[State Name] Application for Medicare Savings Programs for Beneficiaries (Dual Eligibles)

1. INSTRUCTIONS:

These programs may help pay all or part of your Medicare costs. However, this is **NOT** an application for full Medicaid, cash assistance, or food stamps. If you want to apply for these programs, contact your county department of human services. This application **CAN** be used for a single person or a couple (self and spouse). Read the application carefully and follow all instructions given throughout the form.

1. Answer each question the best you can. Attach additional pages if needed.
2. Include copies of all documents. **Do not send original documents.**
3. **Sign and date the application.**
4. Mail the application to:

5. An interview in-person is not required for these Medicare Savings Programs.

AGENCY USE ONLY

Case No. __________

Date Received __________

Date Registered __________

Worker __________

2. PERSONAL INFORMATION:

Name (First, Middle Initial, Last)	**You may have a friend, relative, or someone else help you complete this application. If someone else is completing this form, provide the following information for the individual completing the form.**
Birthdate Sex Race Marital Status	
Social Security Number U.S. Citizen ☐Yes ☐No	Name (First, Middle Initial, Last)
Street Address	Street Address
City State Zip	City State Zip
Phone County	Phone
Nursing Facility (if applicable)	Relationship to Individual

3. INFORMATION ON SPOUSE: Complete this information even if not applying for spouse.

Spouse's Name	Birthdate	Sex	Race	U.S. Citizen	Social Security Number (Optional, if spouse is not applying.)
				☐Yes ☐No	

Address of Spouse if Different from Applicant:

Are you applying for Medicare savings for your spouse, too? ☐Yes ☐No

4. LIVING ARRANGEMENT: Check the one box (☐) that describes current living situation.

	Own Home	Renting	Nursing Facility	In Other's Home	Hospital	Other (example: shelter)
Self	☐	☐	Date Admitted:	☐	Date Admitted:	Describe:
Spouse	☐	☐	Date Admitted:	☐	Date Admitted:	Describe:

5. INCOME AND EARNINGS:

List all types of earnings and income that you or your spouse receive. List the income amount before deductions (such as taxes or insurance) are taken out. Include proof of all income (check stub, benefit letter, etc.), **do not send original documents**. Examples of income include:

* Social Security
* SSI
* Wages/ Self-Employment
* Railroad Retirement Benefits
* Veterans' Benefits
* Trust or Annuity Payments
* Pensions/ Retirement Benefits
* Rental Income
* Oil Royalties/ Mineral Rights

Who Receives Income (Name)?	Type of Income	Employer or Source of Income	Amount	How Often Received?	ID Number (if applicable)

6. RESOURCES:

Do you or your spouse own or co-own any of the following? Include any accounts or properties on which you or your spouse's name(s) appear. Include verification (such as **copies, not originals**, of past 3 bank statements, trust funds, etc.) of all resources.

Do you, or your spouse, have any of the following resources?

Checking account	☐Yes	☐No	Funeral plans/ burial arrangements	☐Yes	☐No
Savings account	☐Yes	☐No	Burial plots	☐Yes	☐No
Government bonds	☐Yes	☐No	Stocks and bonds	☐Yes	☐No
Trust funds	☐Yes	☐No	Certificate of Deposits	☐Yes	☐No
Savings Bonds	☐Yes	☐No	Other (e.g. IRAs, etc.)	☐Yes	☐No

If you answered yes to any of these questions, describe below. Attach additional pages if necessary.

Type of Resource	Account/ Policy Number	Value	Name of Bank, Insurance Company, Etc.

