FINANCIAL ASSISTANCE

BrightView is dedicated to servicing the health care needs of its patients.
To assist in meeting those needs, we have established this "Financial Assistance Policy"
to provide financial relief to those patients who first meet the requirements as described
in this policy.

BrightView is committed to providing medically necessary healthcare services to patients regardless of their insurance status or ability to pay. This financial assistance policy is intended to be in compliance with applicable federal and state laws for our service area. Patients qualifying for assistance under this policy will receive a discount for services rendered.

BrightView offers financial assistance to patients seeking treatment whose income is at or under a percentage of the publicly available Federal Poverty Guidelines. To qualify for financial assistance from BrightView, the patient must:

- Cooperate with Case Manager and Financial Counselor efforts to apply and qualify for Medicaid
- Be deemed ineligible for Medicaid or other governmental programs
- Submit application for financial assistance and all accompanying documentation

Proof of income

As part of the application, at least one of the items in the following list of documentation is required for proof of income. If more than one is applicable, all should be submitted.

a. If you claim that you have no income, a sworn statement from the individual providing you basic support is required.
b. Three consecutive months of pay stubs, or all pay stubs within past three months if not employed for three months.
c. Copy of previous year's federal tax return.
d. Social Security, Unemployment, or retirement income documentation in the form of a written statement, or verification of benefits from the applicable agency.

Some individuals may not have income able to be documented as indicated above but have significant assets available to pay for healthcare services. In these situations, BrightView may require documented proof of assets for evaluation and approval of the application.

Application Processing

Upon receipt of the required documentation, the application will be processed by the Revenue Cycle team and resulting discounts will be applied to outstanding patient balances. The patient or guarantor is responsible for the remaining balance after discounts. The Revenue Cycle team will attempt to notify the patient of discounts, but no guarantees are made of notification, outside of the reflection of discounts on future statements or requests for payment.

Eligibility Criteria

Eligibility for discount will be based upon income for the family, as a percentage of Federal Poverty Guidelines. The qualification for discounts is listed in the table below and may be updated in accordance with updates to the Federal Poverty Guidelines.

For families/households with more than 8 persons, add $4,480 for each additional person.				
	100% discount	**100% discount**	**85% discount**	**50% discount**
Family Size	Under FPL	100% - 200% FPL	200% - 300% FPL	300% - 400% FPL
1	$12,760	$25,520	$38,280	$51,040
2	$17,240	$34,480	$51,720	$68,960
3	$21,720	$43,440	$65,160	$86,880
4	$26,200	$52,400	$78,600	$104,800
5	$30,680	$61,360	$92,040	$122,720
6	$35,160	$70,320	$105,480	$140,640
7	$39,640	$79,280	$118,920	$158,560
8	$44,120	$88,240	$132,360	$176,480

Approval Duration

Approval for Financial Assistance will be for six-month time periods. After six months, an updated application will be required.

RESOURCES

- **Maryland Medicaid Administration**: 1-855-642-8572 https://www.marylandhealthconnection.gov/

- **Maryland Department of Labor-Division of Unemployment Insurance:** 1-667-207-6520, https://www.dllr.state.md.us/employment/unemployment.shtml

- **Maryland Department of Human Services-Child, Family and Adult Services:** 1-800-332-6347, https://dhs.maryland.gov/

