

# **INSTRUCTIONS FOR COMPLETING THE PATIENT APPLICATION**

(Please complete **ALL** areas of the application)  
(If some areas do not apply to you, please mark **N/A**)

- PAGE 1:** **SOCIAL SECURITY NUMBER** – This is your ID number used by the Program for administrative purposes and to pay your medical bills. It is **important** to have the correct number in order to prevent errors, so if you have a Social Security number, please provide a copy of your Social Security Card. If you do not have a social security number, please mark **No SS#**. An ID number will be assigned and will appear on the ID letter sent by the central office.
- PAGE 1:** **MARYLAND RESIDENCY** – Please provide a copy of **ONE** of the following documents displaying applicant's name **AND** current home address:
- ***If you have a P.O. Box ONLY: You will need the Postmaster's Verification Letter (ask at your local Post Office)***
- Maryland Driver's License
  - Maryland State Identification Card
  - Utility Bill:
    - Gas and/or Electric Bill
    - Telephone Bill (residence phone only)
    - Water Bill
  - Lease Agreement
  - Mortgage Agreement
  - School Records
  - Motor Vehicle Registration
  - Voter Registration Card
  - Property Tax Bill or Receipt
  - Residential Service Contract – Repair Service
  - W-2 Statement (not more than 12 months old)
  - Signed Tax Return (not more than 12 months old)
  - Paycheck or Stub with Full Name and Home Address
- PAGE 2:** **ELIGIBLE MEDICAL CONDITION** – A COPY OF **CURRENT TEST RESULTS MUST BE ATTACHED TO THE APPLICATION**. You can obtain a copy from the clinic, doctor's office or hospital. Only precancerous and cancerous medical conditions involving the cervix (mouth of the womb) and/or breast are covered by the Program.
- PAGE 3:** **INSURANCE INFORMATION** – If you have **FULL** Medical Assistance, you are **not** eligible for this Program. If you haven't applied for Medical Assistance, you are strongly urged to submit an application to Medical Assistance. Please see instructions included in this packet. If you have a Family Planning, or Qualified Medicare Beneficiary card, please complete the application and provide a copy of your card(s). The Program can provide coverage for benefits not covered by your Maryland Medical Care Program(s) for the diagnosis and treatment of breast and cervical cancer. Those who have their Medicare premiums paid as a Specified Low-income Medicare Beneficiary do not have to state this since no Medical Care Program benefits are provided.
- **All Other Insurance** – Please complete this portion and provide a copy of the front and back your card(s). It is important to list the effective date and to check off **all** areas covered by your insurance. [Medigap insurance refers to insurance which pays for some or the entire amount left after Medicare pays its part (e.g., AARP, Blue Cross/Blue Shield, etc.)].
- PAGE 3:** **FINANCIAL ELIGIBILITY** – Eligibility is based on your **total yearly income**. A **complete, signed**, copy of your most recent **Federal** income tax return is preferred because it provides the most accurate information. If that is not available, provide one of the following for each type of income you have, such as two pay stubs from a job and documentation of child support.
- **W-2** – Your employer can provide this.
  - **Social Security Entitlement Letter** – The Social Security Administration sends this by mail each January. It lists the amount you will receive each month.
  - **Two Pay-stubs** – Must be for two pays in a row or two pays in the same month.
  - **Notarized Letter** – This letter states you are **not** working and do **not** have **any** income. This is a legal document and must be stamped and signed by a notary public. It means **you** are responsible for refunding any money spent by the State if this statement is found to be false.
- **If you are receiving non-taxable income, such as child support or foster care, YOU MUST provide the legal documentation.**
- **If you are separated from your spouse, but do not have a legal separation agreement, YOU MUST provide documentation of your spouse's income.**
- PAGE 3:** **HOUSEHOLD COMPOSITION** – Only include family members who can be listed as dependents on your income tax return.
- PAGE 3:** **FAMILY INCOME** – Please list **all** that apply.
- PAGE 4:** **PATIENT AGREEMENT** – Please read carefully because the application is a legal document. Your signature indicates: **(1)** the statements you made are true; **(2)** the Program has your permission to check the information provided; and **(3)** the Program has your permission to release information regarding your medical, financial, and insurance information.

