Free or Low-Cost Health Insurance
For Families with Children and Pregnant Women

MaineCare (formerly Medicaid & Cub Care)
Department of Health and Human Services

What services are covered?

- Doctors visits:
  Well checkup and sick care; specialist care, if necessary
- Hospital care:
  inpatient outpatient emergency room
- Immunizations
- Prescriptions
- Surgery
- Laboratory & x-ray
- Dental care:
  Full coverage for children and limited coverage for adult
- Medical equipment and supplies
- School-based health centers
- Chiropractic treatment services
- Therapies:
  speech/language physical occupational
- Vision screening/eyeglasses
- Hearing test/hearing aids
- Ambulance
- Case management
- Mental Health and substance abuse treatment
- Family planning services
- Prenatal care
- Transportation for medical appointments

If you or your children need health insurance, MaineCare may be the answer.

Apply now. Don’t wait.
Note: If applying for children and teens age 18 and under, or if you are a pregnant woman, you need to fill in boxes 1-10 only.

1. **Person filling out The Application**
   Provide information about the person filling out the application. This is usually the parent or guardian of the children listed under “Household Members” (#3 below). If you are applying for yourself because you are pregnant or you are under the age of 19 and living on your own, your name is listed here. Listing Social Security numbers will help avoid delays in processing.

2. **Mailing Address**
   This is the address where you get your mail. Write the address where you live if it is different that your mailing address.

3. **Household Members**
   List everyone who lives in the household including the children for whom you are applying. This tells us what income to count and who may be covered. If a household member is applying due to pregnancy, special rules apply which may help get coverage.

4. **Household Earnings**
   Attach paystubs or photocopies of paystubs for the last 4 weeks. **We need proof of income before we can process the application.** Gross weekly wages are multiplied by 4.3 to arrive at gross monthly wages. Gross monthly wages are what determine eligibility.

5. **Self-Employment**
   Attach a copy of your most recent tax return including all schedules. If your business is incorporated, include the corporate income tax return as well. If you have not filed a tax return, we will send you forms to complete.

6. **Unearned Income**
   Examples are: Unemployment Compensation, Workers Compensation, Social Security, Supplemental Security Income (SSI), VA, interest income and child support received. Attach a copy of the check, check stub or award letter form the income source. You do not need to do this for Social Security or SSI.

7. **Child Care Expenses**
   Depending on your income, these expenses are deductions from earnings when figuring eligibility. The maximum monthly deduction is $200 per child under age 2 and $175 per child age 2 and over.

8. **Child Support (Paid Out)**
   This is the monthly amount paid to comply with a court or child support order. Depending on your income, it is used as a deduction when figuring MaineCare eligibility. Any child support received as income is not listed here. It should be listed as “Unearned Income” (#6 Above).

9. **Health Insurance**
   Most children with health insurance are eligible for MaineCare. Some may not be. If this applies to you, the Department of Health and Human Services will give you more information.

10. **Special Conditions**
    Special rules may apply for children with a disabling condition. This can help them to get coverage.
    
    There is no premium for American Indian children who are members of a Federally recognized tribe or for children who are Alaskan Natives.
    
    In some cases medical expenses for a 3 month period prior to the month of application may be covered.
    
    Children or pregnant women do not need to be citizens to be covered by MaineCare. Some non-citizens who are here temporarily, for example, students or visitors, can get coverage for payment of emergency services only.

    If you are a parent living with your children age 18 and under, and you want to apply for yourself along with your children, fill in box 11 also.

11. **Assets**
    List any assets owned by you, your children or your spouse who lives with you. Include assets owned jointly or together with anyone else.
    
    a. **Cashable Assets** – This includes savings and checking accounts, certificates of deposit (CDs), credit union shares, stocks, bonds, annuities, individuals retirement accounts (IRAs), Keogh, or profit sharing.
    
    b. **Real Estate** – This includes any property you own.
    
    c. **Vehicles** – This includes any motorized vehicle such as a car, truck, boat, camper, motorcycle, snowmobile, or ATV.
### 1. Person Filling Out The Application

<table>
<thead>
<tr>
<th>Name (first, middle initial, last)</th>
<th>Social Security Number</th>
<th>Birthdate (month/day/year)</th>
<th>Sex</th>
</tr>
</thead>
</table>

Check one:  
- [ ] married  
- [ ] widowed  
- [ ] single  
- [ ] divorced  
- [ ] separated

Maiden Name ________________________________

### 2. Mailing Address

Street, PO Box or RR (include apartment number, in care of, etc.)