Service	Additional Criteria	Billing Code	Self Pay Fee	Units
Individual Counseling		90832	$96.82	0-37 Minutes
		90834	$126.69	38-52 minutes
		90837	$188.49	53+ minutes
Group counseling session		90853	$163.00	Session
Case Management session		H0006	$19.54	Per 15 minutes
Medical visits	New Patient, level 1	99201	$67.98	Encounter
	New Patient, level 2	99202	$112.27	Encounter
	New Patient, level 3	99203	$168.92	Encounter
	New Patient, level 4	99204	$246.17	Encounter
	New Patient, level 5	99205	$307.97	Encounter
	Established Patient, level 1	99211	$33.99	Encounter
	Established Patient, level 2	99212	$67.98	Encounter
	Established Patient, level 3	99213	$111.24	Encounter
	Established Patient, level 4	99214	$162.74	Encounter
	Established Patient, level 5	99215	$219.39	Encounter
Urine Pregnancy Screening		81025	$10.00	Test
Alcohol Breath Testing		82075	$30.90	Test
Interactive Complexity		90785	$23.69	Encounter
Behavior Assessment		96156	$38.11	Encounter
Intramuscular Injections		96372	$48.00	Encounter
Smoking Cessation		99406	$24.00	3-10 minutes
		99407	$48.00	10+ minutes
SUD Assessment		H0001	Individual Counseling (see above)	
Withdrawal Management		H0014	$348.50	Encounter
IOP Group (2+ hours)		H0015	Group Counseling (see above)	

OTP	Additional Criteria	Billing Code	Self Pay Fee	Units
J0574 - Buprenorphine/naloxone, oral, >6mg, <10mg		J0574	$13.86	10mg
J0571 - Buprenorphine, oral, 1 mg.		J0571	$2.65	mg
J0572 - Buprenorphine/naloxone, oral, less than or equal to 3 mg.		J0572	$9.24	3mg
S5000 - Buprenorphine/naloxone, generic, per 1mg bup/0.25mg Naloxone		S5000	$1.20	mg
Buprenorphine/naloxone Take Home		S5000: HD	$0.55	mg
Daily dose administration	Methadone/Buprenorphine	T1502: HF	$16.87	Encounter
1-week dose administration	Methadone/Buprenorphine	T1502: TV	$120.15	Encounter
2-week dose administration	Methadone/Buprenorphine	T1502: UB	$236.19	Encounter
3-week dose administration	Methadone/Buprenorphine	T1502: TS	$354.29	Encounter
4-week dose administration	Methadone/Buprenorphine	T1502: HG	$459.00	Encounter

Lab Services	Additional Criteria	Billing Code	Self Pay Fee	Units
Drug Screen		80307	$90.00	Test
Confirmatory Testing	1-7 analytes	G0480	$235.00	Test
	8-14 analytes	G0481	$320.00	Test
	15-21 analytes	G0482	$400.00	Test
	22+ analytes	G0483	$480.00	Test

BrightView

Date Received by Site:	
Primary Site:	
MRN:	
Date Received by FCT:	

FINANCIAL ASSISTANCE APPLICATION

Today's Date: _____

Patient's Name: _____

Home Phone: _____ Cell Phone: _____

Street Address: _____

City: _____ State: _____ Zip: _____

1. This application must be completed in its entirety to be considered for financial assistance.
2. Please list all family members (including yourself). Family members include the applicant, spouse, children (natural or adoptive) under the age of 18 in the home along with the patient. Income includes gross (pretax) wages, rental income, unemployment compensation, Social Security/Pension benefits, alimony, public assistance, self-employment, etc. Income also includes rent or living expenses that are being provided for you.

Family Member	Age	Relationship to Patient	Income Source	Income for 3 months prior to date of service	Income for 12 months prior to date of service
1.		Self			
2.					
3.					
4.					
5.					
6.					

Send proof of three months of gross income with this application:

Gross income is total income before taxes are taken out, and includes but is not limited to:

- Three consecutive months of pay stubs or all pay stubs within the last three months if not employed for three months.
- Copy of previous year's federal tax return.
- Social security, unemployment, alimony, child support, workers compensation award letter, or retirement income documentation in the form of a written statement, or verification of benefits from the applicable agency.
- Any other income statements.

3. If you reported zero total income, how are you being supported?

_____

_____

Please have the following support statement completed by the person(s) helping to support you and/or your family.

FINANCIAL ASSISTANCE APPLICATION

Support Statement

For applicants who stated zero income, the person(s) providing you with basic financial support must provide a brief explanation as to how you are being supported financially. List services, if any, that you are receiving for providing this support.

