



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

The OMB control number for this application is 0960-0696; expiration date 5/31/2008.

## Welcome!

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. However, you must be enrolled in a Medicare Prescription Drug plan to get this extra help.

### What Is This Application?

It is an application for extra help with the prescription drug costs. **It does not enroll you in a Medicare prescription drug plan.** You will have to enroll directly with an approved Medicare prescription drug provider for coverage. 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](http://www.medicare.gov).

### Who Should Complete This Application For Extra Help With Medicare Prescription Drug Plan Costs?

You should complete this application for extra help on the Internet if:

- . You have Medicare Part A (Hospital Insurance) and/or Medicare Part B (Medical Insurance); and
- . You live in one of the 50 states or the District of Columbia; and
- . Your combined savings, investments, and real estate are not worth more than \$23,410, if you are married and living with your spouse, or \$11,710 if you are not currently married or not living with your spouse. (**DO NOT include** the home you live in, vehicles, personal possessions, burial plots or irrevocable burial contracts.) If you have more than those amounts, you may not qualify for the extra help. However, you can still enroll in an approved Medicare prescription drug plan for coverage.

**EXCEPTION:** Even if you meet these conditions, **DO NOT** complete this application if you have Medicare **and** Supplemental Security Income (SSI) or Medicare **and** Medicaid because you automatically will get the extra help.

If your state pays your Medicare premiums because you belong to a Medicare Savings Program, you should contact your state Medicaid office for more information. You could get the extra help automatically and may not need to complete this application.

### How Can You Get The Extra Help?

To get extra help with prescription drug costs, you **must complete and submit this application**. We will review your application and send you a letter to let you know if you qualify for extra help.

If you need help completing this application, call Social Security toll-free at **1-800-772-1213**. If you are deaf or hard of hearing, call our toll-free TTY number at **1-800-325-0778**.

**What Do You Want To Do?**

**Not Sure If You Should Use This?**

## Related Links

Information About This Application:

- [What You Will Need](#)
- [Special Instructions For Blind Users](#)
- [Other Ways To Apply](#)
- [How The Online Application Works](#)

Legal And Official Information:

- [Internet Security Policy](#)
- [Paperwork Reduction Act](#)
- [Website Policies & Other Important Information](#)

Medicare Information:

- [About The Prescription Drug Program](#)
- [Official U.S. Government Medicare Site](#)
- [Centers For Medicare & Medicaid Services](#)

## Privacy Act Statement

Social Security is allowed to collect the facts on this application under Section 205 of the Social Security Act. We need this information to efficiently process your Internet application. Giving us these facts is voluntary. However, without them we may not be able to process your application online. Social Security may provide information collected on this application 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 also may need to share the information with other Social Security programs if Social Security 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 read more information on this subject, read [The Collection and Use of Information From Your Application - Privacy Act Statement](#).

Social Security has access to the information you provide on this application and is authorized to keep information on applications that were partially completed. This is for purposes of helping you complete the application process. If you have decided you want to continue,

you can apply now or, if you are undecided, you may file at a later time.



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- You live in one of the 50 states or the District of Columbia; and
- Your combined savings, investments, and real estate are not worth more than \$23,410, if you are married and living with your spouse, or \$11,710 if you are not married or not living with your spouse. (**DO NOT include** the home you live in, vehicles, personal possessions, burial plots or irrevocable burial contracts.) If you have more than those amounts, you may not qualify for the extra help. However, you can still enroll in an approved Medicare prescription drug plan for coverage.

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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 read more information on this subject, read [The Collection and Use of Information From Your Application - Privacy Act Statement](#).

Social Security has access to the information you provide on this application and is authorized to keep information on applications that were partially completed. This is for purposes of helping you complete the application process. If you have decided you want to continue,

you can apply now or, if you are undecided, you may file at a later time.



# Help With Medicare Prescription Drug Plan Costs

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[Need Help?](#)

## Should You Use This Application?

Not everyone will be able to use the online Application For Help With Medicare Prescription Drug Plan Costs. You must answer a few questions to help determine if you should use this Internet form. Any time there is a link at the end of a question that says "More Info," you can follow that link to get help with that question.

The OMB control number for this application is 0960-0696; expiration date 5/31/2008.

**Are you assisting someone (other than your spouse who lives with you) with this application?** [More Info](#)

If you are helping another person fill out this application, answer the following questions as if you were the person.

No

Yes

**Did you (or your spouse, if married and living together) get an application in the mail from us?** [More Info](#)

No

Yes

**Do you (or your spouse, if married and living together) have Medicare?** [More Info](#) **No**  
**Yes**

**Are you (or your spouse, if married and living together) 64 years and 9 months old or older?** [More Info](#)

No

Yes

**Have you (or your spouse, if married and living together) received:** [More Info](#) **No**  
**Yes**

- **Social Security disability benefits for 24 months;**
- **Disability benefits based on Lou Gehrig's disease (ALS); or**
- **Renal dialysis treatments or a kidney transplant?**

**In which state do you (and your spouse, if married and living together) live?**

[More Info](#)

**What is your marital status?** [More](#)

[Info](#)

**Do you have combined savings, investments and real estate worth more than:** [More Info](#)

- **\$23,410 if you are married and living with your spouse; or**
- **\$11,710 if you are not married or not living with your spouse?**

Include the things you own by yourself, with your spouse or with someone else. **DO NOT include the home you live in, vehicles, personal possessions, burial plots or irrevocable burial contracts.**

**No      Yes      Not**  
**sure**



# Help With Medicare Prescription Drug Plan Costs

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## Welcome Back!

Please enter the applicant's Social Security and Reentry Numbers to return to the Application For Help With Medicare Prescription Drug Plan Costs already started. If you do not have the applicant's Reentry Number, you will not be able to continue with the application already begun. You may start a new online application up to three times. If you have a problem using this online application, call our toll-free number at **1-800-772-1213** (TTY **1-800-325-0778**) and they will help you. However, Social Security cannot access the applicant's Reentry Number.

**Applicant's Social Security  
Number:**

**Reentry  
Number:**



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

[Need Help?](#)

## Sign Out

If you want to, you can stop now. Later, you can come back to where you left off and continue with this application. You can review the parts you already completed and add or change information.

### To Come Back To This Application:

1. Go to this website: [www.socialsecurity.gov/prescriptionhelp](http://www.socialsecurity.gov/prescriptionhelp); and
2. Type in the Applicant's Social Security and Reentry Numbers shown below.

**Applicant's Social Security Number:**

**743991047**

**Reentry Number: 65571762**

Print or save this page so you will have a copy of your Reentry Number. To print this page, please use the Print button at the top of your browser.

If you lose or forget your Reentry Number, you will have to begin this application again, and you will lose all the information already entered. You can start a new application up to three times. Social Security can help you start the process again, but we cannot look up the Reentry Number for you.

### Last Date To Complete This Application

You need to complete an application by **October 22, 2007**; otherwise, you may lose benefits.

### Important Information



You might have received a notice from us advising you of an earlier time period for filing the application. If you did, it was because you or someone on your behalf contacted us about filing before you started the Internet application. Generally, it is to your advantage to file within that earlier period to receive the earliest filing date.



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[Need Help?](#)

## You Are Not Eligible For The Extra Help

**Based on the information you gave us about your combined savings, investments and real estate, you are not eligible for extra help.** You do not need to complete this application. However, if you need a letter stating you are not eligible, complete the application. Whether or not you qualify for the extra help, you may still enroll in an approved Medicare prescription drug plan for coverage. 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](http://www.medicare.gov).

### What You Can Do Next

1. You may begin the application process by selecting Apply Now,
2. You may go back to make changes by selecting Previous, or
3. You may Exit this application.

If you select Apply Now, you will get a Reentry Number after you fill in your name and address. If you choose to Exit this application before it is complete, you may use your Reentry Number at any time to come back. You will also be able to change your answers later.

### What You Will Need

If you decide to complete this application, we will ask about your income (and your spouse's income, if married and living together) and the things that you and your spouse own. Documents that may help you prepare include:

- Social Security card;
- bank account statements, including checking, savings, and certificates of deposit;
- Individual Retirement Accounts (IRA), stocks, bonds, savings bonds, mutual funds, other investment statements;
- tax returns;
- payroll slips;

- your most recent award letters or statements for Railroad Retirement income, Veterans benefits, pensions and annuities; and
- the cash and face values of any life insurance policies you have. Check with your insurance agent for the exact amount you would get if you cashed in your life insurance policies today.

If you do not have these documents, provide us with your best estimate so that we can tell you whether you are likely to qualify for extra help with your prescription drug costs. This information is to help you complete the application. You will not have to submit the documents unless contacted by a Social Security representative.



# Help With Medicare Prescription Drug Plan Costs

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[Need Help?](#)

## Go Ahead

To complete the application, select Apply Now at the bottom of this page.

We will ask about your income, your spouse's income, and the things that you and your spouse own. Documents that may help you prepare include:

- Social Security card;
- bank account statements, including checking, savings, and certificates of deposit;
- Individual Retirement Accounts (IRA), stocks, bonds, savings bonds, mutual funds, other investment statements;
- tax returns;
- payroll slips;
- your most recent award letters or statements for Railroad Retirement income, Veterans benefits, pensions and annuities; and
- the cash and face values of any life insurance policies you have. Check with your insurance agent for the exact amount you would get if you cashed in your life insurance policies today.

If you do not have these documents, provide us with your best estimate so that we can tell you whether you are likely to qualify for extra help with your prescription drug costs. This information is to help you complete the application. You will not have to submit the documents unless contacted by a Social Security representative.



# Help With Medicare Prescription Drug Plan Costs

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## Preparing To Find Out If You Qualify



**Do not use your browser's Back button.**

To go back, select Previous at the bottom of the page.

### What information will you need?

To determine if you could be eligible for help with prescription drug plan costs, Social Security needs information about your (and your spouse's, if married and living together) income and resources.

Documents that may help you prepare include:

- Social Security card;
- bank account statements, including checking, savings, and certificates of deposit;
- Individual Retirement Accounts (IRAs), stocks, bonds, savings bonds, mutual funds, other investment statements;
- tax returns;
- payroll slips;
- your most recent Social Security benefits award letters or statements for Railroad Retirement income, Veterans Benefits, pensions and annuities; and
- the cash value and face value of any life insurance policies you have. Check with your insurance agent for the exact amount you would get if you cashed in your life insurance policies today.

If you do not have these documents, provide us with your best estimate so that we can tell you whether you are likely to qualify for extra help with your prescription drug costs. This information is to help you complete the application. You will not have to submit the documents unless contacted by a Social Security representative.

You may apply regardless of the Qualifier results. If you apply right away, the information you enter will be saved in the application. Whatever you enter here will not affect your benefits or the application decision; you can change your financial information when you enter the application.

### **What if you need to stop and come back later?**

If you select Apply Now, you will get a Reentry Number after you fill in your name and address. If you choose to Sign Out of this application before it is complete, you may use your Reentry Number at any time to come back. You will also be able to change your answers later.

### **Can you edit your information?**

When you have completed the application, you will get a full summary of the information you entered. You can make changes if necessary prior to submission. After you submit the application electronically, you will be able to print or save a receipt, and your submitted application.

### **How long can you work on each page?**

For security reasons, there are time limits on each page. You will receive a warning after 25 minutes but you can extend your time on that page. After the third warning on a page, you must move to another page or your time will run out and all your work on that page will be lost.

If you have turned JavaScript off in your browser, you will not receive these warnings and, after 30 minutes on a page, you must go to another page or your application session will end, and your work on the last page will be lost.

If you are unsure about how to use this application, you can find more details on the following pages:

- [How the Online Application Works](#)
- [Special Instructions for Blind Users](#)



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## Preparing To Use This Application



**Do not use your browser's Back button.**

To go back, select Previous at the bottom of the page.

### What information will you need?

To determine if you could be eligible for help with prescription drug plan costs, Social Security needs information about your (and your spouse's, if married and living together) income and resources.

Documents that may help you prepare include:

- Social Security card;
- bank account statements, including checking, savings, and certificates of deposit;
- Individual Retirement Accounts (IRAs), stocks, bonds, savings bonds, mutual funds, other investment statements;
- tax returns;
- payroll slips;
- your most recent award letters or statements for Railroad Retirement income, Veterans benefits, pensions and annuities; and
- the cash value and face value of any life insurance policies you have. Check with your insurance agent for the exact amount you would get if you cashed in your life insurance policies today.

If you do not have these documents, provide us with your best estimate so that we can tell you whether you are likely to qualify for extra help with your prescription drug costs. This information is to help you complete the application. You will not have to submit the documents unless contacted by a Social Security representative.

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## Application Help

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.

[Information About This Application](#)

[What Is This Application?](#)

[How Can You Get The Extra Help?](#)

[Who Should Complete This Application For Extra Help With Medicare Prescription Drug Plan Costs?](#)

[What Information Will You Need?](#)

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[Can You Edit Your Information?](#)

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[Are There Other Ways To Apply?](#)

[Information About Medicare](#)

[Legal And Official Information](#)

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[Special Instructions For Blind Users](#)

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## How Can You Get The Extra Help?

To get extra help with prescription drug costs, you **must complete and submit this application.** 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 this application, call Social Security toll-free at **1-800-772-1213**. If you are deaf or hard of hearing, call our toll-free TTY number at **1-800-325-0778**.

If you need information about the new Medicare Prescription Drug Program, call **1-800-MEDICARE** (TTY **1-877-486-2048**) or visit [www.medicare.gov](http://www.medicare.gov).

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- Social Security card;
- bank account statements, including checking, savings, and certificates of deposit;
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- your most recent Social Security benefits award letters or statements for Railroad Retirement income, Veterans benefits, pensions and annuities; and
- the cash value and face value of any life insurance policies you have. Check with your insurance agent for the exact amount you would get if you cashed in your life insurance policies today.

\* **Book Entry Securities** - In addition to traditional U.S. Savings Bonds, individuals now may go to the Treasury Department's Internet site and make online purchases of electronic savings bonds. Electronic savings bonds are also called "book entry securities." With book entry securities, the individual's investment is recorded electronically by the Treasury Department and a paper savings bond is not issued. If you have book entry securities, they are counted as resources and should be reported on this application.

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## **Are There Other Ways To Apply?**

If you prefer not to fill out this application on the Internet, you can call our toll-free number, **1-800-772-1213** for a paper application. If you are deaf or hard of hearing, call our toll-free TTY number, **1-800-325-0778**. Representatives are available Monday through Friday from 7 a.m. to 7 p.m. Tell the representative that you want to apply for help with Medicare prescription drug costs.

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## **Information About Medicare**

Follow the links below for more specific information regarding the Prescription Drug Program and Medicare:

[About The Prescription Drug Program](#)

Medicare Information:

[Official U.S. Government Medicare Site](#)

[Centers For Medicare & Medicaid Services](#)

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## **Legal And Official Information**

[Internet Security Policy](#)

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Close this window to return to the application.



# Help With Medicare Prescription Drug Plan Costs

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## Help: Should You Use This Application

### **Are you assisting someone (other than your spouse who lives with you) with this application?**

In order to collect the appropriate contact information, we need to know if this form is being filled out by a third party. If you are assisting someone other than your spouse who lives with you, select Yes.

### **Did you (or your spouse, if married and living together) get an application in the mail from us?**

We mailed scannable paper applications for Help With Medicare Prescription Drug Plan Costs to people who appeared to be below the income limits based on the information already in our records. However, if an individual received an application, it does not mean that the individual automatically qualifies for assistance.

### **Do you (or your spouse, if married and living together) have Medicare?**

Only individuals who are eligible for, or have Medicare may use this application. If you (or your spouse, if married and living together) are, you may be eligible for extra help to pay for your monthly premiums, annual deductibles, and co-payments related to the prescription drug program.

### **Are you (or your spouse, if married and living together) 64 years and 9 months old or older?**

The purpose of this question is to help us determine if you may be eligible for Medicare. If you are eligible for Medicare and have not yet applied, call our toll-free number at **1-800-772-1213**. If you are deaf or hard of hearing, call our toll-free TTY number at **1-800-325-0778**.

### **Have you (or your spouse, if married and living together) received:**

- **Social Security disability benefits for 24 months;**
- **disability benefits based on Lou Gehrig's disease (ALS); or**

## • **renal dialysis treatments or a kidney transplant?**

The purpose of this question is to help us determine if you may be eligible for Medicare. To apply for Medicare a person must:

- be at least 64 years and 9 months old;
- have received Social Security disability benefits for 24 months;
- receive Social Security disability benefits based on Lou Gehrig's disease (ALS); **or**
- have received renal dialysis treatments or a kidney transplant.

If you (or your spouse, if married and living together) are eligible for Medicare and have not yet applied, call our toll-free number at **1-800-772-1213**. If you are deaf or hard of hearing, call our toll-free TTY number at **1-800-325-0778**.

