

**MARYLAND DEPARTMENT OF HUMAN RESOURCES
FAMILY INVESTMENT ADMINISTRATION
ELIGIBILITY DETERMINATION DOCUMENT FOR
CHILD UNDER 21 IN DHR FOSTER CARE OR SUBSIDIZED ADOPTION**

Date Signed Application Received in Local Dept.: Must be Date Stamped

FOR WORKER USE ONLY	LDSS Office:	Programs Applied For/Receiving	Assistance Unit IDs:
	MA Worker's Name:	Service Worker's Name:	Worker's D & T:
	Application/Reapplication Date:	Service Worker's Telephone:	Client ID:

**ANSWER THE FOLLOWING QUESTIONS COMPLETELY.
PLEASE PRINT ALL ANSWERS**

1. IDENTIFYING INFORMATION (CLRE/NAME/ADDR 01)

Child's Last Name	First Name	Middle Name
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2. BENEFITS INFORMATION (DEM1)

The child is currently receiving:

Cash Assistance Food Stamps
 Supplemental Security Income (SSI)
 Medical Assistance, MA#: _____
 Does the child have any unpaid medical bills from the past 3 months? Yes No
 Other benefits, list: _____

Is Maryland paying for your Medical Assistance benefits? Yes No **If no, which state is paying for these benefits?** _____

If child is receiving Medical Assistance in Maryland, is a replacement card requested (once the child's mailing address is updated) because the foster parent or adoptive parent does not have the card? No Yes
 (If the original card is found, it must be destroyed after the replacement card is received, because it will no longer be valid. Keep the child's Medical Assistance and HealthChoice MCO cards in the child's Health Passport.)

3. Do not complete this section for subsidized adoption children. PLACEMENT INFORMATION FOR CHILD'S CASE RECORD (not for entry to CARES)

Child's Former Caregiver's Name:	Address: (Number, Street, City, State, Zip Code)	Relationship to Child:		
Current Placement Date in Foster Care: _____	Name of Current Caregiver:	Relationship to Child:		
Address of Current Caregiver: (Number, Street, Apt. #)	City	State	Zip Code	Telephone Number

4. AUTHORIZED REPRESENTATIVE AND MAILING ADDRESS (NAME/ADDR 01/optional for AREP)

Name of Authorized Representative (service worker or adoptive parent) (First, Middle, Last):	Title/Relationship to the Child:	Telephone Number	
Representative's Address: Number, Street (enter as child's residential address)	City	State	Zip Code
Current Mailing Address (If different from above: local department for child in foster care or adoptive parent's mailing address) (Number, Street) (City) (State) (Zip Code)			

When I sign on the line below it means the information on this application is true and correct as far as I know.

SIGNATURE OF CHILD'S AUTHORIZED REPRESENTATIVE	DATE
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5. INFORMATION ABOUT THE CHILD (CLRE/STAT/DEM1/DEM2/SSNA/ALAS)

Resident of MD? (Yes or No)	SOCIAL SECURITY NUMBER	DATE OF BIRTH	U.S. Citizen (Yes or No)	SEX	RACE	IN SCHOOL (Yes or No)	LAST GRADE COMPLETED	School Name: _____
								School Address: _____ _____
(check one) Attends School: _____ Full-time _____ Half-time _____ Less than Half-time _____ Not in School (check one) School Level: ___ Elementary ___ Secondary ___ College ___ Other: _____								

6. CITIZENSHIP/ IMMIGRATION STATUS (DEM2/ALAS)

If the child **is not** a United States citizen (including a naturalized citizen), fill in this section. Request a copy of the green card or other identifying documentation of the alien status. THIS INFORMATION WILL NOT BE SHARED WITH THE INS.

Resettlement Agency:	INS Status & Verification	Sponsored Immigrant? <input type="checkbox"/> Yes <input type="checkbox"/> No	Country of origin
Status: <input type="checkbox"/> Legal Alien Newly Legalized Status Date: _____ <input type="checkbox"/> Illegal Alien <input type="checkbox"/> U.S. born child of refugee	INS Entry date:	INS Number & Verification:	

7. MEDICAL INSURANCE (DEM2/TPL1)

Does the child have Medicare coverage? NO YES UNKNOWN Medicare #: _____

Entitled to Medicare Part A? NO YES UNKNOWN

Does the child have any private health insurance? NO YES UNKNOWN If you answered yes, fill in the section below. Attach a copy of the front and back of the health insurance card.

HEALTH INSURANCE POLICY NUMBER 1

POLICY HOLDER NAME	Relationship to Child	POLICY NUMBER	GROUP NUMBER	Effective Date
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	Relationship to Child	POLICY NUMBER	GROUP NUMBER	Effective Date
POLICY HOLDER ADDRESS				
Number	Street	City	State	Zip Code Telephone
INSURANCE COMPANY/UNION				
Insurance Company Name				
Number	Street	City	State	Zip Code Telephone

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

9. Do not complete this section for subsidized adoption children. CHILD SUPPORT INFORMATION – Complete this section for a child who has an absent or deceased parent, parental rights have not been terminated. Fill in a separate section for each absent or deceased parent.

#1 **ABSENT PARENT (AP) INFORMATION (MOTHER or other: _____)** Absent Deceased
(DEM1/APID/APAD/APDE/APEM)

Name of Absent Parent (First, Middle, Last)	Other Name (Maiden, other):	Check one: <input type="checkbox"/> Absent <input type="checkbox"/> Deceased Date of Death:
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MARITAL STATUS OF PARENTS AT CHILD'S BIRTH
 Married Divorced Unknown Separated Widowed Never Married

Social Security Number	Other Name	Date of Birth	Age	Race	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
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AP's Last Known Address	Number	Street	City	State	Zip Code	Telephone
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AP's Previous Address	Number	Street	City	State	Zip Code	Telephone
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Driver's License: State and Plate Number	Birth Place (City, State)
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Current/Prior Military Service Dates: From: To:	Paying Military Allotment? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, To whom?	Military Branch
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Incarcerated <input type="checkbox"/> Currently <input type="checkbox"/> Previously <input type="checkbox"/> Never	Institution Name
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ABSENT PARENT INCOME INFORMATION

Last Known Employer	Name & Address:	Number	Street	City	State	Zip Code	Telephone
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Second Employer	Name & Address:	Number	Street	City	State	Zip Code	Telephone
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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? <input type="checkbox"/> YES <input type="checkbox"/> NO	To Whom?	Last Date Paid	Payment Amount
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Court Ordered? <input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, where was the court order issued?	Can you give us a copy? <input type="checkbox"/> YES <input type="checkbox"/> NO
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#2	ABSENT PARENT (AP) INFORMATION (FATHER or other: _____) (DEM1/APID/APAD/APDE/APEM)							
Name of Absent Parent (First, Middle, Last)			Other Name:		Check one: <input type="checkbox"/> Absent <input type="checkbox"/> Deceased Date of Death:			
MARITAL STATUS OF PARENTS AT CHILD'S BIRTH <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Unknown <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Never Married								
Social Security Number		Other Name		Date of Birth	Age	Race	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
AP's Last Known Address	Number	Street	City	State	Zip Code	Telephone		
AP's Previous Address	Number	Street	City	State	Zip Code	Telephone		
Driver's License: State and Plate Number			Birth Place (City, State)					
Current/Prior Military Service Dates: From: To:		Paying Military Allotment? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, To whom?			Military Branch			
Incarcerated <input type="checkbox"/> Currently <input type="checkbox"/> Previously <input type="checkbox"/> 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: <input type="checkbox"/> Social Security <input type="checkbox"/> SSI <input type="checkbox"/> Veteran's Pension <input type="checkbox"/> Unemployment <input type="checkbox"/> Worker's Compensation <input type="checkbox"/> Pension/Retirement <input type="checkbox"/> Union Benefit <input type="checkbox"/> Other, list								
ABSENT PARENT COURT ORDER INFORMATION								
Paying Support? <input type="checkbox"/> YES <input type="checkbox"/> NO	To Whom?			Last Date Paid	Payment Amount			
Court Ordered? <input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, where was the court order issued?				Can you give us a copy? <input type="checkbox"/> YES <input type="checkbox"/> NO			