_____

_____

_____

_____

I certify that all of the above information provided is true and correct to the best of my knowledge. My signature does not obligate me to provide financial support related to the medical service of the applicant.

_____
Signature of person providing financial support to applicant

_____
Address of responsible party

_____
City, State Zip Code

4. Did you have health insurance on the date of service?

_____ No _____ Yes (Provide a copy of your card)

By signing this document, I affirm the answers on this application are true. Should further review of an individual's financial assistance application reveal that information provided was either incorrect of fraudulent, the decision to provide assistance may be reversed and the responsible party will be billed.

Patient Signature: _____ Date: _____

Applicant or Representative Signature: _____

Relationship: _____ Date: _____

Mail completed application and documentation to:

BrightView
P.O. Box 639886
Cincinnati, Ohio 45263-9886

Date Received
(Agency use only)

MARYLAND DEPARTMENT OF HUMAN RESOURCES
FAMILY INVESTMENT ADMINISTRATION
APPLICATION FOR ASSISTANCE

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 1-800-332-6347.
What type of assistance do you need now? (Check all that you need)
□ Cash Assistance □ Child Care Services □ Food Supplement Program (Food Stamps)
□ Medical Assistance - Do you have any unpaid medical bills from the past 3 months? □ Yes □ No
Do you have any of these problems?
□ Utility shut off □ Eviction or foreclosure □ No place to stay □ No heat □ No food □ Cannot afford child care □ other:_____
Are you or anyone in your household pregnant? □ Yes □ No If yes, who?_____ Due Date_____
Are you or anyone in your household disabled? □ Yes □ No If yes, who? _____ Disability?_____

What type of assistance do you or any household members receive now or in the past? (Check Now if you are currently receiving this assistance)		**Under what name?**
Now	1.	1.
Now	2.	2.
Now	3.	3.

If you are applying for the Food Supplement Program (FSP) you can complete all of the form and give it to us now. You may also fill in your name, address, sign this page and give the page to us. You can then finish the rest of the application at home and bring or mail it back to the office.
Your Food Supplement benefit is based on the date you sign this application and give it to the department of social services.
You may get Food Supplement benefits right away if you meet one of the following conditions:

- Your household's monthly rent or mortgage and utilities are more than your household's income and resources.
- Your household's gross monthly income is less than $150, and your resources, such as bank accounts, are $100 or less.
- Your household is a migrant or seasonal farm worker household.

If you qualify to get Food Supplement benefits right away, you will receive them within 7 days from the date you sign the form; however, you may not get expedited Food Supplement Program benefits, if eligible, until we get a completed application form and interview you.

YOUR SIGNATURE	**DATE**

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FOR AGENCY USE ONLY

LDSS Office	Programs applied for or receiving	AU ID #s
Case Manager's Name		
Application/Redetermination Date		MA #s

EXPEDITED SERVICE FOR FSP BENEFITS (CUSTOMERS SHOULD NOT WRITE IN THIS AREA – FOR AGENCY USE ONLY)

Applicants who meet the standards below are eligible to receive Food Supplement benefits within 7 days. The customer must be interviewed, either in person or by telephone, in order to determine eligibility for expedited service. The application must be complete, signed, and identity verified before expedited benefits can be issued.

1. Is the total household income this month, before deductions, less than $150 AND household cash/savings $100 or less? □ **Yes** □ **No**
   Estimated self-reported income for this month **=** $_____ Household's monthly rent or mortgage amount **=** $_____
   Household cash and savings for all members = $_____ Appropriate utility standard (SUA, LUA or actual) = $_____
   A. Total income and liquid resources = $_____ **B. Total shelter costs** = $_____
2. Is the total amount for **B. (Total shelter costs)** greater than the total for **A. (Total income and liquid resources)**? □ **Yes** □ **No**
3. Are the household members destitute migrant or seasonal farm workers whose cash and savings are $100 or less? □ **Yes** □ **No**
   If the answer to any of the above questions is yes, this household is potentially eligible for Expedited FSP.
4. If there is another reason why this household should NOT be expedited, list it here: _____

I certify that I screened this applicant for expedited Food Supplement Program benefits and determined that the household □ **was** □ **was not** eligible for expedited issuance at this time.

