Office for Family Independence
Maine Department of Health and Human Services

Application for MaineCare Benefits

If you want help filling out this application or have questions, please contact us at 1-855-797-4357 or Maine Relay 711 (TTY) – we can help!

MaineCare Program Information

MaineCare (Medicaid)
Provides free or low-cost health insurance to cover doctors' visits, emergencies, prescription drugs, and more.

Medicare Savings Program (Buy-in)
Helps pay for Medicare premiums, and in some cases deductibles, coinsurance, and copayments.

State Supplement
Provides a small cash payment to people over age 65, who are blind, or people with a disability who get SSI or would be eligible for SSI.

Maine Rx / DEL
Provides discounts on some prescription drugs.

Limited Family Planning Services
Limited MaineCare benefit for reproductive and sexual health care services.

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

Special Benefit Waiver
Provides a limited MaineCare benefit for individuals living with HIV or AIDS.

How do I apply?
Fill out this application by answering as many questions as you can. We encourage you to fill out as much of the application as possible but will accept your application if it is submitted with a name, address, and signature. The date we get this information will establish a start date for benefits.

Apply faster online.
You may be able to get a quicker decision using the online application at www.mymaineconnection.gov.

Who can complete this application?
This application should be filled out by you or an adult member of your household, or relative who knows the financial situation of all household members. If you would like to appoint an authorized representative to apply for benefits for your household, you may do so by filling out an Authorized Representative form found in Appendix B.

What may I need to apply?
We ask about income and other information to determine what medical assistance you qualify for. You may be asked for:

- Social Security Numbers or immigration document numbers for any eligible immigrants who need coverage.
- Employer and income information for everyone in your family (like pay stubs, tax statements, award or benefit letters).
- Information about health insurance available to your household.

We will attempt to verify your information electronically with other federal and state agencies before we ask you for proof.

Where do I return the application?

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

Fax: 1-207-778-8429

What happens next?

We will review your application and contact you if any additional documents or information is needed. You'll get an eligibility notice of the results after your application is processed.

How can I get help with this application?

- Phone: Call us at 1-855-797-4357 or Maine Relay 711 (TTY)
- In-Person: Visit your local Office for Family Independence (OFI). Office locations: https://www.maine.gov/dhhs/about/contact/offices

If you need help in your language (including an interpreter) or a disability accommodation, call 1-855-797-4357 or Maine Relay 711 (TTY). These services are free.

Please tear off and keep this page for your records.

Social Security Numbers (SSN)

All persons applying for medical assistance must provide a Social Security Number (SSN), if they have one (See 42 CFR §435.910; 42 CFR §457.340). A SSN is not required if the applicant is not eligible to receive a SSN, does not have a SSN and may only be issued a SSN for a valid non-work reason in accordance with 20 CFR §422.104, or refuses to obtain a SSN because of well-established religious objections. If you need help getting a SSN, we may be able to help. Call us at 1-855-797-4357. You can also visit www.ssa.gov or call the Social Security Administration at 1-800-772-1213 (TTY 1-800-325-0778).

Some lawfully present people may not have or be eligible for a SSN. They can still apply for assistance without a SSN. You don't need to provide immigration status or SSNs for household members who aren't seeking coverage but providing a SSN can speed up the application process. We'll keep all information you provide private and secure as required by law.

SSNs are used to conduct electronic data matches with state and federal agencies to verify information you provide and determine your eligibility for medical assistance programs. If the information you provide does not match the information we get from these agencies, we may ask you to send us proof.

Authorized Representatives

If you would like someone to apply for benefits and/or act on behalf of the household you may need to complete an Authorized Representative form found in **Appendix B**.

Estate Recovery

If you are age 55 or older and receive MaineCare (Maine Medicaid) to pay for nursing facility services, home and community-based services, or any related hospital and prescription drug services related to these services, the State may make a claim on the assets of your estate (upon your death) to recover the money that MaineCare has paid for these services. No claim will be made if the only benefit you get is Medicare Savings Program. For more information about estate recovery call 1-800-977-6740.

Marketplace Health Coverage

If you are determined eligible for MaineCare and have Marketplace health coverage with financial help (premium tax credits) you should cancel it. If you don't cancel your financial help, you may have to pay it back. To cancel your financial help, visit CoverME.gov or call the Consumer Assistant Center at 1-866-636-0355.

