Table of Contents: State Plan Amendment ME 13-025MM2

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2275
Boston, Massachusetts 02203

Division of Medicaid and Children's Health Operations / Boston Regional Office

December10, 2013

Mary C. Mayhew, Commissioner
Department of Health and Human Services
221 State House
11 State House Station
Augusta, Maine 04333-0011

Dear Ms. Mayhew:

Enclosed is an approved copy of Maine's state plan amendment (SPA) 13-0025-MM2, which was submitted to CMS on September 13, 2013. SPA 13-0025-MM2 incorporates the MAGI-based eligibility process requirements, including the single streamlined application, into Maine's Medicaid state plan in accordance with the Affordable Care Act. The effective date of this SPA is October 1, 2013.

The approval of SPA 13-0025-MM2 includes full approval of your state's alternative single streamlined paper application and the paper applications used to apply for multiple human service programs. The state is using an interim alternative single streamlined online application and by April 30, 2014 will implement a revised alternative single streamlined online application that addresses CMS concerns outlined in the companion letter issued with this SPA approval.

Enclosed is a copy of the following S94 state plan pages and attachments to be incorporated within a separate section at the end of Maine's approved state plan:

- S94, pages S94-1, S94-2, and S94-3
- Attachment 1 – State of Maine, Department of Health and Human Services Application for MaineCare and Food Supplement Benefits, Form # OFI IMS01(R1-14)
- Attachment 2 – State of Maine Department of Health and Human Services Application for Health Insurance, MaineCare for Families with Children and Pregnant Women, Form #BF1-CC001 (1/14)
- Attachment 3 – Maine Department of Health and Human Services Application for Food Supplement, TANF, PaS, or MaineCare, Form #OFI APP01 (R1/14)
- Attachment 4 – Statement of use with respect to the alternative single streamlined online application

In addition, enclosed is a summary of the state plan pages which are superseded by SPA 13-0025-MM2, which should also be incorporated into a separate section in the front of the state plan.

- Superseding pages of state plan material, SPA 13-0025-MM2

CMS appreciates the significant amount of work your staff dedicated to preparing this state plan amendment. Please contact Kathryn Holt, kathryn.holt@cms.hhs.gov, or at 617/565-1246, if you have any questions.

Sincerely,

/s/ [redacted]

Richard R. McGreal
Associate Regional Administrator

cc: Stefanie Nadeau, MaineCare Director

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
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CENTERS FOR MEDICARE & MEDICAID SERVICES

Division of Medicaid and Children's Health Operations / Boston Regional Office

December 10, 2013

Mary C. Mayhew, Commissioner
Department of Health and Human Services
221 State House
11 State House Station
Augusta, Maine 04333-0011

Dear Ms. Mayhew,

This letter is being sent as a companion to Centers for Medicare & Medicaid Services (CMS) approval of state plan amendment (SPA13-0025-MM2), which was submitted to CMS on September 13, 2013. Our review of this submission included a review of the state's paper and online alternative single streamlined applications and the applications used to apply for multiple human service programs.

The approval of SPA 13-0025-MM2 includes full approval of your state's alternative single streamlined paper application and the paper applications used to apply for multiple human service programs. Until April 30, 2013, the state is using an interim alternative single streamlined online application. This interim application needs to be revised to reflect the following changes.

Necessary changes:	**Date by which changes will be completed:**
The online application will include an opportunity for the application filer to indicate which household members are seeking benefits, and which are not. The following questions will not appear for household members not seeking any benefits: • Residency questions (other than information needed to determine whether household members live together) • All citizenship and immigration questions • Non-MAGI screening questions related to blindness, disability, and Medicare	April 30, 2014
The following questions will not appear on applications for health coverage only: • Questions regarding Food Supplement benefits, drug or	April 30, 2014

alcohol treatment, felonies, probation or parole, approved activity and fraudulent misrepresentation • Questions regarding income not countable under MAGI, such as worker's compensation and child support income • Questions regarding all types of assets	
In accordance with Maine's verification plan, income documentation will not be requested from application filers unless the income attestation is not reasonably compatible with electronic data, or there is no electronic data available for the income type.	April 30, 2014
Only applicants who do not appear eligible for Medicaid and CHIP based on income attestation will be asked information about access to employer-sponsored coverage, beyond what is needed for Medicaid and CHIP.	April 30, 2014