<table>
<thead>
<tr>
<th>City:</th>
<th>State:</th>
<th>Zip code:</th>
<th>Home phone</th>
<th>Work phone:</th>
</tr>
</thead>
</table>

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

### 3. Household Members (List the people who live with you)

<table>
<thead>
<tr>
<th>Last name</th>
<th>First name</th>
<th>Middle initial</th>
<th>Sex</th>
<th>Date of birth</th>
<th>Place of Birth</th>
<th>Social Security Number</th>
<th>Relationship to you</th>
</tr>
</thead>
</table>

Is anyone in your household applying due to pregnancy?  
- [ ] Yes  
- [ ] No

Name: ____________________________  
Due Date: ____________________________

### 4. Household Earning (Attach paystubs or photocopies of paystubs for the last 4 weeks)

<table>
<thead>
<tr>
<th>Name</th>
<th>Employer’s name and phone</th>
<th>Amount you earn</th>
<th>How often you are paid</th>
<th>Hours worked each week</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>Name of the person who is self-employed</th>
<th>If you did not file a tax return. Check here [ ]</th>
</tr>
</thead>
</table>

Name of business | Hours worked weekly

### 6. Unearned Income (Attach proof of income listed below, except for Social Security or SSI)

<table>
<thead>
<tr>
<th>Name of person Receiving income</th>
<th>Where is income from? (Social Security, Unemployment, etc.)</th>
<th>How often received? (monthly, weekly, etc.)</th>
<th>Amount Before deductions</th>
</tr>
</thead>
</table>
7. Child Care Expenses (Paid by a member of your household)

<table>
<thead>
<tr>
<th>Name of Child care provider</th>
<th>Child’s name</th>
<th>Amount paid</th>
<th>How often paid? (Monthly, weekly, etc.)</th>
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</thead>
<tbody>
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</tbody>
</table>

8. Child Support (Paid by a member of your household)

<table>
<thead>
<tr>
<th>Name of person who pays support</th>
<th>Person to whom support is paid</th>
<th>Amount paid</th>
<th>How often paid? (Monthly, weekly, etc.)</th>
</tr>
</thead>
<tbody>
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</table>

9. Health Insurance

List children in your household who now have health insurance (except for MaineCare) which covers more than one service

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:

10. Special Conditions

☐ Check here if anyone has a disabling condition or is applying for Limited Benefits Program. (There may be special help available to you.)

☐ 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 ______________________

Is everyone for whom you are applying a U.S. citizen? ☐ Yes ☐ No

If English is not your first language, what language do you speak? ______________________________

Are you asking for help with medical bills incurred in the last 3 months? ☐ Yes ☐ No

Do you want to apply for Food Stamps? ☐ Yes ☐ No

11. Assets (Complete only if you are applying for yourself along with your children and teens age 18 and under)

a. Cashable Assets

<table>
<thead>
<tr>
<th>Type of Assets</th>
<th>Name(s) on account</th>
<th>Account number and bank</th>
<th>Value or balance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

b. Real Estate (other than the home where you live)

<table>
<thead>
<tr>
<th>Owners</th>
<th>Type of real estate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

c. Vehicles

<table>
<thead>
<tr>
<th>Year</th>
<th>Make/Model</th>
<th>Owner(s)</th>
<th>Current value</th>
<th>Amount owed</th>
</tr>
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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.

Signature of person filling out this form ______________________ Date ______________________

BFI-CC0001 (4/05)
Who is eligible for this insurance?

- Children and teens age 18 and under, and pregnant women with gross monthly family income at or below the amount listed on this chart. Assets are not counted.
- Parents living with their children and teens age 18 and under with monthly family income at or below the amount listed on this chart, and with certain assets of $2000 or less.

<table>
<thead>
<tr>
<th>Family Size</th>
<th>18 &amp; under Parents with children 18 &amp; under</th>
<th>Effective</th>
<th>Pregnant women</th>
<th>18 &amp; under Parents with children 18 &amp; under</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>10/01/06</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>$1634</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>$2200</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>3</td>
<td>$2767</td>
<td></td>
<td></td>
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<tr>
<td>4</td>
<td>$3334</td>
<td></td>
<td></td>
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<tr>
<td>5</td>
<td>$3900</td>
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<td></td>
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<tr>
<td>6</td>
<td>$4467</td>
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Note: Even if your family income is above the amount on the chart, you are encouraged to apply. Certain expenses may be taken out of your income.

How much does it cost?

- There is no cost for most families. Some families must pay a small monthly premium for their children’s coverage. Premiums are between $8 and $64.00 a month. Some parents must pay a small co-payment for services.

How do I apply?

- For children, teens or pregnant women, fill in boxes 1-10 only on the attached application. Sign and date (box 12).
- For parents applying for themselves along with their children and teens, fill in box 11, plus boxes 1-10 on the attached application. Sign and date (box 12).
- Mail or drop off the attached application to the Department of Health and Human Services nearest you. No interview is necessary.

Non-Discrimination Notice

The Department of Health and Human Services (DHHS) does not discriminate on the basis of disability, race, color, creed, gender, sexual orientation, age, or national origin, in admission to, access to, or operations of its programs, services, or activities, or its hiring or employment practices. This notice is provided as required by Title II of the Americans with Disabilities Act of 1990 and in accordance with the Civil Rights Act of 1964 as amended, Section 504 of the Rehabilitation Act of 1973, as amended, the Age Discrimination Act of 1975, Title IX of the Education Amendments of 1972 and the Maine Human Rights Act and Executive Order Regarding State of Maine Contracts for Services. Questions, concerns, complaints or requests for additional information regarding the ADA may be forwarded to DHHS' ADA Compliance/EEO Coordinators, State House Station #11, Augusta, Maine 04333, 207-287-4289 (V), 207-287-4289 (TDD). Individuals who need auxiliary aids for effective communication in program and services of DHHS are invited to make their needs and preferences known to the ADA Compliance/EEO Coordinators. This notice is available in alternate formats, upon request.