MARYLAND DEPARTMENT of AGING
SENIOR ASSISTED LIVING SUBSIDY PROGRAM RESIDENT APPLICATION FORM

PLEASE PRINT

Section A – Applicant Information

Applicant's Full Name: _____

Social Security Number: _____

Current Address: _____

Telephone Number: _____

Date of Birth: _____ Sex: M ☐ F ☐ Race: _____ (Optional)

Is the applicant related to the assisted living facility's owner (licensee) or any partner or officer of the licensee? YES ☐ NO ☐ If yes, state relationship: _____

Name of Person Completing Application: _____

a. Relationship to Applicant: _____

b. Address of Person Completing Application: _____

c. Telephone/Email: _____

Section B – Income from Working: *Please tell us about any income you or your spouse are currently receiving from working, including any sick leave payments.*

SEND PROOF *Please attach verification of pay such as a pay stub or Form 1099, where applicable.*

Employer Name: _____ _____

Type of Job:

Employer Address:

_____

Telephone: _____

Date Job Began:_____Date Job Ended: _____

Hours Per Pay Period: _____

How often do you get paid? Weekly □ Biweekly □ Monthly □

Gross Wages per Pay Period, Including Tips and Commissions: $ _____ per

_____

If job has ended, what is your last expected pay date?: _____

Section C – Your Benefits And Other Income: *Please tell us about any income or benefits that you are receiving, have applied for, or have been denied.*

SEND PROOF *Please send current copies of statements that verify the gross amount of income you receive.*

TYPE OF BENEFIT OR INCOME	RECEIVING INCOME OR BENETIFS?	AMOUNT	APPLICATION STATUS	APPLICATION DATE OR DENIAL DATE
Social Security Please write claim number:	YES ☐ NO ☐	$	Applied for ☐ Denied ☐	
Black Lung Benefits	YES ☐ NO ☐	$	Applied for ☐ Denied ☐	
SSI (Supplemental Security Income) Please write claim number:	YES ☐ NO ☐	$	Applied for ☐ Denied ☐	
Veteran's Pension/Benefits	YES ☐ NO ☐	$	Applied for ☐ Denied ☐	

Pension or Retirement	YES ☐ NO ☐	$	Applied for ☐ Denied ☐	
Civil Service Annuity	YES ☐ NO ☐	$	Applied for ☐ Denied ☐	
Railroad Retirement Benefits Please write claim number:	YES ☐ NO ☐	$	Applied for ☐ Denied ☐	
Alimony	YES ☐ NO ☐	$	Applied for ☐ Denied ☐	
Worker's Compensation	YES ☐ NO ☐	$	Applied for ☐ Denied ☐	
Disability/Sick Benefits	YES ☐ NO ☐	$	Applied for ☐ Denied ☐	
Union Benefits	YES ☐ NO ☐	$	Applied for ☐ Denied ☐	
Lump Sum Cash Amounts	YES ☐ NO ☐	$	Applied for ☐ Denied ☐	
Interests/Dividends from Stocks, Bonds, Saving, or other investments	YES ☐ NO ☐	$	Applied for ☐ Denied ☐	

Section C – Your Benefits and Other Income (continued)

TYPE OF BENEFIT OR INCOME	RECEIVING INCOME OR BENETIFS?	AMOUNT	APPLICATION STATUS	APPLICATION DATE OR DENIAL DATE
Business Income	YES ☐ NO ☐	$	Applied for ☐ Denied ☐	
Other (e.g. ☐ Rental Income, or ☐ Compensation from a Legal Settlement)	YES ☐ NO ☐	$	Applied for ☐ Denied ☐	