Please submit the revised alternative single streamlined online application to CMS for review no later than April 1, 2014 to ensure approval by April 30, 2014. We continue to be available to provide technical assistance. If you have any questions about your applications, please contact Dena Greenblum at Dena.Greenblum@cms.hhs.gov or (410) 786-8684. If you have any additional questions about this letter, please contact Kathryn Holt, kathryn.holt@cms.hhs.gov, or at (617) 565-1246

Sincerely,

/s/ [redacted]

Richard R. McGreal
Associate Regional Administrator

cc: Stefanie Nadeau, MaineCare Director

Medicaid State Plan Eligibility: Summary Page (CMS 179)

State/Territory name: **Maine**

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

ME-13-0025

Proposed Effective Date

10/01/2013 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

42 CFR 435, Subpart J and Subpart M

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2014	$ 0.00
Second Year	2015	$ 0.00

Subject of Amendment

SPA changes to ensure compliance with the Affordable Care Act.

Governor's Office Review

- ○ **Governor's office reported no comment**
- ○ **Comments of Governor's office received**

  Describe:

- ○ **No reply received within 45 days of submittal**
- ◉ **Other, as specified**

  Describe:

  Commissioner, Department of Human Services

Signature of State Agency Official

Submitted By:	**Reinhold Bansmer**
Last Revision Date:	**Dec 5, 2013**
Submit Date:	**Sep 13, 2013**

SUPERSEDING PAGES OF STATE PLAN MATERIAL	
TRANSMITTAL NUMBER: 13-0025MM2	**STATE:** Maine
PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Section S94 - Eligibility Process	**PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:** Section 2, Page 10, section 2.1(a), TN # 91-14 Section 2, Page 11a, section 2.1(d), TN# 91-13

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

General Eligibility Requirements Eligibility Process	S94

42 CFR 435, Subpart J and Subpart M

Eligibility Process

☑ The state meets all the requirements of 42 CFR 435, Subpart J for processing applications, determining and verifying eligibility, and furnishing Medicaid.

Application Processing

Indicate which application the agency uses for individuals applying for coverage who may be eligible based on the applicable modified adjusted gross income standard.

☐ The single, streamlined application for all insurance affordability programs, developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act

☒ An alternative single, streamlined application developed by the state in accordance with section 1413(b)(1)(B) of the Affordable Care Act and approved by the Secretary, which may be no more burdensome than the streamlined application developed by the Secretary.

An attachment is submitted.

☒ An alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.

An attachment is submitted.

Indicate which application the agency uses for individuals applying for coverage who may be eligible on a basis other than the applicable modified adjusted gross income standard:

☒ The single, streamlined application developed by the Secretary or one of the alternate forms developed by the state and approved by the Secretary, and supplemental forms to collect additional information needed to determine eligibility on such other basis, submitted to the Secretary.

An attachment is submitted.

☐ An application designed specifically to determine eligibility on a basis other than the applicable MAGI standard which minimizes the burden on applicants, submitted to the Secretary.

An attachment is submitted.

The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in 42 CFR 435.1200(f), by telephone, via mail, and in person.

The agency also accepts applications by other electronic means:

◉ Yes ○ No

Medicaid Eligibility

Indicate the other electronic means below:

	Name of Method	Description	
+	On-Line		X
+	Fax		X
+	Telephone		X

☑ The agency has procedures to take applications, assist applicants and perform initial processing of applications for the eligibility groups listed below at locations other than those used for the receipt and processing of applications for the title IV-A program, including Federally-qualified health centers and disproportionate share hospitals.

Parents and Other Caretaker Relatives

Pregnant Women

Infants and Children under Age 19

Redetermination Processing

☑ Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 435.916:

■ Once every 12 months

■ Without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency

■ If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, it provides the individual with a pre-populated renewal form containing the information already available.

■ Redeterminations of eligibility for individuals whose financial eligibility is not based on the applicable modified adjusted gross income standard are performed, consistent with 42 CFR 435.916 (check all that apply):

☒ Once every 12 months

☐ Once every 6 months

☐ Other, more often than once every 12 months

Coordination of Eligibility and Enrollment

☑ The state meets all the requirements of 42 CFR 435, Subpart M relative to coordination of eligibility and enrollment between Medicaid, CHIP, Exchanges and other insurance affordability programs. The single state agency has entered into agreements with the Exchange and with other agencies administering insurance affordability programs.