## **In which state do you (or your spouse, if married and living together) live?**

To be eligible for the help with prescription drug plan costs, you must live in one of the 50 states or the District of Columbia. Select the state where your permanent residence is located.

## **What is your marital status?**

If you are married and living with your spouse, we count the income and resources of both you and your spouse when we determine whether you are eligible to receive help with prescription drug plan costs. We consider that you are living together if you and your spouse live in the same household. We count the income and resources of you and your spouse regardless of whether one or both of you are filing for this help. We consider that you are still living together if you or your spouse are **temporarily** absent from the household in a hospital or nursing home.

## **Do you have combined savings, investments, and real estate worth more than:**

- **\$23,410 if you are married and living with your spouse; or**
- **\$11,710 if you are not married or not living with your spouse?**

To be eligible for help with prescription drug plan costs, your resources must be within certain limits. Your resources may include bank accounts (checking, savings, and certificates of deposit), stocks, bonds, savings bonds (including book entry securities\*), mutual funds, Individual Retirement Accounts (IRA), and any other cash at home or anywhere else. Your resources also include real estate you own **except for the home that you live in**. Examples of other real estate are summer homes, rental properties or undeveloped land you own. Include the things you own by yourself, with your spouse or with someone else. **DO NOT include** vehicles, personal possessions, burial plots, or irrevocable burial contracts.

If you are sure that your combined savings, investments, and real estate are worth more than \$23,410 (married) or \$11,710 (single), select Yes. The actual limits for eligibility are \$20,410

(married) or \$10,210 (single). However, since we may not count some of the resources you expect to use for funeral or burial expenses, you may be able to have up to \$23,410 (married) or \$11,710 (single).

\* **Book Entry Securities** - In addition to traditional U.S. Savings Bonds, individuals now may go to the Treasury Department's Internet site and make online purchases of electronic savings bonds. Electronic savings bonds are also called "book entry securities." With book entry securities, the individual's investment is recorded electronically by the Treasury Department and a paper savings bond is not issued. If you have book entry securities, they are counted as resources and should be reported on this application.

Other examples of resources that should **NOT** be counted are:

- Resources you could not easily convert to cash, such as jewelry or home furnishings;
- Property you need for self support that is used in a trade or business;
- The **cash** value of your life insurance if the total **face** value of the policies you own is \$1,500 or less;
- The **cash** value of your spouse's life insurance if the total **face** value of the policies he or she owns is \$1,500 or less;
- Irrevocable burial trusts;
- Disaster assistance;
- Certain distributions received by an Alaska Native from an Alaska Native Regional and Village Corporation;
- Land held in trust by the United States for an individual Indian or tribe;
- Funds held in trust by the Secretary of the Interior for an Indian tribe and distributed per capita to members of the tribe;
- Payments to members of specific Indian tribes as provided by Federal legislation; and
- Up to \$2,000 per year received by an Indian that is derived from individual interests in trust or restricted lands.

**NOTE:** Certain other money you may be holding is not counted for nine months, such as:

- Retroactive Social Security or Supplemental Security Income benefits;
- Tax advances and refunds related to earned income tax credits and child tax credits;
- Compensation you receive as a crime victim;
- Relocation assistance from a state or local government; and
- Scholarships and education grants.

Close this window to return to the application.



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

## Help: Find Out If You And Your Spouse Qualify: Part 1

### Have you or your spouse worked in this calendar year?

If you or your spouse have worked at any time during the present calendar year, select Yes for this question. If you have not worked at any time during the current calendar year, select No.

### Are you or your spouse UNDER age 65?

If you or your spouse are under age 65, disabled or blind and working, we may be able to exclude some of your earnings when we determine your eligibility for help with prescription drug costs. If you spend part of your earnings to pay for things needed in order to work, we will not count those earnings when we determine eligibility. For example, we would exclude the amount spent on attendant care, certain drugs, medical supplies and devices, certain types of training and therapy, certain work-related equipment, etc.

**Not counting your spouse how many other relatives live in your household an receive at least one-half of their financial support from you or your spouse? Do NOT include yourself or your spouse in the number you enter. If your household consists only of you and your spouse, enter "0."**

Eligibility for the extra help is based on the amount of your income and that of your spouse compared to the Federal Poverty Level for your household's size. Therefore, we need to know how many other relatives are in your household for whom you or your spouse provide at least one-half of their financial support. We count relatives related to you by blood, marriage or adoption.

### Do you count on anyone to help pay for any of the following household expenses?

- Food
- Heating Fuel or Gas
- Mortgage
- Electricity and Water
- Rent
- Property Taxes

If anyone **regularly** provides you or your spouse with assistance with food or shelter costs, select Yes. If Yes, also enter the average amount you receive each month in the space provided.



If you receive help with these expenses for only **part** of the year, it will be necessary for you to compute the average **MONTHLY** amount of this help.

**Example:**

A relative paid your heating bills during the winter months of January through March and your heating bills were about \$180 per month during those three months. This means that you received a total of \$540 in help during the year for your heating bills. However, you must enter the **monthly** average amount of this help on your application. To compute the monthly amount, divide \$540 by 12 months, which is \$45, and enter \$45 as the monthly amount of help you received.

If your heating bills were more than \$193 per month, only use \$193 when computing the average monthly amount. (Any help you received over \$193 per month is not counted.) So, if the heating bills for January through March were about \$300 per month, multiply \$193 (not \$300) by three months, which totals \$579 for the year. Then divide \$579 by 12, which is \$48.25, and enter \$48.25 as the monthly amount of help you received.

If you occasionally or unexpectedly receive small amounts of money or other help, such as your child buying groceries for the week, **do NOT** include that amount. Other examples of possible income sources that should **NOT** be counted are:

- Food Stamps;
- House repairs;
- Help from a housing agency;
- Help from an energy assistance program;
- Meals on Wheels;
- Contributions from food banks;
- Soup kitchens;
- Disaster assistance;
- Help with your telephone bills; and
- Help with medical bills, treatments and drugs.

Also, **do NOT** count any help you received before the month you file your application.

Close this window to return to the application.



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

## Help: Find Out If You Qualify: Part 1

### Have you worked in this calendar year?

If you have worked at any time during the present calendar year, select Yes for this question. If you have not worked at any time during the current calendar year, select No.

### Are you UNDER age 65?

If you are under age 65, disabled or blind and working, we may be able to exclude some of your earnings when we determine your eligibility for help with prescription drug costs. If you spend part of your earnings to pay for things needed in order to work, we will not count those earnings when we determine eligibility. For example, we would exclude the amount spent on attendant care, certain drugs, medical supplies and devices, certain types of training and therapy, certain work-related equipment, etc.

### How many relatives live in your household and receive at least one-half of their financial support from you? Do NOT include yourself in the number you enter. If your household consists only of you, enter "0."

Eligibility for the extra help is based on the amount of your income compared to the Federal Poverty Level for your household's size. Therefore, we need to know how many relatives are in your household for whom you provide at least one-half of their financial support. We count relatives related to you by blood, marriage or adoption.

### Do you count on anyone to help pay for any of the following household expenses?

- Food
- Heating Fuel or Gas
- Mortgage
- Electricity and Water
- Rent
- Property Taxes

If anyone **regularly** provides you with assistance with food or shelter costs, select Yes. If Yes, also enter the average amount you receive each month in the space provided.

If you receive help with these expenses for only **part** of the year, it will be necessary for you to compute the average **MONTHLY** amount of this help.

### Example:

A relative paid your heating bills during the winter months of January through March and your heating bills were about \$180 per month during those three months. This means that you received a total of \$540 in help during the year for your heating bills. However, you must enter the **monthly** average amount of this help on your application. To compute the monthly amount, divide \$540 by 12 months, which is \$45, and enter \$45 as the monthly amount of help you received.

If your heating bills were more than \$193 per month, only use \$193 when computing the average monthly amount. (Any help you received over \$193 per month is not counted.) So, if the heating bills for January through March were about \$300 per month, multiply \$193 (not \$300) by three months, which totals \$579 for the year. Then divide \$579 by 12, which is \$48.25, and enter \$48.25 as the monthly amount of help you received.

If you occasionally or unexpectedly receive small amounts of money or other help, such as your child buying groceries for the week, **do NOT** include that amount. Other examples of possible income sources that should **NOT** be counted are:

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- House repairs;
- Help from a housing agency;
- Help from an energy assistance program;
- Meals on Wheels;
- Contributions from food banks;
- Soup kitchens;
- Disaster assistance;
- Help with your telephone bills; and
- Help with medical bills, treatment and drugs.

Also, **do NOT** count any help you received before the month you file your application.

Close this window to return to the application.



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

## Help: Find Out If You And Your Spouse Qualify: Part 3

### Do you or your spouse have to pay for things that enable you to work?

We will only count part of your earnings toward the income limit if you:

- work;
- receive Social Security benefits based on a disability or blindness; and
- have work-related expenses for which you are not reimbursed.

If you or your spouse receive Social Security benefits based on a disability or blindness and have work-related expenses, select Yes. You will not need to tell us the amount of those expenses. We will not count a percentage of your earnings. When we send you a letter that says whether you are eligible for the extra help or not, we will also tell you how much of your earnings we did not count. If you think the amount of work-related expenses we used was less than your actual work-related expenses, you may contact us to tell us the actual amount of your expenses.

### What do you or your spouse expect to earn in wages before taxes and deductions this calendar year?

If you or your spouse expect to earn money for any labor or services you provide on an hourly, daily, or piecework basis during this calendar year, select Wages of: and enter the amount BEFORE taxes and deductions you think you will earn in the field provided. If you did not, and do not expect to earn wages, select None. **Do NOT** include earned income tax credit payments you may have received.

### What do you or your spouse expect your net earnings from self-employment to be this calendar year?

If you or your spouse expect to have net earnings or a net loss from self-employment this year, select the appropriate response and enter the NET amount you think it will be in the field provided. **Do NOT** include earned income tax credit payments you may have received. If you were not, and do not expect to be self-employed, select None.

### Have you or your spouse stopped working in 2006 or 2007, or plan to stop working in 2007 or 2008?

If you or your spouse have stopped working in the past 24 months, or if you plan to stop working in

the next year, select Yes and enter the month and year in the fields provided.

Close this window to return to the application.



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

## Help: Find Out If You Qualify: Part 3

### Do you have to pay for things that enable you to work?

We will only count part of your earnings toward the income limit if you:

- work;
- receive Social Security benefits based on a disability or blindness; and
- have work-related expenses for which you are not reimbursed.

If you receive Social Security benefits based on a disability or blindness and have work-related expenses, select Yes. You will not need to tell us the amount of those expenses. We will not count a percentage of your earnings. When we send you a letter that says whether you are eligible for the extra help or not, we will also tell you how much of your earnings we did not count. If you think the amount of work-related expenses we used was less than your actual work-related expenses, you may contact us to tell us the actual amount of your expenses.

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

If you expect to earn money for any labor or services you provide on an hourly, daily, or piecework basis during this calendar year, select Wages of: and enter the amount BEFORE taxes and deductions you think you will earn in the field provided. If you did not, and do not expect to earn wages, select None. **Do NOT** include earned income tax credit payments you may have received.

### What do you expect your net earnings from self-employment to be this calendar year?

If you expect to have net earnings or a net loss from self-employment this year, select the appropriate response and enter the NET amount you think it will be in the field provided. **Do NOT** include earned income tax credit payments you may have received. If you were not, and do not expect to be self-employed, select None.

### Have you stopped working in 2006 or 2007, or plan to stop working in 2007 or 2008?

If you have stopped working in the past 24 months, or if you plan to stop working in the next year, select Yes and enter the month and year in the fields provided.

Close this window to return to the application.



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

## Help: Find Out If You and Your Spouse Qualify: Part 2

### Do you or your spouse receive Social Security benefits?

If you or your spouse currently receive benefits from Social Security, enter the total amount received each month in this field. To find out what amount to enter, use the amount on your annual cost-of-living adjustment letter you receive from Social Security. This is the amount BEFORE the premium for Medicare Medical Insurance is deducted. Other types of deductions could include voluntary Federal tax withholding, partial recovery of an overpayment, child support payments, garnishment, etc. (This is **NOT** an all-inclusive list.)

## Your New Benefit Amount

000801

BENEFICIARY'S NAME:

JOHN Q. PUBLIC

SOCIAL SECURITY CLAIM NUMBER

(only the last 4 digits are shown to help prevent identity theft): xxx-xx-1111

Your Social Security benefits will increase by 2.7 percent in 2005, because of a rise in the cost of living. You can use this letter when you need proof of your benefit amount to receive food stamps, rent subsidies, energy assistance, bank loans, or for other business.

### How Much Will I Get And When?

- Your new monthly amount (before deductions) is
- The amount we are deducting for Medicare is (If you did not have Medicare as of Nov. 19, 2004, or if someone else pays your premium, we show \$0.00.)
- The amount we are deducting for voluntary federal tax withholding is (If you did not elect voluntary federal tax withholding as of Nov. 19, 2004, we show \$0.00.)
- After taking any other deductions, we will deposit into your bank account on Jan. 3, 2005.

If you disagree with any of these amounts, you should write to us within 60 days from the date you receive this letter.

\$515.00	This is the amount you should use when we ask for your Social Security Benefit.
\$0.00	
\$0.00	
\$515.00	

### **Do you or your spouse receive Railroad Retirement income?**

If you or your spouse currently receive benefits from the Railroad Retirement Board, enter the total amount received each month in this field. To find out what amount to enter, use the amount on your annual cost-of-living adjustment letter you receive from the Railroad Retirement Board. This is the amount BEFORE the premium for Medicare Medical Insurance is deducted. Other types of deductions could include voluntary Federal tax withholding, partial recovery of an overpayment, child support payments, garnishment, etc. (This is **NOT** an all-inclusive list.)

### **Do you or your spouse receive Veterans benefits?**

If you or your spouse currently receive benefits from the Department of Veterans Affairs, enter the total amount received each month in this field. To find out what amount to enter, use the amount on your annual cost-of-living adjustment letter you receive from the Department of Veterans Affairs. This is the amount BEFORE any deductions have been made. Types of deductions could include voluntary Federal tax withholding, partial recovery of an overpayment, child support payments, garnishment, etc. (This is **NOT** an all-inclusive list.)

### **Do you or your spouse receive income from other pensions or annuities?**

If you or your spouse currently receive income from a pension, enter the total amount received each month in this field. If you receive money from an insurance company (annuity) on a regular basis (monthly, yearly, etc.), enter that amount as well. This includes immediate and deferred annuity payments, and is the amount BEFORE any deductions have been made. Types of deductions could include voluntary Federal tax withholding, partial recovery of an overpayment, child support payments, garnishment, etc. (This is **NOT** an all-inclusive list.)

The entry for this field must be shown in a **MONTHLY** format. If the pension or annuity is received other than monthly, convert to a monthly amount before entering (e.g., if received weekly, multiply by 52 and divide by 12; if received bi-weekly, multiply by 26 and divide by 12; if received yearly, divide by 12, etc.).

**Do NOT include** annuities from certificates of deposit, stocks, bonds, mutual funds, IRAs or any other investments.

### **Do you or your spouse receive other income not listed above, including alimony, net rental income, workers' compensation, etc.?**

Indicate whether you or your spouse receive income from any other source. 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.

(**Do NOT include** help with rent or utilities, money you have in bank accounts, stocks, bonds, savings bonds, mutual funds, IRAs or any similar investments, or any other cash at home or anywhere else.)

**Do NOT** list wages and self-employment, interest income, public assistance, medical reimbursements, or foster care payments here. Other examples of possible income sources that should **NOT** be counted are:

- Food Stamps;
- House repairs;
- Help from an energy assistance program;
- Help with medical bills, treatment and drugs;
- Help from a housing agency;
- Disaster assistance;



- Meals on Wheels;
- Contributions from food banks;
- Soup kitchens;
- Earned income tax credit payments;
- Victim's compensation payments;
- Scholarships and education grants;
- Certain distributions received by an Alaska Native from an Alaska Native Regional and Village Corporation;
- Land held in trust by the United States for an individual Indian or tribe;
- Funds held in trust by the Secretary of the Interior for an Indian tribe and distributed per capita to members of the tribe;
- Payments to members of specific Indian tribes as provided by Federal legislation; and
- Up to \$2,000 per year received by an Indian that is derived from individual interests in trust or restricted lands.

Close this window to return to the application.



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

## Help: Find Out If You Qualify: Part 2

### Do you receive Social Security benefits?

If you currently receive benefits from Social Security, enter the total amount received each month in this field. To find out what amount to enter, use the amount on your annual cost-of-living adjustment letter you receive from Social Security. This is the amount BEFORE the premium for Medicare Medical Insurance is deducted. Other types of deductions could include voluntary Federal tax withholding, partial recovery of an overpayment, child support payments, garnishment, etc. (This is **NOT** an all-inclusive list.)

