Social Security Administration Review Of Your Eligibility For Extra Help

We must review your eligibility for extra help with Medicare Prescription Drug plan costs. We will check to be sure that you are still eligible and that your extra help, also known as the subsidy, is correct. We want to make this review as simple as possible for you, so you will not need to visit the office.

What We Will Do To Review Your Case

As part of the review, we will look at current information in our records. Your continued eligibility is determined by the amount of your income, resources and household size. If you have a spouse and you are living together, your total income and resources count.

What You Need To Do For This Review

- Please complete the enclosed form; do not use the form on the Internet website.
- Refer to the *Income and Resources Summary* on the back of this letter when completing the form.
- Sign and return the form in the enclosed envelope within 30 days.

If You Do Not Return This Form

If you do not return this form within 30 days, your help with Medicare Prescription Drug plan costs will be terminated. If you are waiting for information from another agency or need assistance, you may call Social Security toll-free at **1-800-772-1213** (TTY **1-800-325-0778**). If you do need assistance, we can give you an additional 30 days to return the form to us.

Regional Commissioner

Enclosures

Social Security Administration
Income and Resources Summary

Name XXX-XX-9999
Spouse Name XXX-XX-9999

Refer to these figures when completing the enclosed form (SSA-1026):

Resources (see question 5)	**Value**
Bank accounts	$
Stocks, bonds or other investments	$
Cash	$
Cash value of life insurance	$
Value of real estate other than your home	$

Household Size (see question 7) .....

Help with Household Expenses (see question 8)	**Monthly Amount**
Help With Household Expenses	$

Income Not From Work (see question 9)	**Monthly Amount**
Social Security benefits (before deductions)	$
Railroad Retirement benefits (before deductions)	$
Veteran's benefits (before deductions)	$
Other pensions or annuities	$
Other income	$

Earned Income (see question 10)	**Annual Amount**
Wages (before deductions)	
Yours	$
Your spouse's	$
Net earnings from self-employment	
Yours	$
Your spouse's	$
Net loss from self-employment	
Yours	$
Your spouse's	$

Disability Or Blind Work Expenses (see question 11)	**Monthly Amount**
Disability work expenses	$
Blind work expenses	$

KEEP THIS PAGE FOR YOUR RECORDS

Statement for Continuing Eligibility for Extra Help with Medicare Prescription Drug Plan Costs

Please go to the next page

Instructions for Completing the Statement for Continuing Eligibility for Extra Help with Medicare Prescription Drug Plan Costs

To Provide Extra Help in Paying for Your Drug Expenses

How To Complete This Form

- Refer to the *Income and Resources Summary* on the back of the enclosed letter when completing this form;
- Use **BLACK INK** or a **#2 pencil**;
- Keep your numbers, Xs and letters inside the boxes; use only **CAPITAL** letters;
- Do not use dollar signs when entering money amounts. The dollar sign is preprinted; and
- Cents can be rounded to the nearest whole dollar.

EXAMPLE

Put an X in the box. DO NOT fill in or use check marks in boxes.

EXAMPLE

Use capital letters when entering answers

A	B	C	D

If You Are Assisting Someone Else With This Form

Answer the questions as if that person were completing the form. You must know that person's Social Security number and financial information. Also, complete Section B on page 6.

Completing Your Form

Please use the enclosed pre-addressed stamped envelope to return your completed and signed form to:

Social Security Administration
Wilkes-Barre Data Operations Center
P.O. Box 1080
Wilkes-Barre, PA 18767

The *Income and Resources Summary* sheet on the back of the enclosed letter will assist you in completing this form. **Do not include** the *Income and Resources Summary* sheet or any attachments when you return the form in the enclosed postage-paid envelope. If we need more information, such as statements from financial institutions, we will contact you.

If You Have Questions Or Need Help Completing This Form

You can call us toll-free at **1-800-772-1213**, or if you are deaf or hard of hearing, you may call our TTY number, **1-800-325-0778**.

Form Approved
OMB No. 0960-0723

Statement for Continuing Eligibility for Extra Help with Medicare Prescription Drug Plan Costs

THIS DOES NOT ENROLL YOU IN THE MEDICARE PRESCRIPTION DRUG PROGRAM.

