State of Maine Department of Health and Human Services

Application for Health Insurance

Use this application to apply for MaineCare if you fit within any of the following groups:

- ✓ Families with Children
- ✓ Pregnant Women
- ✓ ~~Former Foster Care Children (under age 26)~~
- ✓ You are seeking help with the following services: Family Planning, Reproductive and Sexual Health Care or Sexually Transmitted Infections

Return to:

REC'D 45th DAY

1. Person Filling Out The Application

Name (first, middle initial, last)	Alice Apple		
Social Security Number (Optional if You Are Not Requesting Coverage)	**Birthdate** (month/day/year)	**Sex**	**Are you requesting Coverage?**
XXX-XX-XXXX	01/01/1985	F	YES

Check one ☐ **married** ☐ **widowed** ☒ **single** ☐ **divorced** ☐ **separated**

Maiden Name _____

2. Mailing Address

Street, PO Box or RR (include apartment number, in care of , etc.)	1 Main St			
City: Portland	**State:** ME	**Zip code:** 04101	**Home phone** 207-777-1234	**Work phone:**

If different from your mailing address, write in the address where you actually live:

3. Former Foster Child

Were you in foster care and enrolled in the MaineCare program through the State of Maine at age 18, and you are now less than 26 years of age? ☐ Yes ☒ No

If yes, you can skip the rest of this application. Just sign and date the last page and return this application to us.

4. Household Members (*List the people who live with you*) *If you are only applying for help with the family planning benefit, and do not want full MaineCare for yourself or any other household member, then answer the remaining questions just for yourself. You do not need to list information about other household members.

Last name	First name	Middle initial	Sex	Date of birth	Requesting Coverage?	Social Security Number (Optional if Not Requesting Coverage)	Relationship to you

Apply for Limited Family Benefit only

5. Household Wages From Work (*You are not required to submit proof of your wages at this time, but you may be asked at a later date to provide paystubs or photocopies of paystubs for the last 4 weeks if electronic verification is not possible.*)

Name	Employer's name and phone	Amount you are paid (before any deductions)	How often you are paid	Hours worked each week
Alice	ABC Tile Co	$400	Wkly	40

*Check here if your wages change a lot. [ ]

6. Self-Employment (*Attach a copy of your most recent tax return including all schedules*)

Name of person(s), if any, who is self-employed	
	If you did not file a tax return, check here ☐
	If you did not file a tax return, check here ☐

7. Unearned Income (*You are not required to submit proof of your income at this time, but you may be asked to at a later date if electronic verification is not possible.*)

Note: You don't need to tell us about child support, veteran's payments, or Supplemental Security Income (SSI).

Name of person receiving income	Where is income from? (Social Security, Unemployment, etc.)	How often received? (monthly, weekly, etc.)	Amount before deductions

8. Health Insurance

Does anyone who is applying have health insurance, including health care coverage from the VA? ☐ Yes ☑ No

If yes, please answer the following questions for each individual:

Name of individual applying who has health insurance	Name of insurance company

List children in your household who lost health insurance (except for MaineCare) in the last 3 months and why they lost insurance:

List children in your household who can be added to a household member's State Employee health insurance:

9. Special Conditions

☐ Check here if any household member has a disability. Name of household member _____

☐ Check here if your child is a member of a Federally recognized American Indian tribe or Alaskan Native. (*No premium is required.*)
Name of tribe _____

[ ] Check here if English is not your first language. What language do you speak? _____

[ ] Check here if any child on this application has a parent living outside of the home.
If yes, you will be asked to cooperate with the agency that collects medical support from an absent parent. If you think that cooperating to collect medical support will harm you or your children, you can tell MaineCare and you may not have to cooperate.

[X] Check here if you are asking for help with medical bills incurred in the last 3 months.

[ ] Check here if you want to apply for Food Supplement benefits.

[ ] Check here if you or anyone in your household served in the US Military. If yes, please answer the following questions for each individual:

Question 1	Name of individual in household who served in the military	Branch of the military served	Dates of service (Start Date – End Date)

Question 2	Have you or anyone in your household ever applied for VA benefits? ☐ Yes ☐ No
	If no, would you like help from the Maine Veterans' Service to apply for VA benefits? ☐ Yes ☐ No
	If yes, please complete the attached Authorization to Release Information form and authorize DHHS to release information to "Maine Veterans' Service".

[ ] Check here if you want DHHS to tell you how much your deductible (spenddown) would be if we decide that your income is too high for the regular MaineCare program.

[X] Check here if you and/or another household member is interested in a MaineCare benefit that provides limited coverage related only to family planning services if you or he/she is not eligible for full MaineCare benefits.

Name of other household member(s) interested in limited coverage related only to family planning services:

10. Citizenship

[ ] check here if someone applying for MaineCare is not a U.S. Citizen.

Complete the following for any applicant who is not a U.S. Citizen

Name	Document Type	Document ID Number	Has he/she lived in US since 1996? Yes or No

11. Authorized Representative

[X] check here if you would like to allow a person or organization to help you with applying for MaineCare. Please complete the attached "Appointment of Authorized Representative" form.

12. Signature

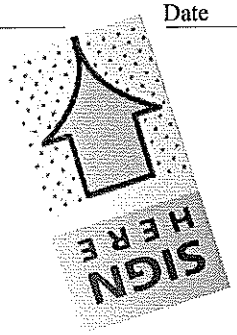
If you have to pay a premium, coverage can start either the month the Dept. of Health and Human Services receives this application, or the next month. Please write the name of the month you want coverage to start. _____

I understand and agree to provide documents to prove what I have stated. **I understand and agree that the information I have given may be verified by federal, state and local officials or other persons and organizations. If I have given incorrect information, my application may be denied and I may be charged with giving false information.** I understand the questions on this application and the penalty for hiding or giving false information or breaking any of the rules in the penalty warning. **I certify under penalty of perjury that my answers, including those concerning citizenship or alien status, are correct and complete for all persons applying for benefits.**

If anyone on this application is eligible for Medicaid, I am giving to the Medicaid agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving to the Medicaid agency rights to pursue and get medical support from a spouse or parent.

Alice Apple 8/1/17

Signature of person filling out this form Date



Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives
Paul R. LePage, Governor — Mary C. Mayhew, Commissioner

Authorization to Release Information

We are committed to the privacy of your health information. Please read this form carefully.

☒ Office of MaineCare Services	☐ Substance Abuse and Mental Health Services
☒ Office for Family Independence including Medical Review Team	☒ Office of Child and Family Services
☐ Maine Centers for Disease Control and Prevention	☒ Office of Aging and Disability Services
☐ Dorothea Dix Psychiatric Center	☐ Office of Administrative Hearings
☐ Riverview Psychiatric Center	☐ Other:

Individual's Name: Alice Apple

Individual's Date of Birth: 01/01/1985

Individual's Social Security Number: XXX-XX-XXXX

Individual's Address: 1 Main St, Portland ME 04101
Street — Town/City — State — Zip Code

Records to be released, including written, electronic and verbal communication:

☐ All Healthcare, including treatment, services, supplies and medicines

☐ Claims Information

☐ Billing, payment, income, banking, tax, asset, and/or other information regarding eligibility for DHHS program benefits such as MaineCare

☒ Other: Please discuss Application / Eligibility Benefits when Access to Care Calls

☐ Limit to the following date(s) or type(s) of information:
(e.g. "lab test dated June 2, 2013" or "hospital records from 1/1/14 - 1/15/14")

Valid for One Year

I authorize the DHHS office(s) checked above to: ☒ Release my information to: ☒ Obtain my information from:

Name: Access to Care Case

Address: MaineHealth 241 Oxford St. — Portland — ME — 04101
Street — Town/City — State — Zip Code

Fax No., where applicable: _____ Phone No. to verify Receipt of Fax 207-662-7953

If requesting that electronic information be transmitted by email, please clearly print the email address below:
N/A

☐ I understand that DHHS systems may not be able to send my information securely through email. I understand that email and the internet have risks that DHHS cannot control and that the information possibly could be read by a third party. I accept those risks and still request that DHHS send my information by email.
Initials _____

