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**MARYLAND DEPARTMENT of HUMAN RESOURCES**  
**MARYLAND DEPARTMENT of HEALTH and MENTAL HYGIENE**  
**LONG-TERM CARE/WAIVER MEDICAL ASSISTANCE APPLICATION**

Date Signed Application  
 Received in Local Department  
 MUST BE DATE STAMPED

<b>FOR WORKER USE ONLY</b>  <i>This part is for our staff. Please continue to Section A.</i>	LDSS Office	Programs Applied For or Receiving	Assistance Unit IDs Client ID
	Worker's Name		
	Application Date		
	Program Medical Coverage Group _____ AU ID _____		

**SECTION A – BENEFIT SELECTION: *Please tell us about which benefits you want and which benefits you already have.***

I am applying for: <input type="checkbox"/> Long-Term Care <input type="checkbox"/> Waiver	Do you need Medical Assistance for medical bills incurred in the past 3 months? <i>If yes, you will need to provide copies of the bills to your case manager.</i>  <input type="checkbox"/> YES <input type="checkbox"/> NO
Tell us if you are currently receiving other assistance. I currently receive: <input type="checkbox"/> Medical Assistance ID # _____ <i>If you already receive Medical Assistance, please provide your ID number.</i> <input type="checkbox"/> Cash Assistance <input type="checkbox"/> Food Stamps <input type="checkbox"/> Other, list: _____ <i>If you receive any other benefits, please list all the benefits here.</i>	

**SECTION B – APPLICANT INFORMATION: *Please tell us about yourself.***

Last Name	First Name	Middle Name	Suffix	Maiden Name or Other Name
_____	_____	_____	_____ <i>(Jr., Sr., etc.)</i>	_____
Social Security Number: <i>If you have a Social Security Number, enter it here.</i> _____		Additional Social Security Number: <i>If you have an additional Social Security Number, enter it here.</i> _____		
Date of Birth: (Month,Day,Year) _____		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		

## SECTION B – APPLICANT INFORMATION (continued)

Ethnicity

*Optional*

1 – Hispanic or Latino

2 – Not Hispanic or Latino

Race

*Optional –*

*Please choose*

*all race codes*

*that apply to you.*

1 – American Indian/Alaskan Native

2 – Asian

3 – Black/African American

4 – Native Hawaiian/Pacific Islander

5 – White

*You do not have to give information about your race or ethnicity. If you do, it will help show how we obey the Federal Civil Rights Law. We will not use this information to decide if you are eligible. If you do not give us your race, it will not affect your application. The case manager will enter a race code for statistical purposes only. Title VI of the Civil Rights Act of 1964 allows us to ask for this information.*

Are you a resident of Maryland?

YES  NO

Marital Status

Single

Married

Divorced

Separated

Widowed

Are you receiving Medical Assistance (Medicaid) benefits from another state?

YES  NO

If yes, please list the state:

\_\_\_\_\_

Are you a U.S. Citizen?  YES  NO

*If you answered NO, please complete SECTION C – IMMIGRATION STATUS, below.*

What is your primary language?

\_\_\_\_\_

Do you need an interpreter?  YES  NO

If you are not registered to vote, would you like to receive a voter registration form?

YES

NO

Already registered to vote

## SECTION C – IMMIGRATION STATUS (FOR NON-CITIZENS ONLY)

**SEND PROOF** Please send a photocopy of the front and back of your INS card.

What is your current INS Status?

\_\_\_\_\_

On what date did you receive your INS Status?

\_\_\_\_/\_\_\_\_/\_\_\_\_

Are you a Sponsored Immigrant?

YES  NO

What is your Country of Origin?

\_\_\_\_\_

When did you enter the U.S.?

\_\_\_\_/\_\_\_\_/\_\_\_\_

What is your INS Number?