FOR OFFICIAL USE ONLY

State Code: ☐☐ WBDOC Exception: ☐

1. Name (Print each letter in a separate box.)

FIRST NAME **MI**

LAST NAME **SUFFIX (Jr., Sr., etc.)**

SOCIAL SECURITY NUMBER **DATE OF BIRTH (MM - DD - YYYY)**

MEDICARE CLAIM NUMBER
(This number is printed on your Medicare card)

EXAMPLE

For January- September put a zero (0) in the first box. May 20, 1935 should read: 0 5 2 0 1 9 3 5 (M M D D Y Y Y Y)

2. Spouse's Name **(if you are married and living together)**

FIRST NAME **MI**

LAST NAME **SUFFIX (Jr., Sr., etc.)**

SPOUSE'S SOCIAL SECURITY NUMBER **SPOUSE'S DATE OF BIRTH (MM - DD - YYYY)**

SPOUSE'S MEDICARE CLAIM NUMBER

3. If your marital status has **not** changed or you already reported the change to us, go to question 4.

If your marital status **has** changed and you did not report it to us, what is your current marital status?

☐ Married (living together) ☐ Divorced/Widowed/Separated/Annulled

4. If **all** of the information on the *Income and Resources Summary* is correct, place an **X** in the red box and go to question 12 on page 5, sign and return this form.

☐

If **any** of the information on the *Income and Resources Summary* is **incorrect**, continue to question 5.

5. We need to know about **resources** that you, your spouse (if married and living together) or both of you have.
Instructions: Please look at the information we have about your resources on the *Income and Resources Summary* on the back of the enclosed letter.

If the information has **not** changed, place an **X** in the red box and go to question 6. ☐

If the information **has** changed, fill in the new amount in the boxes below.

Type of Resource	**The Correct Amount Is**
Bank accounts (checking, savings and certificates of deposit)	$ ☐☐☐,☐☐☐.☐☐
Stocks, bonds, savings bonds, mutual funds, Individual Retirement Accounts or other similar investments	$ ☐☐☐,☐☐☐.☐☐
Cash	$ ☐☐☐,☐☐☐.☐☐
Cash value of life insurance	$ ☐☐☐,☐☐☐.☐☐
Value of real estate other than your home	$ ☐☐☐,☐☐☐.☐☐

6. Do you expect to use money from any sources listed in question 5 to pay for funeral or burial expenses for yourself (or your spouse, if married and living together)?

YOU: ☐ **YES** ☐ **NO**

SPOUSE (if living together): ☐ **YES** ☐ **NO**

7. Your **household size** may affect the amount of help you can get. We need to know how many relatives live with you and your spouse (if married and living together) for whom you or your spouse provide at least one-half of their financial support. Relatives may include anyone related to you by blood, marriage or adoption.
Instructions: Please look at the information we have about your household size on the *Income and Resources Summary* on the back of the enclosed letter.

If the information has **not** changed, place an **X** in the red box and go to question 8. ☐

If the number of these relatives **has** changed, how many relatives live with you now?
Place an **X** in only one box below. If you live alone or only with your spouse check **NONE**.

☐ **NONE** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9 or more**

8. We need to know about **help with household expenses** that you, your spouse (if married and living together) or both of you receive. Help with household expenses is when anyone provides or helps you pay for any of the following: food, mortgage, rent, heating fuel or gas, electricity, water and property taxes. (It does not include food stamps, house repairs, help from a housing agency, an energy assistance program, Meals on Wheels or help with medical treatment and drugs.)

Instructions: Please look at the information we have about help you received with household expenses on the *Income and Resources Summary* on the back of the enclosed letter.

If the amount you receive is the **same** as the amount on the *Summary*, place an **X** in the red box.

☐

If the amount you receive is **more** than the amount on the *Summary*, place an **X** in the red box.

☐

If the amount you receive is **less** than the amount on the *Summary*, place an **X** in the red box.

☐

9. We need to know about **income not from work** that you, your spouse (if married and living together) or both of you have from any of the sources listed below.

Instructions: Please look at the information we have about your income not from work on the *Income and Resources Summary* on the back of the enclosed letter.

If the information has **not** changed, place an **X** in the red box and go to question 10.

☐

If the information **has** changed, fill in the new amount in the boxes below.

	The Correct Monthly Amount Is
Social Security benefits (before deductions)	$ ☐☐,☐☐☐.☐☐
Railroad Retirement benefits (before deductions)	$ ☐☐,☐☐☐.☐☐
Veteran's benefits (before deductions)	$ ☐☐,☐☐☐.☐☐
Other pensions or annuities (Do not include money you receive from any item listed in question 5.)	$ ☐☐,☐☐☐.☐☐
Other income	$ ☐☐,☐☐☐.☐☐

10. We need to know about **annual earned income** from work that you, your spouse (if married and living together) or both of you have.

Instructions: Please look at the information we have about your earned income on the *Income and Resources Summary* on the back of the enclosed letter.

If the information has **not** changed, place an **X** in the red box and go to question 11.