Patient Application

BREAST AND CERVICAL CANCER DIAGNOSIS AND TREATMENT PROGRAM
Maryland State Department of Health and Mental Hygiene
Prevention and Health Promotion Administration

Application Status: [ ] New Application [ ] Renewal Application

PATIENT INFORMATION (Please type or print)

SS#: [ ][ ][ ]-[ ][ ][ ]-[ ][ ][ ][ ][ ]

Date of Birth: [ ][ ]/[ ][ ]/[ ][ ][ ][ ][ ]
MM DD YYYY

Sex: [ ] Male [ ] Female

Name: \_\_\_\_\_
Last First MI

Ethnicity: Are you Hispanic or Latino?
[ ] Yes
[ ] No

Marital Status: [ ] Single/Never Married [ ] Married [ ] Widowed
(Must Select One) [ ] Separated (must provide copy of legal separation agreement)
[ ] Divorced (must provide copy of divorce decree)

Race: If multiracial, select all that apply:

- [ ] White
[ ] Asian
[ ] American Indian or Alaska Native
[ ] Native Hawaiian or Other Pacific Islander
[ ] Black or African American

Patient Employed: [ ] Yes [ ] No If Yes, How Long? \_\_\_\_\_
If yes, place of employment: \_\_\_\_\_

Phone #: \_\_\_\_\_

Spouse Employed: [ ] Yes [ ] No If Yes, How Long? \_\_\_\_\_
If yes, place of employment: \_\_\_\_\_

Phone #: \_\_\_\_\_

Home Address: \_\_\_\_\_
Number, Street / P.O.Box

\_\_\_\_\_
City/Town State Zip Code County of Residence

Maryland Resident: [ ] Yes [ ] No

Home Phone: [ ][ ][ ]/[ ][ ][ ]/[ ][ ][ ][ ][ ]

Work Phone: [ ][ ][ ]/[ ][ ][ ]/[ ][ ][ ][ ][ ] Ext: [ ][ ][ ][ ]

Fax Number: [ ][ ][ ]/[ ][ ][ ]/[ ][ ][ ][ ][ ] E-Mail: \_\_\_\_\_

EMERGENCY CONTACT

Name: \_\_\_\_\_ Phone: [ ][ ][ ]/[ ][ ][ ]/[ ][ ][ ][ ]
Last Name First Name

Relationship to Patient: [ ] Spouse [ ] Parent [ ] Child [ ] Other (Specify): \_\_\_\_\_

REFERRAL INFORMATION

Source: (Who provided the Program application?) [ ] Physician
[ ] Hospital
[ ] Self
[ ] Friend
[ ] Other (Specify) \_\_\_\_\_

HEALTH DEPARTMENT USE ONLY:
[ ] BCC Screening Program
[ ] STD
[ ] Colposcopy
[ ] Family Planning

Contact Person: (Who referred you to this program?)

Name: \_\_\_\_\_
First Name Last Name

Phone: [ ][ ][ ]/[ ][ ][ ]/[ ][ ][ ][ ]

INFORMATION CONTAINED IN THIS APPLICATION IS CONFIDENTIAL

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**State of Maryland**  
**Patient Application for Breast and Cervical Cancer Diagnosis and Treatment Program**

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**MEDICAL ELIGIBILITY: You MUST attach a copy of current test results ( i.e., pathology report, cytology report, or mammogram report) to document eligibility for program.**

Eligible Medical Condition: (Check all that apply)	FOR OFFICE USE ONLY		
	DOCUMENTATION		
<input type="checkbox"/> Abnormal mammogram or other breast imaging requiring further diagnosis .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Initial _____
<input type="checkbox"/> Abnormal clinical breast exam requiring further diagnosis .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
<input type="checkbox"/> Positive breast biopsy indicating need for treatment .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
<input type="checkbox"/> Previous Breast Cancer (Year of Diagnosis: _____ ) .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
<input type="checkbox"/> Atypical Ductal Hyperplasia .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
<input type="checkbox"/> Lobular Neoplasia.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
<input type="checkbox"/> Phylloides tumor .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
<input type="checkbox"/> Abnormal pap test requiring further diagnosis .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
<input type="checkbox"/> Positive cervical biopsy indicating need for treatment .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
<input type="checkbox"/> Previous Cervical Cancer (Year of Diagnosis: _____ ) .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____

**INSURANCE INFORMATION**

The Diagnosis and Treatment Program pays for eligible services only after other applicable insurance has paid their portion. In order to process your claim more efficiently, please complete the following information.

