



## **MAINECARE APPLICATION INSTRUCTIONS**

**When applying for Mayo Regional Hospital's Financial Assistance Program; your entire household is required to apply for MaineCare every 1- 2 years. You must include a copy of the MaineCare determination letter with your Financial Assistance Application.**

**\*\*\*PLEASE NOTE\*\*\*** If everyone in your household already has a MaineCare determination letter dated within the last 1-2 years, please disregard the MaineCare application, if one is attached. Include those determination letters with Mayo Regional Hospital's completed Financial Assistance Application.

### **To apply for MaineCare use one of the listed methods below:**

- In-person: At your local DHHS office (see partial list below)
- Mail: By using MaineCare Application-submitted directly to DHHS-Farmington  
General Application for MaineCare can be printed out at [www.maine.gov/dhhs/ofi/public-assistance](http://www.maine.gov/dhhs/ofi/public-assistance)
- Online Portal: [www.maine.gov/mymaineconnection](http://www.maine.gov/mymaineconnection) -OR- (Google: "My Maine Connection")
- At Penquis CAP: By using MaineCare Enrollment Kiosk, 50 North Street, Dover-Foxcroft, 207-564-7116
- At Mayo Regional Hospital with Carol Blethen, Patient Financial Counselor, 207-564-1615

**DHHS CALL CENTER: 1-855-797-4357**

### **LOCATIONS OF LOCAL DHHS OFFICES**

Maine DHHS- <u>Bangor</u>	Maine DHHS- <u>Skowhegan</u>
396 Griffin Road	98 North Avenue, Suite 10
Bangor, ME 04401	Skowhegan, ME 04976

### **MAILING ADDRESS FOR ALL MAINECARE APPLICATIONS AND REQUIRED DOCUMENTS**

**\*\*\*DON'T SEND MAINECARE APPLICATION TO MAYO; MAIL DIRECTLY TO DHHS\*\*\***

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

### **FAX NUMBER FOR ALL APPLICATIONS AND REQUIRED DOCUMENTS**

207-778-8429

### **EMAIL ADDRESS FOR ALL REQUIRED DOCUMENTS WHEN USING ONLINE PORTAL**

[farmington.dhhs@maine.gov](mailto:farmington.dhhs@maine.gov)

### **REQUIRED COPIES OF DOCUMENTATION FOR ALL MAINECARE APPLICATIONS**

Photo ID  
Birth Certificate  
Social Security Card  
Verification of Maine residence- Utility Bill  
Most recent 4 weeks of pay stubs  
If self-employed, most recent complete Federal Tax Return

State of Maine  
 Department of Health and Human Services (DHHS)  
 Application For

# MaineCare and Food Supplement Benefits

**MAIL W/ DOCUMENTS TO**



Office of Family Independence  
 State of Maine-DHHS  
 114 Corn Shop Lane  
 Farmington, ME 04938

Application for:

- |  |   |
|--|---|
| <input type="checkbox"/> MaineCare – Full Benefits           | <input type="checkbox"/> Medicare Savings Program Only (Buy In) |
| <input type="checkbox"/> Low Cost Drugs (DEL) / MaineRx Plus | <input type="checkbox"/> Food Supplement Benefits               |
| <input type="checkbox"/> MaineCare Limited Benefits Program  |   |

Do you have a physical or mental health condition that keeps you from working full or part time?  Yes  No

Providing a Social Security number is optional for individuals who are not applying for coverage in any program.

Your name (first, middle initial, last)	Maiden Name	Social Security number	Sex
Birth date (month/day/year)	Place of birth	Your Medicare claim number (if any)	

**Mailing address:**

Street, PO Box, or RR (include apartment number, in care of, etc.)			Is this a safe delivery address? <input type="checkbox"/> Yes <input type="checkbox"/> No
City	State	Zip Code	Phone
If different from your mailing address, give the address where you actually live:			

**You need to answer only the questions for the program(s) you are applying for.**

**For Food Supplement Benefits Only:** To file this application now, we need your name (or that of an authorized representative), address and signature. If eligible, your benefits will begin from the date DHHS gets a signed application.

**You may be eligible for Food Supplement benefits right away:**

- does your monthly income and cash/money in a bank add up to less than your monthly living expense? \_\_\_\_\_
- is your monthly income less than \$150 and cash/money in a bank less than \$100? \_\_\_\_\_
- are you a migrant worker and your income has stopped? \_\_\_\_\_

Social Security numbers are used to do computer matches with I.R.S., BMV, IFW, the Social Security Administration, Department of Labor, other government agencies and private financial institutions. DHHS and federal officials may check with other sources to prove the information you give.