PRA Disclosure Statement

Medicaid Eligibility

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

USE OF THE ALTERNATIVE SINGLE STREAMLINED APPLICATION	
☐ Paper Application ☒ Online Application	
TRANSMITTAL NUMBER:	**STATE:**
ME-13-0025MM2	Maine
Through April 30, 2014, the state is using an interim alternative single streamlined application. After April 30, 2014, the state will use a revised alternative single streamlined application. The revised application will address the issues outlined in the CMS letter, which was issued with the approval of this state plan amendment, concerning the state's application. The revised application will be incorporated by reference into the state plan.	

State of Maine Department of Health and Human Services

Application for Health Insurance

MaineCare for Families with Children and Pregnant Women

Return to:
REC'D 45th DAY

1. Person Filling Out The Application

Name (first, middle initial, last)			
Social Security Number (Optional if You Are Not Requesting Coverage)	**Birthdate** (month/day/year)	**Sex**	**Are you requesting Coverage?**

Check one ☐ married ☐ widowed ☐ single ☐ divorced ☐ separated

Maiden Name _____

2. Mailing Address

Street, PO Box or RR (include apartment number, in care of , etc.)				
City:	**State:**	**Zip code:**	**Home phone**	**Work phone:**
If different from your mailing address, write in the address where you actually live:				

3. Household Members (*List the people who live with you*)

Last name	First name	Middle initial	Sex	Date of birth	Requesting Coverage?	Social Security Number (Optional if Not Requesting Coverage)	Relationship to you

4. Household Earning (*You are not required to submit proof of your earnings at this time, but you may be asked at a later date to provide paystubs or photocopies of paystubs for the last 4 weeks if electronic verification is not possible*)

Name	Employer's name and phone	Amount you earn	How often you are paid	Hours worked each week

5. Self-Employment (*Attach a copy of your most recent tax return including all schedules*)

Name of the person who is self-employed	If you did not file a tax return. Check here ☐
Name of business	**Hours worked weekly**

6. Unearned Income (*You are not required at this time to submit proof of your unearned income, but you may be asked to at a later date if electronic verification is not possible.)*

Note: You don't need to tell us about child support, veteran's payments, or Supplemental Security Income (SSI).

Name of person Receiving income	Where is income from? (Social Security, Unemployment, etc.)	How often received? (monthly, weekly, etc.)	Amount Before deductions

7. Health Insurance

List children in your household who now <u>have</u> health insurance (except for MaineCare) which covers more than one service
List children in your household who <u>lost</u> health insurance (except for MaineCare) in the last 3 months and why they lost insurance:
List children in your household who can be added to a household member's State Employee health insurance:

8. Special Conditions

☐ Check here if anyone has a disabling condition or is applying for Limited Benefits Program. (*There may be special help available to you.*)

☐ Check here if your child is a member of a Federally recognized American Indian tribe or Alaskan Native. (*No premium is required.*) Name of tribe _____

Is everyone for whom you are applying a U.S. citizen? ☐ Yes ☐ No

If no, complete the following for everyone who is not a US citizen:

Name	Document Type	Document ID Number	Has he/she lived in US Since 1996? Yes or No	Is his/her spouse or parent a veteran or active-duty member in the US military? Yes or No

If English is not your first language, what language do you speak? _____

Does any child on this application have a parent living outside of the home? ☐ Yes ☐ No

If yes, I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell Medicaid and I may not have to cooperate.

Are you asking for help with medical bills incurred in the last 3 months? ☐ Yes ☐ No

Do you want to apply for Food Stamps? ☐ Yes ☐ No

9. Signature

If you have to pay a premium, coverage can start either the month the Dept. of Health and Human Services receives this application, or the next month. Please write the name of the month you want coverage to start. _____

I understand and agree to provide documents to prove what I have stated. **I understand and agree that the information I have given may be verified by federal, state and local officials or other persons and organizations. 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 or alien status, are correct and complete for all persons applying for benefits.**

If anyone 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 rights to pursue and get medical support from a spouse or parent.

Signature of person filling out this form Date

Transmittal Number: ME-13-0025MM2 Approval Date: December 10, 2013 Effective Date: October 1, 2013

MEDICAID APPLICATION SUPPLEMENT

COMPLETE THIS SUPPLEMENT FOR YOURSELF, YOUR SPOUSE/PARTNER AND CHILDREN WHO LIVE WITH YOU AND/OR ANYONE ON YOUR SAME FEDERAL INCOME TAX RETURN IF YOU FILE ONE. IF YOU DON'T FILE A TAX RETURN, REMEMBER TO STILL ADD FAMILY MEMBERS WHO LIVE WITH YOU.

