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

Application for MaineCare 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. 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 the back of this page. If you are applying for MaineCare because you are disabled, you may need to complete a disability determination form. Forms are available online at http://www.maine.gov/dhhs/ofi/public-assistance/.

Where do I return the application?

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

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

Fax: 1-207-778-8429

Please tear off and keep this page for your records.

MaineCare Programs

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

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.

Medicare Savings Program (Buy-In)
Helps pay Medicare deductibles, co-pays, co-insurance or premiums for low-income Medicare members.

Cub Care (CHIP)
Children's Health Insurance Program is a premium based coverage for children 18 and under.

Katie Beckett
Program provides at home care services for children 18 and under who are determined to have a high medical need.

Family Planning Services
Helps with services, such as: Family Planning, Reproductive and Sexual Health Care or Sexually Transmitted Infections.

Low Cost Drugs (DEL)
Helps with the cost of prescription medications for the elderly.

Maine RX
Prescription assistance program to help with the cost of prescription medication.

Special Benefits Waiver
Provides certain services to people with HIV/AIDS.

Breast/Cervical Cancer
Covers clinical breast exams, pelvic exams, pap tests, and high-risk HPV testing.

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 give us. We will let you know what we need.

Earned Income	**Unearned Income**
✓ Pay stubs (most recent 4 weeks)	✓ Social Security Award Letter
✓ Employer statement verifying gross wages	✓ Pension/Retirement statement
✓ Federal income tax return (if self-employed)	✓ Alimony
✓ Statements from roomer/boarder	✓ Child support payment records
✓ Self-employment business records (for 3 months) if no tax return is available	✓ Unemployment/workers' compensation benefits
✓ Verification of Income ending if in last 60 days	✓ Interest/dividend statements
Identity/Citizenship	✓ Financial aid award letter
✓ Driver's license or state identification card	✓ Veteran/military benefits
✓ Birth certificate	**Assets**
✓ Passport	✓ Bank Statements
✓ Immigration or naturalization documents	✓ Certificates of Deposit
Other Documents Which May be Required	✓ Retirement Funds (IRA/Keogh/401K)
✓ Copies of medical insurance cards	✓ Life Insurance Policies
✓ Student loan interest statement	✓ Stocks/bonds/mutual funds

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?
The Department of Health and Human Services ("DHHS") does not discriminate on the basis of disability, race, color, sex, gender, sexual orientation, age, national origin, religious or political belief, ancestry, familial or marital status, genetic information, association, previous assertion of a claim or right, or whistleblower activity, in admission or access to, or the operation of its policies, programs, services, or activities, or in hiring or employment practices.

This notice is provided as required by and in accordance with Title II of the Americans with Disabilities Act of 1990 ("ADA"); Title VI of the Civil Rights Act of 1964, as amended; Section 504 of the Rehabilitation Act of 1973, as amended; Age Discrimination Act of 1975; Title IX of the Education Amendments of 1972; Section 1557 of the Affordable Care Act; the Maine Human Rights Act; Executive Order Regarding State of Maine Contracts for Services; and all other laws and regulations prohibiting such discrimination.

Questions, concerns, complaints or requests for additional information regarding the ADA and hiring or employment practices may be forwarded to the DHHS ADA/EEO Coordinators at 11 State House Station, Augusta, Maine 04333-0011; 207-287-4289 (V); 207-287-1871(V); or Maine Relay 711 (TTY). Questions, concerns, complaints or requests for additional information regarding the ADA and programs, services, or activities may be forwarded to the DHHS ADA/Civil Rights Coordinator, at 11 State House Station, Augusta, Maine 04333-0011; 207-287-5014 (V); Maine Relay 711 (TTY); or ADA-CivilRights.DHHS@maine.gov. Civil rights complaints may also be filed with the U.S. Department of Health and Human Services, Office of Civil Rights, by phone at 800-368-1019 or 800-537-7697 (TDD); by mail to 200 Independence Avenue, SW, Room 509, HHS Building, Washington, D.C. 20201; or electronically at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Individuals who need auxiliary aids for effective communication in program and services of DHHS are invited to make their needs and preferences known to the ADA/Civil Rights Coordinator. This notice is available in alternate formats, upon request.

SIGN HERE – 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 are correct and complete for all persons applying for benefits. If anyone listed on this application is eligible for Medicaid, I am giving to the Medicaid agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving to the Medicaid agency the rights to pursue and get medical support from a spouse or parent. I understand DHHS has the right to collect from other available insurance or from settlement(s) for accidents or injuries whenever MaineCare pays for medical expenses.

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

What programs do you want to apply for?

☐ **MaineCare** ☐ **State Supplement**

☐ **Medicare Savings Plan (Buy-In)** ☐ **Prescription Help (MaineRX, Low Cost Drugs (DEL))**

☐ **Limited Family Planning:** Check this box if you **only** want to apply for the Limited Family Planning Benefit. You only need to fill out this application for yourself and need not include other household members.

If you need **Long Term Care** benefits, like nursing facility care, residential care, nursing care services at home, or waiver services such as adults with brain injuries, you do not need this application. You will need a Long Term Care application only, which can be found online at www.maine.gov/dhhs/ofi/public-assistance or you can call 1-855-797-4357 and ask to have one mailed to you.

