

For Office Use Only/Date Stamp

# Intent to Apply For Waiver Services

This form is to be utilized for individuals who have already applied for LTC Medicaid and now intend to apply for waiver services within the six month consideration period of the LTC application. This form is forwarded to the Eligibility Determinations Divisions (EDD) located at 6 Saint Paul Street, Suite 400, Baltimore, MD 21202.

### Applicant/Recipient Information: (Please Print)

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

CID #: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

What waiver are you applying for?

- Home and Community Based Options Waiver  Adults with Traumatic Brain Injury
- Community Pathways & New Direction Waivers for Individuals with Developmental Disabilities

Have you completed a Long-Term Care application?

- Yes If yes, please provide the date the application was completed: \_\_\_\_/\_\_\_\_/\_\_\_\_
- No (A long-term care application must be completed prior to submitting this form.)

Are you currently enrolled in a Medical Assistance Program?  Yes  No

### Authorization to Release Information:

I give permission to the State of Maryland as an applicant/recipient of Medical Assistance to release information to assist in the waiver application process. This authorization is valid for 12 months from the date of signature.

Applicant/Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Authorized agency/person to assist in the waiver application process:

Name: \_\_\_\_\_ Agency/Facility: \_\_\_\_\_

Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Signature: \_\_\_\_\_