APP LAST NAME:	APP FIRST NAME:	MI:

AMERICAN INDIANS AND ALASKA NATIVES

Names of those with Indian Health Service Coverage:

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

OTHER MEDICAL INSURANCE

(IF APPLICABLE, LIST THE HOUSEHOLD MEMBERS THAT CURRENTLY RECEIVE HEALTH COVERAGE)

Name:	Company:
Policy:	Type:

EMPLOYER INSURANCE

HOUSEHOLD MEMBERS RECEIVING, OR ELIGIBLE FOR, EMPLOYER SPONSORED HEALTH INSUARNCE (NOW OR IN THE NEXT THREE MONTHS) PROVIDING THE SSN IS OPTIONAL FOR PERSONS WHO ARE NOT APPLYING FOR MEDICAL COVERAGE

Name:	SSN:	Minimal essential coverage?
Date when eligible to enroll:	Monthly premium for lowest-cost plan offered: $	
Employer Name:	Employer EIN:	
Employer Address:		
Employer Phone:	Employer Email:	
Employer Insurance Name:	Employee Contact Info:	

TAX INFORMATION, APPLICANT

(YOU CAN STILL BE ELIGIBLE FOR PROGRAMS EVEN IF YOU DON'T FILE FEDERAL INCOME TAX)

A. Will you file Income Tax Next Year (if yes, please answer questions A-C; if no, skip to question D:	
B. Will you file jointly with spouse:	Name of spouse:
C. Will you claim dependents on your tax return:	Name of dependent 1:
Name of dependent 2:	Name of dependent 3:
D. Will you be claimed as a dependent on someone's tax return:	Name of filer:

DEDUCTIONS, APPLICANT

ENTER AMOUNTS FOR ALL THAT APPLY

Alimony paid:	How often?	Student loan interest:	How often?
Other deductions:	How often?	Type:	

For American Indians and Alaskan Natives Only

Certain money received can be excluded from income; list any money received from these sources: per capita payments from a tribe that comes from natural resources, usage rights, leases or royalties: payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Dept. of Interior; and money from selling things that have cultural significance.

How much received? $ How often?

SIGNATURE

I'M SIGNING THIS APPLICATION UNDER PENALTY OF PERJURY WHICH MEANS I'VE PROVIDED TRUE ANSWERS TO ALL THE QUESTIONS ON THIS FORM TO THE BEST OF MY KNOWLEDGE. I KNOW THAT I MAY BE SUBJECT TO PENALTIES UNDER FEDERAL LAW IF I PROVIDE FALSE AND OR UNTRUE INFORMATION.

Signature of applicant:

Date:

TAX INFORMATION, NAME OF PERSON #1 WHO LIVES WITH YOU:	
A. Will he/she file Income Tax Next Year (if yes, please answer questions A-C; if no, skip to question D:	
B. Will he/she file jointly with spouse:	Name of spouse:
C. Will he/she claim dependents on your tax return:	Name of dependent 1:
Name of dependent 2:	Name of dependent 3:
D. Will he/she be claimed as a dependent on someone's tax return:	Name of filer:
Total Income (list next year's total income for this person):	

DEDUCTIONS, PERSON#1 WHO LIVES WITH YOU - ENTER AMOUNTS FOR ALL THAT APPLY			
Alimony paid:	How often?	Student loan interest:	How often?
Other deductions:	How often?	Type:	

For American Indians and Alaskan Natives Only
Certain money received can be excluded from income; list any money received from these sources: per capita payments from a tribe that comes from natural resources, usage rights, leases or royalties: payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Dept. of Interior; and money from selling things that have cultural significance.

How much received? $ How often?

TAX INFORMATION, NAME OF PERSON #2 WHO LIVES WITH YOU:	
A. Will he/she file Income Tax Next Year (if yes, please answer questions A-C; if no, skip to question D:	
B. Will he/she file jointly with spouse:	Name of spouse:
C. Will he/she claim dependents on your tax return:	Name of dependent 1:
Name of dependent 2:	Name of dependent 3:
D. Will he/she be claimed as a dependent on someone's tax return:	Name of filer:
Total Income (list next year's total income for this person):	

DEDUCTIONS, PERSON #2 WHO LIVES WITH YOU - ENTER AMOUNTS FOR ALL THAT APPLY			
Alimony paid:	How often?	Student loan interest:	How often?
Other deductions:	How often?	Type:	

For American Indians and Alaskan Natives Only
Certain money received can be excluded from income; list any money received from these sources: per capita payments from a tribe that comes from natural resources, usage rights, leases or royalties: payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Dept. of Interior; and money from selling things that have cultural significance.

How much received? $ How often?

TAX INFORMATION, NAME OF PERSON #3 WHO LIVES WITH YOU:	
A. Will he/she file Income Tax Next Year (if yes, please answer questions A-C; if no, skip to question D:	
B. Will he/she file jointly with spouse:	Name of spouse:
C. Will he/she claim dependents on your tax return:	Name of dependent 1:
Name of dependent 2:	Name of dependent 3:
D. Will he/she be claimed as a dependent on someone's tax return:	Name of filer:
Total Income (list next year's total income for this person):	

DEDUCTIONS, PERSON #3 WHO LIVES WITH YOU -ENTER AMOUNTS FOR ALL THAT APPLY			
Alimony paid:	How often?	Student loan interest:	How often?
Other deductions:	How often?	Type:	

For American Indians and Alaskan Natives Only
Certain money received can be excluded from income; list any money received from these sources: per capita payments from a tribe that comes from natural resources, usage rights, leases or royalties: payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Dept. of Interior; and money from selling things that have cultural significance.

How much received? $ How often?

TAX INFORMATION, NAME OF PERSON #4 WHO LIVES WITH YOU:			
A. Will he/she file Income Tax Next Year (if yes, please answer questions A-C; if no, skip to question D:			
B. Will he/she file jointly with spouse:		Name of spouse:	
C. Will he/she claim dependents on your tax return:		Name of dependent 1:	
Name of dependent 2:		Name of dependent 3:	
D. Will he/she be claimed as a dependent on someone's tax return:		Name of filer:	
Total Income (list next year's total income for this person):			
DEDUCTIONS, PERSON #4 WHO LIVES WITH YOU - ENTER AMOUNTS FOR ALL THAT APPLY			
Alimony paid:	How often?	Student loan interest:	How often?
Other deductions:	How often?	Type:	
For American Indians and Alaskan Natives Only Certain money received can be excluded from income; list any money received from these sources: per capita payments from a tribe that comes from natural resources, usage rights, leases or royalties: payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Dept. of Interior; and money from selling things that have cultural significance. How much received? $ How often?			
TAX INFORMATION, NAME OF PERSON #5 WHO LIVES WITH YOU:			
A. Will he/she file Income Tax Next Year (if yes, please answer questions A-C; if no, skip to question D:			
B. Will he/she file jointly with spouse:		Name of spouse:	
C. Will he/she claim dependents on your tax return:		Name of dependent 1:	
Name of dependent 2:		Name of dependent 3:	
D. Will he/she be claimed as a dependent on someone's tax return:		Name of filer:	
Total Income (list next year's total income for this person):			
DEDUCTIONS, PERSON #5 WHO LIVES WITH YOU - ENTER AMOUNTS FOR ALL THAT APPLY			
Alimony paid:	How often?	Student loan interest:	How often?
Other deductions:	How often?	Type:	
For American Indians and Alaskan Natives Only Certain money received can be excluded from income; list any money received from these sources: per capita payments from a tribe that comes from natural resources, usage rights, leases or royalties: payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Dept. of Interior; and money from selling things that have cultural significance. How much received? $ How often?			
TAX INFORMATION, NAME OF PERSON #6 WHO LIVES WITH YOU:			
A. Will he/she file Income Tax Next Year (if yes, please answer questions A-C; if no, skip to question D:			
B. Will he/she file jointly with spouse:		Name of spouse:	
C. Will he/she claim dependents on your tax return:		Name of dependent 1:	
Name of dependent 2:		Name of dependent 3:	
D. Will he/she be claimed as a dependent on someone's tax return:		Name of filer:	
Total Income (list next year's total income for this person):			
DEDUCTIONS, PERSON #6 WHO LIVES WITH YOU - ENTER AMOUNTS FOR ALL THAT APPLY			
Alimony paid:	How often?	Student loan interest:	How often?
Other deductions:	How often?	Type:	
For American Indians and Alaskan Natives Only Certain money received can be excluded from income; list any money received from these sources: per capita payments from a tribe that comes from natural resources, usage rights, leases or royalties: payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Dept. of Interior; and money from selling things that have cultural significance. How much received? $ How often?			

State of Maine
Department of Health and Human Services (DHHS)
Application For

MaineCare and Food Supplement Benefits

Return to:

Application for:

☐ MaineCare – Full Benefits
☐ Low Cost Drugs (DEL) / MaineRx Plus
☐ MaineCare Limited Benefits Program
☐ Medicare Savings Program Only (Buy In)
☐ Food Supplement Benefits

Do you have a physical or mental health condition that keeps you from working full or part time? ☐ Yes ☐ No

Providing a Social Security number is optional for individuals who are not applying for coverage in any program.

Your name (first, middle initial, last)	Maiden Name	Social Security number	Sex

Birth date (month/day/year)	Place of birth	Your Medicare claim number (if any)

Mailing address:

Street, PO Box, or RR (include apartment number, in care of, etc.)	Is this a safe delivery address? ☐Yes ☐No

City	State	Zip Code	Phone

If different from your mailing address, give the address where you actually live:

You need to answer only the questions for the program(s) you are applying for.

For Food Supplement Benefits Only: To file this application now, we need your name (or that of an authorized representative), address and signature. If eligible, your benefits will begin from the date DHHS gets a signed application.

You may be eligible for Food Supplement benefits right away:

- does your monthly income and cash/money in a bank add up to less than your monthly living expense? _____
- is your monthly income less than $150 and cash/money in a bank less than $100? _____
- are you a migrant worker and your income has stopped? _____

Social Security numbers are used to do computer matches with I.R.S., BMV, IFW, the Social Security Administration, Department of Labor, other government agencies and private financial institutions. DHHS and federal officials may check with other sources to prove the information you give.

If you give wrong information, you may be charged with giving false information.
I understand the questions on this form. I certify, under penalty of perjury, that all my answers are correct and complete as far as I know, including those concerning citizenship and alien status for each person applying for benefits. 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.

Signature of person applying _____ **Date** _____

Signature of person filling out this form _____ **Date** _____

If you have someone who knows your situation, and you want us to contact them to help with this application, please complete the following:

Name _____ **Address** _____
Telephone _____

For office use only:
Received _____ **45th day** _____
Residency _____ **ID** _____
Food Supplement Benefit Expedite ☐Yes ☐No

For MaineCare and Food Supplement Benefits

ARE YOU:	If you live with your spouse:
☐ Married	Spouse's name _____ (first, middle initial, last)
☐ Widowed	Date of birth _____ Sex ____ Able to work? ☐Yes ☐No
☐ Single	(month /day/year)
☐ Divorced	Place of birth _____ Maiden name _____
☐ Separated	Spouse's Social Security number _____
(Check only one box)	Spouse's Medicare claim number _____

List other people who live with you and their grade in school if applicable:

Last name	First name	Middle Initial	Sex	Birth - date	Social Security Number (Optional if not Requesting Coverage)	Relationship to you	Grade level

Is everyone you are applying for a U.S. citizen? ☐Yes ☐No
If no, please list their names and Alien Registration Numbers.

_____

_____

Please list place of birth for each person for whom you are requesting assistance					
First Name	Place of Birth	First Name	Place of Birth	First Name	Place of Birth

List *monthly* household income below:

Source	Yourself	Your spouse (who lives with you)	Other family members (please list amount and name of member)
Social Security	$	$	$
SSI	$	$	$
Other Income or Pensions (such as railroad retirement, interest, dividends, etc., please explain)	$	$	$

List household earnings for yourself and your spouse (who lives with you): Please provide the last 4 pay stubs or copies of them (If you are applying for MaineCare only, you are not required to provide verification of earnings at this time, but you may be asked to do so in the future if electronic verification is not possible)

Name	Employer's name and phone number	Gross Amount earned	How often are you paid	Hours worked each week

Is anyone in your household self-employed? ☐Yes ☐No If YES, Who? _____
Source? _____ How often? _____
Please provide a copy of your most recent tax return or business records.
List assets for yourself and your spouse (who lives with you), including jointly owned assets:
(If you are applying for Food Supplement Benefits, also list the assets of others in your household.)

• Checking or Savings Account • Credit Union Shares • IRA, 401K, Keogh • Certificate of Deposit
• Other Accounts
• Profit Sharing • Safety Deposit Box • Assets Owned with Others • Stocks • Annuities • Prepaid Burials • Trusts

Name(s) on account	Type of asset (see above)	Name of bank or institution	Account number	Current balance or value

MEDICAID APPLICATION SUPPLEMENT

COMPLETE THIS SUPPLEMENT FOR YOURSELF, YOUR SPOUSE/PARTNER AND CHILDREN WHO LIVE WITH YOU AND/OR ANYONE ON YOUR SAME FEDERAL INCOME TAX RETURN IF YOU FILE ONE. IF YOU DON'T FILE A TAX RETURN, REMEMBER TO STILL ADD FAMILY MEMBERS WHO LIVE WITH YOU.

APP LAST NAME:	APP FIRST NAME:	MI:

AMERICAN INDIANS AND ALASKA NATIVES

Names of those with Indian Health Service Coverage:

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

OTHER MEDICAL INSURANCE

(IF APPLICABLE, LIST THE HOUSEHOLD MEMBERS THAT CURRENTLY RECEIVE HEALTH COVERAGE)

Name:	Company:
Policy:	Type:

EMPLOYER INSURANCE

HOUSEHOLD MEMBERS RECEIVING, OR ELIGIBLE FOR, EMPLOYER SPONSORED HEALTH INSUARNCE (NOW OR IN THE NEXT THREE MONTHS)
PROVIDING THE SSN IS OPTIONAL FOR PERSONS WHO ARE NOT APPLYING FOR MEDICAL COVERAGE

Name:	SSN:	Minimal essential coverage?
Date when eligible to enroll:	Monthly premium for lowest-cost plan offered: $	
Employer Name:	Employer EIN:	
Employer Address:		
Employer Phone:	Employer Email:	
Employer Insurance Name:	Employee Contact Info:	

TAX INFORMATION, APPLICANT

(YOU CAN STILL BE ELIGIBLE FOR PROGRAMS EVEN IF YOU DON'T FILE FEDERAL INCOME TAX)

A. Will you file Income Tax Next Year (if yes, please answer questions A-C; if no, skip to question D:	
B. Will you file jointly with spouse:	Name of spouse:
C. Will you claim dependents on your tax return:	Name of dependent 1:
Name of dependent 2:	Name of dependent 3:
D. Will you be claimed as a dependent on someone's tax return:	Name of filer:

DEDUCTIONS, APPLICANT

ENTER AMOUNTS FOR ALL THAT APPLY

Alimony paid:	How often?	Student loan interest:	How often?
Other deductions:	How often?	Type:	

For American Indians and Alaskan Natives Only
Certain money received can be excluded from income; list any money received from these sources: per capita payments from a tribe that comes from natural resources, usage rights, leases or royalties: payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Dept. of Interior; and money from selling things that have cultural significance.

How much received? $ How often?

SIGNATURE

I'M SIGNING THIS APPLICATION UNDER PENALTY OF PERJURY WHICH MEANS I'VE PROVIDED TRUE ANSWERS TO ALL THE QUESTIONS ON THIS FORM TO THE BEST OF MY KNOWLEDGE. I KNOW THAT I MAY BE SUBJECT TO PENALTIES UNDER FEDERAL LAW IF I PROVIDE FALSE AND OR UNTRUE INFORMATION.

Signature of applicant:

Date:

TAX INFORMATION, NAME OF PERSON #1 WHO LIVES WITH YOU:			
A. Will he/she file Income Tax Next Year (if yes, please answer questions A-C; if no, skip to question D:			
B. Will he/she file jointly with spouse:		Name of spouse:	
C. Will he/she claim dependents on your tax return:		Name of dependent 1:	
Name of dependent 2:		Name of dependent 3:	
D. Will he/she be claimed as a dependent on someone's tax return:		Name of filer:	
Total Income (list next year's total income for this person):			
DEDUCTIONS, PERSON#1 WHO LIVES WITH YOU - ENTER AMOUNTS FOR ALL THAT APPLY			
Alimony paid:	How often?	Student loan interest:	How often?
Other deductions:	How often?	Type:	
For American Indians and Alaskan Natives Only Certain money received can be excluded from income; list any money received from these sources: per capita payments from a tribe that comes from natural resources, usage rights, leases or royalties: payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Dept. of Interior; and money from selling things that have cultural significance. How much received? $ How often?			
TAX INFORMATION, NAME OF PERSON #2 WHO LIVES WITH YOU:			
A. Will he/she file Income Tax Next Year (if yes, please answer questions A-C; if no, skip to question D:			
B. Will he/she file jointly with spouse:		Name of spouse:	
C. Will he/she claim dependents on your tax return:		Name of dependent 1:	
Name of dependent 2:		Name of dependent 3:	
D. Will he/she be claimed as a dependent on someone's tax return:		Name of filer:	
Total Income (list next year's total income for this person):			
DEDUCTIONS, PERSON #2 WHO LIVES WITH YOU - ENTER AMOUNTS FOR ALL THAT APPLY			
Alimony paid:	How often?	Student loan interest:	How often?
Other deductions:	How often?	Type:	
For American Indians and Alaskan Natives Only Certain money received can be excluded from income; list any money received from these sources: per capita payments from a tribe that comes from natural resources, usage rights, leases or royalties: payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Dept. of Interior; and money from selling things that have cultural significance. How much received? $ How often?			
TAX INFORMATION, NAME OF PERSON #3 WHO LIVES WITH YOU:			
A. Will he/she file Income Tax Next Year (if yes, please answer questions A-C; if no, skip to question D:			
B. Will he/she file jointly with spouse:		Name of spouse:	
C. Will he/she claim dependents on your tax return:		Name of dependent 1:	
Name of dependent 2:		Name of dependent 3:	
D. Will he/she be claimed as a dependent on someone's tax return:		Name of filer:	
Total Income (list next year's total income for this person):			
DEDUCTIONS, PERSON #3 WHO LIVES WITH YOU -ENTER AMOUNTS FOR ALL THAT APPLY			
Alimony paid:	How often?	Student loan interest:	How often?
Other deductions:	How often?	Type:	
For American Indians and Alaskan Natives Only Certain money received can be excluded from income; list any money received from these sources: per capita payments from a tribe that comes from natural resources, usage rights, leases or royalties: payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Dept. of Interior; and money from selling things that have cultural significance. How much received? $ How often?			