To be completed by IV-E Representative:

___ Foster Care ___ Subsidized Adoption ___ Interstate Compact, State: _____ ___ SSI

___ IV-E eligible ___ Not IV-E eligible ___ IV-E status not determined yet

Signature of IV-E Specialist: _____ Date: _____

To be completed by Medical Assistance Case Manager:

___ E01 ___ foster care, IV-E eligible or SSI, MA technical eligibility criteria met
 ___ subsidized adoption, IV-E eligible or SSI, MA technical eligibility criteria met

___ E02 ___ foster care, Not IV-E eligible, MA technical eligibility criteria met
 ___ subsidized adoption with special medical/MH/rehab needs, Not IV-E eligible, MA technical eligibility criteria met

___ E03 ___ other foster care, Not IV-E eligible, MA technical eligibility criteria not met

___ E04 ___ other subsidized adoption, Not IV-E eligible, no special needs, MA technical eligibility criteria not met

Signature of Medical Assistance Case Manager : _____ Date: _____

YOU HAVE THE FOLLOWING RIGHTS

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.

EQUAL RIGHTS – Federal law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy state we cannot discriminate against you because of race, color, national origin, sex, age, or disability. Under the Food Stamp Act and USDA policy, we also cannot discriminate against you because of religion, political beliefs.

If you think we have discriminated against you contact USDA or HHS. To contact USDA write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, S.W., Washington, DC 20250-9410. You may also call toll free, (202)720-5964 (voice and TDD). Write HHS, Director, Office for Civil Rights, Room 506F, 200 Independence Avenue, S.W Washington, D.C. 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TDD). USDA and HHS are equal opportunity providers and employers.

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 your 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.

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.

Collecting application information, including the social security number of each household member, is authorized under the Food Stamp Act of 1977 as amended, 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, we may give the application information, including social security numbers, to federal or state agencies, as well as private claims collections agencies, for action.

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 (10) days unless you have a job and are part of the food stamp 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.

YOUR RIGHTS AND RESPONSIBILITIES

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.

FOOD STAMP PENALTY - Household members shall not:

- Give false information or withhold information to get or continue to get Food Stamps.
- Trade or sell Food Stamps, or electronic benefit cards.
- Use Food Stamps to buy items not allowed, such as alcohol and tobacco.
- Use someone else's Food Stamp benefits.
- Use someone else's Electronic Benefits Card without authorization.

Your food stamps will not increase if your cash assistance case 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 Food Stamp Program.

- 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 Food Stamps.
- 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 Food Stamps, or
 - * After the first time a court finds this person guilty of buying guns, bullets, or explosives, with Food Stamps.
 - * After a court finds this person guilty of trafficking food stamp 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.

TCA PENALTY – If an assistance unit member is convicted of an Intentional Program Violation (IPV), everyone in your family will lose their benefits.

- The first time, you will lose benefits for **6 months** or until you repay all of the money.
- The second time, you will lose benefits for **12 months** or until you repay all of the money.
- The third time, **you cannot get TCA benefits again.**

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.

YOUR RIGHTS AND RESPONSIBILITIES

READ BEFORE SIGNING:

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 stamps 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 select my case for a spot check.

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 and:

Agree that Medicare Part B will make payments directly to doctors and medical suppliers.

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.

Give the Department the right to inspect, review and copy all medical records for services received through the Medical Assistance Program.

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.

SIGNATURE SECTION

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 or lawfully admitted immigrants.

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 withdraw my application for: <input type="checkbox"/> Cash Assistance <input type="checkbox"/> Food Stamps <input type="checkbox"/> Medical Assistance	
Signature of Applicant / Recipient/Authorized Representative	Date

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.
- 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 I receive. If I 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
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