SENIOR ASSISTED LIVING SUBSIDY PROGRAM RESIDENT APPLICATION
RESIDENT APPLICATION (INITIAL AND REDETERMINATION)

PLEASE PRINT

Section A – Applicant Information

Applicant's Full Name: _____

Last Four Digits of the Social Security Number: _____

Current Address: _____

Telephone Number: _____

Sex: M ☐ F ☐ Race: _____

Date of Birth: ____

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:_____

TYPE OF BENEFIT OR INCOME	RECEIVING INCOME OR BENEFITS?	AMOUNT
Social Security	YES ☐ NO ☐	$
SSI (Supplemental Security Income) or DSSI:	YES ☐ NO ☐	$
Veteran's Pension/Benefits **(*should not include Aid and Attendant benefits)**	YES ☐ NO ☐	$
Pension or Retirement	YES ☐ NO ☐	$
Other Civil Service Annuity, Alimony, worker's compensation, union benefits	YES ☐ NO ☐	$

ASSET TYPE	CHECK ONE	OWNER	AMOUNT
Cash on Hand	YES ☐ NO ☐		$
Checking Account	YES ☐ NO ☐		$
Savings Account	YES ☐ NO ☐		$
Trust Fund, IRA or Keogh Account Other Retirement Account Stocks and Bonds Treasury or Other Notes, Annuity	YES ☐ NO ☐		$
Ownership in a Company, Patient Fund Account 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	Estimated Amount

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 ☐

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ADDRESS OF PROPERTY	TYPE OF OWNERSHIP (CHECK ONE)	CURRENT FAIR MARKET VALUE	CURRENT AMOUNT OWNED
	☐ Rental Property ☐ Vacation Property ☐ Vacant Land ☐ Other Property Rights	$	$

ORIGINAL FACE VALUE OR VALUE OF PLAN	CASH VALUE	TYPE OF PLAN	POLICY OWNER
$	$	☐ 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.*

TRANSFER DATE	TYPE OF ASSET	VALUE OF THE ASSET AT THE TIME OF THE TRANSFER	WHO RECEIVED THE ASSET AND THE REASON FOR THE TRANSFER	AMOUNT RECEIVED
		$		$
		$		$
		$		$

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. *See list of examples*	
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 because of race, color, national origin, sex, age, or disability.
2. I have the right to privacy of my personal information. The purpose of requesting this personal information is to determine my eligibility for a SALS Program Subsidy. If I do not provide accurate and 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 allow unauthorized 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 when it determines that I am eligible or ineligible. I have the right to appeal certain actions taken by the Program. Any erroneous subsidies the provider receives 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 the appropriateness of the services received through the SALS Program.
3. Accurate Financial Reporting - I understand that I am responsible for reporting true, correct, and complete financial information about all my income, assets and all other benefits I may be receiving.

DECLARATIONS AND SIGNATURES

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.

_____
Signature of Applicant/Recipient

Date _____

_____
Signature of Witness (If you Signed an X)

Date _____

_____
Signature of Authorized Representative (if applicable)

Date _____

Completed application is to be returned to:

Area Agency on Aging: _____
Program Manager:_____
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