\_\_\_\_\_

If you are a refugee, please list your Refugee Resettlement Agency:

\_\_\_\_\_

**SECTION D – CURRENT ADDRESS of HOME or INSTITUTION/LONG-TERM CARE FACILITY: *Please tell us about your Long-Term Care Facility, if you live in one.***

<p>If you live in a facility, what is the name of the facility?</p> <p>_____</p> <p>On what date did you enter the facility?</p> <p>_____/_____/_____</p>	<p>What is your home address or the address of your facility?</p> <p>Street _____</p> <p>City _____ State _____ ZIP _____</p> <p>Telephone # _____ Cellular Telephone # _____</p> <p>Is this your mailing address? <input type="checkbox"/> YES <input type="checkbox"/> NO If you checked NO, please provide your mailing address information in Section V.</p>
<p>Do you (applicant/recipient) intend to return home? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>Do you (applicant/recipient) intend to return home within 6 months? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>

**SECTION E – PREVIOUS ADDRESSES: *Please tell us where you have lived for the past five years.***

<p>Street _____</p> <p>City _____ State _____ ZIP _____</p>	<p>Did you or your spouse own this home? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<p>Street _____</p> <p>City _____ State _____ ZIP _____</p>	<p>Did you or your spouse own this home? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<p>Street _____</p> <p>City _____ State _____ ZIP _____</p>	<p>Did you or your spouse own this home? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<p>Street _____</p> <p>City _____ State _____ ZIP _____</p>	<p>Did you or your spouse own this home? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>

**SECTION F – AUTHORIZED REPRESENTATIVE: Do you authorize someone to represent you in this application? If so, please tell us about your authorized representative.**

First Name	Middle Name	Last Name	Suffix
_____	_____	_____	_____
<i>(Jr., Sr., III, etc.)</i>			
Address _____			
City _____		State _____ ZIP _____	

**SECTION F – AUTHORIZED REPRESENTATIVE (continued)**

Home Telephone # \_\_\_\_\_  
 Cellular Telephone # \_\_\_\_\_  
 Work Telephone # \_\_\_\_\_

What is the authorized representative's relationship to you?  
 \_\_\_\_\_

*If answer is spouse, please complete the next question:*

Do you or your spouse own this home?     YES    NO

If Authorized Representative is your spouse, please provide spouse's Social Security Number: \_\_\_\_\_

**SECTION G – SPOUSAL INFORMATION: *Please tell us about your spouse. Leave this section blank if your spouse is listed as your Authorized Representative in Section F.***

Last Name	First Name	Middle Name	Suffix	Maiden Name or Other Name
_____	_____	_____	_____ <small>(Jr., Sr., etc.)</small>	_____

Spouse's Social Security Number \_\_\_\_\_

Street _____	Do you or your spouse own this home? <input type="checkbox"/> YES <input type="checkbox"/> NO
City _____ State _____ ZIP _____	
Telephone # _____	

**SECTION H – DISABILITY: *Please tell us about your disability, if you have one.***

Are you disabled?                       YES    NO  
 If yes, when did the disability begin?  
 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

What is your disability?  
 \_\_\_\_\_  
 \_\_\_\_\_

	Premium Amount
Do you receive Medicare Part A? <input type="checkbox"/> YES <input type="checkbox"/> NO	\$ _____
Do you receive Medicare Part B? <input type="checkbox"/> YES <input type="checkbox"/> NO	\$ _____
Do you receive Medicare Part C? <input type="checkbox"/> YES <input type="checkbox"/> NO	\$ _____
Do you receive Medicare Part D? <input type="checkbox"/> YES <input type="checkbox"/> NO	\$ _____

**SEND PROOF** Please send verification of the premium amounts you pay

If yes, please provide your Medicare Claim Number: \_\_\_\_\_

**SECTION I – VETERAN INFORMATION:** *If you are a veteran, a disabled widow(er), or a disabled child of a deceased veteran, fill in this section:*

**SEND PROOF** Please send a photocopy of the front and back of your military service card.

Veteran's Name _____	Relationship to Veteran _____	Veteran's Status _____	Military Service Number _____
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**SECTION J – MEDICAL INSURANCE:** *If the applicant/recipient is insured, fill in this section: If you have more than one policy, place additional information in Section V.*

**SEND PROOF** Please send a photocopy of the front and back of your insurance card(s) and verification of the premium amounts you pay.

