

## Eligibility Verification

Name of Client: \_\_\_\_\_ Renewal Date \_\_\_\_\_

Address \_\_\_\_\_

**The Department of Human Services contract requires documentation of eligibility for the clients we service. Before we can determine your eligibility for transportation we must have these forms filled out completely and returned. This will need to be done every six months.**

**The following are status codes used by the Department of Human Services.**

**Status** (please check one of the following)

\_\_\_\_\_ MX08 – Elderly individuals determined to have long term care needs through a functional assessment completed by the Area Agency on Aging and referred for services by AAA.

\_\_\_\_\_ HX08 – Mentally ill individuals who are returning to the community following inpatient care, who are psychiatrically disabled and homeless or whose functional abilities place them at risk of being homeless; and referred by the Community Support/Case Management Agency designated by the Bureau of Mental Health or Bureau of Children with Special Needs, Department of Mental Health & Mental Retardation.

\_\_\_\_\_ RX08 – Mentally retarded individuals who are referred by the Department of Mental Health & Mental Retardation, Bureau of Mental Retardation case Management System.

\_\_\_\_\_ FX08 – Deaf/Hearing impaired, blind/visually impaired and/or chronically physically disabled individuals.

\_\_\_\_\_ LX08 – Low income individuals who cannot be first identified by one of the above target group definitions.

**Gross monthly earnings** (Before Deductions)

Number of people in household \_\_\_\_\_

List income for household

**SS** \_\_\_\_\_ **SSI** \_\_\_\_\_ **TANF** \_\_\_\_\_ **VET** \_\_\_\_\_

**FS** \_\_\_\_\_ **W** \_\_\_\_\_ **O** \_\_\_\_\_

**W** (Wages)

**TANF** (Temporary Assistance for Needy Families) **FS** (Food stamps)

**SS** (Social Security) **SSI** (Social Security Supplement Income)

**VET** (Veterans pension or disability Payments)

**O** (Other)

Please include verification of earned income and/or unearned income by providing one or more of the following:

**Earned income**

Four or more current, consecutive and complete pay stubs.

W-2 Form

State and/or Federal Income Tax Return

Self employment bookkeeping records

Statement of gross earnings for the past four or more weeks, signed and dated by the employer on company letterhead

Employers Wage record, Employment Security Office records

**Unearned income**

Benefit checks

Support and Alimony payments

Social Security Query Card Response

Social Security District Office verification

Bank Statement

Maine Employment Security Commission/Worker's Compensation/\*Insurance Company verification

Questions please call: WHCA Transportation

Telephone number 1-207-664-2424 or 664-0012, 546-7547

**Signature of Client or  
Authorized Representative** \_\_\_\_\_ **Date** \_\_\_\_\_

**Relationship to Client** \_\_\_\_\_

**Telephone Number** (for facility filling out form) \_\_\_\_\_

## **IMPORTANT INFORMATION – PLEASE READ**

**Important information for all Department of Human Services clients regarding social services provided directly by the Department or through public or private community agencies which provide services under contract to the Department of Human Services.**

### **HEARING RIGHTS**

If you are not satisfied with a decision made regarding your eligibility for or the provision of social services, you have the right to ask for a hearing before the Commissioner of the Department of Human Services or his agent.

If you want an *informal* conference with the Regional Director or Director of the provider agency or his agent you should request it within ten (10) days of the notice of action by contacting the office where you made the application for or received the service.

If you want a *formal* hearing, you must request it by contacting the same office or the commissioner of the Department of Human Services, State House, Augusta, Maine 04333. A request for a formal hearing must be made within thirty (30) days of the effective date of the notice of the action you wish to appeal.

If you request either type of hearing within ten (10) days of the date of the notice regarding your eligibility for or the provision of social services, the proposed action will not go into effect until your appeal has been heard and a decision rendered.

### **CIVIL RIGHTS NOTICE**

If you feel you have been discriminated against because of your race, color, or national origin, you may file a complaint requesting a hearing on this matter with the Regional or the State office of the department of Health, Education, and Welfare, Washington, D.C.

### **REPORTING RESPONSIBILITIES**

**REMEMBER!** It is your responsibility to report to the agency providing the social service to you all changes in your circumstances, which could affect your eligibility for the services. Should you receive benefits to which you are not entitled due to failure to report changes promptly and correctly, you will be expected to repay any benefits for which you are not eligible.

### **FRAUDULENT REPRESENTATION**

*The willing acceptance and/or use of any State or Federal funds under this program for which a person knowingly is not eligible may constitute fraud and subject the user to prosecution under penalty of law.*

**For further information about any of the above, call or write the agency named on the reverse side of this notice.**