Department of Human Resources 311 West Saratoga Street Baltimore MD 21201	**FIA ACTION TRANSMITTAL**
Control Number: # 12-02	**Effective Date: Immediately** **Issuance Date: August 4, 2011**

TO: **DIRECTORS, LOCAL DEPARTMENTS OF SOCIAL SERVICES**
DEPUTY/ASSISTANT DIRECTORS FOR FAMILY INVESTMENT
FAMILY INVESTMENT SUPERVISORS AND ELIGIBILITY STAFF

FROM: **ROSEMARY MALONE, INTERIM EXECUTIVE DIRECTOR, FIA**
DEBBIE RUPPERT, EXECUTIVE DIRECTOR, DHMH/OES

RE: **NEW LONG TERM CARE APPLICATION AND REDETERMINATION FORMS**

PROGRAM AFFECTED: MEDICAL ASSISTANCE

ORIGINATING OFFICES: OFFICE OF PROGRAMS

SUMMARY:

We issued streamlined guidelines for the Long Term Care (LTC) application and redetermination processes in Action Transmittal 11-26 on May 3, 2011. As part of that streamlining, DHMH developed new application and redetermination forms. The forms were vetted by focus groups, approved by the LTC workgroup, put on the FIPNet and are currently being printed. Like the old LTC forms, the application will be printed on yellow paper and the redetermination on green paper.

ACTION DUE:

Please begin using the new forms upon receipt. Many of the nursing homes already have electronic copies of the forms, which are designed to be user friendly for both the applicant (or representative) and the case manager. DHMH is scheduling training on the streamlined application process and the new forms this month.

INQUIRIES:

Please direct policy questions to DHMH Division of Eligibility Policy at 410-767-1463 or 1-800-492-5231 (select option 2 and request extension 1463).

DHMH Management Staff	DHR Help Desk
FIA Management Staff	Constituent Services

ATTACHMENTS:

DHR/FIA 9709 (REVISED 7-1-11) LONG TERM CARE/WAIVER MEDICAL ASSISTANCE APPLICATION
DHR/FIA 9709R (REVISED 7-1-11) LONG TERM CARE REDETERMINATION APPPLICATION

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

Check List of Items Needed for Your Long-Term Care / Waiver Application

(Please keep this page for your records)

SEND PROOF If you do not already receive Long-Term Care Medical Assistance, we need the items listed below to process your application. Please send as many items as you can with this application. Please send copies, **do not send originals.** In some cases, we may need to request additional documents not listed below. If so, we will give you time to supply the additional documents.

DO NOT WAIT TO APPLY

If you do not have copies of all the documents listed, send in all the copies you do have when you apply. It is important to apply as soon as possible. We will give you more time to send additional documents needed.

If you or your spouse sold, traded, gifted, or disposed of any property, motor vehicles, stocks, bonds, cash or other assets in the past 5 years you will have to provide the following:

- ☐ Type of asset
- ☐ Value of asset
- ☐ Amount received for the asset
- ☐ Reason for transfer
- ☐ Who received the asset

If you want to find out if your spouse can keep some of your monthly income, please provide:

- ☐ Spouse's gross monthly income
- ☐ Condo fees
- ☐ Mortgage
- ☐ Lot Rent
- ☐ Property tax bill
- ☐ Rent
- ☐ Electric bill

The following items are needed from you and your spouse to determine if you are eligible for Long-Term Care Medical Assistance:

- ☐ Federal Tax Returns for the current year and the preceding four years (please include all forms and schedules). A Record of Account can be obtained from the IRS free of charge by calling 1-800-908-9946 if your Federal tax returns cannot be located.
- ☐ Bank and Financial statements on all accounts owned and co-owned:
  - ☐ Current Month (month of application)
  - ☐ Previous Month (month prior to application)
  - ☐ The last five years of the anniversary month of the application
- ☐ Current statement of retirement accounts
- ☐ Current statement of IRA or Keogh Accounts
- ☐ Current statements of:
  - ☐ Stocks
  - ☐ Bonds
  - ☐ Money Market Funds
  - ☐ Mutual Funds, Treasury, or Other Notes
  - ☐ Certificates
- ☐ Current gross monthly income from all sources including:
  - ☐ VA Pensions
  - ☐ Railroad Retirement
  - ☐ Pensions
  - ☐ Annuities
- ☐ Face and cash value of Life Insurance policies (current annual statement)
- ☐ Current statement for burial accounts
- ☐ Burial Plot Deeds
- ☐ Life Estate Deeds
- ☐ Promissory Notes
- ☐ Mortgage Notes and Mortgage Deeds
- ☐ Trusts (including appendices, schedules, annual accountings, and amendments for the past five years)
- ☐ Private Health Insurance Cards including Medicare (copy of both sides)
- ☐ Health Insurance premium amounts
- ☐ Power of Attorney or Legal Guardianship Documents (if any)

Please continue by completely answering every question on the attached application. If you need more space to complete the application, please attach additional sheets.

Blank Page

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

FOR WORKER USE ONLY *This part is for our staff. Please continue to Section A.*	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:
- ☐ Long-Term Care
- ☐ Waiver

Do you need Medical Assistance for medical bills incurred in the past 3 months?
If yes, you will need to provide copies of the bills to your case manager.
☐ YES ☐ NO

Tell us if you are currently receiving other assistance. I currently receive:
- ☐ Medical Assistance ID # _____
  If you already receive Medical Assistance, please provide your ID number.
- ☐ Cash Assistance
- ☐ Food Stamps
- ☐ Other, list: _____
  If you receive any other benefits, please list all the benefits here.

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

Last Name	First Name	Middle Name	Suffix	Maiden Name or Other Name
			(Jr., Sr., etc.)	

Social Security Number:
If you have a Social Security Number, enter it here.

Additional Social Security Number:
If you have an additional Social Security Number, enter it here.

Date of Birth: (Month, Day, Year)

Gender: ☐ Male ☐ 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?	What is your Country of Origin?
_____	____/____/____	☐ YES ☐ NO	_____

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.*

If you live in a facility, what is the name of the facility?

_____

On what date did you enter the facility?

_____/_____/_____

What is your home address or the address of your facility?

Street _____

City _____ State _____ ZIP _____

Telephone # _____ Cellular Telephone # _____

Is this your mailing address? ☐ YES ☐ NO If you checked NO, please provide your mailing address information in Section V.

Do you (applicant/recipient) intend to return home? ☐ YES ☐ NO

Do you (applicant/recipient) intend to return home within 6 months? ☐ YES ☐ NO

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

Street _____

City _____ State _____ ZIP _____

Did you or your spouse own this home? ☐ YES ☐ NO

Street _____

City _____ State _____ ZIP _____

Did you or your spouse own this home? ☐ YES ☐ NO

Street _____

City _____ State _____ ZIP _____

Did you or your spouse own this home? ☐ YES ☐ NO

Street _____

City _____ State _____ ZIP _____

Did you or your spouse own this home? ☐ YES ☐ NO

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
_____	_____	_____	_____ *(Jr., Sr., III, etc.)*

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
			(Jr., Sr., etc.)	

Spouse's Social Security Number _____

Street _____

City _____ State _____ ZIP _____

Telephone # _____

Do you or your spouse own this home? ☐ YES ☐ NO

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? ☐ YES ☐ NO	$ _____
Do you receive Medicare Part B? ☐ YES ☐ NO	$ _____
Do you receive Medicare Part C? ☐ YES ☐ NO	$ _____
Do you receive Medicare Part D? ☐ YES ☐ 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