If you give wrong information, you may be charged with giving false information.

I understand the questions on this form. I certify, under penalty of perjury, that all my answers are correct and complete as far as I know, including those concerning citizenship and alien status for each person applying for benefits. I understand DHHS has the right to collect from other available insurance or from settlement(s) for accidents or injuries whenever MaineCare pays for Medical Expenses.

Signature of person applying \_\_\_\_\_ Date \_\_\_\_\_

Signature of person filling out this form \_\_\_\_\_ Date \_\_\_\_\_

If you have someone who knows your situation, and you want us to contact them to help with this application, please complete the following:

Name \_\_\_\_\_ Address \_\_\_\_\_  
 Telephone \_\_\_\_\_

<b>For office use only:</b>	
Received _____	45 <sup>th</sup> day _____
Residency _____	ID _____
Food Supplement Benefit Expedite <input type="checkbox"/> Yes <input type="checkbox"/> No	

**For MaineCare and Food Supplement Benefits**

ARE YOU:	<b>If you live with your spouse:</b>
<input type="checkbox"/> Married	Spouse's name _____ (first, middle initial, last)
<input type="checkbox"/> Widowed	Date of birth _____ Sex _____ Able to work? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Single	(month /day/year)
<input type="checkbox"/> Divorced	Place of birth _____ Maiden name _____
<input type="checkbox"/> Separated	Spouse's Social Security number _____
(Check only one box)	Spouse's Medicare claim number _____

List other people who live with you and their grade in school if applicable:

Last name	First name	Middle Initial	Sex	Birth - date	Social Security Number (Optional if not Requesting Coverage)	Relationship to you	Grade level

Is everyone you are applying for a U.S. citizen?  Yes  No  
 If no, please list their names and Alien Registration Numbers.

\_\_\_\_\_

\_\_\_\_\_

Please list place of birth for each person for whom you are requesting assistance

First Name	Place of Birth	First Name	Place of Birth	First Name	Place of Birth

List *monthly* household income below:

Source	Yourself	Your spouse (who lives with you)	Other family members (please list amount and name of member)
<b>Social Security</b>	\$	\$	\$
<b>SSI</b>	\$	\$	\$
<b>Other Income or Pensions</b> (such as railroad retirement, interest, dividends, etc., please explain)	\$	\$	\$

List household earnings for yourself and your spouse (who lives with you): Please provide the last 4 pay stubs or copies of them (If you are applying for MaineCare only, you are not required to provide verification of earnings at this time, but you may be asked to do so in the future if electronic verification is not possible)

Name	Employer's name and phone number	Gross Amount earned	How often are you paid	Hours worked each week

Is anyone in your household self-employed?  Yes  No If YES, Who? \_\_\_\_\_  
 Source? \_\_\_\_\_ How often? \_\_\_\_\_

Please provide a copy of your most recent tax return or business records.

List assets for yourself and your spouse (who lives with you), including jointly owned assets:

(If you are applying for Food Supplement Benefits, also list the assets of others in your household.)

• Checking or Savings Account • Credit Union Shares • IRA, 401K, Keogh • Certificate of Deposit • Other Accounts • Profit Sharing • Safety Deposit Box • Assets Owned with Others • Stocks • Annuities • Prepaid Burials • Trusts				
Name(s) on account	Type of asset (see above)	Name of bank or institution	Account number	Current balance or value

List life insurance owned by yourself and/or your spouse (who lives with you):

Owner	Company name and address	Face value	Cash value

Do you or anyone in your household own any land, buildings, time shares or jointly held real estate, including where you live? Yes No If YES, list below:

Owner	Type of real estate

Does anyone in your household own any cars, trucks, boats, campers, motorcycles, snowmobiles, ATV's, trailers, tractors, or other motorized vehicles? Yes No If YES, list below:

Year	Make	Model	Owner	Used for	Amount owed

Did you give away anything in the last 3 months? Yes No

Does anyone who is applying have health insurance? Yes Who? \_\_\_\_\_; No

Are you requesting help with medical bills incurred within the last three months?

Yes No Which months? \_\_\_\_\_

Did you or anyone in your household serve in the U. S. military? Yes No

In which branch of the military did you serve? \_\_\_\_\_

When did you serve? (dates) \_\_\_\_\_ to \_\_\_\_\_ Did you serve on foreign soil? Yes No

Are you receiving VA benefits that include payment of prescription drugs? Yes No

If you are applying for medical coverage, please complete the Medicaid Application Supplement pages at the end of this form.