If you are not eligible for MaineCare you might be able to get health coverage – and help paying for it – through the Health Insurance Marketplace. If you or any applicant included on this application are not eligible for MaineCare, we will send your information to the Marketplace to be reviewed for other insurance affordability programs.

Notification of Right to Request a Hearing

We will give you a written notice explaining your benefits. If you do not agree with the Department eligibility decision, you have the right to appeal. You can ask for a hearing by contacting the Office for Family Independence, over the phone, in writing, or in person at your local office.

Non-Discrimination Notice

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. 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; 207-287-3707 (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 1-800-368-1019 or 1-800-537-7697 (TDD); by mail to 200 Independence Avenue, SW, Room 509, HHS Building, Washington, D.C. 20201; or online through Office of Civil Rights (OCR) Complaint Portal at https://ocrportal.hhs.gov/ocr/.

Voter Registration
If you are not a registered to vote where you live now and would like to apply to register to vote, you can download and print a Maine voter registration application at https://www.maine.gov/sos/cec/elec/voter-info/voterguide.html. Applying to register or declining to register to vote will not affect services or benefits from this agency.

Optional Information
Providing race and ethnicity data is optional; it will not affect your eligibility or the amount of benefits your household may receive. This information is collected to help us better understand and improve our programs and benefit delivery.

Getting Started

Making a selection is optional. If you would like this application screened for only a specific type of coverage please indicate which program you would like to apply for below. If this section is left blank we will review eligibility for all MaineCare programs.

☐ **MaineCare** ☐ **Katie Beckett** ☐ **Limited Family Planning Services**
☐ **Special Benefit Waiver** ☐ **Medicare Savings Program** ☐ **Maine Rx/DEL**

Do any applicants need help with any medical bills incurred within the past three (3) months? If yes, which months?	☐ Yes ☐ No
If you are over the income limit for MaineCare, would you like to be quoted a deductible?	☐ Yes ☐ No
If not eligible for full MaineCare coverage, does anyone want to be reviewed for the Limited Family Planning Services program? If yes, who?	☐ Yes ☐ No

If Family Planning Services are requested, we will only consider income of the requesting individual.

STEP 1: Tell us about yourself

Person 1 (Start with yourself; the primary applicant)

A SSN is required for every person applying for health care coverage, if they have one. You do not have to give us the SSN for people in your home that are not applying for coverage but providing an SSN may help speed up the application process.

Name (first, middle initial, last):	Social Security Number:	Date of Birth:
Gender:	Marital Status: ☐ Single ☐ Married	
Home Address:		
☐ Check here if you do not have a home address. You will still need to give a mailing address.		
Mailing Address (if different from home address):		
Phone Number:	Phone Type: ☐ Cell ☐ Home ☐ Work	Preferred language:

Go paperless! If you want electronic notices, you must set up an account online at www.mymaineconnection.gov.

Email Address:

Are you pregnant? ☐ Yes ☐ No	If yes, estimated due date?	How many babies are expected?

Are you enrolled in school fulltime? ☐ Yes ☐ No

Do you want to apply for MaineCare? ☐ **Yes** – Answer the questions below. ☐ **No** – Skip to Step 2.

Are you a U.S. citizen or U.S. national? ☐ Yes ☐ No

If yes, are you a naturalized or derived citizen? (This usually means you were born outside of the U.S.)
☐ Yes, please provide an alien and certificate number. ☐ No

Alien Number: Certificate Number:

If you aren't a U.S. citizen or U.S. national, do you have an immigration status?

☐ Yes, please answer the questions below. See page 13 for a list of immigration statuses.

Immigration status: _____ Alien# or USCIS#: _____

Document type: _____ Card or Document Number: _____

Did you enter the United States before August 22, 1996? ☐ Yes ☐ No

Are you, or is your spouse or parent, a veteran or active-duty member of the military? ☐ Yes ☐ No

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

Race (*Optional – check all that apply*): ☐ White ☐ Black/African American ☐ Native Hawaiian or Pacific Islander ☐ Asian ☐ American Indian/Alaskan Native ☐ Other_____

STEP 2: Tell us about your household

Who do you need to include on this application?