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? ☐ Weekly ☐ Biweekly ☐ 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:	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Black Lung Benefits	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
SSI (Supplemental Security Income) Please write your claim number:	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Veteran's Pension/Benefits	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Pension or Retirement	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Civil Service Annuity	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Railroad Retirement Benefits Please write your claim number:	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Alimony	☐ YES ☐ NO	$	☐ Applied for ☐ 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	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Disability/Sick Benefits	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Union Benefits	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Unemployment Benefits	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Lump Sum Cash Amounts	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Interest/Dividends from Stocks, Bonds, Savings, or other investments	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Business Income	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Other (e.g., ☐ Rental Income, or ☐ Compensation from a Legal Settlement)	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Other Please describe:	☐ YES ☐ NO	$	☐ Applied for ☐ 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	☐ YES ☐ NO		$		
Checking Account	☐ YES ☐ NO		$		
Savings Account	☐ YES ☐ NO		$		
Credit Union Account	☐ YES ☐ NO		$		
Trust Fund	☐ YES ☐ NO		$		
IRA or Keogh Account	☐ YES ☐ NO		$		
Other Retirement Accounts	☐ YES ☐ NO		$		
Stocks and Bonds	☐ YES ☐ NO		$		

SECTION M – ASSETS (continued)

ASSET TYPE	CHECK ONE	OWNER	AMOUNT	ACCOUNT NUMBER	INSTITUTION NAME
Treasury or Other Notes	☐ YES ☐ NO		$		
Annuity	☐ YES ☐ NO		$		
Ownership in a Company	☐ YES ☐ NO		$		
Patient Fund Account	☐ YES ☐ NO		$		
Other _____	☐ YES ☐ NO		$		
Other _____	☐ YES ☐ NO		$		
Other _____	☐ YES ☐ NO		$		
Other _____	☐ YES ☐ 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
_____	_____

SECTION O – POTENTIAL ASSET OR INCOME (continued)

Explanation ______	Lawyer Telephone # ______
Anticipated Date of Receipt ______	

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
	☐ Rental Property ☐ Vacation Property ☐ Time Share ☐ Vacant Land ☐ Other Property Rights ☐ Burial Plot	$	$
	☐ Rental Property ☐ Vacation Property ☐ Time Share ☐ Vacant Land ☐ Other Property Rights ☐ Burial Plot	$	$
	☐ Rental Property ☐ Vacation Property ☐ Time Share ☐ Vacant Land ☐ Other Property Rights ☐ Burial Plot	$	$
	☐ Rental Property ☐ Vacation Property ☐ Time Share ☐ Vacant Land ☐ Other Property Rights ☐ 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
$	$	☐ Life Insurance ☐ Burial Plan			
$	$	☐ Life Insurance ☐ Burial Plan			
$	$	☐ Life Insurance ☐ 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:	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Black Lung Benefits	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
SSI (Supplemental Security Income Please write your claim number:	☐ YES ☐ NO	$	☐ Applied for ☐ 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	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Pension or Retirement	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Civil Service Annuity	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Railroad Retirement Benefits Please write your claim number:	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Alimony	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Worker's Compensation	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Disability/Sick Benefits	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Union Benefits	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Unemployment Benefits	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Lump Sum Cash Amounts	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Interest/Dividends from Stocks, Bonds, Savings, or other investments	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Other Please describe:	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Other Please describe:	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Other Please describe:	☐ YES ☐ NO	$	☐ Applied for ☐ 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	☐ YES ☐ NO		$		
Checking Account	☐ YES ☐ NO		$		
Savings Account	☐ YES ☐ NO		$		

SECTION T – SPOUSAL IMPOVERISHMENT (continued)