**Estate Recovery:**

If you receive benefits from MaineCare after age 55, and certain conditions exist, the Estate Recovery Program will make a claim against the assets of your estate to recover money MaineCare has paid for your care. Estate assets can include real property, including jointly owned property, insurance payments, annuities, any property left to an heir, survivor or assignee. No claim will be made if the only service you receive is the Medicare Buy-In. For more information about the Estate Recovery Program, call MaineCare Member Services at 1-800-977-6740.

Please complete a section for each person applying for benefits. This information is Voluntary. Your benefits <u>will not be</u> affected if you do not answer.	Applicant	Second Person	Third Person	Fourth Person	Fifth Person
Are you Hispanic or Latino?	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>
Are you an American Indian or Alaskan Native?	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>
Circle the tribe you belong to: 1. Houlton Maliseet 2. Peter Dana Pt. Passamaquoddy 3. Pleasant Point Passamaquoddy 4. Penobscot 5. Aroostook Micmac 6. Other					
Do you live on your tribe's reservation?	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>
Are you Asian?	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>
Are you Black or African American?	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>
Are you Native Hawaiian or Pacific Islander?	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>
Are you White?	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>

**Fill out this section of the form only if you are applying for Food Supplement Benefits**

Please list your shelter costs (do not list past due amounts or security deposits).

Rent _____	How often _____	Electricity _____	How often _____
Mortgage _____	How often _____	Telephone (basic) _____	How often _____
Property taxes _____	How often _____	Cooking fuel _____	How often _____
House insurance _____	How often _____	Water _____	How often _____
Condo fees _____	How often _____	Sewer _____	How often _____
Heat _____	How often _____	Trash collection _____	How often _____

If you rent, is your heat included in your rent? Yes No

If you pay a mortgage, are taxes and insurance included in your payment? Yes No

Has anyone received HEAP fuel assistance since last October? Yes No

Have you moved since last October? Yes No

Have you received help with these expenses from the town or city in the last 6 months? Yes No

Does anyone else help pay part or all of these bills? Yes No

If yes, who has helped you? \_\_\_\_\_

How many people, including yourself, live in your home and purchase and prepare meals with you? \_\_\_\_\_

Is anyone in your household a migrant or seasonal farm worker? Yes No

If anyone in your household is 60 or older or receiving disability benefits, do they pay over \$35/month for their medical expenses, such as health insurance (including Medicare), over the counter or prescription medicines, doctor or dentist bills, hearing aids, eye care, transportation and other medical services? Yes No If yes, please list and provide proof of these expenses.

\_\_\_\_\_

Is anyone you are applying for a foster child, in state custody or a boarder Yes No If yes, who?

\_\_\_\_\_

Are you paying someone to care for a child or disabled adult? Yes No

Who do you pay? \_\_\_\_\_ How much do you pay? \_\_\_\_\_ How often? \_\_\_\_\_

Is anyone on strike? Yes No Who? \_\_\_\_\_

Has anyone committed an Intentional Program Violation for Food Supplement Benefits Yes No Who?

\_\_\_\_\_

Has anyone quit a job in the last 60 days? Yes No Who? \_\_\_\_\_

Does anyone pay child support? Yes No Who? \_\_\_\_\_ How much? \_\_\_\_\_

How often? \_\_\_\_\_ To whom? \_\_\_\_\_ For whom? \_\_\_\_\_

Is any household member fleeing to avoid prosecution or jail for a felony or violation of probation or parole? Yes  
No

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and in some cases religion or political beliefs.

The U.S Department of Agriculture also prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complaint of discrimination with USDA, complete the [USDA Program Discrimination Complaint Form](#), found online at [http://www.ascr.usda.gov/complaint\\_filing\\_cust.html](http://www.ascr.usda.gov/complaint_filing_cust.html), or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at [program.intake@usda.gov](mailto:program.intake@usda.gov).

Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the [State Information/Hotline Numbers](#) (click the link for a listing of hotline numbers by State); found online at [http://www.fns.usda.gov/snap/contact\\_info/hotlines.htm](http://www.fns.usda.gov/snap/contact_info/hotlines.htm).

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (TTY).

USDA and HHS are equal opportunity providers and employers.