## Your New Benefit Amount

000801

BENEFICIARY'S NAME:

JOHN Q. PUBLIC

SOCIAL SECURITY CLAIM NUMBER

(only the last 4 digits are shown to help prevent identity theft): xxx-xx-1111

Your Social Security benefits will increase by 2.7 percent in 2005, because of a rise in the cost of living. You can use this letter when you need proof of your benefit amount to receive food stamps, rent subsidies, energy assistance, bank loans, or for other business.

### How Much Will I Get And When?

- Your new monthly amount (before deductions) is
- The amount we are deducting for Medicare is (If you did not have Medicare as of Nov. 19, 2004, or if someone else pays your premium, we show \$0.00.)
- The amount we are deducting for voluntary federal tax withholding is (If you did not elect voluntary federal tax withholding as of Nov. 19, 2004, we show \$0.00.)
- After taking any other deductions, we will deposit into your bank account on Jan. 3, 2005.

If you disagree with any of these amounts, you should write to us within 60 days from the date you receive this letter.

\$515.00	This is the amount you should use when we ask for your Social Security Benefit.
\$0.00	
\$0.00	
\$515.00	

### **Do you receive Railroad Retirement income?**

If you currently receive benefits from the Railroad Retirement Board, enter the total amount received each month in this field. To find out what amount to enter, use the amount on your annual cost-of-living adjustment letter you receive from the Railroad Retirement Board. This is the amount BEFORE the premium for Medicare Medical Insurance is deducted. Other types of deductions could include voluntary Federal tax withholding, partial recovery of an overpayment, child support payments, garnishment, etc. (This is **NOT** an all-inclusive list.)

### **Do you receive Veterans benefits?**

If you currently receive benefits from the Department of Veterans Affairs, enter the total amount received each month in this field. To find out what amount to enter, use the amount on your annual cost-of-living adjustment letter you receive from the Department of Veterans Affairs. This is the amount BEFORE any deductions have been made. Types of deductions could include voluntary Federal tax withholding, partial recovery of an overpayment, child support payments, garnishment, etc. (This is **NOT** an all-inclusive list.)

### **Do you receive income from other pensions or annuities?**

If you currently receive income from a pension, enter the total amount received each month in this field. If you receive money from an insurance company (annuity) on a regular basis (monthly, yearly, etc.), enter that amount as well. This includes immediate and deferred annuity payments, and is the amount BEFORE any deductions have been made. Types of deductions could include voluntary Federal tax withholding, partial recovery of an overpayment, child support payments, garnishment, etc. (This is **NOT** an all-inclusive list.)

The entry for this field must be shown in a **MONTHLY** format. If the pension or annuity is received other than monthly, convert to a monthly amount before entering (e.g., if received weekly, multiply by 52 and divide by 12; if received bi-weekly, multiply by 26 and divide by 12; if received yearly, divide by 12, etc.).

**Do NOT include** annuities from certificates of deposit, stocks, bonds, mutual funds, IRAs or any other investments.

### **Do you receive other income not listed above, including alimony, net rental income, workers' compensation, etc.?**

Indicate whether you receive income from any other source. 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.

**(Do NOT include** help with rent or utilities, money you have in bank accounts, stocks, bonds, savings bonds, mutual funds, IRAs or any similar investments, or any other cash at home or anywhere else.)

**Do NOT** list wages and self-employment, interest income, public assistance, medical reimbursements, or foster care payments here. Other examples of possible income sources that should **NOT** be counted are:

- Food Stamps;
- House repairs;
- Help from an energy assistance program;
- Help with medical bills, treatment and drugs;
- Help from a housing agency;
- Disaster assistance;

- Meals on Wheels;
- Contributions from food banks;
- Soup kitchens;
- Earned income tax credit payments;
- Victim's compensation payments;
- Scholarships and education grants;
- Certain distributions received by an Alaska Native from an Alaska Native Regional and Village Corporation;
- Land held in trust by the United States for an individual Indian or tribe;
- Funds held in trust by the Secretary of the Interior for an Indian tribe and distributed per capita to members of the tribe;
- Payments to members of specific Indian tribes as provided by Federal legislation; and
- Up to \$2,000 per year received by an Indian that is derived from individual interests in trust or restricted lands.

Close this window to return to the application.



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

## Help: About You And Your Spouse

### Your Name:

To ensure your privacy, we must match the name you enter on this application to the name on your most recent Social Security card. Therefore, it is very important that you enter it exactly the same way. If we cannot match these names, you will be unable to file for this extra help on the Internet.

### Your Social Security Number:

Enter your own Social Security number. If you receive Social Security benefits based on someone else's Social Security number, such as a current, former, or deceased spouse, do not enter that individual's Social Security number or Medicare Claim Number in this field.

### What is your date of birth?

We use this date to determine your current age. If you are under age 65, blind or disabled **and** working, we may be able to exclude some of your earnings when we determine eligibility for help with prescription drug costs. If you spend part of your earnings to pay for things needed in order to work, we will not count those earnings when we determine eligibility. For example, we would exclude the amount spent on attendant care, certain drugs, medical supplies and devices, certain types of training and therapy, certain work-related equipment, etc.

### Have you worked in 2006 or 2007?

When we determine whether you are eligible for help with prescription drug plan costs, we consider the wages and self-employment net earnings that you or your spouse receive.

If you or your spouse worked in 2006 or 2007, we will ask you about your wages and self-employment earnings when you complete the application for this help.

If neither you nor your spouse worked in these years, we will not ask you about your wages and self-employment earnings when you complete the application for this help.

If you worked in 2006 or 2007, select Yes.

### Spouse's Name:

To ensure your spouse's privacy, we must match the name entered on this application to the name on his or her most recent Social Security card. Therefore, it is very important that you enter it exactly

the same way. If we cannot match these names, you will be unable to file for this extra help for your spouse on the Internet.

### **Spouse's Social Security Number:**

Enter your spouse's own Social Security number. If your spouse receives Social Security benefits based on someone else's Social Security number, such as yours or a former or deceased spouse, do not enter your or the former spouse's Social Security number or Medicare Claim number in this field.

### **What is your spouse's date of birth?**

We use this date to determine your spouse's current age. If your spouse is under age 65, blind or disabled **and** working, we may be able to exclude some of his or her earnings when we determine eligibility for help with prescription drug costs. If your spouse spends part of his or her earnings to pay for things needed in order to work, we will not count those earnings when we determine eligibility. For example, we would exclude the amount spent on attendant care, certain drugs, medical supplies and devices, certain types of training and therapy, certain work-related equipment, etc.

### **Has your spouse worked in 2006 or 2007?**

When we determine eligibility for help with prescription drug plan costs, we consider the wages and self-employment net earnings that you or your spouse receive.

If you or your spouse worked in 2006 or 2007, we will ask you about your wages and self-employment earnings when you complete the application for this help.

If neither you nor your spouse worked in these years, we will not ask you about your wages and self-employment earnings when you complete the application for this help.

If your spouse worked in 2006 or 2007, select Yes.

### **Your Mailing Address:**

All notices sent to you from Social Security will be mailed to the address we currently have on file. If you have moved in the last three months, check the box to indicate this is a new address. Your mailing address must be within the 50 states or the District of Columbia.

### **Your Phone Number:**

Only phone numbers within the 50 states or the District of Columbia will be accepted in this field.

### **If your spouse has Medicare (or expects to have it in the next three months), does he or she also wish to apply?**

If both you and your spouse have Medicare (or expect to have it in the next three months), you may both apply for the extra help on the same application.

Select **Yes** if your spouse is also applying. Select **No** if your spouse is not applying.

### **Do you have combined savings, investments, and real estate worth more than \$23,410?**

To be eligible for help with prescription drug plan costs, your resources must be within certain limits. Your resources include bank accounts (checking, savings, and certificates of deposit), stocks, bonds, savings bonds (including book entry securities\*), mutual funds, Individual Retirement Accounts (IRA), and any other cash at home or anywhere else. Your resources also include real estate you own, **except for the home that you live in**. Examples of other real estate are summer homes, rental properties or undeveloped land they own. Include the things you own by yourself, with your spouse or with someone else. **Do NOT include** vehicles, personal possessions, burial plots or irrevocable burial contracts.

If you are sure that your combined savings, investments, and real estate are worth more than \$23,410, select Yes. The actual limit for eligibility is \$20,410. However, since we may not count some of the resources you expect to use for funeral or burial expenses, you may be able to have up to \$23,410.

\* **Book Entry Securities** - In addition to traditional U.S. Savings Bonds, individuals now may go to the Treasury Department's Internet site and make online purchases of electronic savings bonds. Electronic savings bonds are also called "book entry securities." With book entry securities, the individual's investment is recorded electronically by the Treasury Department and a paper savings bond is not issued. If you have book entry securities, they are counted as resources and should be reported on this application.

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- Resources you could not easily convert to cash, such as jewelry or home furnishings;
- Property you need for self support that is used in a trade or business;
- The **cash** value of your life insurance if the total **face** value of the policies you own is \$1,500 or less;
- The **cash** value of your spouse's life insurance if the total **face** value of the policies he or she owns is \$1,500 or less;
- Irrevocable burial trusts;
- Disaster assistance;
- Certain distributions received by an Alaska Native from an Alaska Native Regional and Village Corporation;
- Land held in trust by the United States for an individual Indian or tribe;
- Funds held in trust by the Secretary of the Interior for an Indian tribe and distributed per capita to members of the tribe;
- Payments to members of specific Indian tribes as provided by Federal legislation; and
- Up to \$2,000 per year received by an Indian that is derived from individual interests in trust or restricted lands.

**NOTE:** Certain other money you may be holding is not counted for nine months, such as:

- Retroactive Social Security or Supplemental Security Income benefits;
- Tax advances and refunds related to earned income tax credits and child tax credits;
- Compensation you receive as a crime victim;
- Relocation assistance from a state or local government; and
- Scholarships and education grants.

**OPTIONAL: (contact person)**

If there is someone that we should contact instead of you regarding the information you provided on this form, please provide his or her name and phone number. If you provide contact information for someone other than yourself, we will only contact that person by phone.

**Contact's Phone Number:**

Only phone numbers within the 50 states or the District of Columbia will be accepted in this field.

Close this window to return to the application.





# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

## Help: About You

### Your Name:

To ensure your privacy, we must match the name you enter on this application to the name on your most recent Social Security card. Therefore, it is very important that you enter it exactly the same way. If we cannot match these names, you will be unable to file for this extra help on the Internet.

### Your Social Security Number:

Enter your own Social Security number. If you receive Social Security benefits based on someone else's Social Security number, such as a current, former, or deceased spouse, do not enter that individual's Social Security number or Medicare Claim Number in this field.

### What is your date of birth?

We use this date to determine your current age. If you are under age 65, blind or disabled **and** working, we may be able to exclude some of your earnings when we determine eligibility for help with prescription drug costs. If you spend part of your earnings to pay for things needed in order to work, we will not count those earnings when we determine eligibility. For example, we would exclude the amount spent on attendant care, certain drugs, medical supplies and devices, certain types of training and therapy, certain work-related equipment, etc.

### Have you worked in 2006 or 2007?

When we determine whether you are eligible for help with prescription drug plan costs, we consider the wages and self-employment net earnings that you receive.

If you worked in 2006 or 2007, we will ask you about your wages and self-employment earnings when you complete the application for this help.

If you did not work in these years, we will not ask you about your wages and self-employment earnings when you complete the application for this help.

If you worked in 2006 or 2007, select Yes.

### Your Mailing Address:

All notices sent to you from Social Security will be mailed to the address we currently have on file. If you have moved in the last three months, check the box to indicate this is a new address. Your

mailing address must be within the 50 states or the District of Columbia.

### **Your Phone Number:**

Only phone numbers within the 50 states or the District of Columbia will be accepted in this field.

### **OPTIONAL: (contact person)**

If there is someone that we should contact instead of you regarding the information you provided on this form, please provide his or her name and phone number. If you provide contact information for someone other than yourself, we will only contact that person by phone.

### **Contact's Phone Number:**

Only phone numbers within the 50 states or the District of Columbia will be accepted in this field.

### **Do you have combined savings, investments, and real estate worth more than \$11,710?**

To be eligible for help with prescription drug plan costs, your resources must be within certain limits. Your resources include bank accounts (checking, savings, and certificates of deposit), stocks, bonds, savings bonds (including book entry securities\*), mutual funds, Individual Retirement Accounts (IRA), and any other cash at home or anywhere else. Your resources also include real estate you own, **except for the home that you live in**. Examples of other real estate are summer homes, rental properties or undeveloped land you own. Include the things you own by yourself or with someone else. **Do NOT include** vehicles, personal possessions, burial plots or irrevocable burial contracts.

If you are sure that your savings, investments, and real estate are worth more than \$11,710, select Yes. The actual limit for eligibility is \$10,210. However, since we may not count some of the resources you expect to use for funeral or burial expenses, you may be able to have up to \$11,710.

\* **Book Entry Securities** - In addition to traditional U.S. Savings Bonds, individuals now may go to the Treasury Department's Internet site and make online purchases of electronic savings bonds. Electronic savings bonds are also called "book entry securities." With book entry securities, the individual's investment is recorded electronically by the Treasury Department and a paper savings bond is not issued. If you have book entry securities, they are counted as resources and should be reported on this application.

Other examples of resources that should **NOT** be counted are:

- Resources you could not easily convert to cash, such as jewelry or home furnishings;
- Property you need for self support that is used in a trade or business;
- The **cash** value of your life insurance if the total **face** value of the policies you own is \$1,500 or less;
- Irrevocable burial trusts;
- Disaster assistance;
- Certain distributions received by an Alaska Native from an Alaska Native Regional and Village Corporation;

- Land held in trust by the United States for an individual Indian or tribe;
- Funds held in trust by the Secretary of the Interior for an Indian tribe and distributed per capita to members of the tribe;
- Payments to members of specific Indian tribes as provided by Federal legislation; and
- Up to \$2,000 per year received by an Indian that is derived from individual interests in trust or restricted lands.

**NOTE:** Certain other money you may be holding is not counted for nine months, such as:

- Retroactive Social Security or Supplemental Security Income benefits;
- Tax advances and refunds related to earned income tax credits and child tax credits;
- Compensation you receive as a crime victim;
- Relocation assistance from a state or local government; and
- Scholarships and education grants.

Close this window to return to the application.



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

## Help: About The Person Completing This Form And The People You Are Helping

### Relationship to Applicant:

In order to understand who is completing this form, we need to know who is providing the information and your relationship to the people for whom you are applying. Please select the choice from the drop-down menu that best reflects your relationship to the people for whom you are applying.

### Form Completer's Phone Number:

Only phone numbers within the 50 states or the District of Columbia will be accepted in this field.

### Form Completer's Address:

If you are working for an organization or agency that is completing this form on behalf of another individual, enter the business address in this field. Otherwise, enter your home address.

Your mailing address must be within the 50 states or the District of Columbia.

### Primary Applicant's Name:

To ensure the primary applicant's privacy, we must match the name entered on this application to the name on his or her most recent Social Security card. Therefore, it is very important that you enter it exactly the same way. If we cannot match these names, you will be unable to file for this extra help on the Internet.

### Primary Applicant's Social Security Number:

Enter the primary applicant's own Social Security number. If the person for whom you are applying receives Social Security benefits based on someone else's Social Security number, such as a current, former or deceased spouse, do not enter that individual's Social Security number or Medicare Claim Number in this field.

### What is the primary applicant's date of birth?

We use this date to determine the primary applicant's current age. If the person for whom you are applying is under age 65, blind or disabled **and** working, we may be able to exclude some of his or her earnings when we determine eligibility for help with prescription drug costs. If he or she spends

part of his or her earnings to pay for things needed in order to work, we will not count those earnings when we determine eligibility. For example, we would exclude the amount spent on attendant care, certain drugs, medical supplies and devices, certain types of training and therapy, certain work-related equipment, etc.

### **Has the primary applicant worked in 2006 or 2007?**

When we determine eligibility for help with prescription drug plan costs, we consider the wages and self-employment net earnings of the person who is applying for this help. We also consider the wages and net self-employment earnings of that person's spouse.

If the primary applicant or his or her spouse worked in 2006 or 2007, we will ask about wages and self-employment earnings on this application.

If neither the primary applicant nor his or her spouse worked in these years, we will not ask about wages and self-employment earnings on this application.

If the primary applicant worked in 2006 or 2007, select Yes.

### **If the spouse has Medicare (or expects to have it in the next three months), does he or she also wish to apply?**

If both the applicant and his or her spouse have Medicare (or expect to have it within the next three months), you may apply for both individuals on the same application.

Select **Yes** if the spouse is also applying. Select **No** if the spouse is not applying.