Signature of Case Manager	**Date**

A. HOUSEHOLD MEMBERS

Fill in the blanks for everyone that lives with you. 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								

Are any of the household members a roomer or boarder? □ Yes □ No If yes, who?_____

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. **If you are not eligible for other kinds of Medical Assistance and you are applying only for Emergency Medicaid, you do not have to fill-in this section**.

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:	
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:	
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. You may also choose a person to get your benefits through your Independence Card. This person can use your benefits the same way you do. 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 □ Use your Independence Card (cash) □ Receive your notices
□ Sign your application □ Use your Food Supplement benefits □ 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

Does anyone in your household 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

Has anyone in your household 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)

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

Fair Market Value $	Amount Received $	Reason for Transfer

G. EARNED INCOME

Does anyone in your household 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. DEPENDENT CARE

If anyone in your household pays someone to care for a child or disabled adult, fill in this section:

Name of Care Provider	Telephone	Name of Care Provider	Telephone
Number Street		Number Street	
City State Zip code		City State Zip code	
Household Member Receiving Care	Under 2 years old? □ Yes □ No	Household Member Receiving Care	Under 2 years old? □ Yes □ No
Who Pays?	Cost $	Who Pays?	Cost $
Household Member Receiving Care	Under 2 years old? □ Yes □ No	Household Member Receiving Care	Under 2 years old? □ Yes □ No
Who Pays?	Cost $	Who Pays?	Cost $

I. CHILD SUPPORT/ALIMONY EXPENSE

Does any household member pay court ordered child support to a **NON-HOUSEHOLD** member? □ Yes □ No If yes, who? (Includes current payments, arrearages, health insurance)

DEPENDENT'S NAME, ADDRESS AND PHONE NUMBER	AMOUNT PAID	PERSON OR AGENCY PAID	HOW OFTEN PAID

J. OTHER INCOME AND BENEFITS

If anyone in your household 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 □ Temporary Cash Assistance □ 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	
		yes	no		yes	no	
		yes	no		yes	no	
		yes	no		yes	no	

K. SHELTER COSTS – Complete if you are applying for Food Supplement Program Benefits

Is anyone in your household paying for any of the following? Check all those paid and answer the questions.

√	Expenses	Amount	How Often?	Who Pays?	√	Expenses	Amount	How Often?	Who Pays?
	Rent					Water			
	Mortgage					Sewer			
	Electric					Garbage			
	Gas					Wood/Coal			
	Oil					Property Tax			
	Coop/Condo / Assoc. fees					Homeowner's insurance			
	Telephone					Other			

Do you live in: □ Public Housing □ Section 8 Housing □ FMHA 515 Housing □ Private Housing

Is heat included in your rent? □ Yes □ No Do you pay an electric bill for lights or cooking? □ Yes □ No

If heat is not included in the rent, what is your source of heat? _____

Do you pay for air conditioning? □ Yes □ No

Does someone help you with your utility costs? □ Yes □ No If yes, who?_____

Are you sharing any of the shelter costs listed above? □ Yes □ No If yes, with whom? _____

Your share? _____

Have you received Energy Assistance at your current address within the past 12 months? □ Yes □ No

L. MEDICAL EXPENSES – Complete Appropriate Section if Applying for Medical Assistance or Food Supplement Benefits

Medical Assistance – Do you or any household members pay medical expenses? □ Yes □ No If yes, check the appropriate box

Food Supplement Benefits – Do you or any household members pay medical expenses for any person age 60 or over, or any person receiving disability benefits? □ Yes □ No If yes, check the appropriate box and list the monthly amount you pay.

