

Type of Asset	Name of Bank/Institution	Account Number	Current Balance or Value

Vehicles

Include jointly owned vehicles. Examples of vehicles include:

Cars	Campers	ATVs	Tractors
Trucks	Motorcycles	Trailers	Antique Automobiles
Boats	Snowmobiles	Skidders	Other Motorized Vehicles

Year	Make/Model	Name(s) of Owner	Amount Owed	How is this vehicle used?

Property

Do you or anyone you are applying for have property? Examples of property include:

Personal Residence	Warehouse	Commercial Property
Rental Real Estate	Land	Vacation Homes

Description of Property	Primary Residence	Value	Amount Owed	Jointly Owned?
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			

Did anyone sell, trade, or give away anything of value during the last three months? ☐ Yes ☐ No
If yes, explain:

Tell us about your expenses. Fill this out only if you are applying for TANF or Food Supplement benefits.

Do not include past due payments or security deposits.

Expense	How Much	How Often	Expense	How Much	How Often
Rent			Lot Rent		
Heat			Mortgage		
Electricity			Property Taxes		
Telephone (basic)			House Insurance		
Water			Cooking Fuel		
Sewer			Trash Collection		

Is your heating cost included in your rent? ☐ Yes ☐ No

Does your mortgage include taxes and house insurance? ☐ Yes ☐ No ☐ Does not apply

Has General Assistance helped you with any of the above expenses in the last 6 months? ☐ Yes ☐ No

Does anyone pay child support? ☐ Yes ☐ No If yes, who pays? _____
Amount? $_____ How often? _____ To whom? _____ For whom? _____

Do you receive a rent subsidy? ☐ Yes ☐ No If yes, how much? _____ How Often? _____

Does anyone outside your household pay all or part of the expenses that you listed above? ☐ Yes ☐ No
If yes, who? _____ Explain what bills they pay:

Did your household get more than $20.00 in HEAP (fuel assistance) benefit in this month or in the last 12 months?
☐ Yes ☐ No If yes, what was the latest date of receipt?_____

Additional Medicaid Questions – Fill this out only if you are applying for medical coverage.

Tax Information, Applicant, Person 1 *You can still be eligible for programs even if you don't file Federal Income Tax.

A. Will you file Income Tax for the current tax year? ☐ Yes ☐ No
If yes, answer questions B, C, and D. If no, only answer question D.

B. Will you file jointly with a spouse? ☐ Yes ☐ No
If yes, name of spouse:

C. Will you claim dependents on your tax return? ☐ Yes ☐ No
If yes, name of dependent(s):

D. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, name of who will claim you:

Tax Information, Person 2, (From page 3) *Family Planning Only Applicants Need to Only Fill Out Person 1.

A. Will you file Income Tax for the current tax year? ☐ Yes ☐ No
If yes, answer questions B, C, and D. If no, only answer question D.

B. Will you file jointly with a spouse? ☐ Yes ☐ No
If yes, name of spouse:

C. Will you claim dependents on your tax return? ☐ Yes ☐ No
If yes, name of dependent(s):

D. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, name of who will claim you:

Tax Information, Person 3 (From page 3)

A. Will you file Income Tax for the current tax year? ☐ Yes ☐ No
If yes, answer questions B, C, and D. If no, only answer question D.

B. Will you file jointly with a spouse? ☐ Yes ☐ No
If yes, name of spouse:

C. Will you claim dependents on your tax return? ☐ Yes ☐ No
If yes, name of dependent(s):

D. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, name of who will claim you:

Tax Information, Person 4 (From page 3)

A. Will you file Income Tax for the current tax year? ☐ Yes ☐ No
If yes, answer questions B, C, and D. If no, only answer question D.

B. Will you file jointly with a spouse? ☐ Yes ☐ No
If yes, name of spouse:

C. Will you claim dependents on your tax return? ☐ Yes ☐ No
If yes, name of dependent(s):

D. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, name of who will claim you:

Tax Information, Person 5 (From page 4)

A. Will you file Income Tax for the current tax year? ☐ Yes ☐ No
If yes, answer questions B, C, and D. If no, only answer question D.

B. Will you file jointly with a spouse? ☐ Yes ☐ No
If yes, name of spouse:

C. Will you claim dependents on your tax return? ☐ Yes ☐ No
If yes, name of dependent(s):

D. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, name of who will claim you:

Tax Information, Person 6 (From page 4)

A. Will you file Income Tax for the current tax year? ☐ Yes ☐ No
If yes, answer questions B, C, and D. If no, only answer question D.

B. Will you file jointly with a spouse? ☐ Yes ☐ No
If yes, name of spouse:

C. Will you claim dependents on your tax return? ☐ Yes ☐ No
If yes, name of dependent(s):

D. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, name of who will claim you:

Medicare Information – Please list anyone who has a red, white and blue Medicare card.

Name	Medicare Number	Medicare Part A Start Date	Medicare Part B Start Date

Other Medical Insurance

List any household members that receive health coverage or insurance now.

Name(s):	Company:
Policy Number:	Type of Insurance:

Employer Insurance

List household members with or eligible for employer sponsored health insurance, now or in the next three months.

Person Employed:	Social Security Number:
Employee Contact Phone:	Date when eligible to enroll:
Minimal essential coverage? ☐ Yes ☐ No	Monthly premium amount for lowest-cost plan offered:
Employer Name:	Employer EIN:
Employer Address:	
Employer Phone:	Employer Email:
Employer Insurance Name:	

Has any child lost health insurance in the past 3 months? ☐ Yes ☐ No If yes, why?