### **Do the applicants have combined savings, investments, and real estate worth more than \$23,410?**

To be eligible for help with prescription drug plan costs, the resources of the person for whom you are applying and his or her spouse must be within certain limits. Resources include bank accounts (checking, savings, and certificates of deposit), stocks, bonds, savings bonds (including book entry securities\*), mutual funds, Individual Retirement Accounts (IRA), and any other cash at home or anywhere else. Resources also include real estate owned, **except for the home in which the applicants live**. Examples of other real estate are summer homes, rental properties or undeveloped land they own. Include things the person for whom you are applying owns by himself or herself, with his or her spouse or with someone else. **Do NOT include** vehicles, personal possessions, burial plots or irrevocable burial contracts.

If you are sure that their savings, investments, and real estate are worth more than \$23,410, select Yes. The actual limit for eligibility is \$20,410. However, since we may not count some of the resources these people expect to use for funeral or burial expenses, they may be able to have up to \$23,410.

\* **Book Entry Securities** - In addition to traditional U.S. Savings Bonds, individuals now may go to the Treasury Department's Internet site and make online purchases of electronic savings bonds. Electronic savings bonds are also called "book entry securities." With book entry securities, the individual's investment is recorded electronically by the Treasury Department and a paper savings bond is not issued. If the applicants have book entry securities, they are counted as resources and

should be reported on this application.

Other examples of resources that should **NOT** be counted are:

- Resources they could not easily convert to cash, such as jewelry or home furnishings;
- Property they need for self support that is used in a trade or business;
- The **cash** value of the primary applicant's life insurance if the total **face** value of the policies he or she owns is \$1,500 or less;
- The **cash** value of the spouse's life insurance if the total **face** value of the policies he or she owns is \$1,500 or less;
- Irrevocable burial trusts;
- Disaster assistance;
- Certain distributions received by an Alaska Native from an Alaska Native Regional and Village Corporation;
- Land held in trust by the United States for an individual Indian or tribe;
- Funds held in trust by the Secretary of the Interior for an Indian tribe and distributed per capita to members of the tribe;
- Payments to members of specific Indian tribes as provided by Federal legislation; and
- Up to \$2,000 per year received by an Indian that is derived from individual interests in trust or restricted lands.

**NOTE:** Certain other money they may be holding is not counted for nine months, such as:

- Retroactive Social Security or Supplemental Security Income benefits;
- Tax advances and refunds related to earned income tax credits and child tax credits;
- Compensation received as a crime victim;
- Relocation assistance from a state or local government; and
- Scholarships and education grants.

### **Spouse's Name:**

To ensure the spouse's privacy, we must match the name entered on this application to the name on his or her most recent Social Security card. Therefore, it is very important that you enter it exactly the same way. If we cannot match these names, you will be unable to file for this extra help for the spouse on the Internet.

### **Spouse's Social Security Number:**

Enter the spouse's own Social Security number. If the spouse receives Social Security benefits based on someone else's Social Security number, such as his or her current spouse or a former

spouse, do not enter the spouse's or former spouse's Social Security number or Medicare Claim Number in this field.

### **What is the spouse's date of birth?**

We use this date to determine the spouse's current age. If the spouse of the person for whom you are applying is under age 65, blind or disabled **and** working, we may be able to exclude some of his or her earnings when we determine eligibility for help with prescription drug costs. If he or she spends part of his or her earnings to pay for things needed in order to work, we will not count those earnings when we determine eligibility. For example, we would exclude the amount spent on attendant care, certain drugs, medical supplies and devices, certain types of training and therapy, certain work-related equipment, etc.

### **Has the applicant's spouse worked in 2006 or 2007?**

When we determine eligibility for help with prescription drug plan costs, we consider the wages and self-employment net earnings of the person who is applying for this help. We also consider the wages and net self-employment earnings of that person's spouse.

If the primary applicant or his or her spouse worked in 2006 or 2007, we will ask about wages and self-employment earnings on this application.

If neither the primary applicant nor his or her spouse worked in these years, we will not ask about wages and self-employment earnings on this application.

If the primary applicant's spouse worked in 2006 or 2007, select Yes.

### **Mailing Address:**

All notices sent from Social Security to the people for whom you are applying will be mailed to the address we currently have on file. If the people for whom you are applying have moved in the last three months, check the appropriate address-change box. This address must be within the 50 states or the District of Columbia.

### **Phone Number:**

Only phone numbers within the 50 states or the District of Columbia will be accepted in this field.

### **OPTIONAL: (contact person)**

If there is someone that we should contact instead of you regarding the information you provided on this form, please provide his or her name and phone number. If you provide contact information for someone other than yourself, we will only contact that person by phone.

### **Contact's Phone Number:**

Only phone numbers within the 50 states or the District of Columbia will be accepted in this field.

Close this window to return to the application.



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

## Help: About The Person Completing This Form And The Person You Are Helping

### Relationship to Applicant:

In order to understand who is completing this form, we need to know who is providing the information and your relationship to the person for whom you are applying. Please select the choice from the drop-down menu that best reflects your relationship to the person for whom you are applying.

### Form Completer's Phone Number:

Only phone numbers within the 50 states or the District of Columbia will be accepted in this field.

### Form Completer's Address:

If you are working for an organization or agency that is completing this form on behalf of another individual, enter the business address in this field. Otherwise, enter your home address.

Your mailing address must be within the 50 states or the District of Columbia.

### Applicant's Name:

To ensure the applicant's privacy, we must match the name entered on this application to the name on his or her most recent Social Security card. Therefore, it is very important that you enter it exactly the same way. If we cannot match these names, you will be unable to file for this extra help on the Internet.

### Applicant's Social Security Number:

Enter the applicant's own Social Security number. If the person for whom you are applying receives Social Security benefits based on someone else's Social Security number, such as a current, former or deceased spouse, do not enter that individual's Social Security number or Medicare Claim Number in this field.

### What is the applicant's date of birth?

We use this date to determine the applicant's current age. If the person for whom you are applying is under age 65, blind or disabled **and** working, we may be able to exclude some of his or her earnings when we determine eligibility for help with prescription drug costs. If he or she spends part



of his or her earnings to pay for things needed in order to work, we will not count those earnings when we determine eligibility. For example, we would exclude the amount spent on attendant care, certain drugs, medical supplies and devices, certain types of training and therapy, certain work-related equipment, etc.

### **Has the applicant worked in 2006 or 2007?**

When we determine eligibility for help with prescription drug plan costs, we consider the wages and self-employment net earnings of the person who is applying for this help.

If the person you are helping worked in 2006 or 2007, we will ask about his or her wages and self-employment earnings on this application.

If this person did not work in these years, we will not ask about wages and self-employment earnings on this application.

If the person you are helping worked in 2006 or 2007, select Yes.

### **Mailing Address:**

All notices sent from Social Security to the person for whom you are applying will be mailed to the address we currently have on file. If the person for whom you are applying has moved in the last three months, check the appropriate address-change box. This address must be within the 50 states or the District of Columbia.

### **Phone Number:**

Only phone numbers within the 50 states or the District of Columbia will be accepted in this field.

### **OPTIONAL: (contact person)**

If there is someone that we should contact instead of you regarding the information you provided on this form, please provide his or her name and phone number. If you provide contact information for someone other than yourself, we will only contact that person by phone.

### **Contact's Phone Number:**

Only phone numbers within the 50 states or the District of Columbia will be accepted in this field.

### **Does the applicant have combined savings, investments, and real estate worth more than \$11,710?**

To be eligible for help with prescription drug plan costs, the applicant's resources must be within certain limits. Resources include bank accounts (checking, savings, and certificates of deposit), stocks, bonds, savings bonds (including book entry securities\*), mutual funds, Individual Retirement Accounts (IRA), and any other cash at home or anywhere else. Resources also include real estate owned, **except for the home in which the applicant lives**. Examples of other real estate are summer homes, rental properties or undeveloped land he or she owns. Include things the person for whom you are applying owns by himself or herself or with someone else. **Do NOT include** vehicles, personal possessions, burial plots or irrevocable burial contracts.

If you are sure that this person's combined savings, investments, and real estate are worth more

than \$11,710, select Yes. The actual limit for eligibility is \$10,210. However, since we may not count some of the resources the applicant expects to use for funeral or burial expenses, he or she may be able to have up to \$11,710.

\* **Book Entry Securities** - In addition to traditional U.S. Savings Bonds, individuals now may go to the Treasury Department's Internet site and make online purchases of electronic savings bonds. Electronic savings bonds are also called "book entry securities." With book entry securities, the individual's investment is recorded electronically by the Treasury Department and a paper savings bond is not issued. If the applicant has book entry securities, they are counted as resources and should be reported on this application.

Other examples of resources that should **NOT** be counted are:

- Resources that could not easily convert to cash, such as jewelry or home furnishings;
- Property he or she needs for self support that is used in a trade or business;
- The **cash** value of his or her life insurance if the total **face** value of the policies owned is \$1,500 or less;
- Irrevocable burial trusts;
- Disaster assistance;
- Certain distributions received by an Alaska Native from an Alaska Native Regional and Village Corporation;
- Land held in trust by the United States for an individual Indian or tribe;
- Funds held in trust by the Secretary of the Interior for an Indian tribe and distributed per capita to members of the tribe;
- Payments to members of specific Indian tribes as provided by Federal legislation; and
- Up to \$2,000 per year received by an Indian that is derived from individual interests in trust or restricted lands.

**NOTE:** Certain other money he or she may be holding is not counted for nine months, such as:

- Retroactive Social Security or Supplemental Security Income benefits;
- Tax advances and refunds related to earned income tax credits and child tax credits;
- Compensation received as a crime victim;
- Relocation assistance from a state or local government; and
- Scholarships and education grants.

Close this window to return to the application.



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

## Help: About Your And Your Spouse's Living Situation

**Not counting your spouse, how many other relatives live in your household and receive at least one-half of their financial support from you or your spouse? Do NOT include yourself or your spouse in the number you enter. If your household consists only of you and your spouse, enter "0."**

Eligibility for the extra help is based on the amount of your income and that of your spouse compared to the Federal Poverty Level for your household's size. Therefore, we need to know how many other relatives are in your household for whom you or your spouse provide at least one-half of their financial support. We count relatives related to you by blood, marriage or adoption.

**Do you count on anyone to help pay for any of the following household expenses?**

- Food
- Heating Fuel or Gas
- Mortgage
- Electricity and Water
- Rent
- Property Taxes

If anyone **regularly** provides you or your spouse with assistance with your food or shelter costs, select Yes. If Yes, also enter the average amount you receive each month in the space provided.

If you receive help with these expenses for only **part** of the year, it will be necessary for you to compute the average **MONTHLY** amount of this help.

### Example:

A relative paid your heating bills during the winter months of January through March and your heating bills were about \$180 per month during those three months. This means that you received a total of \$540 in help during the year for your heating bills. However, you must enter the **monthly** average amount of this help on your application. To compute the monthly amount, divide \$540 by 12 months, which is \$45, and enter \$45 as the monthly amount of help you received.

If your heating bills were more than \$193 per month, only use \$193 when computing the average monthly amount. (Any help you received over \$193 per month is not counted.) So, if the heating bills for January through March were about \$300 per month, multiply \$193 (not \$300) by three months,

which totals \$579 for the year. Then divide \$579 by 12, which is \$48.25, and enter \$48.25 as the monthly amount of help you received.

If you occasionally or unexpectedly receive small amounts of money or other help, such as your child buying groceries for the week, **do NOT** include that amount. Other examples of possible income sources that should **NOT** be counted are:

- **Food Stamps;**
- **House repairs;**
- **Help from a housing agency;**
- **Help from an energy assistance program;**
- **Meals on Wheels;**
- **Contributions from food banks;**
- **Soup kitchens;**
- **Disaster assistance;**
- **Help with your telephone bills; and**
- **Help with medical bills, treatment and drugs.**

Also, **do NOT** count any help you received before the month you file your application.

Close this window to return to the application.



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

## Help: About Your Living Situation

**How many relatives live in your household and receive at least one-half of their financial support from you? Do NOT include yourself in the number you enter. If your household consists only of you, enter "0."**

Eligibility for the extra help is based on the amount of your income compared to the Federal Poverty Level for your household's size. Therefore, we need to know how many relatives are in your household for whom you provide at least one-half of their financial support. We count relatives related to you by blood, marriage or adoption.

**Do you count on anyone to help pay for any of the following household expenses?**

- Food
- Heating Fuel or Gas
- Mortgage
- Electricity and Water
- Rent
- Property Taxes

If anyone **regularly** provides you with assistance with your food or shelter costs, select Yes. If Yes, also enter the average amount you receive each month in the space provided.

If you receive help with these expenses for only **part** of the year, it will be necessary for you to compute the average **MONTHLY** amount of this help.

### Example:

A relative paid your heating bills during the winter months of January through March and your heating bills were about \$180 per month during those three months. This means that you received a total of \$540 in help during the year for your heating bills. However, you must enter the **monthly** average amount of this help on your application. To compute the monthly amount, divide \$540 by 12 months, which is \$45, and enter \$45 as the monthly amount of help you received.

If your heating bills were more than \$193 per month, only use \$193 when computing the average monthly amount. (Any help you received over \$193 per month is not counted.) So, if the heating bills for January through March were about \$300 per month, multiply \$193 (not \$300) by three months, which totals \$579 for the year. Then divide \$579 by 12, which is \$48.25, and enter \$48.25 as the monthly amount of help you received.

If you occasionally or unexpectedly receive small amounts of money or other help, such as your child buying groceries for the week, **do NOT** include that amount. Other examples of possible income sources that should **NOT** be counted are:

- **Food Stamps;**
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- **Help from a housing agency;**
- **Help from an energy assistance program;**
- **Meals on Wheels;**
- **Contributions from food banks;**
- **Soup kitchens;**
- **Disaster assistance;**
- **Help with your telephone bills; and**
- **Help with medical bills, treatment and drugs.**

Also, **do NOT** count any help you received before the month you file your application.

Close this window to return to the application.



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

## Help: Wages And Earnings

### **What do you or your spouse expect to earn in wages before taxes and deductions this calendar year?**

If you or your spouse expect to earn money for any labor or services you provide on an hourly, daily, or piecework basis during this calendar year, select Wages of: and enter the amount BEFORE taxes and deductions you think you will earn in the field provided. If you did not, and do not expect to earn wages, select None. **Do NOT** include earned income tax credit payments you may have received.

### **What do you or your spouse expect your net earnings from self-employment to be this calendar year?**

If you or your spouse expect to have net earnings or a net loss from self-employment for this year, select the appropriate response and enter the NET amount you think it will be in the field provided. **Do NOT** include earned income tax credit payments you may have received. If you were not, and do not expect to be self-employed, select None.

### **Have these wages or self-employment earnings decreased in the last two years?**

We will be comparing the information you provided about your income and your spouse's income with information from other Federal, State and local government agencies. Since some of that information may be outdated, it will help us process your application if we know that the information we receive from the other agencies is too high.

If the amount of the wages or self-employment income you listed in the questions above has decreased in the last two calendar years, select Yes.

### **Have you or your spouse stopped working in 2006 or 2007, or plan to stop working in 2007 or 2008?**

If you or your spouse stopped working this year or last year, or plan to stop this year or next year, select Yes and enter the month and year in the fields provided.

### **Do you or your spouse have to pay for things related to a disability or blindness that enable you to work?**

We will only count part of your earnings toward the income limit if you:

- work;
- receive Social Security benefits based on a disability or blindness; and
- have work-related expenses for which you are not reimbursed.

If you have work-related expenses, select Yes. You will not need to tell us the amount of those expenses. We will not count a percentage of your earnings. When we send you a letter that says whether you are eligible for the extra help or not, we will also tell you how much of your earnings we did not count. If you think the amount of work-related expenses we used was less than your actual work-related expenses, you may contact us to tell us the actual amount of your expenses.

Close this window to return to the application.





# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

## Help: Wages And Earnings

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

If you expect to earn money for any labor or services you provide on an hourly, daily, or piecework basis during this calendar year, select Wages of: and enter the amount BEFORE taxes and deductions you think you will earn in the field provided. If you did not, and do not expect to earn wages, select None. **Do NOT** include earned income tax credit payments you may have received.

### **What do you expect your net earnings from self-employment to be this calendar year?**

If you expect to have net earnings or a net loss from self-employment for this year, select the appropriate response and enter the NET amount you think it will be in the field provided. **Do NOT** include earned income tax credit payments you may have received. If you were not, and do not expect to be self-employed, select None.

### **Have these wages or self-employment earnings decreased in the last two years?**

We will be comparing the information you provided about your income with information from other Federal, State and local government agencies. Since some of that information may be outdated, it will help us process your application if we know that the information we receive from the other agencies is too high.

If the amount of the wages or self-employment income you listed in the questions above has decreased in the last two calendar years, select Yes.

### **Have you stopped working in 2006 or 2007, or plan to stop working in 2007 or 2008?**

If you stopped working this year or last year, or plan to stop this year or next year, select Yes and enter the month and year in the fields provided.