DISCUSS THESE EXPENSES WITH YOUR CASE MANAGER.

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

M. HOUSEHOLD'S DECLARATION INQUIRY – Complete if you are applying for Temporary Cash Assistance or Food Supplement Benefits

1. Has anyone in your household ever been convicted of a felony committed on or after August 22, 1996 that involved drugs?
   □ YES □ NO If yes, who? _____
2. Is anyone in your household currently violating parole or probation or fleeing from the police or the courts?
   □ YES □ NO If yes, who? _____
3. Has anyone in your household been convicted since August 22, 1996 in a Federal or State Court for not telling the truth about where they lived or their identity in order to receive Food Supplement benefits or cash assistance from more than one place in the same month?
   □ YES □ NO If yes, who? _____
4. Has a court convicted any member of your household for trafficking Food Supplement benefits of $500 or more?
   □ YES □ NO If yes, who?_____
5. Is anyone in your household receiving benefits under another identity or as a member of another household or in another State?
   □ YES □ NO If yes, who?_____

N. MEDICAL INSURANCE – Complete if you are applying for Medical Assistance or Temporary Cash Assistance

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

O. LIFE INSURANCE, FUNERAL PLANS or BURIAL FUNDS – Complete if you are applying for Medical Assistance or Temporary Cash Assistance

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

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

If you need more space, ask for the 9701- Application for Assistance Addendum.

P. CHILD SUPPORT INFORMATION – Complete this section if you want TEMPORARY CASH ASSISTANCE OR MEDICAL ASSISTANCE for a child who has an absent or deceased parent. Fill in a separate section for each absent or deceased parent.

#1 ABSENT PARENT (AP) INFORMATION

Name of Absent Parent (First, Middle, Last)	Relationship of absent parent to you.	Check one: □ Absent □ Deceased

CHILD'S NAME	MARITAL STATUS OF CHILD'S PARENTS AT BIRTH
	□ Married □ Divorced □ Unknown □ Separated □ Never Married
	□ Married □ Divorced □ Unknown □ Separated □ Never Married
	□ Married □ Divorced □ Unknown □ Separated □ Never Married
	□ Married □ Divorced □ Unknown □ Separated □ Never Married

Social Security Number	Other Name	Date of Birth	Age	Race	Sex □ Male □ Female

AP's Last Known Address	Number Street	City	State	Zip Code	Telephone
AP's Parent's Address	Number Street	City	State	Zip Code	Telephone

Driver's License State	Birth Place (City, State)

Current or Prior Military **Dates:** From: To:	Paying Military Allotment? □ Yes □ No If yes, To whom?	Military Branch

Incarcerated □ Currently □ Previously □ Never	Institution Name

ABSENT PARENT INCOME INFORMATION

Last Known Employer	Name, Address & Telephone
Second Employer	Name, Address & Telephone

Other Income/Benefits: □ Social Security □ SSI □ Veteran's Pension □ Unemployment
□ Worker's Compensation □ Pension/Retirement □ Union Benefits □ Other, list_____

ABSENT PARENT COURT ORDER INFORMATION

Paying Support? □ YES □ NO	To Whom?	Last Date Paid	Payment Amount

Court Ordered? □ YES □ NO	If yes, where was the court order issued?	Can you give us a copy? □ YES □ NO

#2 ABSENT PARENT (AP) INFORMATION

Name of Absent Parent (First, Middle, Last)	Relationship of absent parent to you.	Check one: □ Absent □ Deceased

CHILD'S NAME	MARITAL STATUS OF CHILD'S PARENTS AT BIRTH
	□ Married □ Divorced □ Unknown □ Separated □ Never Married
	□ Married □ Divorced □ Unknown □ Separated □ Never Married
	□ Married □ Divorced □ Unknown □ Separated □ Never Married
	□ Married □ Divorced □ Unknown □ Separated □ Never Married

