Application for COVID-19 Testing Coverage

What is COVID-19 Testing coverage?

This coverage provides limited services related to the testing and diagnosis of Coronavirus (COVID-19). It does not include services for treatment of COVID-19 or help pay for other medical costs, such as doctor visits.

Who can qualify for COVID-19 coverage?

You may qualify for COVID-19 Testing coverage if:

- You are a Maine resident;
- You are a U.S. citizen, U.S. national, or eligible immigrant; and
- You are uninsured
    - Not eligible for full MaineCare or CubCare;
    - Not enrolled in another health care program funded by the federal government, including: Medicare, TRICARE and Veterans Administration, and federal employee health plans; and
    - Not enrolled in a group health plan or other health insurance coverage.

There is no income or asset test.

How can I apply for full MaineCare?

We will screen this application for full-benefit MaineCare if you answer the questions on Page 2. The information provide will be verified electronically with other federal and state agencies to determine eligibility. If additional information is needed to make a MaineCare determination, we will contact you.

If you do not qualify for MaineCare but meet the COVID-19 Testing requirements you will be notified of the MaineCare denial reason and enrolled in Maine Rx which will give you coverage for COVID-19 testing services. Maine Rx is a prescription assistance program to help with the cost of prescription medication.

MaineCare eligibility guidelines can be found at: www.coverme.gov/coverage

Important Information About Receiving MaineCare

If you get MaineCare benefits and are age 55 or older, the State may make a claim on the assets of your estate (upon your death) to recover the money that MaineCare has paid for your care. No claim will be made if the only benefit you get is Medicare Savings Program (Buy-In) or COVID-19 Testing/Maine Rx coverage. For more information about the Estate Recovery Program, call 1-800-977-6740.

Where do I return the application?

You can bring it in to a local DHHS office, mail, fax, or email it to us at:

Mail: Office for Family Independence
State of Maine – DHHS
114 Corn Shop Lane
Farmington, ME 04938

Fax: 1-207-778-8429

Email: farmington.dhhs@maine.gov

Application for COVID-19 Testing Coverage and Maine Rx

❶ Tell us about yourself

Name *(first, middle, last)*	☐ Male ☐ Female

Social Security Number	Date of birth	Phone number

Home address

City	State	ZIP code

Mailing address *(if different from home address)*

❷ Tell us about your family

List the members of your family (such as your spouse or children) who live with you.

Name *(first, middle, last)*	Gender	Date of Birth	Social Security Number	Relationship to you

Is everyone listed above applying for coverage? If no, who is not applying for coverage?

❸ Other Information for Applicants

Does everyone live in Maine and intend to remain? ☐ Yes ☐ No
If no, who?

Is everyone a U.S. citizen? ☐ Yes ☐ No
If no, who is not a U.S. citizen?

Is anyone pregnant? ☐ Yes ☐ No
If yes, who? How many babies is she expecting?

Does anyone have other health insurance? ☐ Yes ☐ No
If yes, who?

Do you need help with medical bills incurred within the past 3 months? ☐ Yes ☐ No
If so, which month(s)?

❹ Signature

By signing, you are swearing that everything written on this form is true. If anyone requesting is eligible for MaineCare or COVID-19 Testing coverage, I am giving the agency the right to pursue and collect payments from other health insurance, legal settlements, or other third parties for services that were paid by Medicaid.

Your signature:	Date:

Answer the questions on this page if you are applying for full MaineCare

❺ Family Income

Tell us about the total income before taxes are taken out for all family members.

➢ Earnings: *For example, wages, salaries, and self-employment income.*

Name	Amount	How often? (check one)
	$	☐ Weekly ☐ Biweekly ☐ Monthly ☐ Yearly
	$	☐ Weekly ☐ Biweekly ☐ Monthly ☐ Yearly

➢ Other Income: *For example, unemployment, alimony, social security disability or retirement, pensions.*

Name	Amount	How often? (check one)
	$	☐ Weekly ☐ Biweekly ☐ Monthly ☐ Yearly
	$	☐ Weekly ☐ Biweekly ☐ Monthly ☐ Yearly
	$	☐ Weekly ☐ Biweekly ☐ Monthly ☐ Yearly

❻ Tax Information

Will you file Income Tax for the current tax year?	☐ Yes ☐ No
Will you file jointly with a spouse?	☐ Yes ☐ No
If yes, name of spouse:	
Will you claim dependents on your tax return?	☐ Yes ☐ No
If yes, name of dependent(s):	

❼ Assets - Complete this section only if you are applying for a person with a disability or over age 65

Tell us about the assets you or members of household own or have interest in.

➢ Assets: *For example, checking/savings, stocks, annuities, CDs, IRA/401K, cash, insurance, etc.*

Name on Account	Name of Bank or Institution	Current Value
		$
		$
		$

➢ Other Assets: *For example, land, camps, timeshares, buildings, cars/trucks, ATVs, Motorcycles, campers, etc.*

Name on Account	Property Type/Address or Vehicle Make/Model	Current Value
		$
		$