ANNE ARUNDEL COUNTY
MARYLAND
Department of Aging and Disabilities

Assisted Living Program
2666 Riva Rd., Suite 200
Annapolis, MD 21401
Phone (410)-222-4336

February 16th, 2024

Dear Applicant:

Enclosed is an application for the Maryland Department of Aging Senior Assisted Living Subsidy Program. This assistance offers up to $1,000.00 per month to eligible residents residing in subsidy-approved Assisted Living Program Homes. Applicants must be 62 years of age and functionally appropriate as determined by an Adult Evaluation and Review Services (AERS) assessment.

Financial eligibility is based upon income and asset tests. Current monthly income limits are as follows: Individual: $4,350.00 monthly and $52,200 annually. Current annual asset limits are as follows: Individual: $20,064.00 and Couple $26,400.00.

A list of approved subsidy providers may be obtained by calling this office at 410-222-4328 or visiting our website at https://www.aacounty.org/aging/. All interested applicants will receive an AERS evaluation to confirm functional eligibility.

Due to the subsidy appropriation earmarked to Anne Arundel County, there is currently a wait period to receive this grant. Please contact Maryland Access Point at 410-222-4257 to determine if you may be eligible for any other programs or assistance (request a level 1 screen). Once the application is received, the applicant's name will be placed on the waitlist. When a subsidy slot becomes available, you will be contacted. We do ask that you notify our office if there are any changes in the applicant's status, income, or assets. Applications may be emailed to: agsumt01@aacounty.org or mailed to Fannie Sumter, 7320 Ritchie Highway, Glen Burnie, MD 21061.

All applications should be signed and dated in all designated areas of the forms.

Please feel free to call with any questions about this application or the eligibility process.

Sincerely,

Ryan Shupp

Program Director

Enclosure

Phone: 410-222-4336 Fax: 410-222-7015

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

PLEASE PRINT

Section A – Applicant Information

Applicant's Full Name: _____

Last Four Digits of Social Security Number: _____

Current Address: _____

Telephone Number: _____

Date of Birth:_____Sex: M ☐ F ☐

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 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	YES ☐ NO ☐	$	Applied for ☐	
Black Lung Benefits	YES ☐ NO ☐	$	Applied for ☐	
SSI (Supplemental Security Income)	YES ☐ NO ☐	$	Applied for ☐	
Veteran's Pension/Benefits *(should not include Aid and Attendant benefits)	YES ☐ NO ☐	$	Applied for ☐	
Pension or Retirement	YES ☐ NO ☐	$	Applied for ☐	
Railroad Retirement Benefits	YES ☐ NO ☐	$	Applied for ☐	
Civil Service Annuity	YES ☐ NO ☐	$	Applied for ☐	
Alimony	YES ☐ NO ☐	$	Applied for ☐	
Worker's Compensation	YES ☐ NO ☐	$	Applied for ☐	
Disability/Sick Benefits	YES ☐ NO ☐	$	Applied for ☐	
Union Benefits	YES ☐ NO ☐	$	Applied for ☐	
Lump Sum Cash Amounts	YES ☐ NO ☐	$	Applied for ☐	
Interests/Dividends from Stocks, Bonds, Saving, or other investments	YES ☐ NO ☐	$	Applied for ☐	

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 ☐	
Other (e.g. ☐ Rental Income, or ☐ Compensation from a Legal Settlement)	YES ☐ NO ☐	$	Applied for ☐	
Other Please describe:	YES ☐ NO ☐	$	Applied for ☐	

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 ☐		$		

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 owned.*

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 since July 27, 2020. 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)
$	
$	
$	

Section K – Voter Registration

If the applicant is not registered to vote, would the applicant like to receive a voter registration form?

YES ☐ NO ☐ Already Registered to Vote ☐

Section L – Supplemental Questions

Does the applicant receive:

Medicare: YES ☐ NO ☐
Medicaid: YES ☐ NO ☐
SNAP: YES ☐ NO ☐

RIGHTS AND RESPONSIBILITIES

I UNDERSTAND I HAVE THE FOLLOWING RIGHTS:

1. State and federal law prohibits the SALS 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 in this application so that my eligibility for a SALS Program Subsidy can be assessed. If I do not provide accurate proof of 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.
3. The Program will provide me with a written notice if it determines that I am eligible or ineligible. I have the right to appeal certain actions taken by 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 Application Information - I acknowledge that I must provide true, correct, and complete information and provide proof of this information. This includes, but is not limited to, information about: all of my assets; transfer of assets since July 27, 2020; income; insurance; real property; annuities; and all other benefits I may be receiving. Any subsidies paid out by the Program based on untrue, incorrect, or incomplete information you have submitted must be repaid to the Program.
4. The Program will use the information I provide to verify my eligibility. 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.

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 the Program to contact any person, partnership, corporation, association, or governmental agency that has information relevant to my eligibility. I authorize those same entities to release that information to the Program. 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 _____

Area Agency on Aging: _____

Program Manager: _____

Address: _____

_____

Please return the completed application to the above address.

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

Maryland Department of Aging
Senior Assisted Living Subsidy Program

Statewide Program Eligibility Verification Form

The Senior Assisted Living Subsidy Program is a statewide program that requires all applicants and participants to produce reliable and accurate proof of age and income to qualify. Applicants must present one form of verification for age and one form of verification for income.

The following documents are acceptable forms of proof of age:

- Valid Birth Certificate
- Valid Driver's License
- Valid Maryland State Identification Card
- Valid Passport

The following documents are acceptable forms of proof of income:

- Social Security Award Letter
- Earned Income Statement
- Income Tax Return
- Bank Statement

AAAs must ensure that each individual's file contains a copy of the following documents as evidence of program eligibility:

- A completed and signed Program Eligibility Verification Form;
- One of the acceptable forms of proof of age; and
- One of the acceptable forms of proof of income

I have read the requirements for enrollment in this program and agree to provide the requested documentation as proof of eligibility.

_____ Date: _____
Applicant or Applicant's Representative

I certify that I have received income and age documentation as proof of eligibility and that a copy of these documents will be placed in the applicant's file.

_____ Date: _____
Area Agency on Aging Representative

Maryland Department of Aging
Senior Assisted Living Subsidy Program
Allowance/Allowable Medical Expenses

Please provide the following when submitting the SALS application. **These are examples, not a complete list of MONTHLY MEDICAL EXPENSES.** Note: any recurring, monthly, medically-related expenses can be counted.

- Six-month printout from pharmacy documenting out-of-pocket prescription cost
- Recent receipts of incontinence supplies
- Hospital supplies
- Recent receipts for food supplements (Boost®, Ensure®, etc.)
- Bill(s) for supplemental health insurance, Medigap, or Medicare Part D payments
- Outstanding medical, hospital, or doctors' bills with monthly payment indicated
- Psychiatric day program - this **does not include medical daycare or attendance care**
- Dental
- Eyeglasses
- Hearing aids

Please note: Allowable medical expenses must be documented with written verification and made part of the participant's file.