

Maryland Department of Health and Mental Hygiene

Maryland Primary Adult Care (PAC) Program Eligibility Application



The **Maryland Primary Adult Care Program (PAC)** covers primary health care, some outpatient mental health services, certain emergency hospital services, community based substance abuse services, and prescription drugs for certain low income eligible Maryland residents. Applicants must be 19 years of age or older, not eligible for Medicare, and a U.S. citizen or a qualified alien who meets all requirements for benefits.

- The PAC Program does not cover prenatal services. If you are pregnant, please apply for Medical Assistance for Families.
- If you have children under the age of 21 in your home, please apply for Medical Assistance for Families.
- If you are currently enrolled in the Maryland Family Planning Program and are approved for PAC, your Family Planning will be cancelled.

If you qualify for the program, you will be required to join a managed care organization (MCO). There is no fee to enroll, no deductibles, no monthly premium, and no annual benefit limit. There are small co-payments for prescriptions.

If you have any questions, please see our website, www.dhmh.state.md.us/mma/mmahome or call 1-800-226-2142 for the more information. If you do not speak English, translation services are available. The application is available in Spanish. The Maryland Relay Service is available at 1-800-735-2258 for individuals with disabilities.

Important Application Information and General Instructions

- **Read all the instructions before completing the application.**
- **Print** clearly in blue or black ink. All information must be readable.
- You must include written documentation of all requested information such as Social Security number, citizenship or lawful immigration status, and identity.
- Send copies of documentation only. Original documents will not be returned.
- Applications will NOT be accepted via email.
- The process to determine eligibility takes up to 45 days. Notification of the eligibility determination will be sent by mail.

Instructions for Completing the PAC Application

Important: Print with black or blue ink or type in the required information

Section 1

- A. Print your First Name, Middle Initial, Last Name, Suffix, and Home Phone Number including area code.
- B. Fill in your complete home address for where you live. **You must be a Maryland resident.** If you are homeless, please write "homeless" in the home address line and fill in the county and state. If you live in Baltimore City, enter "Baltimore City" for the county. You can include a message phone number in the message phone box.
- C. If you have a Post Office box to get mail, list it here. If you want a **representative** or someone else to get your mail, put that person's name and address in the mailing address box. If you enter "homeless" in section B, you must enter a mailing address in section C.
- D. Check the box next to your current living arrangement.
- E. Do your parents intend to claim you as a dependant on the current year's income tax return? If they will not be claiming you, check the box next to No on line E.
- F. Check the box next to your current marital status.

Section 2:

- G. Write information for yourself and your spouse. Do not list your spouse if he or she does not live with you.
- H. Write first name, middle initial and last name and suffix for yourself and your spouse. Send in proof of identity for applicants only. This can be a valid Maryland Driver's License, MVA ID, or other government photo identity card.
- I. Social Security numbers are used only to identify applicants and to help verify total household income.
- J. Write the date of birth for yourself and your spouse.
- K. Check male or female.
- L. Check U.S. Citizenship status. If you check "YES", send proof of citizenship (such as a birth certificate or naturalization approval). If you check "NO", send proof of alien status from the Immigration and Naturalization Services (INS) that includes the date the applicant became a permanent alien resident and the alien registration number. **You are not required to provide this information for persons not applying for PAC benefits.**
- M. Please check the box for you, your spouse, or both to let us know who is applying for PAC. If both spouses wish to apply, they must be on the same application. All information must be provided for both spouses.
- N. **Persons eligible to apply for Medicare are not eligible for PAC.** However, a non-Medicare spouse may be eligible for PAC. If you are 65 or over, and do not have Medicare, you must send proof that you applied for Medicare from the Social Security Administration.

Section 3:

- O. Check race. You may check more than one race for each person applying for PAC.
- P. Check whether ethnicity is Hispanic or Latino.
- Q. Primary language information is optional. Indicate if a translation service is needed for us to speak to you.
- R. Check sections for visually or hearing impaired if they apply to you.



This space is for PAC office use only. Do not write or mark on or near the bar code or obscure it in any way. Do not photocopy.

UIIN: _____

Primary Adult Care (PAC) Application

Section 1 Complete with your information

A	First Name	MI	Last Name	Suffix	Home Phone ()	
B	Home Street Address (Include Apt)					County
	City		State	Zip	Message Phone ()	
C	Mailing Name & Street Address or P.O.Box (If different or for representative)			City	State	Zip
D	Living Arrangement	<input type="checkbox"/> At Home <input type="checkbox"/> Nursing Home/Long Term Care Facility <input type="checkbox"/> Assisted Living <input type="checkbox"/> Homeless <input type="checkbox"/> Correctional Facility <input type="checkbox"/> Rehab Facility <input type="checkbox"/> Halfway House <input type="checkbox"/> Other:				
E	Dependent Adult	Do your parents intend to claim you as a dependant for the current year's <u>income tax return</u> ? <input type="checkbox"/> Yes <input type="checkbox"/> No				
F	Marital Status	<input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed				

