Social Security Administration
Important Information

You may be eligible to get extra help paying for your prescription drugs.

The Medicare Prescription Drug program gives you a choice of prescription plans that offer various types of coverage.

You may be able to get extra help to pay for the monthly premiums, annual deductibles, and co-payments related to the Medicare Prescription Drug program.

But before we can help you, **you must fill out the application, put it in the enclosed envelope and mail it today.** Or you may complete an online application at **www.socialsecurity.gov**. We will review your application and send you a letter to let you know if you qualify for extra help. To use the extra help, you must enroll in a Medicare Prescription Drug plan.

If you need help completing the application, call Social Security at **1-800-772-1213** (TTY **1-800-325-0778**). You can find more information at **www.socialsecurity.gov**.

If you need information about Medicare Prescription Drug plans or how to enroll in a plan, call 1-800-MEDICARE (TTY 1-877-486-2048) or visit **www.medicare.gov**.

Mail your application today. We will give you a decision about whether you qualify for the extra help.

Michael J. Astrue
Commissioner

General Instructions for Completing the Application for Help with Medicare Prescription Drug Plan Costs

Do you or the person you are helping apply have Medicare and Supplemental Security Income (SSI) or Medicare and Medicaid?

If the answer is **YES, do not complete this application because you automatically will get the extra help.**

Does your state Medicaid program pay your Medicare premiums because you belong to a Medicare Savings Program?

If the answer is **YES, contact your state Medicaid office for more information. You could get the extra help automatically and may not need to complete this application.**

How To Complete This Application

- Use **BLACK INK** only;
- **Keep your numbers, letters and Xs inside the boxes; use only CAPITAL letters;**
- Do not add any handwritten comments on the application;
- Do not use dollar signs when entering money amounts; and
- Cents can be rounded to the nearest whole dollar.

EXAMPLE

Place 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 Application

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

Completing Your Application

You may complete the online application at **www.socialsecurity.gov** or use the enclosed pre-addressed stamped envelope to return your completed and signed application to:

Social Security Administration
Wilkes-Barre Data Operations Center
P.O. Box 1020
Wilkes-Barre, PA 18767-9910

Return this application package in the enclosed envelope. Do not include anything else in the envelope. If we need more information, we will contact you.

If You Have Questions Or Need Help Completing This Application

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**.

DRAFT 7/23/07

Form Approved
OMB No. 0960-0696

Application for Help with Medicare Prescription Drug Plan Costs

THIS DOES NOT ENROLL YOU IN A MEDICARE PRESCRIPTION DRUG PLAN.

FOR OFFICIAL USE ONLY

State code: ☐☐ WBDOC Exception: ☐

1. Applicant's Name: Print name **as it appears on your Social Security card**. Use one box for each letter.

FIRST NAME **MI**

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

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

2. If you are **married and living with your spouse**, please provide the following information **as it appears on your spouse's Social Security card**. If you are not currently married or do not live with your spouse, skip to question 3 and do not include any information about your spouse on this application.

FIRST NAME **MI**

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

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

If your spouse has Medicare, does he or she also wish to apply for the extra help? ☐ **YES** ☐ **NO**

3. If you are married and living with your spouse, do you have savings, investments or real estate worth more than $23,410? If not married or you don't live with your spouse, do you have savings, investments or real estate worth more than $11,710? **DO NOT include the home you live in, vehicles, personal possessions, burial plots or irrevocable burial contracts.**

☐ **YES** If you place an ☒ in the **YES** box, **STOP**. You are not eligible for the extra help and you do not need to return this application to us. If you need a letter stating you are not eligible, sign the application on page 6 and return it to us.

☐ **NO or NOT SURE** If you place an ☒ in the **NO or NOT SURE** box, complete the rest of this application and return it to us.

DRAFT 7/23/07

If you placed an X in the NO or NOT SURE box in question 3, answer all of the following questions. If you are married and living with your spouse, you must answer all of the questions for both of you.

4. Please enter the money amounts of all bank accounts, investments or cash that either you, your spouse, if married and living together, or both of you own in the boxes below. Include items that either of you own with another person. Include only the dollar figures, not the account number. If you or your spouse do not own an item listed, either separately, jointly or with another person, place an X in the **NONE** box.

• Combined total of all bank accounts (checking, savings and certificates of deposit)	☐ **NONE**	$ ☐☐☐ , ☐☐☐ . ☐☐
• Combined total of all stocks, bonds, savings bonds, mutual funds, Individual Retirement Accounts or other similar investments	☐ **NONE**	$ ☐☐☐ , ☐☐☐ . ☐☐
• Any other cash at home or anywhere else	☐ **NONE**	$ ☐☐☐ , ☐☐☐ . ☐☐

5. Do you own life insurance policies with a total face value of more than $1,500? Answer for you and your spouse if your spouse lives with you.
If you answer **NO** for both you and your spouse, go to question 6.