Tell us about the household members who live with you. The coverage or type of program you qualify for is based on the number of people in your household and your household income. If you don't include someone, even if they already have health insurance, your eligibility results could be affected.

For adults who need coverage:
Include these people even if they aren't applying for health coverage for themselves.

- Any spouse
- Any child under age 21 they live with, including stepchildren
- Any other person on the same federal income tax return (including any children over age 21 who are claimed on a parent's tax return). You don't need to file taxes to get coverage.

For children under age 21 who need coverage:
Include these people even if they aren't applying for health coverage themselves.

- Any parent (or stepparent) they live with
- Any sibling they live with
- Any child they live with, including stepchildren
- Any spouse they live with
- Any other person on the same federal income tax return. You don't need to file taxes to get coverage.

Complete Step 2 for each person in your household.
Add other adults first and then children.

You don't need to provide immigration status or SSNs for household members who don't need health insurance. We'll keep all information you provide private and secure, as required by law. We'll use personal information only to check if you're eligible for health coverage.

Person 2

A SSN is required for every person applying for health care coverage, if they have one. You do not have to give us the SSN for people in your home that are not applying for coverage but providing an SSN may help speed up the application process.

Name (first, middle initial, last): | Social Security Number: | Date of Birth:

Gender: ☐Male ☐ Female ☐ Non-binary | Marital Status: ☐ Single ☐ Married

Relationship to Person 1: | Are they enrolled in school fulltime? ☐ Yes ☐ No

Are they pregnant? ☐ Yes ☐ No | If yes, estimated due date? | How many babies are expected?

Does this person want to apply for MaineCare? ☐ **Yes** – Answer the questions below. ☐ **No** – Skip to next Person.

Are they a U.S. citizen or U.S. national? ☐ Yes ☐ No

If yes, are you a naturalized or derived citizen? (This usually means you were born outside of the U.S.)

☐ Yes, please provide an alien and certificate number. ☐ No

Alien Number: Certificate Number:

If you aren't a U.S. citizen or U.S. national, do you have an immigration status?
☐ Yes, please answer the questions below. See page 13 for a list of immigration statuses.

Immigration status: Alien# or USCIS#:

Document type: Card or Document Number:

Did they enter the United States before August 22, 1996? ☐ Yes ☐ No

Are they, or is their spouse or parent, a veteran or active-duty member of the military? ☐ Yes ☐ No

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

Race (*Optional – check all that apply*): ☐ White ☐ Black/African American ☐ Native Hawaiian or Pacific Islander ☐ Asian ☐ American Indian/Alaskan Native ☐ Other_____

Person 3

A SSN is required for every person applying for health care coverage, if they have one. You do not have to give us the SSN for people in your home that are not applying for coverage but providing an SSN may help speed up the application process.

Name (first, middle initial, last): | Social Security Number: | Date of Birth:

Gender: ☐Male ☐ Female ☐ Non-binary | Marital Status: ☐ Single ☐ Married

Relationship to Person 1: | Are they enrolled in school fulltime? ☐ Yes ☐ No

Are they pregnant? ☐ Yes ☐ No | If yes, estimated due date? | How many babies are expected?

Does this person want to apply for MaineCare? ☐ **Yes** – Answer the questions below. ☐ **No** – Skip to next Person.

Are they a U.S. citizen or U.S. national? ☐ Yes ☐ No

If yes, are they a naturalized or derived citizen? (This usually means you were born outside of the U.S.)
☐ Yes, please provide an alien and certificate number. ☐ No

Alien Number: Certificate Number:

If they aren't a U.S. citizen or U.S. national, do you have an immigration status?
☐ Yes, please answer the questions below. See page 13 for a list of immigration statuses.

Immigration status: Alien# or USCIS#:

Document type: Card or Document Number:

Did they enter the United States before August 22, 1996? ☐ Yes ☐ No

Are they, or is their spouse or parent, a veteran or active-duty member of the military? ☐ Yes ☐ No

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

Race (*Optional – check all that apply*): ☐ White ☐ Black/African American ☐ Native Hawaiian or Pacific Islander ☐ Asian ☐ American Indian/Alaskan Native ☐ Other_____

Person 4

A SSN is required for every person applying for health care coverage, if they have one. You do not have to give us the SSN for people in your home that are not applying for coverage but providing an SSN may help speed up the application process.