Policy Number _____	Group Number _____	Policy Holder Name _____
Relationship to Policy Holder _____		Policy Effective Dates From: _____ To: _____
Policy Holder Address Street _____ City _____ State _____ ZIP _____ Telephone _____		
Insurance Company Insurance Company Name _____ Street _____ City _____ State _____ ZIP _____ Telephone _____		
Union Union Name _____		Union Local Number _____
Street _____ City _____ State _____ ZIP _____ Telephone _____		

**SECTION K – INCOME FROM WORKING:** *Please tell us about any income you or your spouse are currently receiving from working, including any sick leave payments.*

**SEND PROOF** *Please send copies of any proof of pay, such as a paystub. If you need additional space to complete this section, please use Section V or attach additional sheets.*

Employer Name _____	Type of Job _____	
Employer Address _____		
City _____ State _____ ZIP _____		
Telephone # _____		
Date Job Began _____	Date Job Ended _____	Gross Wages per Pay Period, including tips and commissions. \$ _____ per _____
Hours per Pay Period _____	How often do you get paid? <input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Monthly	If the job has ended, what is your last expected pay date? _____

**SECTION L – YOUR BENEFITS AND OTHER INCOME:** *Please tell us about any income or benefits that you are receiving, have applied for, or have been denied.*

**SEND PROOF** *Please send current copies of statements that verify the gross amount of income you receive.*

TYPE OF BENEFIT OR INCOME	RECEIVING INCOME OR BENEFITS?	AMOUNT	APPLICATION STATUS	APPLICATION DATE OR DENIAL DATE
Social Security Please write your claim number:	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	<input type="checkbox"/> Applied for <input type="checkbox"/> Denied	
Black Lung Benefits	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	<input type="checkbox"/> Applied for <input type="checkbox"/> Denied	
SSI (Supplemental Security Income) Please write your claim number:	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	<input type="checkbox"/> Applied for <input type="checkbox"/> Denied	
Veteran’s Pension/Benefits	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	<input type="checkbox"/> Applied for <input type="checkbox"/> Denied	
Pension or Retirement	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	<input type="checkbox"/> Applied for <input type="checkbox"/> Denied	
Civil Service Annuity	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	<input type="checkbox"/> Applied for <input type="checkbox"/> Denied	
Railroad Retirement Benefits Please write your claim number:	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	<input type="checkbox"/> Applied for <input type="checkbox"/> Denied	
Alimony	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	<input type="checkbox"/> Applied for <input type="checkbox"/> Denied	

**SECTION L – YOUR BENEFITS AND OTHER INCOME (continued)**

TYPE OF BENEFIT OR INCOME	RECEIVING INCOME OR BENEFITS?	AMOUNT	APPLICATION STATUS	APPLICATION DATE OR DENIAL DATE
Worker's Compensation	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	<input type="checkbox"/> Applied for <input type="checkbox"/> Denied	
Disability/Sick Benefits	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	<input type="checkbox"/> Applied for <input type="checkbox"/> Denied	
Union Benefits	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	<input type="checkbox"/> Applied for <input type="checkbox"/> Denied	
Unemployment Benefits	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	<input type="checkbox"/> Applied for <input type="checkbox"/> Denied	
Lump Sum Cash Amounts	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	<input type="checkbox"/> Applied for <input type="checkbox"/> Denied	
Interest/Dividends from Stocks, Bonds, Savings, or other investments	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	<input type="checkbox"/> Applied for <input type="checkbox"/> Denied	
Business Income	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	<input type="checkbox"/> Applied for <input type="checkbox"/> Denied	
Other (e.g., <input type="checkbox"/> Rental Income, or <input type="checkbox"/> Compensation from a Legal Settlement)	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	<input type="checkbox"/> Applied for <input type="checkbox"/> Denied	
Other Please describe:	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	<input type="checkbox"/> Applied for <input type="checkbox"/> Denied	

**SECTION M – ASSETS:** *Please tell us about your assets as of the first day of this month. Check YES or NO for each ASSET TYPE. If you check YES, fill in the other boxes. List all assets owned by you or your spouse individually, jointly, or with other persons. If you have more than one asset of the same type, use the "Other" boxes at the bottom of the list.*

**SEND PROOF** *Please send copies of current statements that verify the value of the assets.*

ASSET TYPE	CHECK ONE	OWNER	AMOUNT	ACCOUNT NUMBER	INSTITUTION NAME
Cash on Hand	<input type="checkbox"/> YES <input type="checkbox"/> NO		\$		
Checking Account	<input type="checkbox"/> YES <input type="checkbox"/> NO		\$		
Savings Account	<input type="checkbox"/> YES <input type="checkbox"/> NO		\$		
Credit Union Account	<input type="checkbox"/> YES <input type="checkbox"/> NO		\$		
Trust Fund	<input type="checkbox"/> YES <input type="checkbox"/> NO		\$		
IRA or Keogh Account	<input type="checkbox"/> YES <input type="checkbox"/> NO		\$		
Other Retirement Accounts	<input type="checkbox"/> YES <input type="checkbox"/> NO		\$		
Stocks and Bonds	<input type="checkbox"/> YES <input type="checkbox"/> NO		\$		

