Medicare Savings Program (MSP) Application Instructions

Use

~~The information you are providing in~~ this application ~~will be used~~ to see~~determine~~ if you can get help from your~~the~~ state to pay~~will cover~~ your Medicare premiums and/or cost-sharing. This is NOT an application for full Medicaid. If you would like to apply for full Medicaid coverage or need help completing any part of this form, contact your local Medicaid office - https://www.medicaid.gov/about-us/beneficiary-resources/index.html#statemenu

~~costs.~~ There are three types of Medicare Savings Programs (MSPs): ~~Program coverage.~~

Qualified Medicare Beneficiary (QMB): ~~For QMBs,~~ the state pays your~~for~~ Medicare Part A and/or Part B premiums and cost sharing (deductibles, co-insurance and~~,~~ copays). If you qualify for QMB, you ~~enrollment~~ automatically qualify ~~qualifies you~~ for ~~the~~ Extra Help to pay your~~benefit with~~ Medicare Part D drug coverage costs. ~~.~~

Specified Low-Income Medicare Beneficiary (SLMB): ~~For SLMBs,~~ the state pays your~~for~~ Medicare Part B premiums, and you automatically qualify~~qualifies you~~ for ~~the~~ Extra Help to pay your~~benefit with~~ Medicare Part D drug coverage costs. ~~.~~

Qualifying~~Qualified~~ Individual (QI): ~~For QIs,~~ the state pays your~~for~~ Medicare Part B premiums, and you automatically qualify~~qualifies you~~ for ~~the~~ Extra Help to pay your~~benefit with~~ Medicare Part D drug coverage costs.

Your state determines which program(s) you qualify for. If you're approved for an MSP, your Part B premium will no longer be deducted from your Social Security, railroad or Civil Service retirement benefits, and you'll automatically be enrolled in Extra Help to pay your Medicare Part D premiums and cost sharing for covered prescription drugs.

Estate recovery does not apply to any help you get for payment of Medicare premiums or cost-sharing.

What you may need to apply~~How to complete the form:~~

You may need to provide copies of documents to confirm some information, including: ~~Be sure to answer all questions that apply to you. If you need more room to write, you can attach additional pages. Keep a copy of the application for your records. Once you submit the application to your Medicaid agency, they will review it and determine if you are eligible for one of the Medicare Savings Programs. You may need to provide copies of documents to verify:~~

- ~~Proof of residency (such as a rent receipt, utility bill, state issued ID card)~~
- Proof of income (like~~such as~~ retirement or disability benefits or~~,~~ pay stubs)
- Proof of assets (like~~such as~~ bank statements or life insurance policies)
- Proof of insurance (like~~such as~~ Medicare, Medigap or~~,~~ retiree health benefit cards)
- Proof of U.S. citizenship or eligible immigration status (like~~(such as~~ a birth certificate, green card, passport or other documentation from the Department of Homeland Security)
- Proof of residency (like a rent receipt, utility bill or state issued ID card)

How to submit this application

- **Online:**
- **By phone:**
- **By mail:**
- **In person:**

Keep a copy of the application for your records.

What happens~~to expect~~ next?~~:~~

Your Medicaid agency will review your application. You should get a response ~~from the Medicaid agency~~ about your eligibility within 45 days. If you don't~~do not~~ get a response within 45 days, ~~you should~~ contact your Medicaid agency.

Get help with Medicare questions

For questions about your Medicare benefits, contact your local State Health Insurance Assistance Program (SHIP). Find their contact information at ~~If you are approved for a Medicare Savings Program, your Part B premium will no longer be deducted from your Social Security or railroad retirement benefit. You will also be enrolled in the Extra Help benefit with Medicare Part D. If you currently have prescription drug coverage through Medicare, you will see the cost of your monthly premium and prescription copays go down. If you are not currently enrolled in Medicare prescription drug coverage, you will automatically be enrolled into a Medicare Part D drug plan with no monthly premium. Estate recovery does not apply to any help you receive for payment of Medicare premiums, deductibles, or coinsurance through an MSP. If you have questions about your benefits, contact your local State Health Insurance Assistance (SHIP) Program.~~ https://www.shiphelp.org/

Application ~~Template~~ for Medicare Savings Programs ~~Premium and Cost Sharing Assistance~~

Personal Information			
Applicant – List your name as it appears on your Medicare card			
Last name	First name		Middle name
Address where you live	City	State	ZIP code
Mailing address (if different)	City	State	ZIP code
Primary phone:	Alternate phone (optional)~~:~~		
Email address (optional)	Marital status: Single ☐ Married ☐		
Citizenship status: Are you a U.S. citizen? ☐ Yes ☐ No ~~(~~If not, do you have eligible immigration status? ☐ Yes (Please complete the information below)			
Alien number, I-94 number or document ID number and document type	Date ~~of~~ status was granted	Date you entered the U.S.	Country of origin
Are you, or your spouse or parent, a veteran or an active-duty member of the U.S. military? □ Yes □ No			

Is your spouse a U.S. citizen (if applying for an MSP)?? ☐ Yes ☐ No
(If not, do they have eligible immigration status? ☐ Yes (Please complete the information below)

Alien number, I-94 number or document ID number and document type	Date of status was granted	Date you entered the U.S.	Country of origin

Are you, or your spouse or parent, a veteran or an active-duty member of the U.S. military? □ Yes □ No

Household Members

Include your spouse who is living in the same household and relatives living in the same household who are dependent on either you or your spouse for at least half of their financial support. If you need more room to write, attach additional pages.

