

Medicare Savings Program (MSP) Application Instructions

Use this application to see if you can get help from your state to pay 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>

There are three types of Medicare Savings Programs (MSPs):

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

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

Qualifying Individual (QI): the state pays your Medicare Part B premiums, and you automatically qualify for Extra Help to pay your 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

You may need to provide copies of documents to confirm some information, including:

- Proof of income (like retirement or disability benefits or pay stubs)
- Proof of assets (like bank statements or life insurance policies)
- Proof of insurance (like Medicare, Medigap or retiree health benefit cards)
- Proof of U.S. citizenship or eligible immigration status (like 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 next?

Your Medicaid agency will review your application. You should get a response about your eligibility within 45 days. If you don't get a response within 45 days, 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 <https://www.shiphelp.org/>

Application for Medicare Savings Programs

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 <input type="checkbox"/> Married <input type="checkbox"/>			
Citizenship status: Are you a U.S. citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, do you have eligible immigration status? <input type="checkbox"/> Yes (Please complete the information below)					
Alien number, I-94 number or document ID number and document type		Date 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? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is your spouse a U.S. citizen (if applying for an MSP)? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, do they have eligible immigration status? <input type="checkbox"/> Yes (Please complete the information below)					
Alien number, I-94 number or document ID number and document type		Date 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? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Household Members					
Include your spouse who is living in the same household and relatives living in the same household who are <u>dependent on either you or your spouse for at least half of their financial support</u> . 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
	Self		Yes <input type="checkbox"/> No <input type="checkbox"/>		
	Spouse		Yes <input type="checkbox"/> No <input type="checkbox"/>		
	Other (specify)		N/A	Optional	
	Other (specify)		N/A	Optional	

Medicare Coverage Information	
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Do you have Medicare?		Type of coverage	Medicare Number
Self	Yes <input type="checkbox"/> No <input type="checkbox"/>	Part A <input type="checkbox"/>	
		Part B <input type="checkbox"/>	
Spouse	Yes <input type="checkbox"/> No <input type="checkbox"/>	Part A <input type="checkbox"/>	
		Part B <input type="checkbox"/>	

Other Health Insurance Information

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

Policy holder	Insurer	Type of insurance	Policy number

Income	
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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 Benefits
- Public Assistance
- Unemployment Insurance
- Workers Compensation
- Veterans Benefits
- Alimony Payment
- Wages from a job
- Self-Employment
- Commissions
- Dividends and Interest
- Rental Income

[illegible]

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 <input type="checkbox"/> Joint <input type="checkbox"/>	\$
		Individual <input type="checkbox"/> Joint <input type="checkbox"/>	\$
		Individual <input type="checkbox"/> Joint <input type="checkbox"/>	\$
		Individual <input type="checkbox"/> Joint <input type="checkbox"/>	\$
		Individual <input type="checkbox"/> Joint <input type="checkbox"/>	\$
		Individual <input type="checkbox"/> Joint <input type="checkbox"/>	\$
		Individual <input type="checkbox"/> Joint <input type="checkbox"/>	\$
		Individual <input type="checkbox"/> Joint <input type="checkbox"/>	\$

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 <input type="checkbox"/> Joint <input type="checkbox"/>				\$	\$
	Individual <input type="checkbox"/> Joint <input type="checkbox"/>				\$	\$
	Individual <input type="checkbox"/> Joint <input type="checkbox"/>				\$	\$
	Individual <input type="checkbox"/> Joint <input type="checkbox"/>				\$	\$

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
			\$	\$
			\$	\$

Read Carefully Before Signing

I understand that:

- I must report 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 ask me to show proof if I'm eligible for help. The Medicaid agency may help me get the proof or contact other people 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 found eligible for a Medicare Savings Program, I will **not** be subject to estate recovery for any help I get to pay my 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: