Date Received (Agency use only)

MARYLAND DEPARTMENT OF HEALTH
APPLICATION FOR EMPLOYED INDIVIDUALS with DISABILITIES

Your Name (Last, First, Middle)	Home Telephone		Work Telephone	
Where do you live? (Number and Street)	Apt. #	City	State	Zip Code
Mailing Address (If different from home)			Cell Telephone	

What language do you speak? ☐ English ☐ Spanish ☐ Other _____

If you do not speak English and need free translation services, call your case manager or call 1-800-226-2142.

Are you or anyone in your household disabled? ☐ Yes ☐ No If yes, who? _____ Disability?_____

What type of assistance do you or your spouse (if any) receive now or in the past? (Check Now if you are currently receiving this assistance)		**Under what name?**
Now ☐	1.	1.
Now ☐	2.	2.

A. HOUSEHOLD MEMBERS

Fill in the blanks for you and your spouse (if any). List your own name first. Social Security number and Citizenship are optional for members not applying for benefits. Use the codes below to complete the Citizenship, Race and Ethnicity columns. Enter each code that applies, using at least one code for each person.

Ethnicity Codes: 1= Hispanic or Latino, 2=Not Hispanic/Latino

Race Codes: you can choose one or more race code - 1=American Indian/Alaskan Native, 2=Asian, 3=Black/African American, 4=Native Hawaiian/Pacific Islander, 5=White

Citizenship/Immigration Code: 1=United States Citizen, 2=Permanent Resident, 3=Asylee, 4=Alien granted conditional entry, 5=Parolee 1 year or more, 6=Alien whose deportation is withheld, 7=Refugee, 8=Battered alien spouse, child, or parent of child(ren)

Note: 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.

Only Answer the questions **below for each person who wants benefits**

APPLYING FOR (Yes or No)	NAME (Last, First, Middle)	How are they related to you?	DATE OF BIRTH	SEX	ETHNICITY	RACE	IN SCHOOL (Yes or No)	LAST GRADE COMPLETED	U.S. CITIZEN (Yes or No)	SOCIAL SECURITY NUMBER
		Self								
		Spouse								

B. CITIZENSHIP/ IMMIGRATION STATUS

If anyone for whom you are applying is not a United States citizen, fill in this section. ONLY ANSWER THESE QUESTIONS FOR EACH PERSON WHO WANTS BENEFITS.

Household member	INS Status	Sponsored Immigrant? ☐ Yes ☐ No	Country of origin
	US Entry date:	INS Number:	
Household member	INS Status	Sponsored Immigrant? ☐ Yes ☐ No	Country of origin
	US Entry date:	INS Number:	

C. AUTHORIZED REPRESENTATIVE:

You may choose a person to apply for you. If you choose someone to help you, give us the following information about the person and check what you want this person to do.

Name (Last, First , Middle)	Relationship	Telephone Number	
Number, Street	City	State	Zip Code

Check what you want the representative to do:

☐ Complete interview for you ☐ Receive your notices

☐ Sign your application ☐ Receive your Medical Assistance card

D. STUDENTS

Are any household members between ages 18-50 attending a school for higher education (college, vocational or technical school)?
☐ Yes ☐ No Name of student _____

School_____ Is the student employed? ☐ Yes ☐ No Is the student getting educational grants, scholarships, or loans? ☐ Yes ☐ No Amount $_____ Amount of tuition $_____

Books $_____ Fees $_____ Transportation $_____

E. RESOURCES/ASSETS

Do you or your spouse (if any) have any resources or assets such as a checking or savings account, stocks, bonds, cash on hand, property other than where you live, prepaid burial plan, trust fund, IRA or KEOGH account? ☐ Yes ☐ No If yes, list below:

NAME OF OWNER (Specify if self-employed)	TYPE OF RESOURCE/ASSET	BALANCE/VALUE	LOCATION (Name of Bank, at home, etc.)

F. TRANSFER OF ASSETS

Have you or your spouse (if any) sold, traded or given away any property, stocks, bonds, cash or other assets in the past 36 months? (60 months if a trust is involved) ☐ Yes ☐ No If yes, list below:

Former Owner	Transfer Date	Who Received the Asset?	Type of asset

Fair Market Value $	Amount Received $	Reason for Transfer

G. EARNED INCOME

Do you or your spouse (if any) receive any income from employment? ☐ Yes ☐ No If yes, list all gross income **before deductions** (such as full or part-time employment, self-employment, baby-sitting, odd jobs, day work, roomer/boarder payments, etc.)