## MEDICAID APPLICATION SUPPLEMENT

**COMPLETE THIS SUPPLEMENT FOR YOURSELF, YOUR SPOUSE/PARTNER AND CHILDREN WHO LIVE WITH YOU AND/OR ANYONE ON YOUR SAME FEDERAL INCOME TAX RETURN IF YOU FILE ONE. IF YOU DON'T FILE A TAX RETURN, REMEMBER TO STILL ADD FAMILY MEMBERS WHO LIVE WITH YOU.**

<b>APP LAST NAME:</b>	<b>APP FIRST NAME:</b>	<b>MI:</b>
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### AMERICAN INDIANS AND ALASKA NATIVES

Names of those with Indian Health Service Coverage:

Does Not Receive Indian Health Service Coverage, but is eligible:

### OTHER MEDICAL INSURANCE

**(IF APPLICABLE, LIST THE HOUSEHOLD MEMBERS THAT CURRENTLY RECEIVE HEALTH COVERAGE)**

Name:	Company:
Policy:	Type:

### EMPLOYER INSURANCE

**HOUSEHOLD MEMBERS RECEIVING, OR ELIGIBLE FOR, EMPLOYER SPONSORED HEALTH INSURANCE (NOW OR IN THE NEXT THREE MONTHS) PROVIDING THE SSN IS OPTIONAL FOR PERSONS WHO ARE NOT APPLYING FOR MEDICAL COVERAGE**

Name:	SSN:	Minimal essential coverage?
Date when eligible to enroll:	Monthly premium for lowest-cost plan offered: \$	
Employer Name:	Employer EIN:	
Employer Address:		
Employer Phone:	Employer Email:	
Employer Insurance Name:	Employee Contact Info:	

### TAX INFORMATION, APPLICANT

**(YOU CAN STILL BE ELIGIBLE FOR PROGRAMS EVEN IF YOU DON'T FILE FEDERAL INCOME TAX)**

A. Will you file Income Tax Next Year (if yes, please answer questions A-C; if no, skip to question D:	
B. Will you file jointly with spouse:	Name of spouse:
C. Will you claim dependents on your tax return:	Name of dependent 1:
Name of dependent 2:	Name of dependent 3:
D. Will you be claimed as a dependent on someone's tax return:	Name of filer:

### DEDUCTIONS, APPLICANT

**ENTER AMOUNTS FOR ALL THAT APPLY**

Alimony paid:	How often?	Student loan interest:	How often?
Other deductions:	How often?	Type:	

#### For American Indians and Alaskan Natives Only

Certain money received can be excluded from income; list any money received from these sources: per capita payments from a tribe that comes from natural resources, usage rights, leases or royalties: payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Dept. of Interior; and money from selling things that have cultural significance.

How much received? \$

How often?

#### SIGNATURE:

**I'M SIGNING THIS APPLICATION UNDER PENALTY OF PERJURY WHICH MEANS I'VE PROVIDED TRUE ANSWERS TO ALL THE QUESTIONS ON THIS FORM TO THE BEST OF MY KNOWLEDGE. I KNOW THAT I MAY BE SUBJECT TO PENALTIES UNDER FEDERAL LAW IF I PROVIDE FALSE AND OR UNTRUE INFORMATION.**

Signature of applicant:

Date:

**TAX INFORMATION, NAME OF PERSON #1 WHO LIVES WITH YOU:**

A. Will he/she file Income Tax Next Year (if yes, please answer questions A-C; if no, skip to question D):

B. Will he/she file jointly with spouse: Name of spouse:

C. Will he/she claim dependents on your tax return: Name of dependent 1:

Name of dependent 2: Name of dependent 3:

D. Will he/she be claimed as a dependent on someone's tax return: Name of filer:

Total Income (list next year's total income for this person):

**DEDUCTIONS, PERSON #1 WHO LIVES WITH YOU – ENTER AMOUNTS FOR ALL THAT APPLY**

Alimony paid: How often? Student loan interest: How often?

Other deductions: How often? Type:

**For American Indians and Alaskan Natives Only**

Certain money received can be excluded from income; list any money received from these sources: per capita payments from a tribe that comes from natural resources, usage rights, leases or royalties: payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Dept. of Interior; and money from selling things that have cultural significance.

How much received? \$ How often?

**TAX INFORMATION, NAMES OF PERSON #2 WHO LIVES WITH YOU:**

A. Will he/she file Income Tax Next Year (if yes, please answer questions A-C; if no, skip to question D):

B. Will he/she file jointly with spouse: Name of spouse:

C. Will he/she claim dependents on your tax return: Name of dependent 1:

Name of dependent 2: Name of dependent 3:

D. Will he/she be claimed as a dependent on someone's tax return: Name of filer:

Total Income (list next year's total income for this person):

**DEDUCTIONS, PERSON #2 WHO LIVES WITH YOU - ENTER AMOUNTS FOR ALL THAT APPLY**

Alimony paid: How often? Student loan interest: How often?