Name (first, middle initial, last): | Social Security Number: | Date of Birth:

Gender: ☐Male ☐ Female ☐ Non-binary | Marital Status: ☐ Single ☐ Married

Relationship to Person 1: | Are they enrolled in school fulltime? ☐ Yes ☐ No

Are they pregnant? ☐ Yes ☐ No | If yes, estimated due date? | How many babies are expected?

Does this person want to apply for MaineCare? ☐ **Yes** – Answer the questions below. ☐ **No** – Skip to next Person.

Are they a U.S. citizen or U.S. national? ☐ Yes ☐ No

If yes, are they a naturalized or derived citizen? (This usually means you were born outside of the U.S.)
☐ Yes, please provide an alien and certificate number. ☐ No

Alien Number: Certificate Number:

If they aren't a U.S. citizen or U.S. national, do you have an immigration status?
☐ Yes, please answer the questions below. See page 13 for a list of immigration statuses.

Immigration status: _____ Alien# or USCIS#: _____

Document type: _____ Card or Document Number: _____

Did they enter the United States before August 22, 1996? ☐ Yes ☐ No

Are they, or is their spouse or parent, a veteran or active-duty member of the military? ☐ Yes ☐ No

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

Race (*Optional – check all that apply*): ☐ White ☐ Black/African American ☐ Native Hawaiian or Pacific Islander ☐ Asian ☐ American Indian/Alaskan Native ☐ Other_____

Person 5

A SSN is required for every person applying for health care coverage, if they have one. You do not have to give us the SSN for people in your home that are not applying for coverage but providing an SSN may help speed up the application process.

Name (first, middle initial, last): | Social Security Number: | Date of Birth:

Gender: ☐Male ☐ Female ☐ Non-binary | Marital Status: ☐ Single ☐ Married

Relationship to Person 1: | Are they enrolled in school fulltime? ☐ Yes ☐ No

Are they pregnant? ☐ Yes ☐ No | If yes, estimated due date? | How many babies are expected?

Does this person want to apply for MaineCare? ☐ **Yes** – Answer the questions below. ☐ **No** – Skip to next Person.

Are they a U.S. citizen or U.S. national? ☐ Yes ☐ No

If yes, are they a naturalized or derived citizen? (This usually means you were born outside of the U.S.)
☐ Yes, please provide an alien and certificate number. ☐ No

Alien Number: Certificate Number:

If they aren't a U.S. citizen or U.S. national, do you have an immigration status?
☐ Yes, please answer the questions below. See page 13 for a list of immigration statuses.

Immigration status: _____ Alien# or USCIS#: _____

Document type: _____ Card or Document Number: _____

Did they enter the United States before August 22, 1996? ☐ Yes ☐ No

Are they, or is their spouse or parent, a veteran or active-duty member of the military? ☐ Yes ☐ No

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

Race (*Optional – check all that apply*): ☐ White ☐ Black/African American ☐ Native Hawaiian or Pacific Islander ☐ Asian ☐ American Indian/Alaskan Native ☐ Other_____

Person 6

A SSN is required for every person applying for health care coverage, if they have one. You do not have to give us the SSN for people in your home that are not applying for coverage but providing an SSN may help speed up the application process.

Name (first, middle initial, last):	Social Security Number:	Date of Birth:
Gender: ☐Male ☐ Female ☐ Non-binary	Marital Status: ☐ Single ☐ Married	
Relationship to Person 1:	Are they enrolled in school fulltime? ☐ Yes ☐ No	
Are they pregnant? ☐ Yes ☐ No	If yes, estimated due date?	How many babies are expected?

Does this person want to apply for MaineCare? ☐ **Yes** – Answer the questions below. ☐ **No** – Skip to next Step.

Are they a U.S. citizen or U.S. national? ☐ Yes ☐ No

If yes, are they a naturalized or derived citizen? (This usually means you were born outside of the U.S.)
☐ Yes, please provide an alien and certificate number. ☐ No

Alien Number: Certificate Number:

If they aren't a U.S. citizen or U.S. national, do you have an immigration status?
☐ Yes, please answer the questions below. See page 13 for a list of immigration statuses.

