MAINE DEPARTMENT OF HEALTH AND HUMAN SERVICES

Application for Financial Assistance for Facility Costs

This application is for help with Nursing Facility expenses, cost of nursing care in your home or cost of care in a Residential Care Facility.

I am asking for help with:
(check one)
____ Support Waiver
____ MR Waiver
____ Nursing Facility care
____ Nursing care in my home
____ Residential Care Facility

Return to:

The term **"YOU"** as used in this application means the person who needs financial assistance.

Information about you:

Your Name (First, Middle, Last)	Social Security #	Birthdate	Age

Mailing Address: Street, PO Box, (Include apartment number, care of, etc.)	U.S. Citizen No Yes	Sex M F

City	State	Zip Code	Telephone or Message Number

Street address and town where you actually live. Please give directions to your home.

_____

Race: White ____ Black ____ Hispanic ____ Other _____

Marital Status: Single ____ Married ____ Separated ____ Divorced ____ Widowed ____

Medicare number: Effective date: **Part A** _____ **Part B** _____

Do you have a disability? No ____ Yes ____ Do you receive SSI? No ____ Yes ____
Have you ever received SSI? No ____ Yes ____

Have you ever served in the Armed Forces? No ____ Yes ____

Information about your spouse:

Spouse's Name (First, Middle, Last)	Social Security #	Birthdate	Sex M __ F __

Medicare number: Effective date: **Part A** _____ **Part B** _____

Does your spouse live with you? ⟶ No ____ Yes ____
If no, list your spouse's mailing address:

Has your spouse ever served in the Armed Forces? No ____ Yes ____

Date received:_____ Date logged on:_____ 45th day: _____

The asset questions on pages 2 and 3 are about you and your spouse. You need to provide proof of all assets.

- Cash not in bank - Checking Account - Credit Union Shares - IRA, 401K, Keogh
- Savings Account - Certificate of Deposit - Other Accounts

Name(s) on Account	Type of Asset See Above	Name of Bank or Institution	Account Number	Current Balance Or Value

If you need more space to list accounts, use a separate sheet and check here. ☐

If you are presently in a Nursing Facility or Residential Care Facility, do you have a **Patient Account?** **No** ____ **Yes** ____
If so, what is the balance of your account? $_____

You need to tell us about any annuities, stocks, bonds, profit sharing, trust funds and any other financial investment instruments that you or your spouse have an interest in.

Do you or your spouse have any **Stocks, Bonds, Profit Sharing, Annuities, or any type of Trust Funds**? **No** ____ **Yes** ____

If yes, list here:

Other:

Do you or your spouse have any Life Insurance? If yes, list below: **No** ____ **Yes** ____

Owner	Who is insured	Company name and address	Face Value	Cash Value
			$	$
			$	$
			$	$

Do you or your spouse have a Funeral Plan or Prepaid Burial? **No** ____ **Yes** ____

Does your name or your spouse's name appear on **anyone else's** Bank Account, Savings Account, Checking Account, Credit Union Account, Stocks, Bonds, Money Market Certificates or any type of Property other than those already listed? **No** ____ **Yes** ____

Do you or your spouse have a Safe Deposit Box? **No** ____ **Yes** ____
Name of Bank:

Do you or your spouse have Land, Buildings, Timeshares, jointly-held Real Estate, or a Life Estate, including where you live? **No** ____ **Yes** ____

Do you intend to return to your residence when you no longer need care in a Nursing Facility or an Assisted Living/Residential Care Facility? **No** ____ **Yes** ____

Do you or your spouse have, or jointly own, any cars, trucks, boats, campers, motorcycles, snowmobiles, ATVs, trailers, skidders, tractors, or other motorized vehicles? **No ___ Yes ___**

If yes, please list below:

Year	Make	Model	Name(s) of Owner(s)	Amount Owed
				$
				$
				$

Have you or your spouse disposed of any **Personal Property** or **Real Estate** or closed any **Savings**, **Checking**, or **any other Financial Accounts** in the last 60 months? This includes all things you may have given away or sold during the past 60 months. (Examples of things you may have owned: money, bank accounts, checking accounts, stocks, land, buildings, camps, automobiles, boats, campers, etc.) **No ___ Yes ___**

If yes, please list here:

Have you or your spouse recently received, or do either of you expect to receive in the near future, any retroactive government benefits, pay raises, lawsuit settlements, inheritances, or compensation of any other kind? **No ___ Yes ___**

If yes, please list here:

These income questions are about you and your spouse. Please provide proof of income.