**SECTION M – ASSETS (continued)**

ASSET TYPE	CHECK ONE	OWNER	AMOUNT	ACCOUNT NUMBER	INSTITUTION NAME
Treasury or Other Notes	<input type="checkbox"/> YES <input type="checkbox"/> NO		\$		
Annuity	<input type="checkbox"/> YES <input type="checkbox"/> NO		\$		
Ownership in a Company	<input type="checkbox"/> YES <input type="checkbox"/> NO		\$		
Patient Fund Account	<input type="checkbox"/> YES <input type="checkbox"/> NO		\$		
Other _____	<input type="checkbox"/> YES <input type="checkbox"/> NO		\$		
Other _____	<input type="checkbox"/> YES <input type="checkbox"/> NO		\$		
Other _____	<input type="checkbox"/> YES <input type="checkbox"/> NO		\$		
Other _____	<input type="checkbox"/> YES <input type="checkbox"/> NO		\$		

**SECTION N – OTHER ASSETS:** *Please tell us about any other assets you own and assets jointly owned with other individuals. This could include livestock, recreational vehicles, or any other property of value such as collections of antiques, coins, jewelry, or stamps.*

**SEND PROOF** *Please send copies of current statements or documents that establish the fair market value of the asset(s) as well as the amount owed.*

ASSET TYPE	CURRENT FAIR MARKET VALUE	CURRENT AMOUNT OWED	OWNER(S)
	\$	\$	
	\$	\$	

**SECTION O – POTENTIAL ASSET OR INCOME:** *Please tell us about any accident settlement, trust fund, inheritance, or any other money, property, real property, or assistance you expect to receive.*

**SEND PROOF** *Please send copies of current statements or documents that describe the nature, amount, and payment schedule of the asset.*

Asset Type _____	Lawyer Name _____
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**SECTION O – POTENTIAL ASSET OR INCOME (continued)**

Explanation <hr/> Anticipated Date of Receipt _____	Lawyer Telephone # <hr/>
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**SECTION P – REAL PROPERTY: *Please tell us about any real property that you own in or out of the state of Maryland.***

**SEND PROOF** *Please send a copy of the deed to each property. Please also send copies of current documents that verify the equity value of each property.*

Do you and/or your spouse own or have a legal interest in any other real property?  YES  NO  
*If yes, please answer the following questions:*

ADDRESS OF PROPERTY	TYPE OF OWNERSHIP (CHECK ONE)	CURRENT FAIR MARKET VALUE	CURRENT AMOUNT OWED
	<input type="checkbox"/> Rental Property <input type="checkbox"/> Vacation Property <input type="checkbox"/> Time Share <input type="checkbox"/> Vacant Land <input type="checkbox"/> Other Property Rights <input type="checkbox"/> Burial Plot	\$	\$
	<input type="checkbox"/> Rental Property <input type="checkbox"/> Vacation Property <input type="checkbox"/> Time Share <input type="checkbox"/> Vacant Land <input type="checkbox"/> Other Property Rights <input type="checkbox"/> Burial Plot	\$	\$
	<input type="checkbox"/> Rental Property <input type="checkbox"/> Vacation Property <input type="checkbox"/> Time Share <input type="checkbox"/> Vacant Land <input type="checkbox"/> Other Property Rights <input type="checkbox"/> Burial Plot	\$	\$
	<input type="checkbox"/> Rental Property <input type="checkbox"/> Vacation Property <input type="checkbox"/> Time Share <input type="checkbox"/> Vacant Land <input type="checkbox"/> Other Property Rights <input type="checkbox"/> Burial Plot	\$	\$

**SECTION Q – LIFE INSURANCE AND FUNERAL PLANS:** *Please tell us about any life insurance or pre-paid burial plans or funds that you own. Please list all policies and funds, no matter who pays for them.*

**SEND PROOF** *Please send a copy of the declaration page of each policy. Please also send copies of current statements to verify the cash value of each policy, if applicable.*