Immigration status: _____ Alien# or USCIS#: _____

Document type: _____ Card or Document Number: _____

Did they enter the United States before August 22, 1996? ☐ Yes ☐ No

Are they, or is their spouse or parent, a veteran or active-duty member of the military? ☐ Yes ☐ No

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

Race (*Optional – check all that apply*): ☐ White ☐ Black/African American ☐ Native Hawaiian or Pacific Islander ☐ Asian ☐ American Indian/Alaskan Native ☐ Other_____

If there are more than six (6) people in your household, copy Page 6 and include the completed copy with your application.

Other questions about your household

Does any applicant have a special health care need, physical disability or mental health condition that limits their ability to work, attend school, or take care of their daily needs (like bathing, dressing, daily chores, etc.)? ☐ Yes ☐ No

If yes, who?

Is any applicant in your household American Indian or Alaska Native?
☐ Yes – Complete **Appendix A** and include with application. ☐ No

Were any applicants under the age of 26 previously enrolled in foster care at the age of 18? ☐ Yes ☐ No

If yes, who? In what state where they in foster care?

Is any applicant currently in jail or prison? ☐ Yes ☐ No If yes, who? _____

Incarceration Date: Anticipated release date (if known):

STEP 3: Income Information

We will ask you to submit proof of income if we are not able to verify your income electronically. You may also send in proof (e.g., pay stubs, award letters, etc.) with this application if you choose.

Employment

If anyone in your household is currently employed tell us about their income. Examples of earned income include wages, salary, tips, bonuses, commissions, etc.

Employed Person	Employer Name	Average hours per week	How often paid	Wages/Salary (before taxes)
				$
				$
				$
				$

Has anyone stopped working in the past 90 days? ☐ Yes ☐ No If yes, who? _____

Self-employment

Complete this section If anyone in your household is self-employed. We will request a copy of their most recent federal income tax return (including all schedules) or copies of monthly business income and expense records to verify self-employment income, or you may send these documents with your application to speed up the process.

Name of person who is self-employed:	Type of work:
How much net income (profits once business expenses are paid) will they get from this self-employment this month?	$

Other Income

Please tell us about other types of income members of your household receive. Examples of other income may include Social Security benefits, unemployment, pension/retirement, interest/dividends, alimony *(for divorces finalized before 1/1/2019)*, etc.

Person with income	Type or source of income	How much?	How often?
		$	
		$	
		$	
		$	

If you need additional space to list income, please include the information requested on a separate sheet with your application.

STEP 4: Deductions

Complete this section if anyone pays for certain things that can be deducted on federal income tax return. Examples may include student loan interest, alimony *(for divorces finalized before 1/1/2019)*, pre-tax retirement contributions, health insurance premiums, etc. Proof of these deductions is not required now but may be sent in with this application to speed up the process.

Who pays this expense?	Type/description	How often paid?	How much?
			$
			$

STEP 5: Tax Information

Do any of the people listed on the application plan to file a federal tax return NEXT YEAR? ☐ Yes ☐ No
If yes, list tax filer and list the spouse of the tax filer if filing a joint return.

Name of tax filer:	If filing jointly, name of spouse:

Will any of the people listed on the application claim any dependents on their tax return? ☐ Yes ☐ No
If yes, list tax filer and list dependents.

Name of tax filer:	Dependent(s):

Will any of the persons listed on the application be claimed as a dependent on someone else's tax return who is not part of your household? ☐ Yes ☐ No
If yes, list tax filer for whom the dependent will be claimed.
You do not need to complete this table if the dependent is already listed above.

Name of dependent:	Name of tax filer:	Relationship to tax filer:

STEP 6: Assets
Applicants who are under age 65 and not disabled may skip to Step 7.

While completing Step 6 is optional upfront for applicants who are age 65 or older or who are disabled, providing asset information now may speed up the application process. All other applicants can skip to Step 7.