<p><b>Do you have Medicaid/Medical Assistance?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <ul style="list-style-type: none"> <li><b>If yes, Medicaid/Medical Assistance No:</b> _____  <b>Effective Date:</b> _____ <b>Expiration Date:</b> _____  <small>MM/DD/YYYY MM/DD/YYYY</small></li> <li><b>If no, have you applied for Medical Assistance?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No  <i>(If yes, date applied: _____)</i>  <small>MM/DD/YYYY</small></li> </ul> <p><i>If you have not applied for Medical Assistance, you are strongly urged to submit an application to Medical Assistance. Please see instructions included in this packet.</i></p>	<p align="center">FOR OFFICE USE ONLY</p> <p align="center"><b>VERIFICATION</b></p> <p align="center"><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p align="center">_____</p> <p align="center">Initial</p>
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**Do you have other medical insurance?**  Yes  No **If yes, you MUST attach a copy of all insurance cards.**  
*(Please complete the following insurance information.)*

NAME OF INSURANCE (Check all that apply)	POLICY HOLDER (self, spouse, or parent)	ID # GROUP #	EFFECTIVE DATE	EXPIRATION DATE
<input type="checkbox"/> Medicare <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part D <input type="checkbox"/> HMO		ID # _____	MM/DD/YYYY	MM/DD/YYYY
<input type="checkbox"/> Medigap/Medicare Supplement Name of Insurance Co: _____		ID # _____	MM/DD/YYYY	MM/DD/YYYY
<input type="checkbox"/> Private Insurance (1) Name of Insurance Co: _____		Group # _____	MM/DD/YYYY	MM/DD/YYYY
<input type="checkbox"/> Private Insurance (2) Name of Insurance Co: _____		ID # _____	MM/DD/YYYY	MM/DD/YYYY
<input type="checkbox"/> Military Dependent		Group # _____	MM/DD/YYYY	MM/DD/YYYY

**What does your insurance cover?**

(Check all that apply)

**Hospital Services:**  
**Other Services:**

- Inpatient Care       Outpatient Care  
 Physician Services       Prescriptions

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**State of Maryland**  
**Patient Application for Breast and Cervical Cancer Diagnosis and Treatment Program**

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**FINANCIAL ELIGIBILITY**

In order to determine your financial eligibility for this program we need to collect information regarding household composition and family-income. **PROOF OF INCOME MUST BE ATTACHED** – (Your most recent Income Tax Return is preferred. However, W-2 Forms, Social Security Entitlement Letter, a minimum of 2 Pay Stubs, or a notarized letter stating “No Income and No Employment” can be substituted). Please notify the Program regarding any changes in household composition and income information.

**HOUSEHOLD COMPOSITION** (Please list the names and ages of all family members listed as dependents on your Income Tax Return and indicate their relationship to the patient (i.e., spouse, parent, child))

LAST NAME	FIRST NAME	AGE	RELATIONSHIP TO PATIENT
1.			
2.			
3.			
4.			
5.			

If there are more than five residing in your household, please attach a list of other dependents listed on your Income Tax Return with their name, age and relationship to patient.

Total number of people in household (including patient):