Other deductions: How often? Type:

**For American Indians and Alaskan Natives Only**

Certain money received can be excluded from income; list any money received from these sources: per capita payments from a tribe that comes from natural resources, usage rights, leases or royalties: payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Dept. of Interior; and money from selling things that have cultural significance.

How much received? \$ How often?

**TAX INFORMATION, NAME OF PERSON #3 WHO LIVES WITH YOU:**

A. Will he/she file Income Tax Next Year (if yes, please answer questions A-C; if no, skip to question D):

B. Will he/she file jointly with spouse: Name of spouse:

C. Will he/she claim dependents on your tax return: Name of dependent 1:

Name of dependent 2: Name of dependent 3:

D. Will he/she be claimed as a dependent on someone's tax return: Name of filer:

Total Income (list next year's total income for this person):

**DEDUCTIONS, PERSON #3 WHO LIVES WITH YOU - ENTER AMOUNTS FOR ALL THAT APPLY**

Alimony paid: How often? Student loan interest: How often?

Other deductions: How often? Type:

**For American Indians and Alaskan Natives Only**

Certain money received can be excluded from income; list any money received from these sources: per capita payments from a tribe that comes from natural resources, usage rights, leases or royalties: payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Dept. of Interior; and money from selling things that have cultural significance.

How much received? \$ How often?



**TAX INFORMATION, NAME OF PERSON #4 WHO LIVES WITH YOU:**

A. Will he/she file Income Tax Next Year (if yes, please answer questions A-C; if no, skip to question D):

B. Will he/she file jointly with spouse: Name of spouse:

C. Will he/she claim dependents on your tax return: Name of dependent 1:

Name of dependent 2: Name of dependent 3:

D. Will he/she be claimed as a dependent on someone's tax return: Name of filer:

Total Income (list next year's total income for this person):

**DEDUCTIONS, PERSON #4 WHO LIVES WITH YOU - ENTER AMOUNTS FOR ALL THAT APPLY**

Alimony paid: How often? Student loan interest: How often?

Other deductions: How often? Type:

**For American Indians and Alaskan Natives Only**

Certain money received can be excluded from income; list any money received from these sources: per capita payments from a tribe that comes from natural resources, usage rights, leases or royalties: payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Dept. of Interior; and money from selling things that have cultural significance.

How much received? \$ How often?

**TAX INFORMATION, NAME OF PERSON #5 WHO LIVES WITH YOU:**

A. Will he/she file Income Tax Next Year (if yes, please answer questions A-C; if no, skip to question D):

B. Will he/she file jointly with spouse: Name of spouse:

C. Will he/she claim dependents on your tax return: Name of dependent 1:

Name of dependent 2: Name of dependent 3:

D. Will he/she be claimed as a dependent on someone's tax return: Name of filer:

Total Income (list next year's total income for this person):

**DEDUCTIONS, PERSON #5 WHO LIVES WITH YOU - ENTER AMOUNTS FOR ALL THAT APPLY**

Alimony paid: How often? Student loan interest: How often?

Other deductions: How often? Type:

**For American Indians and Alaskan Natives Only**

Certain money received can be excluded from income; list any money received from these sources: per capita payments from a tribe that comes from natural resources, usage rights, leases or royalties: payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Dept. of Interior; and money from selling things that have cultural significance.

How much received? \$ How often?

**TAX INFORMATION, NAME OF PERSON #6 WHO LIVES WITH YOU:**

A. Will he/she file Income Tax Next Year (if yes, please answer questions A-C; if no, skip to question D):

B. Will he/she file jointly with spouse: Name of spouse:

C. Will he/she claim dependents on your tax return: Name of dependent 1:

Name of dependent 2: Name of dependent 3:

D. Will he/she be claimed as a dependent on someone's tax return: Name of filer:

Total Income (list next year's total income for this person):

**DEDUCTIONS, PERSON #6 WHO LIVES WITH YOU - ENTER AMOUNTS FOR ALL THAT APPLY**

Alimony paid: How often? Student loan interest: How often?

Other deductions: How often? Type:

**For American Indians and Alaskan Natives Only**

Certain money received can be excluded from income; list any money received from these sources: per capita payments from a tribe that comes from natural resources, usage rights, leases or royalties: payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Dept. of Interior; and money from selling things that have cultural significance.

How much received? \$ How often?