



**MARYLAND DEPARTMENT OF HUMAN RESOURCES
FAMILY INVESTMENT ADMINISTRATION APPLICATION FOR ASSISTANCE**

Date Received (Agency use only)

Health Care Addendum

Name (First, Middle, Last)	Jr./Sr.	Date of Birth	Home Telephone	Work Telephone	
Where do you live? (Number, St.)		Apt. #	City	State	Zip Code
Mailing Address (If Different than Home)			Cell Telephone		

A. ALL APPLICANTS, please answer the following questions:

1. Are you or any member of your Household Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	<i>If "yes," please answer the following:</i> Who? _____ Due Date _____ (mm/dd/yy) Number of Babies Expected from Pregnancy: _____	
2. Do you currently have health coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	(Even if you have insurance, there might be a program with better coverage or lower costs.)	
<i>If "yes," what type of coverage do you have? (check all that apply)</i>		
<input type="checkbox"/> Medical Assistance	<input type="checkbox"/> Medicare (65 years old or older)	<input type="checkbox"/> Private Health Insurance (employer)
<input type="checkbox"/> Private Health Insurance (Parent or Spouse)	<input type="checkbox"/> Self-Pay Insurance Policy?	<input type="checkbox"/> Self-Pay for Medical Care
<input type="checkbox"/> TRICARE	<input type="checkbox"/> Veterans Administration	<input type="checkbox"/> Peace Corps <input type="checkbox"/> Other <i>Specify:</i>
3. Do you have a physical, mental or emotional health condition that limits your activities (like bathing, dressing, etc.) or do you live in a nursing home?		<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Do you live with at least one child under the age of 19, and are you the main person taking care of this child?		<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Were you or anyone in your household in foster care at age 18 or older?		<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Did anyone in your household have insurance through a job and lose it in the past three months?		<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If "yes,"</i>	<i>Name:</i> _____	<i>End Date of Insurance:</i> (mm/dd/yyyy)
<i>Reason why insurance ended:</i>		
7. Are you or any member of your household a veteran or active duty member of the U.S. Military, or are you the Spouse or Parent of one?		<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If "yes": Name: _____ Relationship: _____</i> <i>Name: _____ Relationship: _____</i> <i>Name: _____ Relationship: _____</i>		

B. ANNUAL INCOME AND FEDERAL INCOME TAX RETURN INFORMATION

1. Does your income change from Month to Month?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If "yes":</i>	<i>What is your total income this year? \$</i> <i>What is your total expected income next year: \$</i>
2. Do you plan to file a federal income tax return NEXT YEAR? (You can still apply for Health Coverage if you do not file a return.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If "Yes" please answer questions below:</i>	<i>If "No" please answer Questions Below:</i>
<i>Will you file jointly with a spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No</i> <i>If "yes", Name of Spouse _____</i>	<i>Will you be claimed as a dependant on someone's tax return?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No

Will you claim any dependants on your tax return? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes," list name(s) of dependents: _____	If "yes", please list: Name of Filer: _____ Relation to Filer: _____
Will you be claimed as a dependent on someone's tax return? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes," please list name: _____ Relation to filer: _____	
<p>3. If you are applying for Medical Assistance or Health Coverage Please read and answer the following question.</p> <p>To make it easier to determine your eligibility for health coverage in future years, do you agree to allow the Maryland Health Connection to use your income data, including information from your tax returns? (The Maryland Health Connection will send you a notice to let you make any changes, and you can choose not to allow this at any time.)</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO, do not use information from my tax returns to renew my coverage.</p> <p>If yes, choose the time period that you want your eligibility for health coverage to be automatically determined: <input type="checkbox"/> 5 years (the maximum) <input type="checkbox"/> 4 years <input type="checkbox"/> 3 year <input type="checkbox"/> 2 years <input type="checkbox"/> 1 year</p>	

C. MEDICAL EXPENSES

1. Do you or any household members pay medical expenses?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If "yes," please list all relevant expenses below:			
Health/Medicare Insurance	\$	Medical/Dental Insurance	\$
Dentures/Glasses/Hearing Aid	\$	Transportation Costs	\$
Hospital	\$	Nursing	\$
Attendant Care	\$	Pharmacy Expense	\$
OTHER Specify:	\$	OTHER Specify:	\$

D. HOUSEHOLD'S DECLARATION INQUIRY

1. Is anyone on this Health application currently incarcerated, jailed or otherwise detained?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If "yes," Name(s):
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E. MEDICAL INSURANCE

1. Has anyone applying dropped health coverage in the past six months?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Does anyone applying currently have health insurance?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If "yes," please answer fill out the following information listed below:			
Health Insurance Policy #1			
Policy Holder Name:		Policy Number:	
		Group Number:	
Is this COBRA Coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Is this a retiree health plan?	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Household Members Covered	Relationship to Policy Holder	Household Members Covered	Relationship to Policy Holder
Policy Holder Address			
Number and Street	City	State	Zip Code
			Telephone Number
Insurance Company Information			
Number and Street	City	State	Zip Code
			Telephone Number

Signature: _____

Date: _____