ORIGINAL FACE VALUE OR VALUE OF PLAN	CASH VALUE	TYPE OF PLAN	POLICY NUMBER OR ACCOUNT NUMBER	POLICY OWNER	COMPANY, FUNERAL HOME, OR BANK NAME
\$	\$	<input type="checkbox"/> Life Insurance <input type="checkbox"/> Burial Plan			
\$	\$	<input type="checkbox"/> Life Insurance <input type="checkbox"/> Burial Plan			
\$	\$	<input type="checkbox"/> Life Insurance <input type="checkbox"/> Burial Plan			

**SECTION R – TRANSFER OF ASSETS:** *Please tell us about any assets that you sold, traded, gifted, or disposed of in the past five years. This could include personal and real property, motor vehicles, stocks, bonds, cash, or other assets.*

**SEND PROOF** *Please send copies of current statements or documents that verify the date the asset was transferred, the value of the asset at the time of the transfer, and the amount you received for the transferred asset. If you need additional space to complete this section, please use Section V or attach additional sheets.*

TRANSFER DATE	TYPE OF ASSET	VALUE OF THE ASSET AT THE TIME OF THE TRANSFER	WHO RECEIVED THE ASSET AND THE REASON FOR THE TRANSFER	AMOUNT RECEIVED
				\$
				\$
				\$

**SECTION S – SPOUSAL BENEFITS AND OTHER INCOME:** *Please tell us about any income or benefits that your spouse is receiving, has applied for, or has been denied.*

**SEND PROOF** *Please send current copies of statements that verify the gross amount of income your spouse receives.*

TYPE OF BENEFIT	RECEIVING BENEFITS?	AMOUNT	APPLICATION STATUS	APPLICATION DATE OR DENIAL DATE
Social Security Please write your claim number:	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	<input type="checkbox"/> Applied for <input type="checkbox"/> Denied	
Black Lung Benefits	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	<input type="checkbox"/> Applied for <input type="checkbox"/> Denied	
SSI (Supplemental Security Income) Please write your claim number:	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	<input type="checkbox"/> Applied for <input type="checkbox"/> Denied	

## SECTION S – SPOUSAL BENEFITS AND OTHER INCOME (continued)

TYPE OF BENEFIT	RECEIVING BENEFITS?	AMOUNT	APPLICATION STATUS	APPLICATION DATE OR DENIAL DATE
Veteran's Pension/Benefits	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	<input type="checkbox"/> Applied for <input type="checkbox"/> Denied	
Pension or Retirement	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	<input type="checkbox"/> Applied for <input type="checkbox"/> Denied	
Civil Service Annuity	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	<input type="checkbox"/> Applied for <input type="checkbox"/> Denied	
Railroad Retirement Benefits Please write your claim number:	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	<input type="checkbox"/> Applied for <input type="checkbox"/> Denied	
Alimony	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	<input type="checkbox"/> Applied for <input type="checkbox"/> Denied	
Worker's Compensation	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	<input type="checkbox"/> Applied for <input type="checkbox"/> Denied	
Disability/Sick Benefits	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	<input type="checkbox"/> Applied for <input type="checkbox"/> Denied	
Union Benefits	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	<input type="checkbox"/> Applied for <input type="checkbox"/> Denied	
Unemployment Benefits	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	<input type="checkbox"/> Applied for <input type="checkbox"/> Denied	
Lump Sum Cash Amounts	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	<input type="checkbox"/> Applied for <input type="checkbox"/> Denied	
Interest/Dividends from Stocks, Bonds, Savings, or other investments	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	<input type="checkbox"/> Applied for <input type="checkbox"/> Denied	
Other Please describe:	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	<input type="checkbox"/> Applied for <input type="checkbox"/> Denied	
Other Please describe:	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	<input type="checkbox"/> Applied for <input type="checkbox"/> Denied	
Other Please describe:	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	<input type="checkbox"/> Applied for <input type="checkbox"/> Denied	

**SECTION T – SPOUSAL NEEDS (SPOUSAL IMPOVERISHMENT):** *If you have a living spouse, fill in this section. List all assets owned in the month the applicant was admitted to a long-term care facility. Include all assets owned individually or jointly by the applicant, or owned individually or jointly by your spouse.*

**SEND PROOF** Please send copies of statements that verify the value of the assets.

ASSET TYPE	CHECK ONE	OWNER	AMOUNT	ACCOUNT NUMBER	INSTITUTION NAME
Cash on Hand	<input type="checkbox"/> YES <input type="checkbox"/> NO		\$		
Checking Account	<input type="checkbox"/> YES <input type="checkbox"/> NO		\$		
Savings Account	<input type="checkbox"/> YES <input type="checkbox"/> NO		\$		

