Application for
Long Term Care MaineCare

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 Community Benefits Waiver (Section 19)
- [ ] Residential Care Facility
- [ ] Support Services Waiver (Section 29)
- [ ] MR Waiver (Section 21)
- [ ] Other Related Conditions Waiver (Section 20)
- [ ] Adults with Brain Injury Waiver (Section 18)

### Information about you, the applicant.

Your Name (First, Middle, Last, Suffix)

<table>
<thead>
<tr>
<th>Social Security Number</th>
<th>Date of Birth</th>
<th>Place of Birth</th>
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<tbody>
<tr>
<td></td>
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</table>

Mailing Address

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>Telephone Number</th>
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</table>

Home Address (where you actually live, if different from above)

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>Have you lived elsewhere in the last 5 years?</th>
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</thead>
<tbody>
<tr>
<td></td>
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<td>If yes, provide mailing and home addresses.</td>
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</table>

Gender: [ ] Male  [ ] Female

Marital Status: [ ] Single  [ ] Married  [ ] Separated  [ ] Divorced  [ ] Widowed, date of death of your spouse: _______________

Are you a U.S. Citizen? [ ] Yes  [ ] No

Have you ever served in the U.S. Armed Forces? [ ] Yes  [ ] No

If you are a Veteran, would you like assistance from the Maine Bureau of Veterans’ Services? [ ] Yes  [ ] No

Race (optional)  
(Check all that apply)  
[ ] White  [ ] Black or African American  [ ] Native Hawaiian or Pacific Islander  [ ] American Indian or Alaskan Native  [ ] Other _______________________

### Information about your spouse.

Spouse’s Name (First, Middle, Last, Suffix)

<table>
<thead>
<tr>
<th>Social Security Number</th>
<th>Date of Birth</th>
<th>Place of Birth</th>
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<tbody>
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</table>

Gender: [ ] Male  [ ] Female

Does your spouse live with you? [ ] Yes  [ ] No  
*If no, provide mailing and home addresses.*

Spouse’s Mailing Address

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
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Spouse’s Home Address (only if different from above)

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
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<tbody>
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</table>

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? [ ] Yes  [ ] No

Race (optional)  
(Check all that apply)  
[ ] White  [ ] Black or African American  [ ] Native Hawaiian or Pacific Islander  [ ] American Indian or Alaskan Native  [ ] Other _______________________
### Income

Do you or your spouse receive any income? □ Yes  □ No  If yes, list below. **Examples of income types:**

- Social Security Retirement (SSA/SSR)
- Social Security Disability (SSDI)
- Supplemental Security Income (SSI)
- Veterans (VA) Compensation
- Veterans (VA) Aid and Attendance
- Veterans (VA) Pension
- Pension
- Military Retirement (DFAS)
- Civil Service Annuity
- Other Annuity Payments
- Railroad Retirement
- Long/Short Term Disability Payments
- Social Security Retirement (SSA/SSR)
- Social Security Disability (SSDI)
- Supplemental Security Income (SSI)
- Veterans (VA) Compensation
- Veterans (VA) Aid and Attendance
- Veterans (VA) Pension
- Pension
- Military Retirement (DFAS)
- Civil Service Annuity
- Other Annuity Payments
- Railroad Retirement
- Long/Short Term Disability Payments
- Alimony
- Dividend or Interest
- Self-Employment
- Payment from a trust
- Earnings (wages)
- Workers Compensation

<table>
<thead>
<tr>
<th>Your Income</th>
<th>Gross Amount</th>
<th>How often received?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example – Retirement Pension</td>
<td>$500</td>
<td>Bi-Weekly</td>
</tr>
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<thead>
<tr>
<th>Your Spouse’s Income</th>
<th>Gross Amount</th>
<th>How often received?</th>
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<tbody>
<tr>
<td>Example – Social Security Retirement</td>
<td>$800</td>
<td>Monthly</td>
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</table>