### **Do you have to pay for things related to a disability or blindness that enable you to work?**

We will only count part of your earnings toward the income limit if you:

- work;
- receive Social Security benefits based on a disability or blindness; and
- have work-related expenses for which you are not reimbursed.

If you have work-related expenses, select Yes. You will not need to tell us the amount of those expenses. We will not count a percentage of your earnings. When we send you a letter that says whether you are eligible for the extra help or not, we will also tell you how much of your earnings we did not count. If you think the amount of work-related expenses we used was less than your actual work-related expenses, you may contact us to tell us the actual amount of your expenses.

Close this window to return to the application.



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

## Help: Income Other Than Wages

### Do you or your spouse receive Social Security benefits?

If you or your spouse currently receive benefits from Social Security, enter the total amount received each month in this field. To find out what amount to enter, use the amount on your annual cost-of-living adjustment letter you receive from Social Security (see sample below). This is the amount BEFORE the premium for Medicare Medical Insurance is deducted. Other types of deductions could include voluntary Federal tax withholding, partial recovery of an overpayment, child support payments, garnishment, etc. (This is **NOT** an all-inclusive list.)

## Your New Benefit Amount

000801

BENEFICIARY'S NAME:

JOHN Q. PUBLIC

SOCIAL SECURITY CLAIM NUMBER

(only the last 4 digits are shown to help prevent identity theft): xxx-xx-1111

Your Social Security benefits will increase by 2.7 percent in 2005, because of a rise in the cost of living. You can use this letter when you need proof of your benefit amount to receive food stamps, rent subsidies, energy assistance, bank loans, or for other business.

### How Much Will I Get And When?

- Your new monthly amount (before deductions) is
- The amount we are deducting for Medicare is (If you did not have Medicare as of Nov. 19, 2004, or if someone else pays your premium, we show \$0.00.)
- The amount we are deducting for voluntary federal tax withholding is (If you did not elect voluntary federal tax withholding as of Nov. 19, 2004, we show \$0.00.)
- After taking any other deductions, we will deposit into your bank account on Jan. 3, 2005.

\$515.00
\$0.00
\$0.00
\$515.00

This is the amount you should use when we ask for your Social Security Benefit.

If you disagree with any of these amounts, you should write to us within 60 days from the date you receive this letter.

### **Do you or your spouse receive Railroad Retirement income?**

If you or your spouse currently receive benefits from the Railroad Retirement Board, enter the total amount received each month in this field. To find out what amount to enter, use the amount on your annual cost-of-living adjustment letter you receive from the Railroad Retirement Board. This is the amount BEFORE the premium for Medicare Medical Insurance is deducted. Other types of deductions could include voluntary Federal tax withholding, partial recovery of an overpayment, child support payments, garnishment, etc. (This is **NOT** an all-inclusive list.)

### **Do you or your spouse receive Veterans benefits?**

If you or your spouse currently receive benefits from the Department of Veterans Affairs, enter the total amount received each month in this field. To find out what amount to enter, use the amount on your annual cost-of-living adjustment letter you receive from the Department of Veterans Affairs. This is the amount BEFORE any deductions have been made. Types of deductions could include voluntary Federal tax withholding, partial recovery of an overpayment, child support payments, garnishment, etc. (This is **NOT** an all-inclusive list.)

### **Do you or your spouse receive income from other pensions or annuities?**

If you or your spouse currently receive income from a pension, enter the total amount received each month in this field. If you receive money from an insurance company (annuity) on a regular basis (monthly, yearly, etc.), enter that amount in this field as well. This includes immediate and deferred annuity payments, and is the amount BEFORE any deductions have been made. Types of deductions could include voluntary Federal tax withholding, partial recovery of an overpayment, child support payments, garnishment, etc. (This is **NOT** an all-inclusive list.)

The entry for this field must be shown in a **MONTHLY** format. If the pension or annuity is received other than monthly, convert to a monthly amount before entering (e.g., if received weekly, multiply by 52 and divide by 12; if received bi-weekly, multiply by 26 and divide by 12; if received yearly, divide by 12, etc.)

**Do NOT include** annuities from certificates of deposit, stocks, bonds, mutual funds, IRAs or any other investments.

### **Do you or your spouse receive other income not listed above, including alimony, net rental income, workers' compensation, etc.?**

Indicate whether you or your spouse receive income from any other source. 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.

(**Do NOT include** help with rent or utilities, money you have in bank accounts, stocks, bonds, savings bonds, mutual funds, IRAs or any similar investments, or any other cash at home or anywhere else.)

**Do NOT** list wages and self-employment, interest income, public assistance, medical reimbursements, or foster care payments here. Other examples of possible income sources that should **NOT** be counted are:

- Food Stamps;
- House repairs;
- Help from an energy assistance program;
- Help with medical bills, treatment and drugs;
- Housing assistance;
- Disaster assistance;

- Meals on Wheels;
- Contributions from food banks;
- Soup kitchens;
- Earned income tax credit payments;
- Victim's compensation payments;
- Scholarships and education grants;
- Certain distributions received by an Alaska Native from an Alaska Native Regional and Village Corporation;
- Land held in trust by the United States for an individual Indian or tribe;
- Funds held in trust by the Secretary of the Interior for an Indian tribe and distributed per capita to members of the tribe;
- Payments to members of specific Indian tribes as provided by Federal legislation; and
- Up to \$2,000 per year received by an Indian that is derived from individual interests in trust or restricted lands.

**Has any of the income from these sources decreased in the last two years?**

We will be comparing the information you provided about your income and your spouse's income with information from other Federal, State and local government agencies. Since some of that information may be outdated, it will help us process your application if we know that the information we receive from the other agencies is too high.

If the amount of the income you listed in the questions above has decreased in the last two calendar years, select Yes.

Close this window to return to the application.



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

## Help: Income Other Than Wages

### Do you receive Social Security benefits?

If you currently receive benefits from Social Security, enter the total amount received each month in this field. To find out what amount to enter, use the amount on your annual cost-of-living adjustment letter you receive from Social Security (see sample below). This is the amount BEFORE the premium for Medicare Medical Insurance is deducted. Other types of deductions could include voluntary Federal tax withholding, partial recovery of an overpayment, child support payments, garnishment, etc. (This is **NOT** an all-inclusive list.)

## Your New Benefit Amount

000801

BENEFICIARY'S NAME:

JOHN Q. PUBLIC

SOCIAL SECURITY CLAIM NUMBER

(only the last 4 digits are shown to help prevent identity theft): xxx-xx-1111

Your Social Security benefits will increase by 2.7 percent in 2005, because of a rise in the cost of living. You can use this letter when you need proof of your benefit amount to receive food stamps, rent subsidies, energy assistance, bank loans, or for other business.

### How Much Will I Get And When?

- Your new monthly amount (before deductions) is
- The amount we are deducting for Medicare is (If you did not have Medicare as of Nov. 19, 2004, or if someone else pays your premium, we show \$0.00.)
- The amount we are deducting for voluntary federal tax withholding is (If you did not elect voluntary federal tax withholding as of Nov. 19, 2004, we show \$0.00.)
- After taking any other deductions, we will deposit into your bank account on Jan. 3, 2005.

\$515.00	This is the amount you should use when we ask for your Social Security Benefit.
\$0.00	
\$0.00	
\$515.00	

If you disagree with any of these amounts, you should write to us within 60 days from the date you receive this letter.

### **Do you receive Railroad Retirement income?**

If you currently receive benefits from the Railroad Retirement Board, enter the total amount received each month in this field. To find out what amount to enter, use the amount on your annual cost-of-living adjustment letter you receive from the Railroad Retirement Board. This is the amount BEFORE the premium for Medicare Medical Insurance is deducted. Other types of deductions could include voluntary Federal tax withholding, partial recovery of an overpayment, child support payments, garnishment, etc. (This is **NOT** an all-inclusive list.)

### **Do you receive Veterans benefits?**

If you currently receive benefits from the Department of Veterans Affairs, enter the total amount received each month in this field. To find out what amount to enter, use the amount on your annual cost-of-living adjustment letter you receive from the Department of Veterans Affairs. This is the amount BEFORE any deductions have been made. Types of deductions could include voluntary Federal tax withholding, partial recovery of an overpayment, child support payments, garnishment, etc. (This is **NOT** an all-inclusive list.)

### **Do you receive income from other pensions or annuities?**

If you currently receive income from a pension, enter the total amount received each month in this field. If you receive money from an insurance company (annuity) on a regular basis (monthly, yearly, etc.), enter that amount in this field as well. This includes immediate and deferred annuity payments, and is the amount BEFORE any deductions have been made. Types of deductions could include voluntary Federal tax withholding, partial recovery of an overpayment, child support payments, garnishment, etc. (This is **NOT** an all-inclusive list.)

The entry for this field must be shown in a **MONTHLY** format. If the pension or annuity is received other than monthly, convert to a monthly amount before entering (e.g., if received weekly, multiply by 52; if received bi-weekly, multiply by 26; if received yearly, divide by 12, etc.)

**Do NOT include** annuities from certificates of deposit, stocks, bonds, mutual funds, IRAs or any other investments.

### **Do you receive other income not listed above, including alimony, net rental income, workers' compensation, etc.?**

Indicate whether you receive income from any other source. 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.

**(Do NOT include** help with rent or utilities, money you have in bank accounts, stocks, bonds, savings bonds, mutual funds, IRAs or any similar investments, or any other cash at home or anywhere else.)

**Do NOT** list wages and self-employment, interest income, public assistance, medical reimbursements, or foster care payments here. Other examples of possible income sources that should **NOT** be counted are:

- Food Stamps;
- House repairs;
- Help from an energy assistance program;
- Help with medical bills, treatment and drugs;
- Housing assistance;
- Disaster assistance;

- Meals on Wheels;
- Contributions from food banks;
- Soup kitchens;
- Earned income tax credit payments;
- Victim's compensation payments;
- Scholarships and education grants;
- Certain distributions received by an Alaska Native from an Alaska Native Regional and Village Corporation;
- Land held in trust by the United States for an individual Indian or tribe;
- Funds held in trust by the Secretary of the Interior for an Indian tribe and distributed per capita to members of the tribe;
- Payments to members of specific Indian tribes as provided by Federal legislation; and
- Up to \$2,000 per year received by an Indian that is derived from individual interests in trust or restricted lands.

**Has any of the income from these sources decreased in the last two years?**

We will be comparing the information you provided about your income with information from other Federal, State and local government agencies. Since some of that information may be outdated, it will help us process your application if we know that the information we receive from the other agencies is too high.

If the amount of the income you listed in the questions above has decreased in the last two calendar years, select Yes.

Close this window to return to the application.





# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

## Help: Resources

**Do you or your spouse have any of the following resources? If Yes, enter the combined total for those items.**

**Combined total of all bank accounts (checking, savings and certificates of deposit)**

**Combined total of all stocks, bonds, savings bonds, mutual funds, Individual Retirement Accounts or other similar investments**

**Any other cash at home or anywhere else**

To be eligible for help with prescription drug plan costs, your and your spouse's resources must be within certain limits. Your resources include bank accounts (checking, savings, and certificates of deposit), stocks, bonds, savings bonds (including book entry securities\*), Individual Retirement Accounts (IRA), and any other cash at home or anywhere else.

You can look at your most recent statements from your bank or stock broker to find out how much is in your account(s).

\* **Book Entry Securities** - In addition to traditional U.S. Savings Bonds, individuals now may go to the Treasury Department's Internet site and make online purchases of electronic savings bonds. Electronic savings bonds are also called "book entry securities." With book entry securities, the individual's investment is recorded electronically by the Treasury Department and a paper savings bond is not issued. If you have book entry securities, they are counted as resources and should be reported on this application.

**Do NOT** include cash if it is from a Social Security check or pension check that you cashed this month. Also, **do NOT include the home you live in**, vehicle(s), personal possessions, burial plots or irrevocable burial contracts. Other examples of resources that should **NOT** be counted are:

- Resources you could not easily convert to cash, such as jewelry or home furnishings;
- Property you need for self support that is used in a trade or business;
- The **cash** value of your life insurance if the total **face** value of the policies you own is \$1,500 or less;
- The **cash** value of your spouse's life insurance if the total **face** value of the policies he or she owns is \$1,500 or less;
- Irrevocable burial trusts;

- Disaster assistance;
- Certain distributions received by an Alaska Native from an Alaska Native Regional and Village Corporation;
- Land held in trust by the United States for an individual Indian or tribe;
- Funds held in trust by the Secretary of the Interior for an Indian tribe and distributed per capita to members of the tribe;
- Payments to members of specific Indian tribes as provided by Federal legislation; and
- Up to \$2,000 per year received by an Indian that is derived from individual interests in trust or restricted lands.

**NOTE:** Certain other money you may be holding is not counted for nine months, such as:

- Retroactive Social Security or Supplemental Security Income benefits;
- Tax advances and refunds related to earned income tax credits and child tax credits;
- Compensation you receive as a crime victim;
- Relocation assistance from a state or local government; and
- Scholarships and education grants.

**Do you or your spouse own life insurance policies with a total face value of more than \$1,500?**

If you or your spouse own life insurance policies, find out their total face value. To find out how much the face value of your policy is, refer to your policy package. For example, if you have a life insurance policy that would pay out \$20,000 if you or your spouse should pass away, select Yes.

**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.

You do **not** have to turn in your life insurance policies to be eligible for the extra help. However, we may need to know the value of your life insurance policies to decide if you meet the resource limit.

If the total face value of all **your** life insurance policies is \$1,500 or less, we do not need to know about them. Neither do we need to know about **your spouse's** policies if their total face value is not more than \$1,500. The face value of the policy is the amount the insurance company would pay if you should pass away.

If the total face value of your policies is more than \$1,500, we need to know how much the insurance company would pay if you cashed in the policy. This is known as the cash value of the policy.

To find out the cash value of your policies, look at each policy. If the policy says something like, "This policy has no cash value," enter "0" in the field that asks for the value. If the policy has a cash value, the policy may include a table that says what the value is based on and how many years you have owned the policy. If so, enter the value shown in the table. If you have more than one policy, enter the total value of all of the policies.

**NOTE:** Do **NOT** combine the **cash** values of your policies with those of your spouse's unless you each have policies in your own name with a total **face** value of more than \$1,500.

If your policies do not have a cash value table, contact your insurance agent or the insurance company to find out the cash value of the policies.

If you cannot determine the cash value on your policies and cannot obtain it from your insurance agent or company, you may use the following chart to estimate the cash value using the Face Value and the number of years you owned the policy.

### Chart for Estimating Cash Value

Years policy has been in effect	Estimated percentage of Face Value
20 or more	60%
15-19	50%
11-14	45%
6-10	30%
4-5	20%
3	10%
2	5%
1	0%

**EXAMPLE:** You own a 5-year-old policy with a Face Value of \$2,000. Using the chart above, the estimated Cash Value is \$400 (i.e., 20% of \$2,000).

If you are not comfortable estimating the cash value of your policies using this chart, you may call Social Security toll-free at **1-800-772-1213** and we will help you determine the cash value.

### Will some money from any of the sources listed above be used to pay for funeral or burial expenses?

If you do not expect to use any of the money or investments that you listed on this page to pay for your or your spouse's funeral or burial expenses, select **No**. If you do, skip to the next question (i.e., a Yes response is not necessary in this case, and there is no Yes response entry available for this question).

### Other than your home and the property on which it is located, do you or your spouse own any real estate?

Select Yes if you or your spouse own real estate **other than the home in which you live**.

Examples of other real estate are summer homes, rental properties or undeveloped land you own. Include real estate that you own with your spouse or with another person or persons. If Yes, a Social Security representative will contact you to discuss this further.

Close this window to return to the application.



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

## Help: Resources

**Do you have any of the following resources? If Yes, enter the combined total for those items.**

**Combined total of all bank accounts (checking, savings and certificates of deposit)**

**Combined total of all stocks, bonds, savings bonds, mutual funds, Individual Retirement Accounts or other similar investments**

**Any other cash at home or anywhere else**

To be eligible for help with prescription drug plan costs, your resources must be within certain limits. Your resources include bank accounts (checking, savings, and certificates of deposit), stocks, bonds, savings bonds (including book entry securities\*), Individual Retirement Accounts (IRA), and any other cash at home or anywhere else.

You can look at your most recent statements from your bank or stock broker to find out how much is in your account(s).

\* **Book Entry Securities** - In addition to traditional U.S. Savings Bonds, individuals now may go to the Treasury Department's Internet site and make online purchases of electronic savings bonds. Electronic savings bonds are also called "book entry securities." With book entry securities, the individual's investment is recorded electronically by the Treasury Department and a paper savings bond is not issued. If you have book entry securities, they are counted as resources and should be reported on this application.