## SECTION T – SPOUSAL IMPOVERISHMENT (continued)

ASSET TYPE	CHECK ONE	OWNER	AMOUNT	ACCOUNT NUMBER	INSTITUTION NAME
Credit Union Account	<input type="checkbox"/> YES <input type="checkbox"/> NO		\$		
Trust Fund	<input type="checkbox"/> YES <input type="checkbox"/> NO		\$		
IRA or Keogh Account	<input type="checkbox"/> YES <input type="checkbox"/> NO		\$		
Other Retirement Accounts	<input type="checkbox"/> YES <input type="checkbox"/> NO		\$		
Stocks and Bonds	<input type="checkbox"/> YES <input type="checkbox"/> NO		\$		
Certificates and Money Market Funds	<input type="checkbox"/> YES <input type="checkbox"/> NO		\$		
Treasury or Other Notes	<input type="checkbox"/> YES <input type="checkbox"/> NO		\$		
Annuity	<input type="checkbox"/> YES <input type="checkbox"/> NO		\$		
Ownership in a Company	<input type="checkbox"/> YES <input type="checkbox"/> NO		\$		
Other _____	<input type="checkbox"/> YES <input type="checkbox"/> NO		\$		
Other _____	<input type="checkbox"/> YES <input type="checkbox"/> NO		\$		
Other _____	<input type="checkbox"/> YES <input type="checkbox"/> NO		\$		

## SECTION U – RESIDENTIAL, SPOUSAL, OR DEPENDENT ALLOWANCE

Have you or your spouse been in an institution/Long-Term Care Facility in the past?  YES  NO

*If yes, please provide the following:*

Date Entered Institution/ Long-Term Care Facility \_\_\_\_\_ Name of the Facility \_\_\_\_\_

Is there a spouse, child under 21, or any other dependent relatives at home?  YES  NO

*If YES, fill in the section below. If you need additional space for assets for dependent children and relatives at home, please use Section V or attach additional sheets.*

NAME	RELATIONSHIP	AGE	GROSS MONTHLY INCOME <b>SEND PROOF</b>	TYPE OF INCOME	VALUE OF ASSET <b>SEND PROOF</b>	ASSET TYPE
			\$		\$	

**SECTION U – RESIDENTIAL, SPOUSAL, OR DEPENDENT ALLOWANCE (continued)**

NAME	RELATIONSHIP	AGE	GROSS MONTHLY INCOME <b>SEND PROOF</b>	TYPE OF INCOME	VALUE OF ASSET <b>SEND PROOF</b>	ASSET TYPE
			\$		\$	
			\$		\$	

If applicant/recipient intends to return home within six months and if there is no spouse, child under 21, or other dependent relatives, fill in the section below:

**SEND PROOF** Please provide your most recent statements to verify the expenses you listed below:

Rent/Mortgage \$ _____	Utilities \$ _____	Heat (if separate from utilities) \$ _____	Property Taxes \$ _____
Home Owner's Insurance \$ _____	Condo Fees \$ _____	Other Shelter Costs (Specify) \$ _____	Other Shelter Costs (Specify) \$ _____

**SECTION V – ADDITIONAL INFORMATION: Please use this area for any information that would not fit in the spaces provided on this application.**

**SECTION W – TAX RETURNS: *Please tell us about any tax returns filed by you and/or your spouse in the last five years.***

Did you or your spouse file Federal income tax returns in the last five years?  YES  NO

**SEND PROOF** *Please send copies of Federal tax returns for the current year and the preceding four years, including all forms and schedules.*

**SECTION X – PRE-ELIGIBILITY MEDICAL EXPENSES (NON-COVERED SERVICES):  
*Please tell us about any unpaid medical bills that you incurred in the last three months.  
You may be eligible for deductions from your income.***

Do you have any unpaid medical bills that you incurred in the last three months?  YES  NO

**SEND PROOF** *If you answered yes, provide a newly dated, itemized, unpaid medical bill(s) that you incurred up to three months prior to this application. The bill must contain a service date, charge, and a detailed description of the service(s) provided. Attach copies of the bill(s) to the form and submit them with your Long-Term Care Medical Assistance application. If you do not have the bills at the time you submit the application, the bills may be submitted at a later date during this application process.*

Please check one of the YES or NO choices below and sign where you have indicated your choice:

- YES, I HAVE unpaid medical bills from the last three months.
  - I am sending copies of my bills with this application.
  - I will send copies of my bills at a later date during this application process.