Section 2 Complete for yourself and your spouse living with you

G	Relation to Applicant	Self	Spouse
H	First Name and Middle Initial		
	Last Name and Suffix		
I	Social Security No.		
J	Date of Birth		
K	Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
L	U.S. Citizen?	<input type="checkbox"/> Yes <input type="checkbox"/> No If "no", immigrant documentation Number :	<input type="checkbox"/> Yes <input type="checkbox"/> No If "no", immigrant documentation Number :
M	Are you applying...	For yourself? <input type="checkbox"/> Yes <input type="checkbox"/> No	For your spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No
N	Do you have Medicare?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete the Claim number as it appears on your Medicare card: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete the Claim number as it appears on your Medicare card: _____

Section 3 Optional Information

O	Race	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White
P	Hispanic/ Latino	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Q	Primary Language:	Translation services needed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Secondary Language:		
R	Are you or your spouse visually impaired? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	If yes, do you want large print notices? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Are you hearing impaired? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, should we use Maryland Relay Services? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Please Turn Page and Complete The Other Side

PAC FINANCIAL INFORMATION

Section 4 Please complete financial information for yourself and your spouse living with you

	Income Type	Received	Self	How Often	Spouse	How Often
S	Wages	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		\$	
	Self Employment	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		\$	
	Unemployment	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		\$	
	SSI	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		\$	
	SSDI	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		\$	
	Social Security Retirement	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		\$	
	Pension / Retirement	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		\$	
	Railroad Retirement	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		\$	
	Veteran's Benefit	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		\$	
	Workers Compensation	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		\$	
	Insurance Benefit	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		\$	
	Interest / Dividends	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		\$	
	Trust /Annuity	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		\$	
	Other Income	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		\$	
T	Do you have other insurance, including Medicaid that pays for health care? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please write the name of the insurance company or program and your ID/ policy number.					
U	Do you require health cares services because of a recent accident or injury? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Section 5 Signature Section						
V	I have read and agree to the rights and responsibilities listed elsewhere in this application packet. I swear and 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. Applicant's Signature: _____ Date: _____					
W	Spouse's Signature: _____ Date: _____ (only if applying)					
X	Representative's Signature _____ Date : _____ (if applicable):					

When finished: Please remove instructions and mail the application page and required documentation to:

Primary Adult Care Program
P.O. Box 386
Baltimore, MD 21203-0386

Or you can fax it to (410)528-6047

Instructions for Completing the PAC Application (Continued)

Section 4: Instructions for Completing Financial Section Income

S. YOU MUST ANSWER ALL QUESTIONS. DO NOT LEAVE ANY BLANK SPACES.

If you are married and living with your spouse, you must provide your spouse's income even if your spouse is not applying for PAC.

- List the **GROSS** amount (**before any deductions**) and frequency of **all** income received.
- Additional information may be required if there has been any job status changes in the last 120 days.
- If self employed, a **signed copy** of the latest **tax return and schedule C** showing business profit or loss must be submitted.
- Social security income information must be provided.
- If money is received from a source other than employment, a copy of the current income statement from the agency or company that sends the money must be submitted. This would include things like alimony, rent paid, or money received on a regular basis. Please list the type of income as well as the amount and frequency in the "Other income" box.
- If little or no income is received, the person or agency providing food and shelter must submit a supporting statement.

T. If you or your spouse have any other form of health insurance, including insurance through your employer, or as a retirement benefit, mark the yes box. Include the name of the insurance company or program through which you have the coverage. You will also need to provide the policy or your ID number.

U. Let us know if you require health care services as a result of a recent accident or injury.

Section 5:

V. Please read the PAC Rights and Responsibilities on the last page of this packet before signing and dating the application.

W. If your spouse is applying for PAC, your spouse has to sign and date the application, indicating he or she also read the rights and responsibilities.

X. If someone else, an Authorized Representative, completed the application on your behalf, he or she must sign and date the application.

PLEASE REMEMBER TO SIGN AND DATE YOUR APPLICATION. AN UNSIGNED APPLICATION IS NOT VALID AND WILL BE RETURNED.

PAC RIGHTS AND RESPONSIBILITIES

Please read and save these rights and responsibilities for your records.

I understand and agree to the following:

- This application is a request for the Primary Adult Care Program only.
- If I am determined eligible for PAC, I understand that I will be required to choose a managed care organization (MCO) or the State will choose one for me.
- My Social Security number will be used to verify identity and eligibility. My Social Security number may also be used to cross-match information in federal, state, and local government files.
- The Department may conduct independent verification of the statements made by me on this application.
- I must notify the Department within 10 business days of any changes in the household income or change of address or living arrangements.
- I understand that the information given on this form is confidential and will only be used for the purpose of program administration, except as permitted by Federal and State law.
- I have the right to appeal any decision made concerning my eligibility or benefits.
- The State may recover monies spent on the cost of care from all third party payments and I agree to cooperate with the State in securing such payments.
- I certify that everyone requesting benefits is a U.S. citizen or qualified alien.
- I agree to the release of personal and financial information from any financial institution, insurance company, present or past employer, federal, state or local governmental agency, private or public organization to the Department for eligibility determination.

YOUR APPLICATION MUST BE COMPLETE AND SIGNED. IF YOU HAVE QUESTIONS, CALL OUR OFFICE AT 1-800-226-2142 BEFORE YOU SEND YOUR APPLICATION.