

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.

Return to:

I am asking for help with:

- (check one) Nursing Facility care
 Support Waiver Nursing care in my home
 MR Waiver Residential Care Facility

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 <input type="checkbox"/> F <input type="checkbox"/>
Medicare number: _____		Effective date: Part A _____ Part B _____		
Does your spouse live with you? _____ →			No <input type="checkbox"/> Yes <input type="checkbox"/>	
<i>If no, list your spouse's mailing address:</i>				
Has your spouse ever served in the Armed Forces? No <input type="checkbox"/> Yes <input type="checkbox"/>				

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

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