Please allow the office(s) named above to disclose my information for the following purpose(s):

☐ For a legal matter, including an administrative hearing

☒ To see if I qualify for insurance coverage or benefits

☒ For coordination of my care ☒ A Personal Request ☐ Other (note here): _____

OVER

initialing below, I agree to disclose the following types of records:

_____**Mental health treatment provider or program**

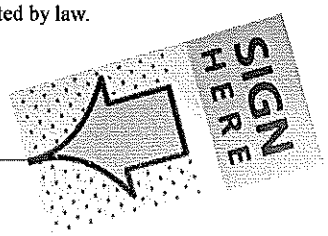
_____ **Substance/alcohol/drug Abuse treatment provider or program**

_____**HIV infection status or test results:** Maine law requires us to tell you that releasing this information may have implications. Positive implications may include giving you more complete care, and negative implications may include discrimination if the data is misused. DHHS will protect your HIV data, and all your records, as the law requires.

I (individual/personal representative of individual) permit DHHS to release and/or obtain my records as written on Page 1 of this form. I understand and agree to the following:

- This form will expire one year from the date I sign below, unless I revoke (take back) my permission sooner by completing, signing and sending in the Revocation Form found on the DHHS website at http://www.maine.gov/dhhs/privacy/index.shtml. I may call DHHS at 207-287-3707 and ask for the office where I receive services if I need help revoking this form.
- I understand that taking back my permission to release my information does not apply to the information that was already shared after I signed this form.
- If I take back my permission to release my information, or if I refuse to release some or all of my healthcare or insurance information, that may result in improper diagnosis or treatment, denial of insurance coverage or a claim for health benefits, or other adverse consequences.
- This form permits the people or offices listed on Page 1 to speak to each other for the purpose(s) on this form.
- If I am disclosing healthcare information, I agree that records of other providers (such as doctors, hospitals, and counselors) in my file are included in this release.
- Unless I am applying for benefits, DHHS will not condition my treatment, payment for services, or benefits on whether I sign this form.
- I have the right to make a written request to review my records. If I wish to receive a copy of my healthcare or billing information, a fee may be charged as permitted by law.
- If I want to review my mental health program or provider records before they are released, I must check **THIS BOX.** ☐ I understand that the review will be supervised.
- DHHS offices will keep my information confidential as required by law. If I give my permission to share my records with people who are not required by law to keep them private, they may no longer be protected by federal confidentiality laws.
- If alcohol or drug treatment or program records are included in this release, federal law requires the person sharing those records to include a notice saying that such information may not be re-released or shared without my written permission, unless required or permitted by law.
- I am signing this form voluntarily, and I have the right to a signed copy of this form if I request one.

Date: 8/1/17 Signature Alice Appleton



Personal Representative's authority to sign: _____

FAMILY PLANNING COVERAGE SUPPLEMENT FORM

Family Independence
An Office of the Department of Health and Human Services

Paul R. LePage, Governor Mary C. Mayhew, Commissioner

Family Planning coverage is a limited benefit under MaineCare that provides coverage to men and women solely for family planning and related reproductive health services.

IN ADDITION TO THE FULL MAINECARE APPLICATION, PLEASE COMPLETE THIS SUPPLEMENT FORM FOR YOURSELF, SPOUSE/PARTNER, OR ANYONE YOU LIVE WITH WHO IS INTERESTED IN APPLYING FOR THIS LIMITED FAMILY PLANNING COVERAGE.

Applicant #1

Name	Alice Apple
Interested in retroactive coverage?	Yes

Applicant #2

Name	
Interested in retroactive coverage?	

Applicant #3

Name	
Interested in retroactive coverage?	

Applicant #4

Name	
Interested in retroactive coverage?	

If there are any other individuals in your household requesting Family Planning MaineCare coverage, please list them in the box below:

IF YOU HAVE QUESTIONS ON WHAT LIMITED SERVICES ARE COVERED UNDER FAMILY PLANNING COVERAGE, PLEASE CONTACT MAINECARE MEMBER SERVICES AT 1-800-977-6740, TTY: 711.