ASSET TYPE	CHECK ONE	OWNER	AMOUNT	ACCOUNT NUMBER	INSTITUTION NAME
Credit Union Account	☐ YES ☐ NO		$		
Trust Fund	☐ YES ☐ NO		$		
IRA or Keogh Account	☐ YES ☐ NO		$		
Other Retirement Accounts	☐ YES ☐ NO		$		
Stocks and Bonds	☐ YES ☐ NO		$		
Certificates and Money Market Funds	☐ YES ☐ NO		$		
Treasury or Other Notes	☐ YES ☐ NO		$		
Annuity	☐ YES ☐ NO		$		
Ownership in a Company	☐ YES ☐ NO		$		
Other _____	☐ YES ☐ NO		$		
Other _____	☐ YES ☐ NO		$		
Other _____	☐ YES ☐ 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 SEND PROOF	TYPE OF INCOME	VALUE OF ASSET SEND PROOF	ASSET TYPE
			$		$	

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

NAME	RELATIONSHIP	AGE	GROSS MONTHLY INCOME SEND PROOF	TYPE OF INCOME	VALUE OF ASSET SEND PROOF	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: _____

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_____

☐ I withdraw my application for Medical Assistance

_____ _____

Signature of Applicant, Recipient, or Authorized Representative Date

Signature of Case Manager	Date

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

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

Check List of Items Needed for the Recipient's Long-Term Care / Waiver Redetermination Application

(Please keep this page for the recipient's records)

SEND PROOF We have provided a check list of items to help the recipient and/or their authorized representative gather the information needed to process the recipient's redetermination application. Please send copies of the recipient's documents along with the recipient's redetermination application. **Do not send originals.** In some cases, we may need to request additional documents not listed below. If so, we will give the recipient time to supply the additional documents.

Has the recipient, spouse, or anyone sold, traded, gifted, or disposed of recipient's property, motor vehicles, stocks, bonds, cash or other assets in the past 12 months? If so, the recipient will need to provide the following:

- ☐ Type of asset
- ☐ Value of asset
- ☐ Amount received for the asset
- ☐ Reason for transfer
- ☐ Who received the asset

If the recipient wants to find out if their spouse can keep some of the recipient's monthly income, please provide current statements for:

- ☐ Spouse's gross monthly income
- ☐ Condo fees
- ☐ Mortgage
- ☐ Lot Rent
- ☐ Property tax bill
- ☐ Rent
- ☐ Electric bill

Submit copies of the following items:

- ☐ Federal Tax Return for the tax current year (please include all forms and schedules). A Record of Account can be obtained from the IRS free of charge by calling 1-800-908-9946 if the recipient's Federal tax return cannot be located.
- ☐ A Wage and Income Transcript can be obtained from the IRS free of charge by calling 1-800-908-9946 if the recipient filed a joint Federal tax return for the current tax year.
- ☐ Current statements of:
  - ☐ Stocks
  - ☐ Bonds
  - ☐ Money Market Funds
  - ☐ Mutual Funds, Treasury, or Other Notes
  - ☐ Certificates
  - ☐ Retirement account
  - ☐ IRA or Keogh accounts
  - ☐ Bank and financial accounts owned and co-owned
- ☐ Current statement for burial accounts
- ☐ Burial Plot Deeds
- ☐ Current gross monthly income from all sources including:
  - ☐ VA Pensions
  - ☐ Railroad Retirement
  - ☐ Pensions
  - ☐ Annuities
- ☐ Mortgage Notes and Mortgage Deeds
- ☐ Trusts (including appendices, schedules, annual accountings, and amendments for the past 12 months)
- ☐ Private Health Insurance Cards including Medicare (copy of both sides)
- ☐ Health Insurance premium amounts
- ☐ Power of Attorney or Legal Guardianship Documents (if any)
- ☐ Face and cash value of Life Insurance policies (current annual statement)
- ☐ Life Estate Deeds
- ☐ Promissory Notes

Please continue by completely answering every question on the attached application. If you need more space to complete the application, please attach additional sheets.

Blank Page

MARYLAND

MARYLAND DEPARTMENT OF HUMAN RESOURCES
MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE
LONG-TERM CARE / WAIVER MEDICAL ASSISTANCE

REDETERMINATION APPLICATION

Date Signed Application Received in Local Department MUST BE DATE STAMPED

Worker Name

Case Number

R

USE THIS FORM ONLY FOR THE REDETERMINATION PROCESS. SEND PROOF Attach current verifications of all income and resources. Failure to complete the redetermination will result in cancellation of Medical Assistance coverage.