Name (last, first, middle)	Relationship to you	Date of birth	Applying for MSP benefits?	Social Security number	Sex M, F or other F
	Self		Yes ☐ No ☐		
	Spouse		Yes ☐ No ☐		
	Other (specify)		N/A	Optional	
	Other (specify)		N/A	Optional	

Medicare Coverage Information

Do you have Medicare?		Type of coverage	Medicare Number
Self	Yes ☐ No ☐	Part A ☐ Part B ☐	
Spouse	Yes ☐ No ☐	Part A ☐ Part B ☐	

Other Health Insurance Information

(such as employer, Medigap, Tricare, VA health benefits)

Policy holder	Insurer	Type of insurance	Policy number

Income

List any income you or your spouse receive. Provide the amount of income before any deductions such as taxes or insurance premiums are taken out. Types of income include, but are not limited to:

- Social Security Benefits
- Supplemental Security Income (SSI)
- Railroad Benefits
- Civil Service Retirement~~Veterans~~ Benefits
- Public Assistance
- Unemployment Insurance
- Workers Compensation
- Veterans Benefits~~Pensions/Retirement~~
- Wages from a job
- Self-Employment
- Commissions
- Dividends and Interest
- Alimony Payment
- Rental Income

Recipient Name	Type of income (such as employer or Social Security)	How much do you receive?	How often is it received? (weekly, every two weeks, monthly)
		$	
		$	
		$	
		$	
		$	
		$	
		$	

Assets

If you or your spouse has assets, list the type of asset, who owns the asset and if the asset is owned individually or jointly. Assets include, but are not limited to:

- Cash
- Checking Account
- Savings Account
- Money Market Accounts
- Mutual Funds
- Savings Bonds
- Stocks
- Certificates of Deposit (CD)
- Individual Retirement Accounts (IRAs)
- Burial Funds
- Real Property (excluding primary residence)

Type of asset	Name of owner(s)	Ownership	Current value
		Individual □ Joint □	$
		Individual □ Joint □	$
		Individual □ Joint □	$

		Individual □ Joint □	$
		Individual □ Joint □	$
		Individual □ Joint □	$
		Individual □ Joint □	$
		Individual □ Joint □	$

Do you or your spouse own any vehicles (car, truck, boat, motor home, motorcycle, camper, and/or trailer)? If yes, please list below and indicate which is your primary vehicle:

Name of owner(s)	Ownership	Type of vehicle	Year	Make/Model	Value	Amount owed
	Individual □ Joint □				$	$
	Individual □ Joint □				$	$
	Individual □ Joint □				$	$
	Individual □ Joint □				$	$

Do you or your spouse have a whole life insurance policy with a cash value above $1,500? If yes, please list below:

Policy owner	Name of insurance company/policy number	Individual(s) covered	Face value	Cash value
			$	$
			$	$

~~If you have questions about the Medicare Savings Programs or would like help completing the application, contact your local State Health Insurance Assistance Program (SHIP) to connect with a counselor, https://www.shiphelp.org/~~

Read Carefully Before Signing

I understand that:

- I must report ~~immediately to the Medicaid agency~~ any changes in my situation to the Medicaid agency right away.~~.~~ Late reporting may cause incorrect benefits.
- My situation is subject to verification by the Medicaid agency or other state or federal agencies.
- The Medicaid agency may ~~later~~ ask me to show~~provide~~ proof if I'm~~I am~~ eligible for help. The Medicaid agency may help me get~~obtain~~ the proof or contact other people~~persons~~ or agencies for it.
- By asking for and receiving medical care benefits, I assign to the state all rights to any medical support and to any third-party payments for medical care.
- If I'm~~I am~~ found eligible for a Medicare Savings Program, I will **not** be subject to estate recovery for any help I get to pay my~~receive for payment of~~ Medicare premiums, deductibles or coinsurance.

You'll get an Eligibility Notice in the mail after we process your application. If you don't agree with what you qualify for, in many cases, you can ask for an appeal. Review your Eligibility Notice to find appeals instructions specific to each person in your household who applies for coverage, including how many days you have to request an appeal. Here's important information to consider when requesting an appeal:

• You can have someone request or participate in your appeal if you want to. That person can be a friend, relative, lawyer, or other individual. Or, you can request and participate in your appeal on your own.

• If you request an appeal, you may be able to keep your eligibility for coverage while your appeal is pending.

To ask for an appeal, call us at 1-800-XXX-XXXX (TTY: 1-800-XXX-XXXX). Or, go to [medicaid.state.gov] to get an appeals form. Or, you can write your own letter and send or bring it to us at the State Medicaid Agency, 321 Any Road, Any City, Any State 00100.

Declaration and Signatures

I have read and understood the information in this application. I declare, under penalty of perjury, the information I have given in this application is true, correct, and complete to the best of my knowledge.

Applicant/representative signature:	Date:
Spouse signature (if applicable):	Date:

Representative name:	Representative phone number:	Relationship to applicant:
Representative mailing address:		