Examples of assets include:
Cash *IRA/401k/403b* *Trust Fund* *Promissory Note* *Direct Express Card/Acct*
Checking/Saving Account *Stocks/bonds* *Annuities* *Certificate of Deposit* *Burial Assets*

Owner(s)	Type of Asset	Name of Bank or Institution	Current Value
			$
			$
			$
			$

Vehicles
If you or anyone in your household own, or jointly own any vehicles, list them below. Examples of vehicles:
Cars/Trucks *Campers/RV* *ATVs* *Tractors* *Boats*
Motorcycles *Trailers* *Snowmobiles* *Aircraft* *Farm Equipment*

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

Property
If you or anyone in your household own, or jointly own property, list them below. Examples of property:
Land *House* *Camp* *Life Estate* *Timeshare* *Rental Property* *Buildings*

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

Life Insurance
Tell us about any life insurance policies you or members of your household own.

Policy Owner:	Insurance Company Name:		
Type ☐ Term ☐ Whole	Policy Number	Face Value $	Cash Surrender Value $

STEP 7: Health Insurance

Is anyone enrolled in health coverage? ☐ Yes ☐ No

Health Coverage Information

Policy holder name: _____ Policy holder SSN or DOB: _____

Name of health insurance company: _____ Policy number: _____

Coverage start date: _____ Coverage end date: _____

Type of coverage: ☐ Employer ☐ Private ☐ Long Term Care ☐ Dental ☐ Vision ☐ Prescription ☐ Other

List all household members covered under this plan: _____

Additional Health Coverage Information (if more than one policy)

Policy holder name: _____ Policy holder SSN or DOB: _____

Name of health insurance company: _____ Policy number: _____

Coverage start date: _____ Coverage end date: _____

Type of coverage: ☐ Employer ☐ Private ☐ Long Term Care ☐ Dental ☐ Vision ☐ Prescription ☐ Other

List all household members covered under this plan: _____

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

If more than 2 people have health coverage, include the information requested in Step 7 on a separate sheet with your application.

Medicare

Complete this section if any applicant has Medicare. List the name exactly as it is shown on the Medicare Card.

Name	Medicare Number	Part A Start Date	Part B Start Date

STEP 8: Sign Here **This application cannot be accepted without a signature.**

I understand that information provided on this form may be verified by financial institutions, consumer reporting, and federal, state, and local agencies. If information cannot be verified, I agree to provide documents to prove what I have stated on this application. If I have given incorrect information, my benefits may be denied.

I understand that if anyone applying is eligible for MaineCare (Medicaid), I am giving the Medicaid agency the right to pursue and collect payment from any other health insurance, legal settlements, or other third parties who may be

responsible for paying for our health costs. I am also giving the Medicaid agency rights to pursue and get medical support from a parent.

If a MaineCare eligible child has a parent who lives outside of my home, I know I will be asked to cooperate with the agency that collects medical support from the absent parent. If I think cooperating to collect medical support will harm me or my children, I can tell the Office of Family Independence and I may not have to cooperate.

I am signing this application under penalty of perjury, which means to the best of my knowledge I have given true, correct, and complete answers to all questions on this form for all person applying for benefits. I know that I must tell the Office for Family Independence if anything changes and is different than what I wrote on this application. I understand that a change in my information could affect my eligibility as well as eligibility for member(s) of my household. I know that I may be subject to penalties under federal law if I intentionally provide false or untrue information.

X

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

If you are an authorized representative you may sign here only if you and the applicant have completed and signed the authorized representative form (see Appointment of Authorized Representative form in **Appendix B**).

Appendix A: American Indian or Alaska Native Household Members

American Indians and Alaska Natives can get services from Indian Health Services, tribal health programs, or urban Indian health programs. They may also not have to pay copayments and premiums. Complete this section if you or a family member are American Indian or Alaska Native to make sure your family gets the most help possible.

Is any applicant a citizen of a federally recognized tribe? ☐ Yes ☐ No If yes, list each member below.

Name of person(s)	Tribe name

Are any applicants eligible to get services from Indian Health Services, tribal health programs, or urban Indian health program? ☐ Yes ☐ No If yes, who?

Have any applicants ever gotten a service from the Indian Health Services, a tribal health programs, or urban Indian health program, or through a referral from one of these programs? ☐ Yes ☐ No If yes, who?