**Do NOT** include cash if it is from a Social Security check or pension check that you cashed this month. Also, **do NOT include the home you live in**, vehicle(s), personal possessions, burial plots or irrevocable burial contracts. Other examples of resources that should **NOT** be counted are:

- Resources you could not easily convert to cash, such as jewelry or home furnishings;
- Property you need for self support that is used in a trade or business;
- The **cash** value of your life insurance if the total **face** value of the policies you own is \$1,500 or less;
- Irrevocable burial trusts;
- Disaster assistance;
- Certain distributions received by an Alaska Native from an Alaska Native Regional and

Village Corporation;

- Land held in trust by the United States for an individual Indian or tribe;
- Funds held in trust by the Secretary of the Interior for an Indian tribe and distributed per capita to members of the tribe;
- Payments to members of specific Indian tribes as provided by Federal legislation; and
- Up to \$2,000 per year received by an Indian that is derived from individual interests in trust or restricted lands.

**NOTE:** Certain other money you may be holding is not counted for nine months, such as:

- Retroactive Social Security or Supplemental Security Income benefits;
- Tax advances and refunds related to earned income tax credits and child tax credits;
- Compensation you receive as a crime victim;
- Relocation assistance from a state or local government; and
- Scholarships and education grants.

### **Do you own life insurance policies with a total face value of more than \$1,500?**

If you own life insurance policies, find out their total face value. To find out how much the face value of your policy is, refer to your policy package. For example, if you have a life insurance policy that would pay out \$20,000 if you should pass away, select Yes.

### **If Yes, how much money would you get if you turned in your policies for cash right now?**

This is NOT the face value of your policies. You may need to call your insurance company to help answer this question.

You do **not** have to turn in your life insurance policies to be eligible for the extra help. However, we may need to know the value of your life insurance policies to decide if you meet the resource limit.

If the total face value of all your life insurance policies is \$1,500 or less, we do not need to know about them. The face value of the policy is the amount the insurance company would pay if you should pass away.

If the total face value of your policies is more than \$1,500, we need to know how much the insurance company would pay if you cashed in the policy. This is known as the cash value of the policy.

To find out the cash value of your policies, look at each policy. If the policy says something like, "This policy has no cash value," enter "0" in the field that asks for the value. If the policy has a cash value, the policy may include a table that says what the value is based on and how many years you have owned the policy. If so, enter the value shown in the table. If you have more than one policy, enter the total value of all of the policies.

If your policies do not have a cash value table, contact your insurance agent or the insurance

company to find out the cash value of the policies.

If you cannot determine the cash value on your policies and cannot obtain it from your insurance agent or company, you may use the following chart to estimate the cash value using the Face Value and the number of years you owned the policy.

### Chart for Estimating Cash Value

Years policy has been in effect	Estimated percentage of Face Value
20 or more	60%
15-19	50%
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6-10	30%
4-5	20%
3	10%
2	5%
1	0%

**EXAMPLE:** You own a 5-year-old policy with a Face Value of \$2,000. Using the chart above, the estimated Cash Value is \$ 400 (i.e., 20% of \$2,000).

If you are not comfortable estimating the cash value of your policies using this chart, you may call Social Security toll-free at **1-800-772-1213** and we will help you determine the cash value.

### Will some money from any of the sources listed above be used to pay for funeral or burial expenses?

If you do not expect to use any of the money or investments that you listed on this page to pay for your funeral or burial expenses, select **No**. If you do, skip to the next question (i.e., a Yes response is not necessary in this case, and there is no Yes response entry available for this question).

### Other than your home and the property on which it is located, do you own any real estate?

Select Yes if you own real estate **other than the home in which you live**. Examples of other real estate are summer homes, rental properties or undeveloped land you own. Include real estate that you own by yourself, or with another person or persons. If Yes, a Social Security representative will contact you to discuss this further.

Close this window to return to the application.



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

## Help: Worked In 2006 or 2007

### Have You Worked In 2006 or 2007?

When we determine whether you are eligible for help with prescription drug plan costs, we consider the wages and self-employment net earnings that you (and your spouse, if married and living together) receive.

If you (or your spouse, if married and living together) worked in 2006 or 2007, we will ask you about your wages and self-employment earnings when you complete the application for this help.

If neither you nor your spouse worked in these years, we will not ask you about your wages and self-employment earnings when you complete the application for this help.

If you worked in 2006 or 2007, select Yes.

Close this window to return to the application.





# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

## Help: Spouse Worked In 2006 or 2007

### Has Your Spouse Worked In 2006 or 2007?

When we determine eligibility for help with prescription drug plan costs, we consider the wages and self-employment net earnings that you and your spouse receive.

If you or your spouse worked in 2006 or 2007, we will ask you about your wages and self-employment earnings when you complete the application for this help.

If neither you nor your spouse worked in these years, we will not ask you about your wages and self-employment earnings when you complete the application for this help.

If your spouse worked in 2006 or 2007, select Yes.

Close this window to return to the application.



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

## **Help: Have You Worked In This Calendar Year**

### **Have You Worked In This Calendar Year?**

If you have worked at any time during the present calendar year, select Yes for this question. If you have not worked at any time during the current calendar year, select No.

Close this window to return to the application.



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

## **Help: Has Your Spouse Worked In This Calendar Year**

### **Has Your Spouse Worked In This Calendar Year?**

If your spouse has worked at any time during the present calendar year, select Yes for this question. If your spouse has not worked at any time during the current calendar year, select No.

Close this window to return to the application.



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

## Help: Under 65 Years Old

### Are You UNDER 65 Years Old?

If you are under age 65, blind or disabled **and** working, we may be able to exclude some of your earnings when we determine your eligibility for help with prescription drug costs. If you spend part of your earnings to pay for things needed in order to work, we will not count those earnings when we determine eligibility. For example, we would exclude the amount spent on attendant care, certain drugs, medical supplies and devices, certain types of training and therapy, certain work-related equipment, etc.

Close this window to return to the application.



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

## Help: Spouse Under 65 Years Old

### Is Your Spouse UNDER 65 Years Old?

If your spouse is under age 65, blind or disabled **and** working, we may be able to exclude some of his or her earnings when we determine eligibility for help with prescription drug costs. If your spouse spends part of his or her earnings to pay for things needed in order to work, we will not count those earnings when we determine eligibility. For example, we would exclude the amount spent on attendant care, certain drugs, medical supplies and devices, certain types of training and therapy, certain work-related equipment, etc.

Close this window to return to the application.



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

## Help: Ready To Submit

### To The Best Of My Knowledge

This statement means that everything you have told us on the application is true and correct **to the best of your knowledge**. We realize that some of the information we asked for can change from one day to the next. We also realize that some of the amounts you entered are estimates. You will not be penalized as long as you have given us your best estimates in those situations. However, if you know that something you told us on the application is not correct, select Previous to go back and correct the information.

If the information you told us on the application is true and correct to the best of your knowledge, check the box next to your name and select Submit Now to finish this application.

Close this window to return to the application.

# Overview of Pages in i1020

These screenshots were generated on 8/23/2007 around 3:39 p.m.

Screen Number	Screen Name
<b>Section: Entry and Exit</b>	
<a href="#">ee001</a>	<a href="#">Welcome</a>
<a href="#">ee001fe</a>	<a href="#">Welcome</a>
<a href="#">ee002</a>	<a href="#">Should You Use This Application?</a>
<a href="#">ee003</a>	<a href="#">Welcome Back</a>
<a href="#">ee004</a>	<a href="#">Sign Out</a>
<a href="#">ee005a</a>	<a href="#">You Are Not Eligible For The Extra Help</a>
<a href="#">ee005b</a>	<a href="#">Go Ahead</a>
<a href="#">ee006a</a>	<a href="#">Preparing To Find Out If You Qualify</a>
<a href="#">ee006b</a>	<a href="#">Preparing To Use This Application</a>
<b>Section: MC pages</b>	
<a href="#">mc001a</a>	<a href="#">About You And Your Spouse</a>
<a href="#">mc001a_WITH</a>	<a href="#">About You And Your Spouse</a>
<a href="#">mc001b</a>	<a href="#">About You</a>
<a href="#">mc001c</a>	<a href="#">About The Person Completing The Form And The People You Are Helping</a>
<a href="#">mc001d</a>	<a href="#">About The Person Completing The Form And The Person You Are Helping</a>
<a href="#">mc002</a>	<a href="#">Reentry Number Issued Normal Process</a>
<a href="#">mc003a</a>	<a href="#">About Your And Your Spouse's Living Situation - Married</a>
<a href="#">mc003b</a>	<a href="#">About Your Living Situation - Single</a>
<a href="#">mc004a_WITHOUT</a>	<a href="#">Wages And Earnings - Married</a>
<a href="#">mc004a_WITH</a>	<a href="#">Wages And Earnings - Married</a>
<a href="#">mc004b_WITHOUT</a>	<a href="#">Wages And Earnings - Single</a>

<a href="#">mc004b_WITH</a>	<a href="#">Wages And Earnings - Single</a>
<a href="#">mc005a</a>	<a href="#">Income Other Than Wages And Earnings - Married</a>
<a href="#">mc005b</a>	<a href="#">Income Other Than Wages And Earnings - Single</a>
<a href="#">mc006a</a>	<a href="#">Resources - Married</a>
<a href="#">mc006b</a>	<a href="#">Resources - Single</a>
<a href="#">mc007a</a>	<a href="#">Tool: Add Up Your Accounts</a>
<a href="#">mc007b</a>	<a href="#">Tool: Add Up Your Investments</a>
<a href="#">mc007c</a>	<a href="#">Tool: Add Up Your Other Pensions And Annuities</a>
<a href="#">mc007d</a>	<a href="#">Tool: Add Up Your Types Of Income</a>
<b>Section: Qualifier pages</b>	
<a href="#">qu001a_WITHOUT</a>	<a href="#">Find Out If You And Your Spouse Qualify: Part 1 - Married</a>
<a href="#">qu001a_WITH</a>	<a href="#">Find Out If You And Your Spouse Qualify: Part 1 - Married</a>
<a href="#">qu001b</a>	<a href="#">Find Out If You Qualify: Part 1 - Single</a>
<a href="#">qu002a_WITH</a>	<a href="#">Find Out If You And Your Spouse Qualify: Part 3 - Married</a>
<a href="#">qu002b_WITHOUT</a>	<a href="#">Find Out If You Qualify: Part 3 - Single</a>
<a href="#">qu002b_WITH</a>	<a href="#">Find Out If You Qualify: Part 3 - Single</a>
<a href="#">qu003a</a>	<a href="#">Find Out If You Qualify: Part 2 Of 3</a>
<a href="#">qu003b</a>	<a href="#">Find Out If You Qualify: Part 2 Of 3</a>
<a href="#">qu004a</a>	<a href="#">Find Out If You Qualify: Results - You Should Apply</a>
<a href="#">qu004b</a>	<a href="#">Find Out If You Qualify: Results - You Probably Do Not Qualify</a>
<b>Section: Review and Send</b>	
<a href="#">rs001</a>	<a href="#">Review Your Information</a>
<a href="#">rs001_MISSING_DATA</a>	<a href="#">Review Your Information</a>
<a href="#">rs003_NO_SINGLE</a>	<a href="#">Ready To Submit</a>
<a href="#">rs003_YES_SINGLE</a>	<a href="#">Ready To Submit</a>
<a href="#">rs003_NO_MARRIED_BOTH</a>	<a href="#">Ready To Submit</a>
<a href="#">rs003_NO_MARRIED_SELF</a>	<a href="#">Ready To Submit</a>
<a href="#">rs003_YES_MARRIED</a>	<a href="#">Ready To Submit</a>
<a href="#">rs004_NO_SINGLE</a>	<a href="#">Successful Submission - Print Or Save Your Receipt</a>



<a href="#">rs004_NO_MARRIED_BOTH</a>	<a href="#">Successful Submission - Print Or Save Your Receipt</a>
<a href="#">rs004_NOT_SUBMITTED</a>	<a href="#">Unsuccessful Submission</a>
<a href="#">rs005</a>	<a href="#">Next Steps</a>
<a href="#">rs006</a>	<a href="#">Missing Information (Fix Errors)</a>
<a href="#">rs007_NO_SINGLE</a>	<a href="#">Successful Submission - Print Or Save Your Receipt</a>
<a href="#">rs007_NO_MARRIED_BOTH</a>	<a href="#">Successful Submission - Print Or Save Your Receipt</a>
<a href="#">rs007_NOT_SUBMITTED</a>	<a href="#">Unsuccessful Submission</a>
<b>Section: Help pages</b>	
<a href="#">hlp001</a>	<a href="#">Main Help Page</a>
<a href="#">hlp002</a>	<a href="#">Help: Should You Use This Application</a>
<a href="#">hlp003a</a>	<a href="#">Help: Find Out If You And Your Spouse Qualify: Part 1</a>
<a href="#">hlp003b</a>	<a href="#">Help: Find Out If You Qualify: Part 1</a>
<a href="#">hlp004a</a>	<a href="#">Help: Find Out If You And Your Spouse Qualify: Part 3</a>
<a href="#">hlp004b</a>	<a href="#">Help: Find Out If You Qualify: Part 3</a>
<a href="#">hlp005a</a>	<a href="#">Help: Find Out If You and Your Spouse Qualify: Part 2</a>
<a href="#">hlp005b</a>	<a href="#">Help: Find Out If You Qualify: Part 2</a>
<a href="#">hlp006a</a>	<a href="#">Help: About You And Your Spouse</a>
<a href="#">hlp006b</a>	<a href="#">Help: About You</a>
<a href="#">hlp006c</a>	<a href="#">Help: About The Person Completing This Form And The People You Are Helping</a>
<a href="#">hlp006d</a>	<a href="#">Help: About The Person Completing This Form And The Person You Are Helping</a>
<a href="#">hlp007a</a>	<a href="#">Help: About Your And Your Spouse's Living Situation</a>
<a href="#">hlp007b</a>	<a href="#">Help: About Your Living Situation</a>
<a href="#">hlp008a</a>	<a href="#">Help: Wages And Earnings</a>
<a href="#">hlp008b</a>	<a href="#">Help: Wages And Earnings</a>
<a href="#">hlp009a</a>	<a href="#">Help: Income Other Than Wages</a>
<a href="#">hlp009b</a>	<a href="#">Help: Income Other Than Wages</a>
<a href="#">hlp010a</a>	<a href="#">Help: Resources</a>
<a href="#">hlp010b</a>	<a href="#">Help: Resources</a>

<a href="#">hlp011a</a>	<a href="#">Help: Worked In 2006 or 2007</a>
<a href="#">hlp011b</a>	<a href="#">Help: Spouse Worked In 2006 or 2007</a>
<a href="#">hlp012a</a>	<a href="#">Help: Have You Worked In This Calendar Year</a>
<a href="#">hlp012b</a>	<a href="#">Help: Has Your Spouse Worked In This Calendar Year</a>
<a href="#">hlp013a</a>	<a href="#">Help: Under 65 Years Old</a>
<a href="#">hlp013b</a>	<a href="#">Help: Spouse Under 65 Years Old</a>
<a href="#">hlp014</a>	<a href="#">Help: Ready To Submit</a>
<b>Section: Message pages</b>	
<a href="#">msg105</a>	<a href="#">Authentication - Medicare Part D Database Not Eligible Or SSI Recipient</a>
<a href="#">msg016_MARRIED</a>	<a href="#">Check The Social Security Number You Entered</a>
<a href="#">msg016_SINGLE</a>	<a href="#">Check The Social Security Number You Entered</a>
<a href="#">msg023</a>	<a href="#">How The Online Application Works</a>
<a href="#">msg004</a>	<a href="#">Internet Security Policy</a>
<a href="#">msg031</a>	<a href="#">Limit Number Of Restarts</a>
<a href="#">msg029</a>	<a href="#">Limit Number Of Starts For A New Application</a>
<a href="#">msg034</a>	<a href="#">Limit On The Number Of Tries To Start An Application</a>
<a href="#">msg104</a>	<a href="#">Name Check Mismatch</a>
<a href="#">msg102</a>	<a href="#">Not Eligible For The Prescription Drug Plan</a>
<a href="#">msg028</a>	<a href="#">Off Hours Message</a>
<a href="#">msg061</a>	<a href="#">Other Ways To Apply</a>
<a href="#">msg015</a>	<a href="#">Paperwork Reduction Act Statement</a>
<a href="#">msg047_WORKED_2Y</a>	<a href="#">Please Confirm</a>
<a href="#">msg047_WORKED_2Y_SPOUSE</a>	<a href="#">Please Confirm</a>
<a href="#">msg047_WORKED_1Y</a>	<a href="#">Please Confirm</a>
<a href="#">msg047_WORKED_1Y_SPOUSE</a>	<a href="#">Please Confirm</a>
<a href="#">msg047_65_SELF</a>	<a href="#">Please Confirm</a>
<a href="#">msg047_65_SPOUSE</a>	<a href="#">Please Confirm</a>
<a href="#">msg063</a>	<a href="#">Print/Save/View Guide</a>

<a href="#">msg030</a>	<a href="#">Processing Alert</a>
<a href="#">msg017</a>	<a href="#">Sign-In Problem</a>
<a href="#">msg024</a>	<a href="#">Special Instructions For Blind Users</a>
<a href="#">msg027</a>	<a href="#">System Failure</a>
<a href="#">msg018</a>	<a href="#">There Is A Pending Application For This Social Security Number</a>
<a href="#">msg045</a>	<a href="#">Warning System Shutdown</a>
<a href="#">msg026</a>	<a href="#">We Cannot Process Your Request</a>
<a href="#">msg106</a>	<a href="#">What You Will Need</a>
<a href="#">msg008</a>	<a href="#">You Do Not Live In One Of The 50 States Or DC</a>
<a href="#">msg019</a>	<a href="#">You Have Already Sent Us An Application</a>
<a href="#">msg025</a>	<a href="#">Your Session Has Expired</a>



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

[Need Help?](#)

Step: **Complete Application** Review Submit Print Receipt

## About You And Your Spouse

We need some basic information about how to contact you and your spouse in case we have any questions about this application. Once you complete all the information on this page, we will provide you with a reentry number and you will be able to exit the application and return to complete it later.