**FAMILY-INCOME INFORMATION**

	INCOME (Please indicate week, month or year)			FOR OFFICE USE ONLY DOCUMENTATION	
<b>Patient Income</b> (Includes Social Security and any other retirement benefits)	\$ .	<input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year	Yearly Total: \$ .	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Initial: _____	
<b>Spouse's Income</b> (Includes Social Security and any other retirement benefits)	\$ .	<input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year	Yearly Total: \$ .	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Initial: _____	
<b>Parents' Income</b> (If patient is a dependent child on parents' income tax return)	\$ .	<input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year	Yearly Total: \$ .	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Initial: _____	
<b>Child Support</b>	\$ .	<input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year	Yearly Total: \$ .	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Initial: _____	
<b>Foster Child Supplement</b> (If child(ren) counted in household composition)	\$ .	<input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year	Yearly Total: \$ .	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Initial: _____	
<b>Unemployment Insurance</b> <input type="checkbox"/> patient <input type="checkbox"/> spouse <input type="checkbox"/> parent	\$ .	<input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year	Yearly Total: \$ .	Start Date:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Initial: _____
				End Date:	
<b>Workman's Compensation</b> <input type="checkbox"/> patient <input type="checkbox"/> spouse <input type="checkbox"/> parent	\$ .	<input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year	Yearly Total: \$ .	Start Date:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Initial: _____
				End Date:	
<b>Social Security Disability Insurance</b> <input type="checkbox"/> dependent child <input type="checkbox"/> patient <input type="checkbox"/> spouse <input type="checkbox"/> parent	\$ .	<input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year	Yearly Total: \$ .	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Initial: _____	
<b>Alimony</b> <input type="checkbox"/> patient <input type="checkbox"/> spouse <input type="checkbox"/> parent	\$ .	<input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year	Yearly Total: \$ .	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Initial: _____	
<b>TOTAL ANNUAL FAMILY INCOME</b>			\$ .		



STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene

Larry Hogan, Governor - Boyd Rutherford, Lt. Governor - Van Mitchell, Secretary

**Patient Statement**

I, \_\_\_\_\_, state that:

I am not employed at this time and receive no unemployment, support or income of any kind. I live with my \_\_\_\_\_ (parents, friend, relative, etc.) and receive only room and board.

I receive public assistance. Check all that apply:

Food Stamps

Cash Assistance

Housing Allowance

\_\_\_\_\_  
(SIGNATURE)

\_\_\_\_\_  
(DATE)

Notary Public: \_\_\_\_\_

Date: \_\_\_\_\_

My commission expires on \_\_\_\_\_

Patient Name: _____ Date of Birth: _____
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<p align="center"><b>State of Maryland</b> <b>Patient Application for Breast and Cervical Cancer Diagnosis and Treatment Program</b> <i>(Page 4 of 4)</i></p>
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**PATIENT AGREEMENT**  
*(Please read carefully before signing)*

I certify that all the information on this form is true, correct and complete. I understand that any false statements would subject me to penalties under Federal or State law and would result in a denial of program eligibility.

I authorize the Maryland State Department of Health and Mental Hygiene, Center for Cancer Prevention and Control, to verify any information provided by me on this form. I will provide proof of any information on this form as required by the Program.

I agree to the release of medical/financial/insurance information regarding the diagnosis and/or treatment pertinent to my care to the following: the physician, nurse practitioner, nurse anesthetist, hospital, home health agency, and the physical therapist providing my care; the pharmacy and medical supply company I have chosen; the local health department responsible for referral to the Diagnosis and Treatment Program; and the State Department of Health and Mental Hygiene that administers the Diagnosis and Treatment Program.

\_\_\_\_\_  
**Signature of Applicant**

\_\_\_\_\_  
**Name of Person to Contact**  
*(Please Print or Type)*

\_\_\_\_\_  
**Name of Applicant**  
*(Please Print or Type)*

\_\_\_\_\_  
**Address of Contact Person**  
*(Please Print or Type)*

\_\_\_\_\_  
**Date of Application**

\_\_\_\_\_  
**Office Phone of Contact Person**

<p align="center"><b>PLEASE RETURN COMPLETED APPLICATION TO:</b></p> <p align="center"><b>Center for Cancer Prevention and Control</b> <b>Maryland Department of Health and Mental Hygiene</b> <b>Prevention and Health Promotion Administration</b> <b>P.O. Box 13528</b> <b>Baltimore, Maryland 21203-2399</b></p>
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**For questions, please call 410-767-6787**

**STATE OF MARYLAND  
BREAST AND CERVICAL CANCER DIAGNOSIS AND TREATMENT PROGRAM  
FACT SHEET**

*This Program ONLY pays for medical services related to breast and cervical cancer.*

**WHO IS ELIGIBLE?**

You must:

- ❑ Be a Maryland resident (if you move out of State, you are no longer eligible) and proof of residency is required, and
- ❑ Meet the income requirements for the Program, and
- ❑ Meet the medical requirements.