Signature: \_\_\_\_\_ (Applicant)

Date: \_\_\_\_\_

Signature: \_\_\_\_\_ (Authorized Representative)

Date: \_\_\_\_\_

- NO, I DO NOT HAVE unpaid medical bills at this time.

Signature: \_\_\_\_\_ (Applicant)

Date: \_\_\_\_\_

Signature: \_\_\_\_\_ (Authorized Representative)

Date: \_\_\_\_\_



**MARYLAND DEPARTMENT of HUMAN RESOURCES**  
**MARYLAND DEPARTMENT of HEALTH and MENTAL HYGIENE**  
**LONG-TERM CARE/WAIVER MEDICAL ASSISTANCE APPLICATION**

**RIGHTS AND RESPONSIBILITIES**

**I UNDERSTAND I HAVE THE FOLLOWING RIGHTS:**

- **The Department cannot discriminate against me.** Federal and State law prohibit the Department from discriminating against me because of race, color, national origin, sex, age, or disability. If I think the Department has discriminated against me, I may contact the U.S. Department of Health and Human Services at: HHS, Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or by calling 202-619-0403 (voice) or 202-619-3257 (TDD).
- **I have the right to privacy of my personal information.** I am providing personal information (that includes, but is not limited to: name, address, date of birth, Social Security number, income history, employment history, medical history) in this application for Medical Assistance. The purpose of requesting this personal information is to determine my eligibility for Medical Assistance. If I do not provide this information, the Department may deny my application for benefits. I have a right to inspect, amend, or correct this personal information. The Department will not permit inspection of my personal information, or make it available to others, except as permitted by Federal and State law. I understand, however, that the Department may deny my application for Medical Assistance if I do not provide this information.
- **If my case is approved, the Department will provide me with a written notice explaining my benefits.** The Department must give me written notice when it changes my benefits or, determines that I am ineligible for Medical Assistance. I have 90 days from the date of the notice to request a hearing. If I am already receiving benefits and request a hearing within 10 days from the date of the notice, I may continue to receive benefits while I wait for the hearing. Any erroneous benefits I receive from the Department must be repaid to the Department.
- **I have the right to appeal certain actions taken by the Department.** I can request a hearing if: my application for Medical Assistance eligibility is denied; I assert the Department's decision about Medical Assistance services was erroneous; or, there was a delay in the Department's action(s) related to my application. I may call the Department at 1-800-332-6347 for help requesting a hearing. I am responsible for providing the reason for requesting a hearing. At the hearing, I may speak for myself or I may be accompanied by a lawyer, friend, or relative to speak on my behalf.

**IF I ACCEPT MEDICAL ASSISTANCE, I UNDERSTAND BY SIGNING THIS APPLICATION:**

- **Payment Authorization** - I authorize payment under Medicare Part B to be made directly to health care providers and medical suppliers.
- **Assignment of Health Insurance/Third Party Payments** - I assign all rights, title, and interest of health insurance payments I may have to the Department and give the Department the right to seek payment from private or public health insurance and any liable third party for the costs the Department incurs for the benefits I receive under Medical Assistance. The Department may seek payment without legal action, providing it does not keep more than the amount Medical Assistance paid. I agree to promptly forward, to the Department, any health insurance payments I receive, including payments received as a settlement from an accident.
- **Access to Records** - I give the Department the right to inspect, review, and copy all relevant portions of my medical records for purposes of determining my eligibility for, and for determining the appropriateness of the services received through, the Medical Assistance program.
- **Quality Review Cooperation** - I understand that the Department may select my case for a random check or audit for quality control purposes. I agree to allow any representative from the Department to visit me where I reside. I will fully assist the Department in retrieving all proof needed from any source.
- **Estate Recovery** - I understand that the Department may recover, from the estate of a deceased Medical Assistance recipient, Medical Assistance payments made on his or her behalf on or after the person attained age 55. The Department may recover only if there is no surviving spouse, unmarried child younger than 21, or blind or disabled child (married or unmarried) of any age.
- **Accurate and Confidential Application Information** - I acknowledge that I must provide true, correct, and complete information and provide proof of this information.