Certain money received may not be counted for MaineCare. List any income (amount and how often) reported on your application that includes money from these sources:

- Per capita payments from a tribe that come 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 Department of Interior (including reservations and former reservations)
- Money from selling things that have cultural significance.

Name of person	How much?	How often?
	$	
	$	
	$	
	$	
	$	

Appendix B: Appointment of an Authorized Representative

You have the right to appoint an authorized representative to act on your behalf with the Department. If you want to name a person or organization as your authorized representative, use this form.

We are committed to the privacy of your health information. Please read this form carefully.

Individual's Name: _____

Date of Birth: _____ Social Security Number: _____

Individual's Address: _____

I (individual named above) herby appoint the following individual/organization to act as Authorized Representative for me.

Authorized Representative's Name: _____

Address: _____

Telephone Number: _____ Email Address: _____

Existing legal authority (if any) for individual to act on my behalf (check all that apply):

☐ Guardianship ☐ Power of Attorney ☐ Advance Healthcare Directive

☐ Other (explain): _____

By making this appointment, I want my Authorized Representative to (check all that apply):

☐ Sign and submit an application on my behalf (including an electronic application)

☐ Sign and submit a recertification form on my behalf (including an electronic application)

☐ Receive copies of Notices of Decisions and all other written communications from the Department

☐ Obtain SNAP benefits on behalf of my household

☐ Represent me at fair hearings

☐ Other (please describe):

☐ Act on my behalf in all other matters with the Department of Health and Human Services

- My authorized representative's authority is limited to the task or tasks I have delegated, above.
- This appointment is valid until:
  - I change this appointment in writing by notifying the Department that this Authorized Representative is no longer authorized to act on my behalf; or
  - My Authorized Representative informs the Department in writing that he/she is no longer acting as my Authorized Representative.
- I understand that taking back this appointment does not apply to any documents signed by or sent to my Authorized Representative before I took back the appointment.
- I understand that if I want my Authorized Representative to receive copies of the Notices of Decisions and all other written communications from the Department, the information shared will be for all programs in which I participate that are administered by the Department.

I am signing this form voluntarily, and I have the right to a signed copy of this form if I request one.

Signature of the Individual: _____ Date: _____

For the Authorized Representative

I (Individual Named as Authorized Representative) hereby agree to:

- Fulfill all above-designated responsibilities on behalf of the individual who appointed me as their Authorized Representative;
- Maintain the confidentiality of any information regarding the individual who appointed me as their Authorized Representative;
- Adhere to the regulations 42 C.F.R. § 431(F) and at 45 C.F.R §155.260(f) (relating to confidentiality of information), 42 C.F.R. §447.10 (relating to the prohibition against reassignment of provider claims as appropriate for a facility or an organization

acting on the facility's behalf), as well as all other applicable state and federal laws concerning conflicts of interest and confidentiality of information.

Signature of the Authorized Representative: _____ Date: _____

Immigration Statuses and Document Types

For applicants who are not U.S. citizens: Information about current immigration status is needed to determine eligibility. We will attempt to verify declared immigration status through an electronic data match. It may help us process this application faster if you include a copy of immigration documents for all individuals who are applying.

See the list below for common document types. If your status isn't listed here, you can write in another status or choose to leave the question blank. If needed, we will send you a letter to get more information.

If information regarding immigration status is not provided the individual may only be eligible for coverage of emergency services. Exception: *Children under 21 years of age and pregnant people who would be otherwise eligible for federal Medicaid benefits but are not eligible due to their immigration status may still qualify for MaineCare.*