Do you or your spouse receive rent monthly from property? □ Yes  □ No
Do you or your spouse receive money from someone who pays room and board? □ Yes  □ No
Do you or your spouse receive money from irregular income during the year? □ Yes  □ No

### Assets

You will need to provide proof of all assets you and your spouse own or have an interest in. **Examples of assets:**

- Cash
- Checking Account
- Savings Account
- Credit Union Account
- Money Market Account
- Resident Account at Facility
- Certificate of Deposit (CD)
- IRA, 401K, or 403B
- Keogh Plan
- Deferred Compensation
- Stocks
- Stock Options
- Bonds
- Profit Sharing
- Safe Deposit Box
- Trust Funds
- Annuities
- Promissory Note
- Direct Express Account
- Other Financial Investments

<table>
<thead>
<tr>
<th>Name(s) on Account</th>
<th>Asset Type (see above)</th>
<th>Name of Bank or Institution</th>
<th>Account Number</th>
<th>Current Balance or Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example</td>
<td>Checking</td>
<td>Any Bank</td>
<td>12345</td>
<td>$500</td>
</tr>
</tbody>
</table>
Do you or your spouse have any Life Insurance Policies?  □ Yes  □ No  If yes, list below.

<table>
<thead>
<tr>
<th>Policy Owner</th>
<th>Policy Number</th>
<th>Individual(s) Covered</th>
<th>Insurance Company</th>
<th>Face Value</th>
<th>Cash Value</th>
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</table>

Do you or your spouse have a Funeral Plan, Pre-Paid Burial, or Mortuary Trust?  □ Yes  □ No  If yes, list below.

<table>
<thead>
<tr>
<th>Date Set Up</th>
<th>Who is it for?</th>
<th>Where are the funds held?</th>
<th>Is it irrevocable?</th>
<th>Amount</th>
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<td>□ Yes  □ No</td>
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<td>□ Yes  □ No</td>
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<td>□ Yes  □ No</td>
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</table>

Do you or your spouse own, or jointly own, any vehicles?  □ Yes  □ No  If yes, list below.  Examples of vehicles:

Cars  Boats  RVs  Motorcycles  ATVs  Skidders
Trucks  Trailers  Campers  Snowmobiles  Tractors  Other motorized vehicles

<table>
<thead>
<tr>
<th>Vehicle Type</th>
<th>Year</th>
<th>Make/Model</th>
<th>Owner Name(s)</th>
<th>Amount Owed</th>
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Do you or your spouse own, or jointly own, any property?  □ Yes  □ No  If yes, list below.  Examples of property:

Land  Buildings  Timeshare  Camp
Empty Lot  Life Estate  House  Rental Property

<table>
<thead>
<tr>
<th>Property Type</th>
<th>Full Address of Property</th>
<th>Owner Name(s)</th>
<th>Amount Owed</th>
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Would you return to your residence if you no longer need care in a Nursing Facility or Residential Care Facility?  □ Yes  □ 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?  □ Yes  □ No  If yes, explain:

Have you or your spouse recently received, or do either of you expect to receive, any retroactive government benefits, pay raises, lawsuit settlements, inheritances, lottery winnings or compensation of any other kind?  □ Yes  □ No  If yes, explain:
**Transfer of Assets**

Have you, your spouse, or anyone acting on your or your spouse’s behalf disposed of, sold, or given away anything of value within the last 60 months?  ☐ Yes  ☐ No  *If yes, list below.* **Examples of things you may have owned:**

<table>
<thead>
<tr>
<th>Personal Property</th>
<th>Money</th>
<th>Life Insurance</th>
<th>Vehicles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Real Estate</td>
<td>Bank Accounts</td>
<td>Stocks</td>
<td>Foreign Assets</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Item Given Away</th>
<th>Value of Item</th>
<th>Person Who Gave Item Away</th>
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Have you, your spouse, or anyone acting on your or your spouse’s behalf closed any savings, checking, or any other financial accounts within the last 60 months?  ☐ Yes  ☐ No  *If yes, list below.*