Other Please describe:	YES ☐ NO ☐	$	Applied for ☐ Denied ☐	

Section D – Assets: *Please tell us about your assets. Check YES or NO for each ASSET TYPE. If you check YES, fill in the other boxes. List all assets owned by you or your spouse individually, jointly, or with other persons. If you have more than one asset of the same type, use the "Other" boxes at the bottom of the list.*					
SEND PROOF *Please send copies of current statements that verify the value of the assets.*					
ASSET TYPE	CHECK ONE	OWNER	AMOUNT	ACCOUNT NUMBER	INSTITUTION NAME
Cash on Hand	YES ☐ NO ☐		$		
Checking Account	YES ☐ NO ☐		$		
Savings Account	YES ☐ NO ☐		$		
Credit Union Account	YES ☐ NO ☐		$		
Trust Fund	YES ☐ NO ☐		$		
IRA or Keogh Account	YES ☐ NO ☐		$		
Other Retirement Account	YES ☐ NO ☐		$		
Section D – Assets (continued)					
ASSET TYPE	CHECK ONE	OWNER	AMOUNT	ACCOUNT NUMBER	INSTITUTION NAME
Stocks and Bonds	YES ☐ NO ☐		$		

Treasury or Other Notes	YES ☐ NO ☐		$		
Annuity	YES ☐ NO ☐		$		
Ownership in a Company	YES ☐ NO ☐		$		
Patient Fund Account	YES ☐ NO ☐		$		
Other:	YES ☐ NO ☐		$		
Other:	YES ☐ NO ☐		$		
Other:	YES ☐ NO ☐		$		
Other:	YES ☐ NO ☐		$		

Section E – Other Assets: *Please tell us about any other assets you own and assets jointly owned with other individuals. This could include livestock, recreational vehicles, or any other property of value such as collections of antiques, coins, jewelry, or stamps.*

SEND PROOF *Please send copies of current statements or documents that establish the fair market value of the asset(s) as well as the amount owed.*

ASSET TYPE	OWNER	CURRENT FAIR MARKET VALUE	CURRENT AMOUNT OWNED
		$	$
		$	$

Section F – Potential Assets or Income: *Please tell us about any accident settlement, trust fund, inheritance, or any other money, property, real property or assistance you expect to receive.*

SEND PROOF *Please send copies of current statements or documents that describe the nature, amount, and payment schedule of the asset.*

ASSET TYPE	LAWYER NAME
EXPLANATION	LAWYER TELEPHONE NUMBER
ANTICIPATED DATE OF RECEIPT	

Section G – Real Property: *Please tell us about any real property that you own in or out of the state of Maryland.*			
SEND PROOF *Please send a copy of the deed or current property tax assessment for each property. Please also send copies of current documents that verify the equity value of each property.*			
Do you and/or your spouse own or have a legal interest in any other real property? YES ☐ NO ☐			
ADDRESS OF PROPERTY	TYPE OF OWNERSHIP (CHECK ONE)	CURRENT FAIR MARKET VAULE	CURRENT AMOUNT OWNED
	☐ Rental Property ☐ Vacation Property ☐ Time Share ☐ Vacant Land ☐ Other Property Rights ☐ Burial Plot	$	$
	☐ Rental Property ☐ Vacation Property ☐ Time Share ☐ Vacant Land ☐ Other Property Rights ☐ Burial Plot	$	$

	☐ Rental Property ☐ Vacation Property ☐ Time Share ☐ Vacant Land ☐ Other Property Rights ☐ Burial Plot	$	$

Section H – Life Insurance and Funeral Plans: *Please tell us about any life insurance or pre-paid burial plans or funds that you own. Please list all policies and funds, no matter who pays for them.*

SEND PROOF *Please send a copy of the declaration page of each policy. Please also send copies of current statements to verify the cash value of each policy, if applicable.*

ORIGINAL FACE VALUE OR VALUE OF PLAN	CASH VALUE	TYPE OF PLAN	POLICY NUMBER OR ACCOUNT NUMBER	POLICY OWNER	COMPANY, FUNERAL HOME OR BANK NAME
$	$	☐ Life Insurance ☐ Burial Plan			
$	$	☐ Life Insurance ☐ Burial Plan			
$	$	☐ Life Insurance ☐ Burial Plan			

Section I – Transfer of Assets: *Please tell us about any assets that you sold, traded, gifted, or disposed of in the past five years. This could include personal and real property, motor vehicles, stocks, bonds, cash, or other assets.*