NAME	NAME OF EMPLOYER (INCLUDE ADDRESS AND PHONE NUMBER)	RATE OF PAY	NUMBER OF HOURS WORKED	AMOUNT PER PAY PERIOD	HOW OFTEN RECEIVED

H. OTHER INCOME AND BENEFITS

If you or your spouse (if any) receives, applied for or was denied any benefit listed below, place a check in the box next to the benefit

☐ Alimony ☐ Child Support ☐ Social Security ☐ SSI
☐ Railroad Retirement ☐ Veteran's Pension/Benefit ☐ Unemployment Benefits ☐ Education Grants or Loans
☐ Worker's Compensation ☐ Pension or Retirement ☐ Union Benefits ☐ Disability, Sick or Maternity Benefits
☐ Military Allotment ☐ Money from Rental Income ☐ Black Lung Benefits ☐ Money from Friends or Relatives
☐ Lump Sum Cash Amounts ☐ Civil Service Annuity ☐ TDAP
☐ Social Security Disability ☐ Interest Dividends from Stocks, Bonds, Savings or Other Investments
☐ Other _____

Do you agree to apply for all benefits you may be entitled to receive? ☐ Yes ☐ No

If you checked yes to receiving, applying for or being denied any benefits, fill in below:

HOUSEHOLD MEMBER	TYPE OF BENEFIT	Applied		CLAIM NUMBER	Received		Amount
		☐ Yes	☐ No		☐ Yes	☐ No	
		☐ Yes	☐ No		☐ Yes	☐ No	

I. MEDICAL EXPENSES Complete as Appropriate

Do you or your spouse (if any) pay medical expenses? ☐ Yes ☐ No If yes, check the appropriate box
DISCUSS THESE EXPENSES WITH YOUR CASE MANAGER.

☐ Health/Medicare Insurance	$ 566.00	☐ Medical/Dental Insurance	$ 566.00	Others _____
☐ Dentures/Glasses/Hearing Aids	$ 566.00	☐ Transportation Costs	$ 566.00	_____
☐ Hospital	$ 566.00	☐ Nursing	$ 566.00	_____
☐ Attendant Care	$ 566.00	☐ Pharmacy Expense	$ 566.00	_____

J. LIFE INSURANCE, FUNERAL PLANS or BURIAL FUNDS Complete as Appropriate

NAME OF PERSON INSURED	NAME OF PERSON WHO PAYS	FACE VALUE OR VALUE OF PLAN	CASH VALUE	POLICY NUMBER OR ACCOUNT NUMBER	COMPANY, FUNERAL HOME OR BANK NAME

K. MEDICAL INSURANCE Complete as Appropriate

1. Has anyone applying dropped health insurance coverage in the past six months? ☐ YES ☐ NO

2. Does anyone applying have any health insurance? ☐ YES ☐ NO If you answered yes to question 2, fill in the section below.

HEALTH INSURANCE POLICY NUMBER 1

POLICY HOLDER NAME	POLICY NUMBER	GROUP NUMBER

HOUSEHOLD MEMBER(S) COVERED BY POLICY	RELATIONSHIP OF MEMBER TO POLICY HOLDER	HOUSEHOLD MEMBER(S) COVERED BY POLICY	RELATIONSHIP OF MEMBER TO POLICY HOLDER

POLICY HOLDER ADDRESS

Number	Street	City	State	Zip Code	Telephone

INSURANCE COMPANY/UNION

Insurance Company Name

Number	Street	City	State	Zip Code	Telephone

HEALTH INSURANCE POLICY NUMBER 2

POLICY HOLDER NAME	POLICY NUMBER	GROUP NUMBER

HOUSEHOLD MEMBER(S) COVERED BY POLICY	RELATIONSHIP OF MEMBER TO POLICY HOLDER	HOUSEHOLD MEMBER(S) COVERED BY POLICY	RELATIONSHIP OF MEMBER TO POLICY HOLDER

POLICY HOLDER ADDRESS

Number	Street	City	State	Zip Code	Telephone

INSURANCE COMPANY/UNION

Insurance Company Name

Number	Street	City	State	Zip Code	Telephone

PLEASE USE THIS SPACE IF YOU NEED TO GIVE US MORE INFORMATION ABOUT ANY APPLICATION QUESTION.

YOUR RIGHTS AND RESPONSIBILITIES

FACTS YOU SHOULD KNOW ABOUT APPLYING FOR MEDICAL ASSISTANCE
Social Security Numbers

- You must give us a social security number for each family member who wants benefits.
- If a person who wants benefits does not have a social security number, that person must apply for a number. We can help applicants get their numbers.
- If you or your spouse (if any) has applied for a social security number, we will not delay your application while you wait for the number.
- We use social security numbers to prove income. We do not give numbers to other agencies like Immigration and Customs Enforcement.

Citizenship and Immigration Status

- You must tell us about the citizenship and immigration status for you and your spouse (if any) who wants benefits.
- Maryland uses the Systematic Alien Verification and Eligibility or SAVE system through the United States Citizenship and Immigration Service (USCIS) formerly known as Immigration and Naturalization Service (INS) to verify the alien status of all applicant and recipient non-citizen households. Information received from USCIS may affect your household's eligibility and benefit amount.

Information

- If a family member will not tell us about citizenship, immigration status or social security number, that person will not get benefits.
- They must still give us proof of income, expenses and other things.
- The other family members who give us their information will get benefits if they meet the rules.

Interviews

- You, a responsible family member or someone you choose to represent you must be interviewed.
- In most cases, we can interview you by telephone.
- You must give or send us the proof we ask for at your interview.

If you need help applying for benefits, or have questions about information you must give us, want to know what will happen to your benefits, do not speak English and need free translation services**. Call your case manager or call 1-800-226-2142. Si necesita ayuda para llenar el formulario favor de llamar al 1-800-226-2142.**

The Maryland Department of Health is committed to providing access, and reasonable accommodation in its services, programs, activities, education and employment for individuals with disabilities. If you need assistance or need to request a reasonable accommodation, please contact your case manager or call 1-800-226-2142 or fill out the form on the next page.

Requesting a reasonable accommodation:

If you are an individual with a disability, you may be entitled to reasonable accommodation to help you access programs and services. This applies even if you are working with a local department of social services or a vendor who provides services for customers.

A reasonable accommodation is a modification or adjustment to an activity, program or service which helps a qualified individual with a disability have meaningful access to activities, programs and services.

Examples of reasonable accommodations:

Hearing Impairment: sign language interpreter; providing an assistive listening device

Visual Impairment: having a qualified reader read to a customer

Mobility Impairments: mailing forms to a customer; meeting a customer at a more accessible location

Developmental Disabilities: Having things written down; taking breaks; scheduling appointments around a customer's medical needs

You may request a reasonable accommodation from the local department of social services or a vendor at any time. Your request may be oral or written. A request for a reasonable accommodation may be made in person, in writing or over the telephone. There are no particular words that you need to use to request an accommodation. A request may be made by you or someone helping you. If you need to request a reasonable accommodation because of your disability, you should speak with the case manager or the supervisor. You may use the form on the reverse side of this notice.

YOUR RIGHTS AND RESPONSIBILITIES

1. Dial 7-1-1 or 800-735-2258 to initiate a TTY call through Maryland Relay.
2. The Maryland Relay Operator's typed greeting, including the Operator's identification number, will display on your TTY or VCO phone.
3. When the Operator is finished typing, you will see the letters "GA." This means "Go Ahead.".
4. Type the number of the person you want to call, along with any special calling instructions. Then type "GA".

Request for Reasonable Accommodation	
Name of Person Needing an Accommodation	Name of Person Requesting the Accommodation
Address:	
Street Address/City/State/Zip Code:	Telephone number:
Nature of Disability or Impairment (specify):	
Accommodation Request (Type of accommodation requested.) Please print or type. Be as specific as possible. If required, attach additional comments.	
Note: If requesting sign language services, specify type: American Sign Language Interpreter (ASL), Certified Deaf Interpreter (CDI) or Communication Access Real Time Translation (CART). Please provide any additional information that may assist us in providing a reasonable accommodation (specify):	

EQUAL RIGHTS – This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and in some cases religion or political beliefs.

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (TTY).

This institution is an equal opportunity provider.

RIGHT TO WRITTEN NOTICE – We must always give you a written notice explaining your benefits when we approve your case. We must always give you written notice when we change your benefits, deny or close your case. You have 90 days from the notice date to ask for a hearing. If you ask for a hearing within 10 days, you may be able to keep getting benefits while you wait for the hearing.

RIGHT TO APPEAL – Ask for a hearing if you disagree with the Department's decision. Your case manager can help you write your appeal. At the hearing, you can speak for yourself or bring a lawyer, friend or relative to speak for you.

RIGHT TO PRIVACY – You are giving personal information in the application. We use the information to see if you are eligible for benefits. If you do not give the information, we may deny your application. You have a right to review, change, or correct any information. We will not show your information or give it to others unless you give us permission or federal and state law allows us to do so.

RIGHT TO REFUSE HELP – You do not have to accept help from a religious organization if it is against your religious beliefs.

YOUR RIGHTS AND RESPONSIBILITIES

RIGHT TO TIMELY APPLICATION PROCESSING – Except for certain Medical Assistance programs, we must process your application within 30 days. There are times when there is a delay in processing. If there is a delay, we will send you a letter to tell you why there is delay in processing your application.

YOU HAVE THE FOLLOWING RESPONSIBILITIES

PROVIDE INFORMATION – You must give true and complete information. You may need to give us proof of this information. We will keep this information private. Any delay in providing proof may result in your case being delayed or denied.