All 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
• Are you applying for MaineCare because of the Medicaid expansion law?	☐ Yes ☐ No

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

About Person 1 – Continued

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 questions to the right:	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, what 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, then just sign and mail this to us. You do not need to complete the rest of this application.****

Tax Information, Applicant, 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:

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

Home Address

City	State	Zip Code	Telephone Number

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

If this person is not a U.S. Citizen, then answer the questions to the right:	What is your immigration status?	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) ☐ White ☐ Black or African American ☐ Native Hawaiian or Pacific Islander
(check all that apply) ☐ Asian ☐ American Indian or Alaskan Native ☐ Other

If applicable, what 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

Tax Information, Person 2

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:

About Person 3

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

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

If this person is not a U.S. Citizen, then answer the questions to the right:	What is your immigration status?	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

About Person 3 – Continued

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, what 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

Tax Information, Person 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:

About Person 4

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

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

If this person is not a U.S. Citizen, then answer the questions to the right:	What is your immigration status?	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) ☐ White ☐ Black or African American ☐ Native Hawaiian or Pacific Islander
(check all that apply) ☐ Asian ☐ American Indian or Alaskan Native ☐ Other

If applicable, what 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

Tax Information, Person 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):

Tax Information, Person 4 – Continued

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

About Person 5

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

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

If this person is not a U.S. Citizen, then answer the following questions:	What is your immigration status?	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) ☐ White ☐ Black or African American ☐ Native Hawaiian or Pacific Islander
(check all that apply) ☐ Asian ☐ American Indian or Alaskan Native ☐ Other

If applicable, what 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

Tax Information, Person 5

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:

About Person 6

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

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

About Person 6 – Continued

If this person is not a U.S. Citizen, then answer the following questions:	What is your immigration status?	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) ☐ White ☐ Black or African American ☐ Native Hawaiian or Pacific Islander
(check all that apply) ☐ Asian ☐ American Indian or Alaskan Native ☐ Other

If applicable, what 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

Tax Information, Person 6

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:

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

Pregnancy

Is anyone in your household pregnant? ☐ Yes ☐ No If yes, who?

What is the expected due date? How many babies are expected?

Military Service

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 applying for VA benefits, please be sure to complete the Authorization to Release Information form and authorize DHHS to release information to "Maine Veterans' Service."

Disability

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?

Please tell us about the disability:

Income

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

If yes, who and how much?

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:

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				
	☐ Yes ☐ No				
	☐ Yes ☐ No				
	☐ Yes ☐ No				

Self-Employment

If you are self-employed, 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

Complete this section if anyone in your household has unearned income. Examples of unearned income:

Social Security Benefits	Unemployment	Railroad Retirement	Rental Income
SSI	Child Support	Workers' Compensation	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

Assets

Complete this section ONLY if you are applying because of a disability or if you or someone in your household is age 65 or older.

You will need to provide proof of all assets you own or have interest in. Examples of assets:

Cash	IRA/401k/403b	Trust Funds	Promissory Note
Checking Account	Stocks	Annuities	Certificate of Deposit (CD)
Savings Account	Bonds	Money Market Account	Other Investments

Name on Account	Asset Type (see above)	Name of Bank or Institution	Account Number	Current Balance or Value

If you or anyone in your household own any vehicles, list them below. Include jointly owned vehicles. Examples of vehicles:

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

Vehicle Type	Year	Make/Model	Owner Name(s)	Amount Owed

Assets – Continued

If you or anyone in your household own any property, list them below. Examples of property:

Land	Buildings	Timeshare	Camp
Empty Lot	Life Estate	Rental Property	House

Property Type	Full Address of Property	Owner Name(s)	Amount Owed

If you or anyone in your household owns any life insurance policies, list them below.

Policy Owner	Policy Number	Individual Covered	Insurance Company	Face Value	Cash Value

Expenses

Complete this section if anyone in your household pays any of the following expenses:

Student Loan Interest	Retirement Contributions	Medical Insurance Payments
Section 125 Deduction	Alimony	Any Other Pre-Tax Deductions

Type and Description	Who Pays?	How Much?	How Often?

Medicare Information

Complete this section if you or anyone in your household has Medicare insurance. This information can be found on the red, white and blue Medicare card.

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

For American Indians and Alaskan Natives only

Do you or anyone in your household have Indian Health Service Coverage? ☐ Yes ☐ No
If yes, who?

Is anyone in your household eligible for Indian Health Service Coverage but not receiving it? ☐ Yes ☐ No
If yes, who?

Other Health Insurance

Complete this section if you or anyone in your household have other medical insurance coverage. Examples of other medical insurance:

Private Health Insurance Employer Offered Health Insurance
Dental Insurance Vision Insurance Medicare Supplement Plans

Insurance Type	Name of Insured	Name of Insurance Company	Policy Number	Minimal Essential Coverage
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

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

Out of State Assistance

Is there anyone in your household getting benefits from another state? ☐Yes ☐No If yes, answer below.

Person Covered	Program Type	State Providing Assistance	Date Assistance Started	Date Assistance Ended

Notification of Right to Request a Hearing

If you do not agree with a Department decision you may have the right to an administrative hearing. You can ask for a hearing by calling 1-855-797-4357, or by coming into your local office and talking to an eligibility worker. You may also ask for a hearing by writing a letter to the Commissioner of DHHS. The address is 11 SHS, Augusta, ME 04333.

Estate Recovery

If you get MaineCare benefits and are age 55 or older, the State may make a claim on the assets of your estate (after you die) to recover the money that MaineCare has paid for your care. Estate assets can include real property, including jointly owned property, insurance payments, annuities, any property left to an heir, survivor or assignee. No claim will be made if the only benefit service you get is the Medicare Savings Program (Buy-In Program). For more information about the Estate Recovery Program, call 1-800-977-6740.

This application will not be accepted and cannot be processed without a signature.
Please make sure you have signed page 1.