### About You

**Your Name:** [More Info](#)

(First, Middle Initial, Last, Suffix)

Enter your name as it appears on your most recent Social Security card.

**Your Social Security Number:** [More Info](#)

(Do NOT include dashes or hyphens.)

**What is your date of birth?** [More Info](#)

**Have you worked in 2006 or 2007?** [More Info](#)  No  Yes

### About Your Spouse

**Spouse's Name:** [More Info](#)

(First, Middle Initial, Last, Suffix)

Enter your spouse's name as it appears on his or her most recent Social Security card.

**Spouse's Social Security Number:** [More](#)

[Info](#)

(Do NOT include dashes or hyphens.)

**What is your spouse's date of birth?** [More](#)

[Info](#)

**Has your spouse worked in 2006 or 2007?** [More](#)

No

[Info](#)

Yes

## Contact Information

**Your Mailing Address:** [More](#)

[Info](#)

**We have changed our address within the last three months**

(Address Line  
1)

**Apt. No.**

(Address Line  
2)

(Address Line  
3)

(City, State,  
ZIP)

**Your Phone Number:** [More](#)

[Info](#)

(       )       -

## Other Information

**If your spouse has Medicare (or expects to have it in the next three months), does he or she also wish to apply?** [More Info](#)

No

Yes

**Do you have combined savings, investments, and real estate worth more than \$23,410?** [More Info](#)

Include the things you own by yourself, with your spouse or with another person. **DO NOT include the home**

you live in, vehicles, personal possessions, burial plots or irrevocable burial contracts.

No Yes Not

Sure

**OPTIONAL:** If you want us to contact someone else if we have additional questions, please provide the person's name and a daytime phone number. [More Info](#)

**Contact Person's**

**Name:**

(First, Last)

**Contact's Phone Number:** [More Info](#) (       )       -



# Help With Medicare Prescription Drug Plan Costs


1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

[Need Help?](#)

**Step:**  **Complete Application**

 Review

 Submit

 Print Receipt

## About You And Your Spouse

We need some basic information about how to contact you and your spouse in case we have any questions about this application. Once you complete all the information on this page, we will provide you with a reentry number and you will be able to exit the application and return to complete it later.

### About You

**Your Name:** [More Info](#)

**John  
Doe**

(First, Middle Initial, Last, Suffix)

Enter your name as it appears on your most recent Social Security card.

**Your Social Security Number:** [More Info](#) **743993047**

[Info](#)

(Do NOT include dashes or hyphens.)

**What is your date of birth?** [More Info](#) **January 01**

[Info](#)

**1960**

**Have you worked in 2006 or 2007?** [More Info](#)

[Info](#)

No  Yes

### About Your Spouse

**Spouse's Name:** [More Info](#)

**Jane  
Doe**

(First, Middle Initial, Last, Suffix)

Enter your spouse's name as it appears on his or her most recent Social Security card.

**Spouse's Social Security Number:** [More Info](#) **743991047**

[Info](#)

(Do NOT include dashes or hyphens.)

What is your spouse's date of birth? [More](#) February 02

[Info](#) 1901

Has your spouse worked in 2006 or 2007? [More](#)

[Info](#)  No  Yes

### Contact Information

Your Mailing Address: [More](#) We have changed our address within the last three months  
[Info](#)

(Address Line 1) Apt. No.

(Address Line 2)

(Address Line 3)

(City, State, ZIP)

Your Phone Number: [More](#) ( ) -  
[Info](#)

### Other Information

If your spouse has Medicare (or expects to have it in the next three months), does he or she also wish to apply? [More Info](#)

No  
Yes

Do you have combined savings, investments, and real estate worth more than \$23,410? [More Info](#)

Include the things you own by yourself, with your spouse or with another person. **DO NOT include the home you live in, vehicles, personal possessions, burial plots or irrevocable burial contracts.**

No Yes Not  
Sure

**OPTIONAL:** If you want us to contact someone else if we have additional questions, please provide the person's name and a daytime phone number. [More Info](#)



---

**Contact Person's**

**Name:**

(First, Last)

---

**Contact's Phone Number:** [More](#) (      )      -  
[Info](#)





# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

[Need Help?](#)

**Step:**  **Complete Application**

 Review

 Submit

 Print Receipt

## About You

We need some basic information about how to contact you in case we have any questions about this application. Once you complete all the information on this page, we will provide you with a reentry number and you will be able to exit the application and return to complete it later.

**Your Name:** [More Info](#)

(First, Middle Initial, Last, Suffix)

Enter your name as it appears on your most recent Social Security card.

**Your Social Security Number:** [More Info](#)

(Do NOT include dashes or hyphens.)

**What is your date of birth:** [More Info](#)

**Have you worked in 2006 or 2007?** [More Info](#)

No

Yes

## Contact Information

**Your Mailing Address:** [More Info](#)

**I have changed my address within the last three months**

(Address Line  
1)

Apt. No.

(Address Line  
2)

(Address Line  
3)

(City, State,  
ZIP)

Your Phone Number: [More Info](#) (      ) -

### Other Information

**OPTIONAL:** If you want us to contact someone else if we have additional questions, please provide the person's name and a daytime phone number. [More Info](#)

**Contact Person's  
Name:**

(First, Last)

Contact's Phone Number: [More Info](#) (      ) -

**Do you have combined savings, investments, and real estate worth more than \$11,710?** [More Info](#)

Include the things you own by yourself or with another person. **DO NOT** include the home you live in, vehicles, personal possessions, burial plots or irrevocable burial contracts.

**No      Yes      Not  
Sure**



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

[Need Help?](#)

Step: **Complete Application**

Review

Submit

Print Receipt

## About The Person Completing The Form And The People You Are Helping

We need some basic information about how to contact you and the people you are helping in case we have any questions about this application. Once you complete all the information on this page, we will provide you with a reentry number and you will be able to exit the application and return to complete it later.

### About The Person Completing The Form

#### Form Completer's

**Name:**

(First, Middle Initial, Last)

**Relationship to Applicant:** [More](#)

[Info](#)

If other, please indicate:

**Form Completer's Phone Number:** [More](#)

[Info](#)

(       ) -

**Form Completer's Address:** [More](#)

[Info](#)

**(Address Line**

1)

**Apt. No.**

**(Address Line**

2)

**(Address Line**

3)

**(City, State,**

ZIP)

## About The Person You Are Helping

**Primary Applicant's Name:** [More Info](#)

(First, Middle Initial, Last, Suffix)

Enter the name as it appears on the primary applicant's most recent Social Security card.

**Primary Applicant's Social Security Number:** [More Info](#)

(Do NOT include dashes or hyphens.)

**What is the primary applicant's date of birth?** [More Info](#)

**Has the primary applicant worked in 2006 or 2007?** [More Info](#)

No

Yes

**If the spouse has Medicare (or expects to have it in the next three months), does he or she also wish to apply?** [More Info](#)

No

Yes

**Do the applicants have combined savings, investments, and real estate worth more than \$23,410?** [More Info](#)

Include the things owned by the primary applicant separately, jointly with his or her spouse, or with another person. **DO NOT include the home they live in, vehicles, personal possessions, burial plots or irrevocable burial contracts.**

No Yes Not

Sure

## About The Applicant's Spouse

**Spouse's Name:** [More Info](#)

(First, Middle Initial, Last, Suffix)

Enter the spouse's name as it appears on his or her most recent Social Security card.

**Spouse's Social Security Number:** [More](#)  
[Info](#)

(Do NOT include dashes or hyphens.)

**What is the spouse's date of birth?** [More](#)  
[Info](#)

**Has the applicant's spouse worked in 2006 or 2007?** [More](#)      **No**  
[Info](#)      **Yes**

### Applicant's Contact Information

**Mailing Address:** [More](#)      **The applicant has changed his/her address within the last three**  
[Info](#)      **months**

**(Address Line**  
**1)**      **Apt. No.**

**(Address Line**  
**2)**

**(Address Line**  
**3)**

**(City, State,**  
**ZIP)**

**Phone Number:** [More](#) (      )      -  
[Info](#)

### Other Information

**OPTIONAL:** If you want us to contact someone else if we have additional questions, please provide the person's name and a daytime phone number. [More Info](#)

**Contact Person's**  
**Name:**

(First, Last)

**Contact's Phone Number:** [More](#) (      )      -  
[Info](#)





# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

[Need Help?](#)

Step: **Complete Application**

Review

Submit

Print Receipt

## About The Person Completing The Form And The Person You Are Helping

We need some basic information about how to contact you and the person you are helping in case we have any questions about this application. Once you complete all the information on this page, we will provide you with a reentry number and you will be able to exit the application and return to complete it later.

### About The Person Completing The Form

#### Form Completer's

#### Name:

(First, Middle Initial, Last)

#### Relationship to Applicant: [More](#)

[Info](#)

If other, please indicate:

#### Form Completer's Phone Number: [More](#) (     )     -

[Info](#)

#### Form Completer's Address: [More](#)

[Info](#)

(Address Line  
1)

Apt. No.

(Address Line  
2)

(Address Line  
3)



(City, State,  
ZIP)

## About The Person You Are Helping

**Applicant's Name:** [More Info](#)

(First, Middle Initial, Last, Suffix)

Enter the name as it appears on the applicant's most recent Social Security card.

**Applicant's Social Security Number:** [More Info](#)

(Do NOT include dashes or hyphens.)

**What is the applicant's date of birth?** [More Info](#)

**Has the applicant worked in 2006 or 2007?** [More Info](#)      **No**  
**Yes**

## Applicant's Contact Information

**Mailing Address:** [More Info](#)      **The applicant has changed his/her address within the last three months**

(Address Line 1)      **Apt. No.**

(Address Line 2)

(Address Line 3)

(City, State,  
ZIP)

**Phone Number:** [More Info](#)      (      )      -

## Other Information

**OPTIONAL:** If you want us to contact someone else if we have additional questions, please provide the person's name and a daytime phone number. [More Info](#)

### Contact Person's

**Name:**

(First, Last)

**Contact's Phone Number:** [More Info](#) (      )      -

**Does the applicant have combined savings, investments, and real estate worth more than \$11,710?**

[More Info](#)

Include the things the applicant owns separately or with another person. **DO NOT include the home he or she lives in, vehicles, personal possessions, burial plots or irrevocable burial contracts.**

**No      Yes      Not  
Sure**



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

[Need Help?](#)

Step:  Complete Application

Review

Submit

Print Receipt

## Print The Reentry Number

Before going any further, we are giving you a Reentry Number. If you get disconnected, or if you decide to continue the application later, you will need this number. It will let you come back to the application and continue where you left off without losing any information you already entered.

**Applicant's Social Security Number:**

**743997047**

**Reentry Number: 49952662**

Print or save this page so you will have a copy of your Reentry Number. To print this page, please use the Print button at the top of your browser.

If you lose or forget your Reentry Number, you will have to begin this application again, and you will lose all the information you already entered. You can start a new application up to three times. Social Security can help you start the process again, but we cannot look up the Reentry Number for you.

### To Come Back To This Application:

1. Go to this website: <http://www.socialsecurity.gov/prescriptionhelp>; and
2. Type in the Social Security and Reentry Numbers shown above.

## **Last Date To Complete This Application**

You need to complete an application by **October 22, 2007**; otherwise you may lose benefits.

## **Important Information**

You might have received a notice from us advising you of an earlier time period for filing the application. If you did, it was because you or someone on your behalf contacted us about filing before you started the Internet application. Generally, it is to your advantage to file within that earlier period to receive the earliest filing date.



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

[Need Help?](#)

Step: **Complete Application**      Review   Submit   Print Receipt

## About Your And Your Spouse's Living Situation

**Not counting your spouse, how many other relatives live in your household and receive at least one-half of their financial support from you or your spouse? Do NOT include yourself or your spouse in the number you enter. If your household consists only of you and your spouse, enter "0." [More Info](#)**

We ask this because your household size may affect the amount of help you can get. We count relatives related to you by blood, marriage or adoption.

**Do you count on anyone to help pay for any of the following household expenses?**

[More Info](#)

**No**      **Yes, they provide: \$**      **per month**  
(If the amount changes from month to month or you do not receive it every month, enter the average monthly amount for the past year.)

- . Food
- . Mortgage
- . Rent
- . Heating Fuel or Gas
- . Electricity and Water
- . 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.



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

[Need Help?](#)

Step: **Complete Application**      Review   Submit   Print Receipt

## About Your Living Situation

**How many relatives live in your household and receive at least one-half of their financial support from you? Do NOT include yourself in the number you enter. If your household consists only of you enter "0."**

[More Info](#)

We ask this because your household size may affect the amount of help you can get. We count relatives related to you by blood, marriage or adoption.

**Do you count on anyone to help pay for any of the following household expenses?**

[More Info](#)

**No**      **Yes, they provide: \$**      **per month**  
(If the amount changes from month to month or you do not receive it every month, enter the average monthly amount for the past year.)

- . Food
- . Mortgage
- . Rent
- . Heating Fuel or Gas
- . Electricity and Water
- . 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.



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

[Need Help?](#)

Step:  **Complete Application**

Review  Submit

Print Receipt

## Wages And Earnings

To qualify for help with your prescription drug costs, we need to know your and your spouse's combined income, including wages and self-employment income. However, if your spouse lives at a different address permanently, like a nursing home, we do not count your spouse's income when we determine your eligibility for extra help.

You told us that you **worked in 2006 or 2007**. If this is not correct, please

You told us that your spouse **worked in 2006 or 2007**. If this is not correct, please

**What do you or your spouse expect to earn in wages before taxes and deductions this calendar year?** [More Info](#)

You  None  Wages of:, \$  this year

Spouse  None  Wages of:, \$  this year

**What do you or your spouse expect your net earnings from self-employment to be this calendar year?** [More Info](#)

You  None  Net EARNINGS of: \$  this year  
 Net LOSS

**Spouse**    **None**

**Net EARNINGS of: \$**                      **this**  
**year**

**Net LOSS**

**Have these wages or self-employment earnings decreased in the last two years?**

[More Info](#)

**No**

**Yes**

**Have you or your spouse stopped working in 2006 or 2007, or plan to stop working in 2007 or 2008?** [More Info](#)

**You**    **No**    **Yes, stopped/plan to stop:**

**Spouse**    **No**    **Yes, stopped/plan to stop:**

**Do you or your spouse have to pay for things related to a disability or blindness that enable you to work?** [More Info](#)

We will count only a part of your earnings towards 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 modification, driver assistance, or other special work-related transportation needs; work-related assistive technology; guide dog expenses; sensory and visual aids; and Braille translations.

**You** Not Applicable for  
**You**

**Spouse**    **No**  
**Yes**





# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

[Need Help?](#)

Step:  **Complete Application**

Review

Submit

Print Receipt

## Wages And Earnings

To qualify for help with your prescription drug costs, we need to know your and your spouse's combined income, including wages and self-employment income. However, if your spouse lives at a different address permanently, like a nursing home, we do not count your spouse's income when we determine your eligibility for extra help.