Social Security Number	Other Name	Date of Birth	Age	Race	Sex □ Male □ Female

AP's Last Known Address	Number Street	City	State	Zip Code	Telephone
AP's Parent's Address	Number Street	City	State	Zip Code	Telephone

Driver's License State	Birth Place (City, State)

Current or Prior Military **Dates:** From: To:	Paying Military Allotment? □ Yes □ No If yes, To whom?	Military Branch

Incarcerated □ Currently □ Previously □ Never	Institution Name

ABSENT PARENT INCOME INFORMATION

Last Known Employer	Name & Address: Number Street	City	State	Zip Code	Telephone
Second Employer	Name & Address: Number Street	City	State	Zip Code	Telephone

Other Income/Benefits: □ Social Security □ SSI □ Veteran's Pension □ Unemployment
□ Worker's Compensation □ Pension/Retirement □ Union Benefit □ Other, list_____

ABSENT PARENT COURT ORDER INFORMATION

Paying Support? □ YES □ NO	To Whom?	Last Date Paid	Payment Amount

Court Ordered? □ YES □ NO	If yes, where was the court order issued?	Can you give us a copy? □ YES □ NO

ASSIGNMENT OF SUPPORT RIGHTS FOR TEMPORARY CASH ASSISTANCE

- I assign to the State of Maryland all rights, titles, and interest in support that I may have for myself or for any person receiving TCA.

- This includes any overdue support that has not been collected for the time that I or any person received TCA assistance.

- I agree to have the child support agency collect any support owed to me and to keep up to the amount of TCA paid to me.

- I agree to send to the State of Maryland any support l receive. If l do not turn over this support, I will have to repay this amount to the State of Maryland. I may also be prosecuted for fraud.

When I am eligible for Medical Assistance:

- I assign all rights, title, and interest in medical support and health insurance payments I may have for myself or any person receiving Medical Assistance. This includes overdue medical support or health insurance payments that have not been collected.

- I agree to have the child support agency collect medical support payments owed to me and to keep up to the amount of Medical Assistance payments that were made for me.

- I agree to give the State of Maryland any medical support or health insurance payments I receive.

- I will cooperate to the best of my ability and knowledge with the child support agency while I am receiving TCA and Medical Assistance
- If I do not cooperate with the child support agency, I may lose all my benefits and my case may be closed

I HAVE READ THESE STATEMENTS OR SOMEONE READ THEM TO ME. I UNDERSTAND WHAT THEY MEAN. BY SIGNING MY NAME BELOW, I AGREE TO FOLLOW WHAT THEY SAY.

Signature	**Date**

Your Rights and Responsibilities

FACTS YOU SHOULD KNOW ABOUT APPLYING FOR TEMPORARY CASH ASSISTANCE, FOOD SUPPLEMENT PROGRAM (FORMERLY FOOD STAMPS) AND 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 a family member 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 each family member 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.

Emergency Medical Assistance

- Immigrants who are not eligible for other kinds of medical assistance and apply only for emergency medical assistance do not have to tell us their social security number, immigration or citizenship status.

Time Limits

- Temporary Cash Assistance has time limits.
- The Food Supplement Program (formerly Food Stamps) and Medical Assistance do not have a time limit.
- When Temporary Cash Assistance ends because of time limits, earnings or other reasons, you may still get Food Supplement benefits and Medical Assistance.

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 1-800-332-6347. Si necesita ayuda para llenar el formulario favor de llamar al 1-800-332-6347.**

DHR/FIA CARES 9701 Revised 09/2014 other versions obsolete

YOUR RIGHTS AND RESPONSIBILITIES

The Family Investment Administration 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 1-800-332-6347 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 DHR's activities, programs and services. This applies even if you are working with a local department of social services or a vendor who provides services for DHR's 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 DHR's 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 or the Customer Access Coordinator (CAC) at your local department of social services. You may ask the case manager for the name of the Customer Access Coordinator at your local department of social services. You may use the form on the reverse side of this notice. You may also ask for more information at the front desk.