*Note: Those covered by Medical Assistance are not eligible for this Program*

**WHAT ARE YOUR RESPONSIBILITIES?**

You must:

- ❑ Complete and sign the application for the Program, provide proof of Maryland residency, and provide proof of income. (If you have no income, you must provide a notarized letter stating that fact.)
- ❑ Show the Program "ID" letter each time you visit a Program provider. PLEASE KEEP THE ORIGINAL LETTER.
- ❑ Visit only Program Providers. You can determine which providers participate by calling your local contact or the central office in Baltimore. You will be responsible for bills from non-Program providers if they do not choose to participate in the Program.
- ❑ Let the Program know when:
  - your income changes, or
  - your health insurance changes, or
  - your in-state address or phone number changes, or
  - you move out of the State, or
  - you have questions about the Program
- ❑ Renew your application to the Program each year if you are found to have breast or cervical cancer or you continue to have a breast or cervical abnormality needing further treatment.
- ❑ You may also be asked to complete an application for Maryland Medical Assistance if the program deems you to be potentially eligible.

## **WHAT MEDICAL SERVICES ARE COVERED?**

Only services directly related to the diagnosis and treatment of breast and/or cervical cancer will be paid by the Program. These include:

- ❑ Tests to check for breast cancer (diagnostic procedures) (e.g. ultrasound, breast biopsy, etc.)
- ❑ Breast cancer treatment procedures (e.g. lumpectomy, mastectomy, radiation therapy, or being part of a research study)
- ❑ Tests to check for cervical cancer (diagnostic procedures) (e.g. colposcopy, cervical biopsy)
- ❑ Cervical cancer treatment procedures (e.g. cryotherapy, laser, hysterectomy, etc.)
- ❑ Medications related to the treatment of breast or cervical cancer
- ❑ Occupational Therapy and Physical Therapy for breast or cervical cancer
- ❑ Wigs
- ❑ Medical Equipment (one external prosthesis every 3 years, two mastectomy bras each year, hospital beds, etc.)
- ❑ Breast reconstruction (nipple reconstruction or tattooing are NOT covered)
- ❑ Other costs related to diagnosis and treatment (lab tests, x-rays, or hospital care)

## **WHAT SERVICES ARE NOT COVERED BY THE PROGRAM?**

- ❑ Pap tests
- ❑ Head coverings other than wigs
- ❑ Experimental procedures
- ❑ Home health aides (Home health nurses, occupational and physical therapists are covered)
- ❑ Transportation including ambulance services.
- ❑ Medications for conditions other than the treatment of breast and/or cervical cancer (e.g. insulin, heart medications, etc.). If the treatment for breast or cervical cancer causes the need for treatment of other conditions, the Program may pay for those medications.
- ❑ Nipple reconstruction/tattooing
- ❑ Genetic testing
- ❑ Prophylactic mastectomy (removal of a breast with no cancer)

## HOW DOES PAYMENT UNDER THIS PROGRAM WORK?

- ❑ The Program can only pay providers who have signed a written agreement to participate in this Program. Providers may be doctors, hospitals, pharmacies, home health agencies, laboratories, free standing ambulatory surgical centers, medical supply companies, physical therapists and occupational therapists.
- ❑ The Program pays providers directly. (No payment is made to a patient.)
- ❑ If you are uninsured, the Program pays the provider for the breast and/or cervical cancer diagnostic or treatment procedures you received
- ❑ If you have Medicare or commercial insurance your provider will bill your insurance first
- ❑ If you are covered by Medicare or commercial insurance, the Program will pay for:
  - Your patient co-insurance amount and any co-pay
  - Your annual deductible if it has not already been met
  - Services related to breast and cervical cancer that are not covered by Medicare or commercial insurance

## REMEMBER:

- If you have any questions or get a bill, call your local contact. If you have no local contact, call the central office at (410) 767-6787 and ask for a diagnosis and treatment nurse.
- The Program ONLY covers services related to breast or cervical cancer.
- You must use Program providers.
- You MUST show your gold seal “ID” letter each time you use a Program provider. Be sure the provider notices the “Send Billing to:” section of the ID letter.