For MaineCare Applicants

Does any child on this application have a parent living outside of the home? ☐ Yes ☐ No If yes, I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell the Department and I may not have to cooperate.	Are you asking for help with medical bills incurred in the last 3 months? ☐ Yes ☐ No

If you are applying for TANF or Parents as Scholars, are under 18 and are a parent or pregnant, please read this.

Maine law prevents TANF or PaS cash benefits from being paid directly to unmarried minor parents. Instead of cash payments, the Department will send portions of the TANF or PaS benefit directly to vendors to pay monthly expenses. The rest of the TANF or PaS benefit must be sent to an adult payee who agrees to manage the money and agrees to explain how it is used on the minor's behalf. List the name, relationship, address and telephone number of the payee you would like the Department to consider:

Important Information for Food Supplement Applicants

Information about Food Supplement Penalties

If you do the following…	You will lose food benefits for…
• Hide information or make false statements • Use food benefits to buy alcohol or tobacco • Trade or sell benefits or EBT cards • Dump containers only for the cash redemption value • Resell food bought with food benefits for cash • Use Electronic Benefits Transfer (EBT) cards that belong to someone else	• 12 months for the first offense • 24 months for the second offense • Permanently for the third offense
• Trade food benefits for controlled substance such as drugs	• 24 months for the first offense • Permanently for the second offense
• Trade food benefits for firearms, ammunition or explosives	• Permanently
• Trade, buy or sell food benefits of $500 or more	• Permanently
• Give false information about your identity and where you live so you can get extra food benefits	• 10 years for each offense
You can also be fined up to $250,000 or put in prison for up to 20 years or both, for doing these things. You may also be charged under other federal laws.	
If you knowingly do the following...	**You may be...**
• Use EBT cards that are not yours • Transfer your EBT cards to other people • Acquire or possess EBT cards that are not yours	• Guilty of a felony or misdemeanor • Fined • Put in prison • Ineligible for food benefits for a period of time

Notification of Right to Request a Hearing

At the time of application, each household shall be informed in writing of its right to a hearing, of the method by which a hearing may be requested, and that its case may be presented by a household member or a representative, such as a legal counsel, a relative, a friend or other spokesperson. In addition, at any time the household expresses to the State agency that it disagrees with a State agency action, it shall be reminded of the right to request a fair hearing. If there is an individual or organization available that provides free legal representation, the household shall also be informed of the availability of that service.

Privacy Act (HIPAA) Statement

(i) The collection of this information, including the social security number (SSN) of each household member, is authorized under the Food Stamp Act of 1977, as amended, 7 U.S.C. 2011-2036. The information will be used to determine whether your household is eligible or continues to be eligible to participate in the Food Stamp Program. We will verify this information through computer matching programs. This information will also be used to monitor compliance with program regulations and for program management.

(ii) This information may be disclosed to other Federal and State agencies for official examination, and to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law.

(iii) If a food stamp claim arises against your household, the information on this application, including all SSNs, may be referred to Federal and State agencies, as well as private claims collection agencies, for claims collection action.

Food Supplement Processing

The normal processing time for food supplement applications is 30 days. Certain households are entitled to expedited processing. Those households include those with less than $150.00 in gross income, migrant or seasonal farmworker households whose total liquid assets do not exceed $100, and households whose monthly rent or mortgage and utilities expenses are higher than the combined monthly gross income.

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 over issuance 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:_____

Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives

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 Mental Health Services
❒ Office for Family Independence including Medical Review	❒ Office of Child and Family Services
❒ Maine Centers for Disease Control and Prevention	❒ Office of Aging and Disability Services
❒ Dorothea Dix Psychiatric Center	❒ Office of Administrative Hearings
❒ Riverview Psychiatric Center	❒ Other:
Individual's Name:	Individual's Date of Birth: Individual's Social Security Number:

Individual's Address:

Street Town/City State Zip Code

Records to be released, including written, electronic and verbal communication:

❒ All Healthcare, including treatment, services, supplies and medicines

❒ Claims Information ❒ Billing, payment, income, banking, tax, asset, and/or other information regarding eligibility for DHHS program benefits such as MaineCare

❒ Other: _____

❒ Limit to the following date(s) or type(s) of information:
(e.g. "lab test dated June 2, 2013" or "hospital records from 1/1/14 - 1/15/14")

I authorize the DHHS office(s) checked above to: ❒ Release my information to: ❒ Obtain my information from:

Name: _____

Address: _____
Street Town/City State Zip Code

Fax No., where applicable: _____ Phone No. to verify Receipt of Fax _____

If requesting that electronic information be transmitted by email, please clearly print the email address below:
❒ I understand that DHHS systems may not be able to send my information securely through email. I understand that email and the internet have risks that DHHS cannot control and that the information possibly could be read by a third party. I accept those risks and still request that DHHS send my information by email. Initials __

Please allow the office(s) named above to disclose my information for the following purpose(s):

❒ For a legal matter including an administrative hearing ❒ To see if I qualify for insurance coverage or benefits

❒ For coordination of my care ❒ A Personal Request ❒ Other (note here):

By initialing 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 implications. Positive implications may include giving you more complete care, and negative implications may include

I (individual/personal representative of individual) permit DHHS to release and/or obtain my records as written on Page 1 of this form. 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: _____