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"...

YOUR RIGHTS AND RESPONSIBILITIES

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):	
Local Department of Social Services Location:	
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):	

YOUR RIGHTS AND RESPONSIBILITIES

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.

The U.S. Department of Agriculture also prohibits discrimination based on race, color, national origin, sex, religious creed, disability, age, political beliefs or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027), found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the State Information/Hotline Numbers (click the link for a listing of hotline numbers by State); found online at: http://www.fns.usda.gov/snap/contact_info/hotlines.htm.

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.

YOUR RIGHTS AND RESPONSIBILITIES

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 CLAIM GOOD CAUSE – If you want Temporary Cash Assistance (TCA), you must help the Department get child support. You may not have to help if it puts you or your family in danger.

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

RIGHT TO TIMELY APPLICATION PROCESSING – If you are eligible for expedited Food Supplement Program benefits we must give you your benefits within 7 days. For the regular Food Supplement Program and other programs, 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. If you are incarcerated or in another such institution and file an application for Food Supplement benefits or cash assistance, you may not receive FSP or cash benefits until you are released. The filing date of your application for assistance will be the date of your release from the institution, if it is less than 30 days from the date your signed application was received in the Local Department of Social Services (LDSS). FSP benefits are issued from the date of your release based upon your application date.

Authorization to Receive Family Planning Information

If you want information, you can ask your case manager for a Family Planning Guide. You may also contact:

- 1-800-546-8900 if you need help in finding a provider for birth control or arranging prenatal care, or
- The Center for Maternal and Child Health at 410-767-6713 www.fha.state.md.us/mch

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 Food and Nutrition Act of 2008, 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.

YOUR RIGHTS AND RESPONSIBILITIES

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 unless you are part of the Food Supplement Program simplified reporting group and are not receiving Cash Assistance or Medical Assistance. If you want to know if you are part of this group, ask your case manager. 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.

WORK REQUIREMENTS FOR THE FOOD SUPPLEMENT PROGRAM

Individuals applying for or receiving Food Supplement (FSP) benefits must know and understand the following information about the Food Supplement Program work registration and work requirements. Food Supplement work requirements are covered in federal law at 7 CFR 273.24.

Everyone over age 18 **is required to be registered for work** unless otherwise exempt, because they are: over age 60, caring for a child under age 6 living in their home, applied for or receiving unemployment benefits, self-employed- working a minimum of 30 hours or more per week at the equivalent of federal minimum wage, attending a recognized school or institution of higher education at least half time, or the individual is mentally or physically unfit for work. Work registration is not the same as participation.

Beginning **January 1, 2016** able bodied individuals without dependents (ABAWDS), ages 18-50, who are not exempt for work registration under one of the above reasons or they reside in an area that is designated as exempt, are required to be work registered and participate in a work program/activity or be employed.

These individuals known as ABAWDS may only receive Food Supplement benefits for three months in a fixed 36 month period unless the individual is employed or participating in an approved work or educational activity a minimum of 80 hours per month. The individual may not receive Food Supplement benefits again until he or she meets the work requirements. You will receive additional information from the case manager and information is available on the DHR website at http://www.dhr.state.md.us/blog/

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.

If a drug and alcohol treatment center or a group living arrangement acts as your authorized representative for your food benefits and they willfully give us wrong information about your situation, we may prosecute the person under applicable State or federal law.

YOUR RIGHTS AND RESPONSIBILITIES

TCA and FOOD SUPPLEMENT PROGRAM PENALTIES

Do not:

- Give false information or withhold information to get or continue to get TCA and/or FSP benefits.
- Trade or sell TCA or FSP benefits, or electronic benefit cards.
- Use TCA and FSP or electronic benefit cards to buy items not allowed, such as alcohol and tobacco or to pay on credit accounts.
- Use someone else's TCA or FSP benefits.
- Use someone else's Electronic Benefits Card without authorization.
- Use your EBT card containing TCA benefits in a liquor store, adult entertainment venue such as a strip club or in a gambling establishment such as a casino.