7. LIFE INSURANCE:

Do you, or your spouse, have a life insurance policy? ☐Yes ☐No

If yes, please complete the following information and attach a **copy** of the policy:

Policy Owner	Insurance Company	Policy Number	Face Value	Cash Value

8. PROPERTY:

Do you own all or part of any real estate in which you do not live? ☐**Yes** ☐**No**

If yes, please complete the following for each piece of real estate and attach proof **(copies)** of ownership and current value. **Do not list the house in which you live.**

Address	Value	Amount Owed

Do you, or your spouse, own or co-own a car, truck, motorcycle, boat, trailer, or other vehicle?
☐**Yes** ☐**No**

If yes, please complete the following information about each vehicle:

Owner(s)	Year	Make	Model	Value	Amount Owed

9. INFORMATION ON MEDICARE:

Attach **copies** (front and back) of Medicare card(s) if you, or your spouse, have Medicare.

Do you have Medicare? ☐Yes ☐No	Type of Coverage **(Check Each Box that Applies)** ☐ Part A ☐ Part B	Effective Date	Medicare ID Number
Does your spouse have Medicare? ☐Yes ☐No	Type of Coverage **(Check Each Box that Applies)** ☐ Part A ☐ Part B	Effective Date	Medicare ID Number

10. INFORMATION ON OTHER INSURANCE:

Do you have other health insurance? ☐**Yes** ☐**No**

Does your spouse have other health insurance? ☐**Yes** ☐**No**

If you, or your spouse, have other insurance, please complete the following information and attach a **copy** (front and back) of insurance card(s):

	Health Insurance Company Name **and** Company Address	Annual Premium	Type of Coverage (Hospital, Medigap, RX)	Effective Date	ID Number
Self		$			
Spouse		$			

PRIVACY STATEMENT:

Federal and state laws and regulations limit the use and disclosure of confidential information concerning applicants and recipients of all agency programs to purposes directly related to the administration of these programs.

ASSIGNMENT OF RIGHTS OF PAYMENT FOR MEDICAL SUPPORT AND OTHER MEDICAL CARE:

(If you are applying on behalf of another individual and do not have the power to execute an assignment for that individual, the individual will need to execute an assignment of the rights described below, as a condition of his or her eligibility for the benefits covered by this application.) As a condition of my eligibility, I assign to the state any rights to medical support and to payment for medical care from any third party. I agree to cooperate with the state in identifying and providing information to assist the state in pursuing any third party who may be liable to pay for care and services. I understand that I must report any payments received for medical care within ten days.

APPLICANT'S STATEMENT OF UNDERSTANDING AND AGREEMENT:

I understand that, by signing this application, I am agreeing to a full investigation or review of my eligibility by state and/or federal officials. This may include inquiries of employers, medical providers, financial institutions, and other business and professional persons and review of any agency records. I also agree that my application authorizes these agencies to release to this agency the information needed to determine my eligibility. I agree to provide the documents necessary to establish eligibility. If documents are not available, I agree to give the name of the person or organization from which this agency may obtain the necessary proof.

I understand that each individual who receives assistance must provide or apply for a Social Security Number. I authorize the use of my (our) Social Security Number for such purposes as identification, program reviews or audits, and computer matching with other agencies and institutions such as banks, saving and loan associations, and other government agencies, including Internal Revenue Service, to verify eligibility for assistance.

I understand that my application will be considered without regard to race, color, sex, age, handicap, religion, national origin, or political belief. I understand that I may request a fair hearing if I disagree with an agency decision in my case and that I may be represented by any person I choose.

I certify that I (or if filing for my spouse, my spouse and I) am a U.S. citizen, national, or alien in qualified alien status. If this application is being filed on behalf of another individual or individuals, the actual applicant(s) will need to make this certification.

APPLICANT(S) OR REPRESENTATIVE MUST READ AND SIGN:

State and federal law provide for fine, imprisonment, or both for any person who withholds or gives false information to obtain assistance to which he is not entitled. I understand the questions on this application and I certify, under penalty of perjury, that the information given by me on this form is correct and complete to the best of my knowledge. I agree to notify this agency of changes in my income, resources, or living arrangements, which might affect my right to receive assistance.

Signature of Applicant or Representative:	**Date:**
Signature of Applicant's Spouse:	**Date:**