Collecting application information, including the social security number of each household member, is authorized under the U.S.C.2011-2036, Social Security Act §1137(f) and 42 U.S.C. §1320b-7(d). We use the information to find out if your household is eligible. We check this information by matching computer programs.

We also use the information to see if you meet program rules. We may contact your employer, bank or other party. We may also contact local, state or federal agencies to make sure the information is correct. We can give your information to other federal or State agencies for official use and to law enforcement officers who need it to find persons fleeing to avoid the law.

If you get too much in benefits:

- You may have to repay the money for the benefits, and
- We may give the application information, including social security numbers, to federal or state agencies, as well as private claims collections agencies, for action.

Giving information is voluntary. If you do not give us information such as social security numbers for everyone who wants help, we may deny benefits for each person who does not give a social security number. If you do not have a social security number, we will help you get one.

REPORT CHANGES - You must report all changes within ten days. You may tell us about any changes in person, by telephone, or by mail to the Department.

Warning – We may deny, lower or stop your benefits if you give us wrong information or do not report changes. A judge may fine and/or imprison you if you deliberately give wrong information or do not report changes.

AUTHORIZED REPRESENTATIVES – In most instances, if your authorized representative gives us wrong information, you will have to pay back any amount you are overpaid.

If your authorized representative knowingly gives us the wrong information or does not use your benefits properly, we may disqualify the person from being an authorized representative and prosecute them for fraud under state and federal law.

MEDICAID WARNING AND PENALTY - Only use Medical Assistance cards if you are eligible.

Every person convicted of "Medicaid Fraud" with a value of **$500** or more in money, services, or goods is guilty of a felony, and shall:

1. Pay back money, services or goods; or the value of those services or goods unlawfully received;
2. Be subject to a fine of no more than $10,000, imprisoned for no longer than five years, or both.

Every person convicted of "Medicaid Fraud" with a value of less than **$500** in money, services or goods is guilty of a misdemeanor, and shall:

1. Pay back money, services or goods; or the value of those services or goods unlawfully received;
2. Be fined no more than $1,000 and imprisoned for no longer than three years or both.

READ BEFORE SIGNING:

I understand that it is important to give true information and if I do not, I am breaking the law.

I understand that I can be fined, imprisoned or have my benefits reduced for making false statements or for pretending to be another person.

I know I can be punished for not reporting changes that may affect my eligibility or benefit amount.

I know the Department can use the application against me in a court of law for fraud prosecution.

I know that failing to report or verify shelter, medical or dependent care expenses is the same as saying I do not want a deduction for the expenses I did not verify or report.

I understand that the Department may check the information on this form to see if it is correct and may select my case for a spot check, such as for a Quality Control Review.

I agree to allow someone from the Department to visit me at home. I will help them get all needed proofs from any source.

YOUR RIGHTS AND RESPONSIBILITIES

I understand by signing this application:

- I accept Medical Assistance.
- I agree that Medicare Part B will make payments directly to doctors and medical suppliers.
- I give the Department the right to seek payment from private or public health insurance and any liable third party. I understand that I must cooperate with the department in securing such payments. The Department may seek payment without legal action, as long as it does not keep more than the amount Medical Assistance paid.
- I give the Department the right to inspect, review and copy all medical records for services received through the Medical Assistance Program.

I understand that when a person is deceased who was at least 55 years old when receiving Medical Assistance the state may take money from the estate to repay payments made on behalf of that person. The program may take the money only if there is no surviving spouse, unmarried child younger than 21, or blind or disabled child (married or unmarried) of any age.

SIGNATURE SECTION

I understand that, as required by Maryland law, certain law enforcement agencies that investigate fraud can obtain information about my application, income, benefits and other documentation as part of their investigation. While access to my application and benefit information is normally limited (under Md. Code Ann. Human Resources Article § 1-201), these limits do not apply to these investigative agencies. Such agencies include the Department of Human Resources' Office of the Inspector General. I understand that I do not need to provide consent to these agencies in order for them to investigate any allegations of fraud against me. Any information found as a result of the investigation may be used against me if an allegation of fraud is prosecuted.

I have read or someone has read and explained the entire application to me. I swear or affirm under penalty of perjury, that all the information I gave is true, correct, and complete to the best of my ability, belief and knowledge. I received a copy of my rights and responsibilities. I authorize any person, partnership, corporation, association, or governmental agency that knows the facts about my eligibility to give that information to the Department. I also authorize the Department to contact any person, partnership, corporation, association, or governmental agency that has given proof of my eligibility for benefits. I certify, under penalty of perjury, that by signing my name below, all persons for whom I am applying are U.S. citizens, lawfully admitted immigrants or individuals in satisfactory immigration status.

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
Signature of Case Manager		Date
☐ **I do not wish to apply for assistance at this time. I withdraw my application for Medical Assistance.**		
Signature of Applicant/ Recipient		Date
Printed Name of Applicant		