Your FSP benefits will not increase if your cash assistance is reduced or closed because you did not follow the rules.

If a household member deliberately breaks the rules, we may bar the person from the TCA or FSP.

- We may bar this person for **one year** after the first violation.

- We may bar this person for **two years**:
  * After the second violation, or
  * After the first time a court finds this person guilty of buying illegal drugs with TCA or Food Supplement Program benefits.

- We may bar this person **permanently**:
  * After the third violation, or
  * After the second time a court finds a person guilty of buying illegal drugs with TCA or FSP benefits, or
  * After the first time a court finds this person guilty of buying guns, bullets, or explosives, with TCA or FSP benefits.
  * After a court finds this person guilty of trafficking TCA or FSP benefits of $500 or more.

- We may bar this person for ten years if found guilty of making a false statement about the person's identity in order to receive multiple benefits at the same time.

A judge can also fine this person up to $250,000, imprison the person for up to 20 years, or both. A judge can also bar this person for an additional 18 months. The person may also have to face further prosecution under other federal laws.

Individuals who request four or more replacement Independence cards in one year <u>may be</u> referred to the Office of the Inspector General for investigation of trafficking benefits.

YOUR RIGHTS AND RESPONSIBILITIES

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 understand that if I get more Food Supplement benefits than I should, all adult members of my household are liable for repaying the debt.

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 or child support payments 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.

I understand by signing this application:

- I accept cash assistance and/or 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.

YOUR RIGHTS AND RESPONSIBILITIES

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:

☐ **Cash Assistance** ☐ **Food Supplement Program** ☐ **Medical Assistance**

☐ **Emergency Assistance to Families and Children**

Signature of Applicant/ Recipient		**Date**
Printed Name of Applicant		

maryland health connection

AUTHORIZED REPRESENTATIVE FORM

An authorized representative is someone you choose to act on your behalf with Maryland Health Connection, like a family member or other trusted person. If you want to choose an authorized representative, submit this form by mail to: Maryland Health Connection, P.O. Box 857, Lanham, MD 20703. Do not complete Part I of this form if you are the applicant and the only person you wish to appoint is yourself.

1 For Applicants/Recipients. If you want an Authorized Representative, complete questions 1-18

1. Name of Authorized Representative (First Name, Middle Name, Last Name)		
2. Street Address		3. Apartment or Suite Number
4. City	5. State	6. Zip Code
7. Phone Number		8. Organization Name (If Applicable)
9. Your Name		10. Your Phone Number
11. Your Street Address		12. Your Apartment or Suite Number
13. City	14. State	15. Zip Code
16. Your Maryland Health Connection Person ID# (if available)		

By signing below, you allow the person named in question 1 to act for you on your behalf.

17. Signature _____ 18. Date _____

2 For Legal Representatives of Applicants:

If you are legally authorized to act on behalf of the applicant: 1. Complete this section by placing an "X" in the appropriate box below; 2. Fill out the questions above with the applicant's information; and 3. Submit proof (e.g. guardianship order or advance directive naming a health care agent) with this form.

A. Responsible Adult (Parent, guardian, healthcare surrogate, attorney, or other individual as defined in COMAR 10.01.04.12.) ☐	**B.** Applicant's Power of Attorney ☐

3 For Certified Application Counselors, Navigators, Agents, and Brokers only

Complete this section if you are a certified application counselor, navigator, agent, or broker who is filling out this form for somebody else.

1. First Name, Middle Name, Last Name, & Suffix	
2. Organization Name	3. ID Number(if applicable)

If you ever want to change your Authorized Representative or have any questions,
Call Maryland Health Connection at 1-855-642-8572 (Deaf and hard of hearing use Relay service).