☐

If the information **has** changed, fill in the new amount in the boxes below.

Type of Earned Income		The Correct Annual Amount Is
Wages	You	$ ☐☐☐,☐☐☐.☐☐
	Your Spouse	$ ☐☐☐,☐☐☐.☐☐
Net earnings from self-employment	You	$ ☐☐☐,☐☐☐.☐☐
	Your Spouse	$ ☐☐☐,☐☐☐.☐☐
Net loss from self-employment	You	$ ☐☐☐,☐☐☐.☐☐
	Your Spouse	$ ☐☐☐,☐☐☐.☐☐

11. Do you, your spouse (if married and living together) or both have to pay for things that enable you to work (also known as **disability or blind work expenses**)? We will count only a part of your earnings toward the income limit if you work and receive Social Security benefits based on a disability or blindness and you have work-related expenses for which you are not reimbursed. Examples of such expenses are: the costs of medical treatment and drugs for AIDS, cancer, depression or epilepsy; a wheelchair; personal attendant services; vehicle modifications, driver assistance or other special work-related transportation needs; work-related assistive technology; guide dog expenses; sensory and visual aids; and Braille translations.

YOU: ☐ **YES** ☐ **NO** **SPOUSE (if living together):** ☐ **YES** ☐ **NO**

12. If you or your spouse (if married and living together) work and plan to stop working, enter month and year. Otherwise sign the form on page 6 and return it to us.

EXAMPLE

For January – September, put a zero (0) in the first box. May 2006 should read: 0 5 (M M) 2 0 0 6 (Y Y Y Y)

YOU: ☐☐ – 2 0 ☐☐ (M M) (Y Y Y Y)

YOUR SPOUSE: ☐☐ – 2 0 ☐☐ (M M) (Y Y Y Y)

Signatures

IMPORTANT INFORMATION - PLEASE READ CAREFULLY

I/We understand that the Social Security Administration (SSA) will check my/our statements and compare its records with records from Federal, State, and local government agencies, including the Internal Revenue Service (IRS) to make sure the determination is correct.

By submitting this application, I am/we are authorizing SSA to obtain and disclose information related to my/our income, resources, and assets, foreign and domestic, consistent with applicable privacy laws. This information may include, but is not limited to, information about my/our wages, account balances, investments, insurance policies, benefits, and pensions.

I/We declare under penalty of perjury that I/we have examined all the information on this form and it is true and correct to the best of my/our knowledge.

Please complete Section A. If you cannot sign, a representative may sign for you. If someone assisted you, complete Section B as well.

Section A

Your Signature:	Date:	Phone Number: ( ) —
Spouse's Signature:	Date:	
Your Mailing Address:		Apt. #:
City:	State:	Zip Code:

If you changed your mailing address within the last three months, place an **X** in the red box: ☐

If you would prefer that we contact someone else if we have additional questions, please provide the person's name and a daytime phone number.

Print First Name:	Print Last Name:	Phone Number: ( ) —

Section B

If you are assisting someone else, place an **X** in the red box that describes who you are and provide your daytime phone number and address.

☐ Family Member ☐ Attorney ☐ Other Advocate ☐ Other Specify: _____

☐ Friend ☐ Agency ☐ Social Worker _____

Print First Name:	Print Last Name:	Phone Number: ( ) —
Address:		Apt. #:
City:	State:	Zip Code:

Privacy Act / Paperwork Reduction Notice

Section 1860 D-14 of the *Social Security Act* authorizes the collection of information requested on this form. The information you provide will be used to enable the Social Security Administration (SSA) to determine if you continue to be eligible for help paying your share of the cost of a Medicare Prescription Drug Plan. You do not have to give us the information requested. However, failure to provide all or part of the information could prevent an accurate and timely decision on your continuing eligibility for benefits and could result in the loss of your extra help with Medicare Prescription Drug plan costs. We may provide information collected on this form to another Federal, State, or local government agency to assist us in determining your eligibility for the subsidy or if a Federal law requires the release of the information. We also may need to share the information with other SSA programs if SSA needs to determine your eligibility in those programs.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it. Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

Paperwork Reduction Act Statement — This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the *Paperwork Reduction Act of 1995*. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 20 minutes to read the instructions, gather the facts, and answer the questions. You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. **Send only comments relating to our time estimate to this address, not the completed form.**

SEND THE COMPLETED FORM TO US AT THE ADDRESS SHOWN ON THE ENCLOSED PRE-ADDRESSED, POSTAGE-PAID ENVELOPE:

Social Security Administration
Wilkes-Barre Data Operations Center
P.O. Box 1080
Wilkes-Barre, PA 18767