A. Identifying Information:

Recipient's Name: _____ Social Security # _____

Is the recipient a resident of Maryland? ☐Yes ☐No

Date of Birth: _____ Telephone # _____

Address (where recipient actually lives): _____

Mailing address (if different):

_____

Marital Status: ☐Never married ☐Married ☐Separated ☐Divorced ☐Widowed

Is the recipient a U.S. citizen? ☐Yes ☐No

If not a U.S. citizen, alien status: _____ Status effective date: _____

Name of nursing facility,
state institution, or
community-based care provider: _____

If the recipient is married or separated:

Spouse's Name: _____

Spouse's Address (if different):

_____

Spouse's Telephone # _____ Spouse's Social Security # _____

Has the recipient's Authorized Representative changed in the last 12 months? ☐Yes ☐No If Yes, complete the information below:

Authorized
Representative Name: _____ Telephone #: _____

Address: _____

B. Recipient's Income: (Attach Current Verification)

SEND PROOF

				Verification Method/Date	Amount
Social Security	$_____	SSI	$_____	____/____	$_____
Civil Service	$_____	VA	$_____	____/____	$_____
Retirement/Pension	$_____	Disability	$_____	____/____	$_____
Wages	$_____	Other	$_____	____/____	$_____
Business Income	$_____	*(Examples: Trusts, Stocks, Annuities, Dividends, Interest, Bonds, CD's)*		Recipient's Total Income	$_____

C. Spouse's Income: (Attach Current Verification)

SEND PROOF

				Verification Method/Date	Amount
Social Security	$_____	SSI	$_____	____/____	$_____
Civil Service	$_____	VA	$_____	____/____	$_____
Retirement/Pension	$_____	Disability	$_____	____/____	$_____
Wages	$_____	Other	$_____	____/____	$_____
Business Income	$_____	*(Examples: Trusts, Stocks, Annuities, Dividends, Interest, Bonds, CD's)*		Spouse's Total Income	$_____

D. Spouse's Shelter Expenses: (Attach Current Verification)

SEND PROOF

Is there a spouse, child under 21, or any other dependent relative residing in the recipient's home? ☐Yes ☐No If yes, complete the information below:

				Verification Method/Date	Amount
Rent/Mortgage	$_____	Utilities	☐Yes ☐No	____/____	$_____
Homeowner's/Renters Insurance	$_____	Real Estate Taxes	$_____	____/____	$_____
Maintenance Charges for Condominium			$_____	Spouse's Shelter Expenses	$_____
Other _____			$_____		

E. Dependent's Income: (Attach Current Verification)

SEND PROOF				Verification Method/Date	Amount
Social Security	$_____	SSI	$_____	____/____	$_____
Civil Service	$_____	VA	$_____	____/____	$_____
Retirement/Pension	$_____	Disability	$_____	____/____	$_____
Wages	$_____	Other	$_____	____/____	$_____
Business Income	$_____	*(Examples: Trusts, Stocks, Annuities, Dividends, Interest, Bonds, CD's)*		Dependent's Total Income	$_____

F. Assets: (Attach Current Verification)

SEND PROOF Does the recipient have:				Verification Method/Date	Amount
Cash	☐Yes ☐No	Amount	$_____	____/____	$_____
Patient Fund Acct.	☐Yes ☐No	Amount	$_____	____/____	$_____
Checking Acct.	☐Yes ☐No	Amount	$_____	____/____	$_____
Bank Name _____		Acct # _____			
Savings Acct.	☐Yes ☐No	Amount	$_____	____/____	$_____
Bank Name _____		Acct # _____			
Burial Fund/Prearrangement		☐Yes ☐No		____/____	$_____
Company Name _____		Amount	$_____		
Other (CD, stocks, bonds, etc.)	☐Yes ☐No	Amount	$_____	____/____	$_____
Company Name _____		Acct # _____			