TAX INFORMATION, NAME OF PERSON #4 WHO LIVES WITH YOU:			
A. Will he/she file Income Tax Next Year (if yes, please answer questions A-C; if no, skip to question D:			
B. Will he/she file jointly with spouse:		Name of spouse:	
C. Will he/she claim dependents on your tax return:		Name of dependent 1:	
Name of dependent 2:		Name of dependent 3:	
D. Will he/she be claimed as a dependent on someone's tax return:		Name of filer:	
Total Income (list next year's total income for this person):			
DEDUCTIONS, PERSON #4 WHO LIVES WITH YOU - ENTER AMOUNTS FOR ALL THAT APPLY			
Alimony paid:	How often?	Student loan interest:	How often?
Other deductions:	How often?	Type:	
For American Indians and Alaskan Natives Only Certain money received can be excluded from income; list any money received from these sources: per capita payments from a tribe that comes from natural resources, usage rights, leases or royalties: payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Dept. of Interior; and money from selling things that have cultural significance. How much received? $		How often?	
TAX INFORMATION, NAME OF PERSON #5 WHO LIVES WITH YOU:			
A. Will he/she file Income Tax Next Year (if yes, please answer questions A-C; if no, skip to question D:			
B. Will he/she file jointly with spouse:		Name of spouse:	
C. Will he/she claim dependents on your tax return:		Name of dependent 1:	
Name of dependent 2:		Name of dependent 3:	
D. Will he/she be claimed as a dependent on someone's tax return:		Name of filer:	
Total Income (list next year's total income for this person):			
DEDUCTIONS, PERSON #5 WHO LIVES WITH YOU - ENTER AMOUNTS FOR ALL THAT APPLY			
Alimony paid:	How often?	Student loan interest:	How often?
Other deductions:	How often?	Type:	
For American Indians and Alaskan Natives Only Certain money received can be excluded from income; list any money received from these sources: per capita payments from a tribe that comes from natural resources, usage rights, leases or royalties: payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Dept. of Interior; and money from selling things that have cultural significance. How much received? $		How often?	
TAX INFORMATION, NAME OF PERSON #6 WHO LIVES WITH YOU:			
A. Will he/she file Income Tax Next Year (if yes, please answer questions A-C; if no, skip to question D:			
B. Will he/she file jointly with spouse:		Name of spouse:	
C. Will he/she claim dependents on your tax return:		Name of dependent 1:	
Name of dependent 2:		Name of dependent 3:	
D. Will he/she be claimed as a dependent on someone's tax return:		Name of filer:	
Total Income (list next year's total income for this person):			
DEDUCTIONS, PERSON #6 WHO LIVES WITH YOU - ENTER AMOUNTS FOR ALL THAT APPLY			
Alimony paid:	How often?	Student loan interest:	How often?
Other deductions:	How often?	Type:	
For American Indians and Alaskan Natives Only Certain money received can be excluded from income; list any money received from these sources: per capita payments from a tribe that comes from natural resources, usage rights, leases or royalties: payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Dept. of Interior; and money from selling things that have cultural significance. How much received? $		How often?	