



**MARYLAND DEPARTMENT of HUMAN RESOURCES
MARYLAND DEPARTMENT of HEALTH and MENTAL HYGIENE
LONG-TERM CARE/WAIVER MEDICAL ASSISTANCE
REDETERMINATION APPLICATION**

Check List of Items Needed for the Recipient's Long-Term Care / Waiver
Redetermination Application

(Please keep this page for the recipient's records)

SEND PROOF We have provided a check list of items to help the recipient and/or their authorized representative gather the information needed to process the recipient's redetermination application. Please send copies of the recipient's documents along with the recipient's redetermination application. **Do not send originals.** In some cases, we may need to request additional documents not listed below. If so, we will give the recipient time to supply the additional documents.

Has the recipient, spouse, or anyone sold, traded, gifted, or disposed of recipient's property, motor vehicles, stocks, bonds, cash or other assets in the past 12 months? If so, the recipient will need to provide the following:

- Type of asset
- Value of asset
- Amount received for the asset
- Reason for transfer
- Who received the asset

If the recipient wants to find out if their spouse can keep some of the recipient's monthly income, please provide current statements for:

- Spouse's gross monthly income
- Condo fees
- Mortgage
- Lot Rent
- Property tax bill
- Rent
- Electric bill

Submit copies of the following items:

- Federal Tax Return for the tax current year (please include all forms and schedules). A Record of Account can be obtained from the IRS free of charge by calling 1-800-908-9946 if the recipient's Federal tax return cannot be located.
- A Wage and Income Transcript can be obtained from the IRS free of charge by calling 1-800-908-9946 if the recipient filed a joint Federal tax return for the current tax year.
- Current statements of:
 - Stocks
 - Bonds
 - Money Market Funds
 - Mutual Funds, Treasury, or Other Notes
 - Certificates
 - Retirement account
 - IRA or Keogh accounts
 - Bank and financial accounts owned and co-owned
- Current statement for burial accounts
- Burial Plot Deeds
- Current gross monthly income from all sources including:
 - VA Pensions
 - Railroad Retirement
 - Pensions
 - Annuities
- Mortgage Notes and Mortgage Deeds
- Trusts (including appendices, schedules, annual accountings, and amendments for the past 12 months)
- Private Health Insurance Cards including Medicare (copy of both sides)
- Health Insurance premium amounts
- Power of Attorney or Legal Guardianship Documents (if any)
- Face and cash value of Life Insurance policies (current annual statement)
- Life Estate Deeds
- Promissory Notes

**Please continue by completely answering every question on the attached application.
If you need more space to complete the application, please attach additional sheets.**

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MARYLAND DEPARTMENT OF HUMAN RESOURCES
 MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 LONG-TERM CARE / WAIVER MEDICAL ASSISTANCE

REDETERMINATION APPLICATION

Date Signed Application
 Received in Local Department
 MUST BE DATE STAMPED

Worker Name

Case Number

R

USE THIS FORM ONLY FOR THE REDETERMINATION PROCESS. SEND PROOF Attach current verifications of all income and resources. Failure to complete the redetermination will result in cancellation of Medical Assistance coverage.

A. Identifying Information:

Recipient's Name: _____ Social Security # _____

Is the recipient a resident of Maryland? Yes No

Date of Birth: _____ Telephone # _____

Address (where recipient actually lives): _____

Mailing address (if different):

Marital Status: Never married Married Separated Divorced Widowed

Is the recipient a U.S. citizen? Yes No

If not a U.S. citizen, alien status: _____ Status effective date: _____

Name of nursing facility,
 state institution, or
 community-based care provider: _____

If the recipient is married or separated:

Spouse's Name: _____

Spouse's Address (if different):

Spouse's Telephone # _____ Spouse's Social Security # _____

Has the recipient's Authorized Representative changed in the last 12 months? Yes No If Yes, complete the information below:

Authorized Representative Name: _____ Telephone #: _____

Address: _____

B. Recipient's Income: (Attach Current Verification)

SEND PROOF				Verification Method/Date	Amount
Social Security	\$ _____	SSI	\$ _____	_____/____/____	\$ _____
Civil Service	\$ _____	VA	\$ _____	_____/____/____	\$ _____
Retirement/Pension	\$ _____	Disability	\$ _____	_____/____/____	\$ _____
Wages	\$ _____	Other	\$ _____	_____/____/____	\$ _____
Business Income	\$ _____	(Examples: Trusts, Stocks, Annuities, Dividends, Interest, Bonds, CD's)		Recipient's Total Income	\$ _____

C. Spouse's Income: (Attach Current Verification)

SEND PROOF				Verification Method/Date	Amount
Social Security	\$ _____	SSI	\$ _____	_____/____/____	\$ _____
Civil Service	\$ _____	VA	\$ _____	_____/____/____	\$ _____
Retirement/Pension	\$ _____	Disability	\$ _____	_____/____/____	\$ _____
Wages	\$ _____	Other	\$ _____	_____/____/____	\$ _____
Business Income	\$ _____	(Examples: Trusts, Stocks, Annuities, Dividends, Interest, Bonds, CD's)		Spouse's Total Income	\$ _____

D. Spouse's Shelter Expenses: (Attach Current Verification)

SEND PROOF				Verification Method/Date	Amount
Is there a spouse, child under 21, or any other dependent relative residing in the recipient's home? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete the information below:					
Rent/Mortgage	\$ _____	Utilities	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____/____/____	\$ _____
Homeowner's/Renters Insurance	\$ _____	Real Estate Taxes	\$ _____	_____/____/____	\$ _____
Maintenance Charges for Condominium	\$ _____		Spouse's Shelter Expenses		\$ _____
Other _____	\$ _____				

E. Dependent's Income: (Attach Current Verification)

SEND PROOF				<i>Verification Method/Date</i>	<i>Amount</i>
Social Security	\$ _____	SSI	\$ _____	_____/____/____	\$ _____
Civil Service	\$ _____	VA	\$ _____	_____/____/____	\$ _____
Retirement/Pension	\$ _____	Disability	\$ _____	_____/____/____	\$ _____
Wages	\$ _____	Other	\$ _____	_____/____/____	\$ _____
Business Income	\$ _____	<i>(Examples: Trusts, Stocks, Annuities, Dividends, Interest, Bonds, CD's)</i>		Dependent's Total Income	\$ _____

F. Assets: (Attach Current Verification)

SEND PROOF				<i>Verification Method/Date</i>	<i>Amount</i>
Does the recipient have:					
Cash	<input type="checkbox"/> Yes <input type="checkbox"/> No	Amount	\$ _____	_____/____/____	\$ _____
Patient Fund Acct.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Amount	\$ _____	_____/____/____	\$ _____
Checking Acct.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Amount	\$ _____	_____/____/____	\$ _____
Bank Name _____		Acct # _____			
Savings Acct.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Amount	\$ _____	_____/____/____	\$ _____
Bank Name _____		Acct # _____			
Burial Fund/Prearrangement	<input type="checkbox"/> Yes <input type="checkbox"/> No			_____/____/____	\$ _____
Company Name _____		Amount	\$ _____		
Other (CD, stocks, bonds, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Amount	\$ _____	_____/____/____	\$ _____
Company Name _____		Acct # _____			

F. Assets: (continued) Attach Current Verification

	<i>Verification Method/Date</i>	<i>Amount</i>
Did the recipient purchase or anyone purchase on behalf of the recipient any life insurance not already reported as burial funds? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes:		
Company _____ Policy # _____	_____/____/____	\$ _____
Policy Face Value \$ _____ Policy Cash Value \$ _____	_____/____/____	\$ _____
Company _____ Policy # _____	_____/____/____	\$ _____
Policy Face Value \$ _____ Policy Cash Value \$ _____		
Does the recipient own or have ownership interest in any real or personal property in or out of the state of Maryland (such as land, deeds of trust, buildings, mobile homes, rental or vacation property, recreational vehicles, and collections of antiques, coins, jewelry, or stamps)? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes:		
Name Items: _____	_____/____/____	\$ _____
Value \$ _____		Total \$ _____
Has the recipient, their spouse, or anyone sold, traded, gifted, or disposed of any of the recipient's assets and/or real property (such as income, land, building, stocks, trust funds, money, cars, etc.) during the past 12 months?		
<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes:		
Name Items: _____		
Value \$ _____ Date: _____	_____/____/____	\$ _____
Has the recipient received or is expected to receive or inherit any money or property from any source?		
<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes:		
Source: _____		
Value \$ _____ Date: _____	_____/____/____	\$ _____