F. Assets: (continued) Attach Current Verification

	Verification Method/Date	Amount
Did the recipient purchase or anyone purchase on behalf of the recipient any life insurance not already reported as burial funds? ☐Yes ☐No If Yes:		
Company _____ Policy # _____ Policy Face Value $_____ Policy Cash Value $ _____	____/____	$_____
Company _____ Policy # _____ Policy Face Value $ _____ Policy Cash Value $_____	____/____	$_____
	____/____	$_____
Does the recipient own or have ownership interest in any real or personal property in or out of the state of Maryland (such as land, deeds of trust, buildings, mobile homes, rental or vacation property, recreational vehicles, and collections of antiques, coins, jewelry, or stamps)? ☐Yes ☐No If Yes:		
Name Items: _____	____/____	$_____
Value $ _____	Total	$_____
Has the recipient, their spouse, or anyone sold, traded, gifted, or disposed of any of the recipient's assets and/or real property (such as income, land, building, stocks, trust funds, money, cars, etc.) during the past 12 months? ☐Yes ☐No If Yes:		
Name Items: _____		
Value $ _____ Date: _____	____/____	$_____
Has the recipient received or is expected to receive or inherit any money or property from any source? ☐Yes ☐No If Yes:		
Source: _____		
Value $ _____ Date: _____	____/____	$_____

G: Medical Expenses for Non-Covered Services:

Does the recipient have any non-covered medical bills (e.g., dentistry, audiology, vision) that he/she incurred in the last 12 months? ☐ YES ☐ NO

SEND PROOF *If the recipient answered yes, provide newly dated, itemized medical bill(s) that the recipient incurred within the 12 months prior to this redetermination application. The bill must contain a service date, the charge, and a detailed description for each service provided. Attach copies of the bill(s) with the recipient's Long-Term Care Medical Assistance Redetermination application.*

H: Medical Expenses: (Attach Premium Notice or Statement)

SEND PROOF
Does the recipient have Medicare?:

Verification Method/Date | *Amount*

Medicare Part A: ☐Yes ☐No Part B: ☐Yes ☐No _____/_____ $_____

Part C: ☐Yes ☐No Part D: ☐Yes ☐No

If yes, provide Medicare Claim Number: _____

Other health insurance? ☐Yes ☐No If Yes:

Company _____ Policy # _____

Coverage Type _____ Premium Amount $_____ _____/_____ $_____

Company _____ Policy # _____

Coverage Type _____ Premium Amount $_____ _____/_____ $_____

Medical expenses other than insurance premiums? ☐Yes ☐No _____/_____ $_____

Describe _____ Amount $ _____ Total Medical Expenses $_____

Has the recipient had an accident or does the recipient have a lawsuit pending where someone else is liable? ☐Yes ☐No

If yes, explain: _____ If yes, date: _____

I: Tax Returns: (Attach Required Documentation)

SEND PROOF Did the recipient file a Federal income tax return in the last 12 months? ☐Yes ☐No

If yes, attach a copy of the recipient's Federal tax return for the current tax year, including all forms and schedules. If the recipient filed a joint Federal tax return, do not send the Federal tax return. The recipient will need to provide a Wage and Income Transcript which can be obtained from the IRS free of charge by calling 1-800-908-9946.

If no, attach quarterly bank and financial statements for the past 12 months.

_____/_____

Is additional information needed? ☐Yes ☐No

J: Voter Registration

If the recipient is not registered to vote, would the recipient like to receive a voter registration form? ☐ YES ☐ NO ☐ Already registered to vote

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_____

☐ I withdraw my application for Medical Assistance

_____ _____

Signature of Recipient or Authorized Representative Date

Signature of Case Manager	Date

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 that have occurred within the last 12 months prior to my redetermination 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