YOU: ☐ **YES** ☐ **NO**

SPOUSE: ☐ **YES** ☐ **NO**

If you answered **YES** for either of you, how much money would you get if you turned in your policies for cash right now? Enter the amount. If you answered **YES** for both you and your spouse, enter the combined amount. This is not the face value of your policies. You may need to call your insurance company to help answer this question.

$ ☐☐☐ , ☐☐☐ . ☐☐

6. Will some money from the sources listed in **questions 4 and 5** be used to pay for funeral or burial expenses? **If YES, skip to question 7.**
If **NO**, place an X in the **NO** box, then go to question 7.

YOU: ☐ **NO**

SPOUSE: ☐ **NO**

7. Other than your home and the property on which it is located, do you or your spouse, if married and living together, own any real estate? Examples of other real estate are summer homes, rental properties or undeveloped land you own.

☐ **YES** ☐ **NO**

8. Not counting your spouse if you are married, how many other relatives live in your household and receive **at least one-half** of their financial support from you or your spouse? We count relatives related to you by blood, marriage or adoption.

Place an X in only one box. **Do not include yourself or your spouse in the number you enter.** If your household consists only of you or you and your spouse, place an X in the **NONE** box.

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

9. If you or your spouse, if married and living together, receive income from any of the sources listed below, please enter the total amount you receive each month. **If the amount changes from month to month or you do not receive it every month, enter the average monthly income for the past year for each type** in the appropriate boxes. Do not list wages and self-employment, interest income, public assistance, medical reimbursements or foster care payments here. If you or your spouse do not receive income from a source listed below, place an X in the **NONE** box for that source.

		Monthly Benefit
• Social Security benefits **before deductions**	☐ **NONE**	$ ☐☐,☐☐☐.☐☐
• Railroad Retirement benefits **before deductions**	☐ **NONE**	$ ☐☐,☐☐☐.☐☐
• Veterans benefits **before deductions**	☐ **NONE**	$ ☐☐,☐☐☐.☐☐
• Other pensions or annuities **before deductions.** Do not include money you receive from any item you included in question 4.	☐ **NONE**	$ ☐☐,☐☐☐.☐☐
• Other income not listed above, including alimony, net rental income, workers' compensation, etc. (Specify): _____	☐ **NONE**	$ ☐☐,☐☐☐.☐☐

10. Have any of the amounts you included in question 9 decreased during the last two years?

☐ **YES** ☐ **NO**

11. Do you count on anyone to help pay for any of the following household expenses — food, mortgage, rent, heating fuel or gas, electricity, water and property taxes? **Do NOT include** food stamps, house repairs, help from a housing agency, an energy assistance program, Meals on Wheels, contributions from food banks, soup kitchens or help with medical treatment and drugs. Do not include small amounts of money given occasionally or unexpectedly.

☐ **YES** ☐ **NO**

If you place an X in the **YES** box, enter the monthly amount or, if the amount changes from month to month, enter the average monthly amount for the past year.

$ ☐☐,☐☐☐.☐☐

If you have worked in the last two years, you need to answer questions 12-16. If you are married and living with your spouse and either one of you has worked in the last two years, you need to answer questions 12-16. Otherwise, sign the application on page 6 and return it to us.

12. What do you expect to earn in wages before taxes and deductions **this calendar year**?

YOU: ☐ **NONE** $ ☐☐☐,☐☐☐.☐☐

SPOUSE: ☐ **NONE** $ ☐☐☐,☐☐☐.☐☐

13. What do you expect your net earnings from self-employment to be **this calendar year**? Place an X in the **NONE** box if you are not self-employed and go to question 14.

YOU: ☐ **NONE** $ ☐☐☐,☐☐☐.☐☐

SPOUSE: ☐ **NONE** $ ☐☐☐,☐☐☐.☐☐

Place an X in the box(es) if you or your spouse expect a net loss. → **YOU:** ☐ **SPOUSE:** ☐

14. Have the amounts you included in questions 12 or 13 decreased in the last two years?

☐ **YES** ☐ **NO**

15. If you or your spouse, stopped working in 2006 or 2007, or plan to stop working in 2007 or 2008, enter the month and year.

EXAMPLE

For January – September, place a zero (0) in the first box. May 2007 should read: 0 5 (M M) 2 0 0 7 (Y Y Y Y)

YOU: ☐☐ (M M) 2 0 ☐☐ (Y Y Y Y)

SPOUSE: ☐☐ (M M) 2 0 ☐☐ (Y Y Y Y)

If you are younger than age 65, answer question 16. If you are married and living with your spouse and either one of you is younger than age 65, answer question 16. Otherwise, sign the application on page 6 and return it to us.

16. Do you or your spouse have to pay for things that enable you to work? 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 cost 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:** ☐ **YES** ☐ **NO**

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 here: ☐

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 someone assisted you, place an X in the box that describes that person and provide the rest of the information requested below.

☐ 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 to determine if you are 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, if you do not provide the information, we will be unable to make an accurate and timely decision on your application. 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 extra help or if a Federal law requires the release of information.

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 35 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 ENVELOPE:

Social Security Administration
Wilkes-Barre Data Operations Center
P.O. Box 1020
Wilkes-Barre, PA 18767-9910