G: Medical Expenses for Non-Covered Services:

Does the recipient have any non-covered medical bills (e.g., dentistry, audiology, vision) that he/she incurred in the last 12 months? YES NO

SEND PROOF *If the recipient answered yes, provide newly dated, itemized medical bill(s) that the recipient incurred within the 12 months prior to this redetermination application. The bill must contain a service date, the charge, and a detailed description for each service provided. Attach copies of the bill(s) with the recipient's Long-Term Care Medical Assistance Redetermination application.*



REDETERMINATION APPLICATION

RIGHTS AND RESPONSIBILITIES

I UNDERSTAND I HAVE THE FOLLOWING RIGHTS:

- **The Department cannot discriminate against me.** Federal and State law prohibit the Department from discriminating against me because of race, color, national origin, sex, age, or disability. If I think the Department has discriminated against me, I may contact the U.S. Department of Health and Human Services at: HHS, Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or by calling 202-619-0403 (voice) or 202-619-3257 (TDD).
- **I have the right to privacy of my personal information.** I am providing personal information (that includes, but is not limited to: name, address, date of birth, Social Security number, income history, employment history, medical history) in this application for Medical Assistance. The purpose of requesting this personal information is to determine my eligibility for Medical Assistance. If I do not provide this information, the Department may deny my application for benefits. I have a right to inspect, amend, or correct this personal information. The Department will not permit inspection of my personal information, or make it available to others, except as permitted by Federal and State law. I understand, however, that the Department may deny my application for Medical Assistance if I do not provide this information.
- **If my case is approved, the Department will provide me with a written notice explaining my benefits.** The Department must give me written notice when it changes my benefits or, determines that I am ineligible for Medical Assistance. I have 90 days from the date of the notice to request a hearing. If I am already receiving benefits and request a hearing within 10 days from the date of the notice, I may continue to receive benefits while I wait for the hearing. Any erroneous benefits I receive from the Department must be repaid to the Department.
- **I have the right to appeal certain actions taken by the Department.** I can request a hearing if: my application for Medical Assistance eligibility is denied; I assert the Department's decision about Medical Assistance services was erroneous; or, there was a delay in the Department's action(s) related to my application. I may call the Department at 1-800-332-6347 for help requesting a hearing. I am responsible for providing the reason for requesting a hearing. At the hearing, I may speak for myself or I may be accompanied by a lawyer, friend, or relative to speak on my behalf.

IF I ACCEPT MEDICAL ASSISTANCE, I UNDERSTAND BY SIGNING THIS APPLICATION:

- **Payment Authorization** - I authorize payment under Medicare Part B to be made directly to health care providers and medical suppliers.
- **Assignment of Health Insurance/Third Party Payments** - I assign all rights, title, and interest of health insurance payments I may have to the Department and give the Department the right to seek payment from private or public health insurance and any liable third party for the costs the Department incurs for the benefits I receive under Medical Assistance. The Department may seek payment without legal action, providing it does not keep more than the amount Medical Assistance paid. I agree to promptly forward, to the Department, any health insurance payments I receive, including payments received as a settlement from an accident.
- **Access to Records** - I give the Department the right to inspect, review, and copy all relevant portions of my medical records for purposes of determining my eligibility for, and for determining the appropriateness of the services received through, the Medical Assistance program.
- **Quality Review Cooperation** - I understand that the Department may select my case for a random check or audit for quality control purposes. I agree to allow any representative from the Department to visit me where I reside. I will fully assist the Department in retrieving all proof needed from any source.
- **Estate Recovery** - I understand that the Department may recover, from the estate of a deceased Medical Assistance recipient, Medical Assistance payments made on his or her behalf on or after the person attained age 55. The Department may recover only if there is no surviving spouse, unmarried child younger than 21, or blind or disabled child (married or unmarried) of any age.
- **Accurate and Confidential Application Information** - I acknowledge that I must provide true, correct, and complete information and provide proof of this information.