**We know this is a hard time for you. If you qualify for the Program, we can help by taking some of the worry out of paying for care.**

# MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE AND YOUR HEALTH INFORMATION

## NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.**

### **Safeguarding Your Protected Health Information**

The Maryland Department of Health and Mental Hygiene (DHMH) is committed to protecting your health information. In order to provide treatment or to pay for your healthcare, DHMH will ask for certain health information and that health information will be put into your record. The record usually contains your symptoms, examination and test results diagnoses, and treatment. That information, referred to as your health or medical record, and legally regulated as health information may be used for a variety of purposes. DHMH is required to follow the privacy practices described in this Notice, although DHMH reserves the right to change our privacy practices and the terms of this Notice at any time. You may request a copy of the new notice from any DHMH agency. It is also posted on our website at <http://dhmh.maryland.gov/>.

### **How DHMH May Use and Disclose Your Protected Health Information**

DHMH employees will only use your health information when doing their jobs. For uses beyond what DHMH normally does, DHMH must have your written authorization unless the law permits or requires it. The following are some examples of our possible uses and disclosures of your health information.

### **Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations:**

**For treatment:** DHMH may use or share your health information to approve, deny treatment and to determine if your medical treatment is appropriate. For example, DHMH health care providers may need to review your treatment plan with your healthcare provider for medical necessity or for coordination of care.

**To obtain payment:** DHMH may use and share your health information in order to bill and collect payment for your health care services and to determine your eligibility to participate in our services. For example, your health care provider may send claims for payment of medical services provided to you.

**For health care operations:** DHMH may use and share your health information to evaluate the quality of services provided, or to our state or federal auditors.

### **Other Uses and Disclosures of health information required or allowed by law:**

**Information purposes:** Unless you provide us with alternative instructions, DHMH may send appointment reminders and other materials about the program to your home.

**Required by law:** DHMH may disclose health information when a law requires us to do so.

**Public health activities:** DHMH may disclose health information when DHMH is required to collect or report information about disease or injury, or to report vital statistics to other divisions in the department and other public health authorities.

**Health oversight activities:** DHMH may disclose your health information to other divisions in the department and other agencies for oversight activities required by law. Examples of these oversight activities are audits, inspections, investigations, and licensure.

**Coroners, Medical Examiners, Funeral Directors and Organ Donations:** DHMH may disclose health information relating to a death to coroners, medical examiners or funeral directors, and to authorized organizations relating to organ, eye, or tissue donations or transplants.

**Research purposes:** In certain circumstances, and under supervision of our Institutional Review Board or other designated privacy board, DHMH may disclose health information to assist medical research.

**Avert threat to health or safety:** In order to avoid a serious threat to health or safety, DHMH may disclose health information as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.

**Abuse and Neglect:** DHMH will disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence, or some other crime. DHMH may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**Specific government functions:** DHMH may disclose health information of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government benefit programs relating to eligibility and enrollment, and for national security reasons, such as protection of the President

## NOTICE OF PRIVACY PRACTICES

Page 2 of 2

**Families, friends or others involved in your care:** DHMH may share your health information with people as it is directly related to their involvement in your care or payment of your care. DHMH may also share health information with people to notify them about your location, general condition, or death.

**Worker's Compensation:** DHMH may disclose health information to worker's compensation programs that provide benefits for work-related injuries or illnesses without regard to fault.

**Patient Directories:** The health plan under which you are enrolled does not maintain a directory for disclosure to callers or visitors who ask for you by name. You will not be identified to an unknown caller or visitor without authorization.

**Lawsuits, Disputes and Claims:** If you are involved in a lawsuit, a dispute, or a claim, DHMH may disclose your health information in response to a court or administrative order, subpoena, discovery request, investigation of a claim filed on your behalf, or other lawful process.

**Law Enforcement:** DHMH may disclose your health information to a law enforcement official for purposes that are required by law or in response to a subpoena.

### **You have a Right to:**

**Request restrictions:** You have a right to request a restriction or limitation on the health information DHMH uses or discloses about you. DHMH will accommodate your request if possible, but is not legally required to agree to the requested restriction. If DHMH agrees to a restriction, DHMH will follow it except in emergency situations.

**Request Confidential Communications:** You have the right to ask that DHMH send you information at an alternative address or by alternative means. DHMH must agree to your request as long as it is reasonably easy for us to do so.

**Inspect and copy:** You have a right to see your health information upon your written request. If you want copies of your health information, you may be charged a fee for copying, depending on your circumstances. You have a right to choose what portions of your information you want copied and to have prior information on the cost of copying.