SEND PROOF *Please send copies of current statements or documents that verify the date the asset was transferred, the value of the asset at the time of the transfer, and the amount you received for transferred asset. If you need additional space to complete this section, please attach additional sheets.*

TRANFER DATE	TYPE OF ASSET	VALUE OF THE ASSET AT THE TIME OF THE TRANSFER	WHO RECEIVED THE ASSET AND THE REASON FOR THE TRANSFER	AMOUNTY RECIEVED
		$		$
		$		$
		$		$

Section J – Monthly Medical Expenses: *List **out-of-pocket** (non-reimbursable**)** costs for all recurring medical expenses including health insurance premiums and medications. Attach verification of expenses.*	
SEND PROOF *Please attach verification of expenses.*	
RECURRING MEDICAL EXPENSES	FREQUENCY (monthly, quarterly, annually)
$	
$	
$	

RIGHTS AND RESPONSIBILITIES

I UNDERSTAND I HAVE THE FOLLOWING RIGHTS:

1. The SALS Program cannot discriminate against me. State and federal law prohibits the Program from discriminating against me because of race, color, national origin, sex, age, or disability.
2. I have the right to privacy of my personal information. I am providing personal information (that includes, but is not limited to: name, address, date of birth, Social Security number, income history, employment history, medical history) in this application. The purpose of requesting this personal information is to determine my eligibility for a SALS Program Subsidy. If I do not provide this information, the Program may deny my application for a subsidy. I have a right to inspect, amend, or correct this personal information. The Program will not permit inspection of my personal information, or make it available to others, except as permitted by Federal and State law. I understand, however, that the Program may deny my application if I do not provide this information.
3. The Program will provide me with a written notice if it determines that I am ineligible. I have the right to appeal certain actions taken by the Program. Any erroneous subsidies I receive from the Program must be repaid to the Program.

IF I ACCEPT A SALS PROGRAM SUBSIDY, I UNDERSTAND BY SIGNING THIS APPLICATION:

1. Payment Authorization - I authorize payment to be made directly to my assisted living providers.
2. Access to Records - I give the Program the right to inspect, review, and copy all relevant portions of my medical records for purposes of determining my eligibility for, and for determining the appropriateness of the services received through, the SALS Program.

3. Accurate and Confidential Application Information - I acknowledge that I must provide true, correct, and complete information and provide proof of this information.
4. Social Security Number - I must provide my Social Security number as an applicant for Medical Assistance. The Program will use the Social Security number and other information I provide to verify the information I provide and to make sure I am eligible. The Program may also verify my information by contacting my employer, bank, or other parties; and/or, the Program may contact local, State, or Federal agencies to make sure the information I provide is correct.
5. Accurate Financial Reporting - I understand that I am responsible for reporting true, correct, and complete financial information. This includes, but is not limited to information about: of all my assets; transfer of assets within the last 5 years; income; insurance; real property; annuities; and all other benefits I may be receiving.

DECLARATIONS AND SIGNATURES

I swear or affirm that I have read or had read to me this entire application. I also swear or affirm, under penalty of perjury, that all the information I have given is true, correct, and complete to the best of my ability, knowledge, and belief. I have received a copy of my rights and responsibilities. I authorize any person, partnership, corporation, association, or governmental agency which knows the facts relevant to determining my eligibility to release that information to the Program. I also authorize the Program to contact any person, partnership, corporation, association, or governmental agency that has provided information relevant to my eligibility. I also certify, under penalty of perjury, by signing my name below, that the person for whom I am applying is a U.S. citizen or lawfully admitted immigrant.

_____
Signature of Applicant/Recipient

Date _____

_____
Signature of Witness (If you Signed an X)

Date _____

_____
Signature of Authorized Representative (if applicable)

Date _____

For Office Use Only **Date Application Filed:** _____

Check one:

_____ Approved for SAL Subsidy

_____ Not Approved for SAL Subsidy

_____ Approved but place on the Wait List for SAL Subsidy

_____ Reapproved for SAL Subsidy

_____ _____

Signature Date