- **Social Security Number(s)** - I must provide my (and my spouse's) Social Security number as an applicant for Medical Assistance. The Department will use the Social Security number(s) and other information I provide to verify the information I provide for program reviews. The Department will do this to make sure I am eligible. The Department may also verify my information by contacting my employer, bank, or other parties; and/or, the Department may contact local, State, or Federal agencies to make sure the information I provide is correct. If I do not have a Social Security number, I must apply for one and the Department can provide assistance in applying for a number.
- **Accurate Financial Reporting** - I understand that I am responsible for reporting true, correct, and complete financial information. This includes, but is not limited to information about: all my assets; potential assets; transfer of assets within the last 5 years of my initial application; transfer of assets within the last 12 months of the date of the annual redetermination of my eligibility; income; insurance; real property; annuities; and all other benefits I may be receiving. I understand that Federal law requires that, as a condition of receiving long-term care services, the Department must be named, in my annuity, as the primary remainder beneficiary.
- **Report Changes** - I am responsible for reporting changes in my situation. I must report changes within 10 days. The best way for me to report changes is in writing. Examples of changes in my situation are changes in my income, assets, address, health insurance premiums, or persons living in my home. My representative (person acting on my behalf who may file my application) is responsible for reporting such changes. Changes must be reported to the appropriate Local Department of Social Services or the Bureau of Long-Term Care Eligibility.
- **Medical Assistance Card Misuse** - If I become eligible for Medical Assistance, I must use my Medical Assistance card properly. It is against the law to allow another person to use my card.
- **Medical Assistance Fraud** - If I do not report true, correct, and complete information, or report changes, the Department may deny, stop, or reduce my benefits. A judge may fine me and/or imprison me if I intentionally do not give correct information or report changes.

**SIGNATURES:**

I swear or affirm that I have read or had read to me this entire application. I also swear or affirm, under penalty or perjury, that all the information I have given is true, correct, and complete to the best of my ability, knowledge and belief. I have received a copy of my rights and responsibilities. I authorize any person, partnership, corporation, association, or governmental agency which knows the facts relevant to determining my eligibility to release that information to the Department. I also authorize the Department to contact any person, partnership, corporation, association, or governmental agency that has provided information relevant to my eligibility for benefits. I certify, under penalty of perjury, by signing my name below, that the person for whom I am applying is a U.S. citizen or lawfully admitted immigrant.

Signature of Applicant/Recipient \_\_\_\_\_ Date \_\_\_\_\_

Signature of Witness (If you Signed an X) \_\_\_\_\_ Date \_\_\_\_\_

Signature of Spouse (If applicable) \_\_\_\_\_ Date \_\_\_\_\_

Signature of Authorized Representative (if applicable) \_\_\_\_\_ Date \_\_\_\_\_

<input type="checkbox"/> I withdraw my application for Medical Assistance	
_____ Signature of Applicant, Recipient, or Authorized Representative	_____ Date

Signature of Case Manager	Date
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MARYLAND DEPARTMENT of HUMAN RESOURCES  
MARYLAND DEPARTMENT of HEALTH and MENTAL HYGIENE  
LONG-TERM CARE/WAIVER MEDICAL ASSISTANCE APPLICATION

DECLARATION

I swear or affirm, under penalty of perjury, that all information, including financial information, I have provided on this application is true, correct, and complete to the best of my knowledge. The requirement to report true, correct, and complete information includes the requirement to report financial changes that may affect my eligibility for benefits. Federal and State law requires that I disclose all transfers or gifting of assets within the 60 month (5 year) period prior to the month of application.

I understand that if I knowingly do not tell the truth, hide information, pretend to be someone else, or withhold information about myself (and my spouse, if any) or about the person for whom I am applying (and that person’s spouse, if any), I may be breaking the law. Information provided on the application may be verified or investigated by Federal, State, and local officials including Federal and State Quality Control staff.

The consequences of not complying with the law are: my benefits may be denied; I may be required to pay back the State for benefits received; my case may be investigated for suspected fraud; and I may be prosecuted for perjury, larceny, and/or Federal health care fraud [not limited to Statute 42 U.S.C. sec. 1320a-7b(a)(ii)], which may involve a fine up to \$10,000 per offense and/or federal imprisonment.

\_\_\_\_\_  
Signature of Applicant/Recipient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness (If signed with X)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Spouse (If applicable)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Authorized Representative (If applicable)

\_\_\_\_\_  
Date