<table>
<thead>
<tr>
<th>Type of Account Closed</th>
<th>Date Closed</th>
<th>Reason for Closure</th>
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**Expenses**

If you are in a hospital or nursing facility, does your spouse live at home and pay shelter expenses?  ☐ Yes  ☐ No  *If yes, list below.* **Examples of shelter expenses:**

<table>
<thead>
<tr>
<th>Mortgage</th>
<th>Heat</th>
<th>Water/Sewer</th>
<th>Homeowners Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rent</td>
<td>Electricity</td>
<td>Trash Collection</td>
<td>Renters Insurance</td>
</tr>
<tr>
<td>Property Taxes</td>
<td>Telephone/Cell Phone</td>
<td>Lot Rent</td>
<td>Condo Association Fees</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of Expense</th>
<th>Who Pays this Expense</th>
<th>Who is it paid to</th>
<th>Amount</th>
<th>How Often Paid</th>
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</table>

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 Insurance**

Do you have Medicare Coverage?  ☐ Yes  ☐ No  Medicare Claim Number: ____________________________

<table>
<thead>
<tr>
<th>Part A Effective Date:</th>
<th>Part B Effective Date:</th>
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</table>

Part A Premium Amount: _________________________  Part B Premium Amount: _________________________

Does your Spouse have Medicare Coverage?  ☐ Yes  ☐ No  Medicare Claim Number: ____________________________

<table>
<thead>
<tr>
<th>Part A Effective Date:</th>
<th>Part B Effective Date:</th>
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Part A Premium Amount: _________________________  Part B Premium Amount: _________________________
Do you or your spouse have any other medical insurance?  ☐ Yes  ☐ No  If yes, list below.  **Examples of insurance:**

<table>
<thead>
<tr>
<th>Insurance Type</th>
<th>Name of Insured</th>
<th>Name of Insurance Company</th>
<th>Policy Number</th>
<th>Premium Amount</th>
<th>How Often Paid</th>
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</table>

Do you or your spouse have any Long Term Care Insurance?  ☐ Yes  ☐ No  If yes, list below.

<table>
<thead>
<tr>
<th>Name of Insured</th>
<th>Name of Insurance Company</th>
<th>Policy Number</th>
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<tbody>
<tr>
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</table>

Are you now, or have you in the past 90 days been in a hospital, nursing facility, or residential care facility?  ☐ Yes  ☐ No  If yes, list below.

<table>
<thead>
<tr>
<th>Facility Name</th>
<th>Facility Address</th>
<th>Admission Date</th>
<th>Discharge Date</th>
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Do you need help with any medical bills incurred within the past three months?  ☐ Yes  ☐ No  If yes, which months?  __________________________  Note: You must send proof of income and assets for these months.

**Assistance with Application**

Do you have a power of attorney, conservator, or court-ordered guardian?  ☐ Yes  ☐ No  If yes, list below.

Person’s Name:  ___________________________________________  Type:  ___________________________

Address:  ___________________________________________  Phone:  ___________________________

*Please provide a copy of the court order or the power of attorney.*

Is there someone else who knows about your financial situation, and whom we may contact to help with this application?  ☐ Yes  ☐ No  If yes, list below.

Person’s Name:  ___________________________________________  Type:  ___________________________

Address:  ___________________________________________  Phone:  ___________________________

*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.

Person’s Name:  ___________________________________________  Phone:  ___________________________
**Acknowledgements**

**Annuity Disclosure:** You need to tell us about any annuity that you or your spouse have an interest in. In order to 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/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 only 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 benefits.

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.

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

_____ 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: __________

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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: ________
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 Team ☐ 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 initializing 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 discrimination if the data is misused. DHHS will protect your HIV data, and all your records, as the law requires.

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: ____________________________________________