

**Maryland Medical Assistance Program
Declaration of Unpaid Medical Expenses**

Date _____
Applicant Name _____
Customer Id# _____

Please complete and sign this form and return it with your application for Long Term Care Medicaid. If you have unpaid medical bills, you may be eligible for deductions from your income.

Please check one of the choices below:

If you answer **yes**, please sign below, provide a newly dated, itemized, unpaid medical bill(s) that you incurred up to three months prior to this application. The bill must contain a service date, charge, and a detailed description of the service(s) provided. Attach copies of the bill(s) to the form and submit them with your Long Term Care Medicaid application. (If you do not have the bills at the time you submit the application, the bills may be submitted at a later date during this application process.)

Yes, I Have unpaid medical bills and am sending copies of the bills with this form and my application.

Signed: _____ Applicant

Date: _____

Signed: _____ Authorized Representative

Date: _____

No, I Do Not Have unpaid medical bills at this time.

Signed: _____ Applicant

Date: _____

Signed: _____ Authorized Representative

Date: _____