- **Social Security Number(s)** - I must provide my (and my spouse's) Social Security number as an applicant for Medical Assistance. The Department will use the Social Security number(s) and other information I provide to verify the information I provide for program reviews. The Department will do this to make sure I am eligible. The Department may also verify my information by contacting my employer, bank, or other parties; and/or, the Department may contact local, State, or Federal agencies to make sure the information I provide is correct. If I do not have a Social Security number, I must apply for one and the Department can provide assistance in applying for a number.
- **Accurate Financial Reporting** - I understand that I am responsible for reporting true, correct, and complete financial information. This includes, but is not limited to information about: all my assets; potential assets; transfer of assets within the last 5 years of my initial application; transfer of assets within the last 12 months of the date of the annual redetermination of my eligibility; income; insurance; real property; annuities; and all other benefits I may be receiving. I understand that Federal law requires that, as a condition of receiving long-term care services, the Department must be named, in my annuity, as the primary remainder beneficiary.
- **Report Changes** - I am responsible for reporting changes in my situation. I must report changes within 10 days. The best way for me to report changes is in writing. Examples of changes in my situation are changes in my income, assets, address, health insurance premiums, or persons living in my home. My representative (person acting on my behalf who may file my application) is responsible for reporting such changes. Changes must be reported to the appropriate Local Department of Social Services or the Bureau of Long-Term Care Eligibility.
- **Medical Assistance Card Misuse** - If I become eligible for Medical Assistance, I must use my Medical Assistance card properly. It is against the law to allow another person to use my card.
- **Medical Assistance Fraud** - If I do not report true, correct, and complete information, or report changes, the Department may deny, stop, or reduce my benefits. A judge may fine me and/or imprison me if I intentionally do not give correct information or report changes.

SIGNATURES:

I swear or affirm that I have read or had read to me this entire application. I also swear or affirm, under penalty or perjury, that all the information I have given is true, correct, and complete to the best of my ability, knowledge and belief. I have received a copy of my rights and responsibilities. I authorize any person, partnership, corporation, association, or governmental agency which knows the facts relevant to determining my eligibility to release that information to the Department. I also authorize the Department to contact any person, partnership, corporation, association, or governmental agency that has provided information relevant to my eligibility for benefits. I certify, under penalty of perjury, by signing my name below, that the person for whom I am applying is a U.S. citizen or lawfully admitted immigrant.

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 _____

<input type="checkbox"/> I withdraw my application for Medical Assistance	
Signature of Recipient or Authorized Representative _____	Date _____

Signature of Case Manager _____	Date _____
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REDETERMINATION APPLICATION

DECLARATION

I swear or affirm, under penalty of perjury, that all information, including financial information, I have provided on this application is true, correct, and complete to the best of my knowledge. The requirement to report true, correct, and complete information includes the requirement to report financial changes that may affect my eligibility for benefits. Federal and State law requires that I disclose all transfers or gifting of assets that have occurred within the last 12 months prior to my redetermination application.

I understand that if I knowingly do not tell the truth, hide information, pretend to be someone else, or withhold information about myself (and my spouse, if any) or about the person for whom I am applying (and that person's spouse, if any), I may be breaking the law. Information provided on the application may be verified or investigated by Federal, State, and local officials including Federal and State Quality Control staff.

The consequences of not complying with the law are: my benefits may be denied; I may be required to pay back the State for benefits received; my case may be investigated for suspected fraud; and I may be prosecuted for perjury, larceny, and/or Federal health care fraud [not limited to Statute 42 U.S.C. sec. 1320a-7b(a)(ii)], which may involve a fine up to \$ 10,000 per offense and/or federal imprisonment.

Signature of Applicant/Recipient

Date

Signature of Witness (If signed with X)

Date

Signature of Spouse (If applicable)

Date

Signature of Authorized Representative (If applicable)

Date