Immigration Status	Document Types
• Refugee • Asylee • Granted Withholding of Deportation or Withholding of Removal, under the immigration laws or under the Convention against Torture (CAT) • Cuban or Haitian entrant • Amerasian • Victim of trafficking and his or her spouse, child, sibling, or parent • Afghan or Iraqi special immigrant visa holder • Citizen of Compact of Free Association (Micronesia, the Marshall Islands, and Palau) • Lawful Permanent Resident (LPR/Green Card holder) • Battered non-citizens and spouse, child, or parent • Paroled into the U.S. for at least one year • Paroled into the U.S. for less than one year • Lawful temporary resident • Conditional entrant granted before 1980 • Citizen of a federally recognized Indian tribe or American Indian born in Canada • Non-immigrant status (worker visas, student visas, U-visa, T-visa, and other visas) • Temporary Protected Status (TPS) or applicant for TPS with employment authorization • Granted employment authorization • Family Unity beneficiaries • Deferred Enforced Departure (DED) • Deferred Action Status except for Deferred Action for Childhood Arrivals (DACA) • Pending application for Special Immigrant Juvenile status • Adjustment to LPR Status with an approved visa petition • Granted an administrative stay of removal • Applicant for asylum or for Withholding of Removal, under immigration laws or under the Convention against Torture (CAT) who has either been granted employment authorization, OR is under 14 and has had an application pending for at least 180 days • Resident of American Samoa • Other	• Permanent Resident Card, "Green Card" (I-551) • Reentry Permit (I-327) • Refugee Travel Document (I-571) • Employment Authorization Document (I-766) • Machine Readable Immigrant Visa (with temporary I-551 language) • Temporary I-551 Stamp (on passport or I-94/I-94A) • Arrival/Departure Record (I-94/I-94A) • Arrival/Departure Record in foreign passport (I-94) • Foreign Passport • Certificate of Eligibility for Nonimmigrant Student Status (I-20) • Certificate of Eligibility for Exchange Visitor Status (DS-2019) • Notice of Action (I-797) • Document indicating citizenship in a federally recognized Indian tribe or American Indian born in Canada • Certification from U.S. Department of Health and Human Services (HHS) Office of Refugee Resettlement (ORR) • Document indicating withholding of removal • Office of Refugee Resettlement (ORR) eligibility letter (if under 18) • Resident of American Samoa card • Alien number (also called alien registration number or USCIS number) or I-94 number

Get help in a language other than English

Language assistance services, free of charge, are available to you. Call 1-877-797-4357 (TTY: 711)

Français (French)	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-797-4357 (ATS: 711).
español (Spanish)	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-797-4357 (TTY: 711).
繁體中文 (Chinese)	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-797-4357 (TTY: 711)。
Afaan Oromoo (Cushite-Oromo)	XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-855-797-4357 (TTY:711).
Tiếng Việt (Vietnamese)	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-797-4357 (TTY: 711).
العربية (Arabic)	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-797-4357 (رقم هاتف الصم والبكم 117).
ខ្មែរ (Cambodian)	ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-855-797-4357 (TTY: 711)។
Русский (Russian)	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-797-4357 (телетайп: 711).
Tagalog (Tagalog)	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-797-4357 (TTY: 711).
Deutsch (German)	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-797-4357 (TTY: 711).
ภาษาไทย (Thai)	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-855-797-4357 (TTY: 711).
Thuɔŋjaŋ (Nilotic – Dinka)	PIƆ KENE: Na ye jam në Thuɔŋjaŋ, ke kuɔny yenë kɔc waar thook atɔ kuka lëu yök abac ke cïn wënh cuatë piny. Yuɔpë 1-855-797-4357 (TTY: 711).
한국어 (Korean)	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-797-4357 (TTY: 711) 번으로 전화해 주십시오.
Polski (Polish)	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-797-4357 (TTY: 711).
日本語 (Japanese)	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 1-855-797-4357 (TTY: 711)まで、お電話にてご連絡ください。
Português (Portuguese)	ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-797-4357 (TTY: 711).
Kiswahili (Swahilli)	KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu 1-855-797-4357 (TTY: 711).
Ikirundi (Bantu – Kirundi)	ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-855-797-4357 (TTY: 711).
رسی (Farsi)	توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-855-797-4357 (TTY: 711) تماس بگیرید.
Ikiyarwanda (Kinyarwanda)	ICYITONDERWA: Nimba uvuga Ikinyarwanda, uzahabwa serivisi zo kugufasha mundimi. Hamagara 1-855-797-4357 (TTY: 711)
Lingala (Lingála)	KEBA, soki olobaka Lingala, yeba ete lisalisi ya mobongoli ya lonkota olobaka epesamaka ofele. Benga 1-855-797-4357 (ATS: 711).
دری (Dari)	توجه: اگر به زبان دری صحبت می کنید، سهولت های زبانی بطور رایگان برای شما فراهم می شود. با 4357-797-855-1 (TTY: 711) تماس بگیرید.