**Request amendment:** You may request in writing that DHMH correct or add to your health record. DHMH may deny the request if DHMH determines that the health information is: (1) correct and complete; (2) not created by us and/or not part of our records; or (3) not permitted to be disclosed. If DHMH approves the request for amendment, DHMH will change the health information and inform you, and will tell others that need to know about the change in the health information.

**Accounting of disclosures:** You have a right to request a list of the disclosures made of your health information after April 14, 2003. Exceptions are health information that has been used for treatment, payment, and operations. In addition, DHMH does not have to list disclosures made to you, based on your written authorization, provided for national security, to law enforcement officials or correctional facilities. There will be no charge for up to one such list each year.

**Notice:** You have the right to receive a paper copy of this Notice and/or an electronic copy by email upon request.

### **For More Information**

This document is available in other languages and alternate formats that meet the guidelines for the Americans with Disabilities Act. If you have questions and would like more information, you may contact: **Gwendolyn Patterson Askew at 410-767-0965.**

### **To Report a Problem about our Privacy Practices**

If you believe your privacy rights have been violated, you may file a complaint.

You can file a complaint with the Department of Health and Mental Hygiene, Division of Corporate Compliance at 1-866-770-7175.

You can file a complaint with the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights. You may call the Department of Health and Mental Hygiene for the contact information.

DHMH will take no retaliatory action against you if you make such complaints.

Effective Date: This notice is effective on April 14, 2003.

## Important Information about Medical Assistance

### Medicaid Information

#### Total Yearly Household Income (Approximate)

Family Size	Adults**	Children (MCHP)	Children (MCHP Premium) *	Pregnant Woman	
1	\$16,104	\$24,623	\$30,808	\$37,577	N/A
2	\$21,707	\$33,190	\$41,527	\$50,650	\$41,527
3	\$27,310	\$41,756	\$52,245	\$63,723	\$52,245
4	\$32,913	\$50,323	\$62,964	\$76,797	\$62,964
5	\$38,515	\$58,890	\$73,682	\$89,870	\$73,682
6	\$44,118	\$67,456	\$84,400	\$102,943	\$84,400
Each person add	\$5,602	\$8,566	\$10,718	\$13,073	\$10,718
You Pay	\$0	\$0	\$52	\$65	\$0

Effective March 1, 2014

\*Premium cost is per family/household each month.

\*\*Parents, caretaker relatives, and nondisabled childless adults under age 65

### How to Apply

- **Contact your local health department for information about applying for Medicaid.**

#### Local Health Department Contact Numbers

<b>Allegany</b>	(301) 759-5076	<b>Harford</b>	(443) 643-0343
<b>Anne Arundel</b>	(410) 222-4792	<b>Howard</b>	(410) 313-7500
<b>Baltimore City</b>	(410) 649-0521	<b>Kent</b>	(410) 778-7023
<b>Baltimore County</b>	(410) 887-2957	<b>Montgomery</b>	(240) 777-3120
<b>Calvert</b>	(410) 535-5400	<b>Prince George's</b>	(888) 561-4049
<b>Caroline</b>	(410) 479-8004	<b>Queen Anne's</b>	(410) 758-0720
<b>Carroll</b>	(410) 876-4916	<b>St. Mary's</b>	(301) 475-4275
<b>Cecil</b>	(410) 996-5126	<b>Somerset</b>	(443) 523-1700
<b>Charles</b>	(301) 609-6869	<b>Talbot</b>	(410) 819-5670
<b>Dorchester</b>	(410) 228-3294	<b>Washington</b>	(240) 313-3330
<b>Frederick</b>	(301) 600-1324	<b>Wicomico</b>	(410) 543-6944
<b>Garrett</b>	(301) 334-7720	<b>Worcester</b>	(410) 629-0164

- **Apply On-line:** visit [www.marylandhealthconnection.gov](http://www.marylandhealthconnection.gov) or [www.marylandSAIL.org](http://www.marylandSAIL.org)
- **By Mail or Fax:** print an application form from [www.dhr.state.md.us/blog/?p=96](http://www.dhr.state.md.us/blog/?p=96) and mail or fax the form to your local department of social services.
- **In Person:** visit your local department of social services to fill out an application.
- **Call Maryland Health Connection** at 1-855-642-8572 (TTY 1-855-642-8573)