* Alimony
* Social Security (Retirement or Disability)
* Self-Employment
* Other Disability Income
* Military Allotment
* SSI
* Other Income
* Railroad Retirement
* Pensions
* Worker's Compensation
* Veteran Benefits (List Claim # _____)
* Dividends or Interest
* Earnings – Wages
* Civil Service Annuity or Other Annuities

List Type (See Above) →	Your Income				Your Spouse's Income			
Gross Amount →	$	$	$	$	$	$	$	$
How often received? →								

Do you or your spouse receive rent money from property? → **No ___ Yes ___**

Do you or your spouse receive money from someone who pays room and board? → **No ___ Yes ___**

Do you or your spouse receive money from irregular income during the year? → **No ___ Yes ___**

If you are in a hospital or nursing facility and your spouse is living at home, please list your **spouse's shelter expenses**. (Do not include past due payments and Security Deposits.)

Lot Rent	$_____per_____	Rent	$_____per_____	Cooking Fuel	$_____per_____
Mortgage	$_____per_____	Heat	$_____per_____	Water	$_____per_____
Property Taxes	$_____per_____	Telephone	$_____per_____	Sewer	$_____per_____
House Insurance	$_____per_____	Electricity	$_____per_____	Trash Collection	$_____per_____

Is your heating cost included in your rent? ⟶ **No __ Yes __**

Does your mortgage payment include taxes and house insurance? ⟶ **No __ Yes __**

Does anyone else live in the household of your spouse? ⟶ **No __ Yes __**

Do you need help with any medical bills incurred within the past three months? **No __ Yes __**

Which months?

Please send proof of income and assets for these months.

Do you have any medical insurance? ⟶ **No __ Yes __**

Name of insurance company: _____ Premium $ _____ How often paid? ____

Please provide the latest receipt for the premium paid.

If you are now, or in the past 90 days have been in a Hospital, Nursing Facility, or Residential Care Facility, please tell us about this.	Facility Name _____ Address _____ Date admitted _____ Date discharged _____	Facility Name _____ Address _____ Date admitted _____ Date discharged _____

Do you have a power of attorney, conservator, or court-ordered guardian? **No __ Yes __**

Name: _____ Telephone #: _____

Address: _____

Please provide a copy of the court order or the power of attorney.

Is there someone else who knows about your financial situation, and whom we may contact to help with this application? **No __ Yes __**

Person's Name: _____ Relationship: _____

Address: _____ Telephone #: _____

If someone helped you fill out this form, please write his or her name and telephone number below:

Name: Telephone #:

Assignment of Rights to Medical Payments: If MaineCare pays a bill for you, MaineCare has the right to collect for that bill from other medical support or medical insurance you may have.

Estate Recovery: If you receive MaineCare benefits and are age **55 or older**, the State may make a claim on the assets of your estate to recover the money that MaineCare has paid for your care. **No claim will be made if the only service you receive is the Medicare Buy-In.** For more information about the Estate Recovery Program, please call MaineCare Member Services at 1-800-977-6740.

I understand all the information requested on this form. I certify (under penalty of perjury) that all my answers are correct and complete to the best of my knowledge—including those concerning citizenship and alien status. I agree to give paperwork or other information to prove what I have said. I also agree that the Department of Health and Human Services and Federal officials may check with other people to verify the information I have provided.

_____ _____

Signature Date