You told us that you **worked in 2006 or 2007**. If this is not correct, please

You told us that your spouse **did not work in 2006 or 2007**. If this is not correct, please

**What do you or your spouse expect to earn in wages before taxes and deductions this calendar year?** [More Info](#)

You  None  Wages of: \$ \_\_\_\_\_ this year

**Spouse** Not Applicable for Your Spouse

**What do you or your spouse expect your net earnings from self-employment to be this calendar year?** [More Info](#)

You  None  Net EARNINGS of: \$ \_\_\_\_\_ this year

Net LOSS

---

**Spouse** Not Applicable for Your  
Spouse

**Have these wages or self-employment earnings decreased in the last two years?**

[More Info](#)

**No**

**Yes**

**Have you or your spouse stopped working in 2006 or 2007, or plan to stop working in 2007 or 2008?** [More Info](#)

**You**    **No**    **Yes, stopped/plan to stop:**

---

**Spouse** Not Applicable for Your  
Spouse



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

[Need Help?](#)

Step: **Complete Application**

Review

Submit

Print  
Receipt

## Wages And Earnings

To qualify for help with your prescription drug costs, we need to know your income, including wages and self-employment income.

You told us that you **worked in 2006 or 2007**. If this is not correct, please

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

[More Info](#)

**None**      **Wages of: \$**                      **this**  
year

**What do you expect your net earnings from self-employment to be this calendar year?**

[More Info](#)

**None**  
**Net EARNINGS of: \$**                      **this**  
year

**Net LOSS**

**Have these wages or self-employment earnings decreased in the last two years?**

[More Info](#)

**No**

**Yes**

**Have you stopped working in 2006 or 2007, or plan to stop working in 2007 or 2008?**

[More Info](#)

**No**      **Yes, stopped/plan to stop:**

**Do you have to pay for things related to a disability or blindness that enable you to work?** [More Info](#)

We will count only a part of your earnings towards 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 modification, driver assistance, or other special work-related

transportation needs; work-related assistive technology; guide dog expenses; sensory and visual aids; and Braille translations.

**No**

**Yes**



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

[Need Help?](#)

Step:  **Complete Application**

Review

Submit

Print Receipt

## Wages And Earnings

To qualify for help with your prescription drug costs, we need to know your income, including wages and self-employment income.

You told us that you **worked in 2006 or 2007**. If this is not correct, please

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

[More Info](#)

None Wages of: \$ this year

**What do you expect your net earnings from self-employment to be this calendar year?**

[More Info](#)

None  
Net EARNINGS of: \$ this year

Net LOSS

**Have these wages or self-employment earnings decreased in the last two years?**

[More Info](#)

No

Yes

**Have you stopped working in 2006 or 2007, or plan to stop working in 2007 or 2008?**

[More Info](#)

**No**      **Yes, stopped/plan to stop:**





# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

[Need Help?](#)

Step:  **Complete Application**

 Review

 Submit

 Print Receipt

## Income Other Than Wages And Earnings

If you or your spouse 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 fields.

Do NOT list wages and self-employment, interest income, public assistance, medical reimbursements or foster care payments here. If you do not receive income from a source listed below, select **No** for that source.

If you need help adding your pensions or annuities, select Add Pensions Or Annuities. If you need help adding your other income, select Add Other Income. The total dollar amount calculated will appear in the dollar amount field on this page when Add And Use Total is selected on the page calculating the totals.

Do you or your spouse receive Social Security benefits? [More Info](#)

You      No      Yes, \$      per month (before deductions)

Spouse      No      Yes, \$      per month (before deductions)

Do you or your spouse receive Railroad Retirement income? [More Info](#)

You      No      Yes, \$      per month (before deductions)

**Spouse**      **No**      **Yes, \$**                      **per month (before**  
**deductions)**

**Do you or your spouse receive Veterans benefits?** [More Info](#)

**You**      **No**      **Yes, \$**                      **per month (before**  
**deductions)**

**Spouse**      **No**      **Yes, \$**                      **per month (before**  
**deductions)**

**Do you or your spouse receive income from other pensions or annuities?** [More Info](#)

(Do NOT include include annuities from certificates of deposit, stocks, bonds, mutual funds, IRAs or any other investments.)

**You**

**No**      **Yes, \$**                      **per month (before deductions)**

**Spouse**

**No**      **Yes, \$**                      **per month (before deductions)**

**Do you or your spouse receive other income not listed above, including alimony, net rental income, workers' compensation, etc.?** [More Info](#)

(Do NOT include help with rent or utilities, money you have in bank accounts, stocks, bonds, savings bonds, mutual funds, IRAs or any similar investments, or any cash at home or anywhere else.)

**You**      **No**      **Yes**  
**If Yes, specify monthly amount and type(s):**

**Amount: \$**                      **per month**

**Type:**

**Spouse**      **No**      **Yes**  
**If Yes, specify monthly amount and type(s):**  
**Amount: \$**                      **per month**



Type:

---

**Has any of the income from these sources decreased in the last two years?**

[More Info](#)

**No**

**Yes**



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

[Need Help?](#)

Step: **Complete Application**

Review

Submit

Print Receipt

## Income Other Than Wages And Earnings

If you 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 fields.

Do NOT list wages and self-employment, interest income, public assistance, medical reimbursements or foster care payments here. If you do not receive income from a source listed below, select **No** for that source.

If you need help adding your pensions or annuities, select Add Pensions Or Annuities. If you need help adding your other income, select Add Other Income. The total dollar amount calculated will appear in the dollar amount field on this page when Add And Use Total is selected on the page calculating the totals.

Do you receive Social Security benefits? [More](#)

[Info](#)

No Yes, \$ per month (before deductions)

Do you receive Railroad Retirement income? [More](#)

[Info](#)

No Yes, \$ per month (before deductions)

Do you receive Veterans benefits? [More](#)

[Info](#)

No Yes, \$ per month (before deductions)

Do you receive income from other pensions or annuities? [More Info](#)

(Do NOT include include annuities from certificates of deposit, stocks, bonds, mutual funds, IRAs or any other investments.)

No Yes, \$ per month (before deductions)

---

**Do you receive other income not listed above, including alimony, net rental income, workers' compensation, etc.?** [More Info](#)

(Do NOT include help with rent or utilities, money you have in bank accounts, stocks, bonds, savings bonds, mutual funds, IRAs or any similar investments, or any cash at home or anywhere else.)

**No      Yes**

**If Yes, specify monthly amount and type(s):**

**Amount: \$**                      per month

**Type:**

---

**Has any of the income from these sources decreased in the last two years?**

[More Info](#)

**No**

**Yes**



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

[Need Help?](#)

Step:  Complete Application  Review  Submit  Print Receipt

## Resources

Please enter the money amounts of all bank accounts, investments or cash that either you, your spouse, or both of you own. Include items that either of you own with another person.

If you need help adding your bank accounts, select Add Accounts. If you need help adding your investments, select Add Investments. The total dollar amount calculated will appear in the dollar amount field on this page when Add And Use Total is selected on the page calculating the totals.

**Do you or your spouse have any of the following resources? If Yes, enter the combined total for those items.**

[More Info](#)

**Combined total of all bank accounts (checking, savings and certificates of deposit)**

No Yes, we have: \$

**Combined total of all stocks, bonds, savings bonds, mutual funds, Individual Retirement Accounts or other similar investments**

No Yes, we have: \$

**Any other cash at home or anywhere else**

No Yes, we have: \$

**Do you or your spouse own life insurance policies with a total face value of more than \$1,500?** [More Info](#)

You No  
Yes

Spouse

**No**      **Yes**

**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.

\$

**Will some money from any of the sources listed above be used to pay for funeral or burial expenses?** [More Info](#)

This includes any bank accounts, investments, cash, and life insurance policies that you listed.

**If Yes, skip to the next question.** If no, select **No** and then go to the next question.

**You**      **No**

**Spouse**      **No**

**Other than your home and the property on which it is located, do you or your spouse own any real estate?** [More Info](#)

Examples of other real estate are summer homes, rental properties or undeveloped land you own.

**No**

**Yes**



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

[Need Help?](#)

Step: **Complete Application**

Review

Submit

Print Receipt

## Resources

Please enter the money amounts of all bank accounts, investments or cash that you own. Include items that you own with another person.

If you need help adding your bank accounts, select Add Accounts. If you need help adding your investments, select Add Investments. The total dollar amount calculated will appear in the dollar amount field on this page when Add And Use Total is selected on the page calculating the totals.

Do you have any of the following resources? If Yes, enter the combined total for those items. [More Info](#)

**Combined total of all bank accounts (checking, savings and certificates of deposit)**

No Yes, I have: \$

**Combined total of all stocks, bonds, savings bonds, mutual funds, Individual Retirement Accounts or other similar investments**

No Yes, I have: \$

**Any other cash at home or anywhere else** No Yes, I have: \$

**Do you own life insurance policies with a total face value of more than \$1,500?**

[More Info](#)

No Yes

If Yes, how much money would you get if you turned in your insurance policies for cash right now? Enter the amount.

This is not the face value of your policies. You may need to call your insurance company to help answer this question.

\$

**Will some money from any of the sources listed above be used to pay for funeral or burial expenses?**

[More Info](#)

No

This includes any bank accounts, investments, cash, and life insurance policies that you listed.

**If Yes, skip to the next question.** If no, select **No** and then go to the next question.

**Other than your home and the property on which it is located, do you own any real estate?**

[More Info](#)

**No**

**Yes**

Examples of other real estate are summer homes, rental properties or undeveloped land you own.



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

[Need Help?](#)

Step:  Complete Application

Review

Submit

Print Receipt

## Tool: Add Up Your Accounts

We have provided a tool to help you accurately calculate the total value of your bank accounts. Enter the appropriate amounts and we will calculate it for you.

**Note:** Once you leave this page, this tool will not save the individual amounts.

### Bank Accounts: Checking Accounts

Checking Account \$  
1

Checking Account \$  
2

Checking Account \$  
3

Checking Account \$  
4

### Bank Accounts: Savings Accounts

Savings Account \$  
1

Savings Account \$  
2



**Savings Account \$**  
**3**

**Savings Account \$**  
**4**

### **Bank Accounts: Certificates of Deposit (CD)**

**Certificate of Deposit \$**  
**Account 1**

**Certificate of Deposit \$**  
**Account 2**

**Certificate of Deposit \$**  
**Account 3**

**Certificate of Deposit \$**  
**Account 4**



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

[Need Help?](#)

Step: **Complete Application**

Review

Submit

Print Receipt

## Tool: Add Up Your Investments

We have provided a tool to help you accurately calculate the total value of your investments. Enter the appropriate amounts and we will calculate it for you.

**Note:** Once you leave this page, this tool will not save the individual amounts.

**Investments: Stocks, Bonds, Savings Bonds, Mutual Funds, Individual Retirement Accounts (IRAs)**

Investment Type \$  
1

Investment Type \$  
2

Investment Type \$  
3

Investment Type \$  
4

Investment Type \$  
5

Investment Type \$  
6

**Investment Type \$**  
**7**

**Investment Type \$**  
**8**



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

[Need Help?](#)

Step:  Complete Application

Review  Submit

Print Receipt

## Tool: Add Up Your Other Pensions And Annuities

We have provided a tool to help you accurately calculate the total value of your pensions and annuities. Enter the appropriate amounts and we will calculate it for you.

**Note:** Once you leave this page, this tool will not save the individual amounts.

**You said that your other pensions and annuities total: \$500**

If you use the amounts you enter here, the new total will replace your previous answer.

### Other Pensions and Annuities

Pension or Annuity \$  
Type 1

Pension or Annuity \$  
Type 2

Pension or Annuity \$  
Type 3

Pension or Annuity \$  
Type 4

Pension or Annuity \$  
Type 5

Pension or Annuity \$  
Type 6

**Pension or Annuity \$**  
**Type 7**

**Pension or Annuity \$**  
**Type 8**



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

[Need Help?](#)

Step:  Complete Application

Review

Submit

Print Receipt

## Tool: Add Up Your Types Of Income

We have provided a tool to help you accurately calculate the total value of your other types of income. Enter the appropriate amounts and we will calculate it for you.

**Note:** Once you leave this page, this tool will not save the individual amounts.

**You said that your other income totals: \$500**

If you use the amounts you enter here, the new total will replace your previous answer.

**Other Types of Income (including alimony, net rental income, workers' compensation, etc.)**

Other Income Type \$  
1

Other Income Type \$  
2

Other Income Type \$  
3

Other Income Type \$  
4

Other Income Type \$  
5

Other Income Type \$

**6**

**Other Income Type \$**

**7**

**Other Income Type \$**

**8**



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

## Internet Security Policy

### **Is it safe to apply for Social Security Benefits over the Internet?**

Social Security is taking all reasonable and proper measures, including encryption, to ensure that your personal information is disclosed only to you. However, the Internet is an open system and there is no absolute guarantee that others will not intercept the personal information you have entered or requested and decrypted. Although this possibility is remote, it does exist.

### **What is encryption?**

Encryption means that all information relating to you and your account is scrambled and locked with a mathematical key during the electronic transfer. Most browsers have an icon such as a key or a lock to represent an encrypted mode or session. A broken key, open lock, or no lock indicates that the session or mode is not encrypted.

### **Why is special software necessary to access the Internet application?**

So that your online request can remain confidential, Social Security uses a security protocol (method) called Secure Sockets Layer (SSL) for this application. You must use a Web browser that supports SSL. Netscape Navigator and Microsoft Internet Explorer are two browsers that support SSL. Using this security protocol, all information sent between your computer and our server is encrypted before being sent on the Internet.

### **Why SSL?**

SSL provides a high level of security and is the security protocol supported by more browsers than any other. It is estimated that about 92% of Web browsers have an SSL browser available for their use.

We have found that a number of business, government, and educational networks do not have their firewalls configured to allow passage of secure Web traffic. Check with your systems administrator to determine if this is the case at your site. If this is the case you will not be able to access this application web site.

Close this window to return to the application.





# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

## **You Do Not Live In One Of The 50 States Or DC**

People who live outside of the 50 states and the District of Columbia are not eligible for this help. For more information, visit [www.medicare.gov](http://www.medicare.gov).

To contact Social Security, visit our [Service Around the World](#) web page.

Select Exit to leave this application. You will be taken to the Social Security home page.



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

## Paperwork Reduction Act

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 45 minutes to read the instructions, gather the facts, and answer the questions.

You may send comments on our time estimate above to: Social Security Administration, 1338 Annex Building, Baltimore, MD 21235-6401. **Send only comments relating to our time estimate to this address, not the completed form.**

The OMB control number for this application is 0960-0696; expiration date 5/31/2008.

Close this window to return to the application.



# Help With Medicare Prescription Drug Plan Costs

**1-800-772-1213** or TTY **1-800-325-0778**, 7am-7pm Monday-Friday

## Check The Social Security Numbers You Entered

Our system cannot accept an application on at least one of the Social Security numbers you entered: **743997047; 743991047**.

Please check these numbers.

- If you typed the wrong number(s), you will need to correct it before continuing.
- If these are the correct Social Security numbers, contact Social Security to make other arrangements to complete an application.

Be sure to tell the representative that you tried the online application and received this message.

To contact Social Security, call our toll-free number, **1-800-772-1213**. If you are deaf or hard of hearing, call our toll-free TTY number, **1-800-325-0778**. Representatives are available Monday through Friday from 7 a.m. to 7 p.m.



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

## Check The Social Security Number You Entered

Our system cannot accept an application on the Social Security number you entered: **743991047**.

Please check this number.

- If you typed the wrong number, you will need to correct it before continuing.
- If this is your correct Social Security number, contact Social Security to make other arrangements to complete an application.

Be sure to tell the representative that you tried the online application and received this message.

To contact Social Security, call our toll-free number, **1-800-772-1213**. If you are deaf or hard of hearing, call our toll-free TTY number, **1-800-325-0778**. Representatives are available Monday through Friday from 7 a.m. to 7 p.m.



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

## Sign-In Problem

We could not find a match for the Social Security number and Reentry Number you entered.

Please check the numbers and sign in again. You can retry no more than three times.

If you can not sign in after three tries, your application will be locked. You can start a new application or call us to apply. To ensure your privacy, we cannot access your Reentry Number.

To contact Social Security, call our toll-free number, **1-800-772-1213**. If you are deaf or hard of hearing, call our toll-free TTY number, **1-800-325-0778**. Representatives are available Monday through Friday from 7 a.m. to 7 p.m.



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

## There Is A Pending Application For This Social Security Number

Based on the Social Security number you entered, it appears that you have already started to complete this application. To continue with the application you already started, select Reentry Sign In. If you have not already started an application, check the Social Security number you entered and reenter it by selecting Previous.

If you have lost your Reentry Number, you can start over, but you will lose all of the information you already entered. To ensure your privacy, we cannot access your Reentry Number.

If you decide to start over, select Start a New Application. Starting a new application does NOT extend the time you have to complete this application. You may lose benefits if we do not receive your application within 60 days from when you first started completing an online application.

To contact Social Security, call our toll-free number, **1-800-772-1213**. If you are deaf or hard of hearing, call our toll-free TTY number, **1-800-325-0778**. Representatives are available Monday through Friday from 7 a.m. to 7 p.m.



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

## You Have Already Sent Us An Application

An Application for Help With Medicare Prescription Drug Plan Costs has already been electronically submitted to Social Security for this applicant. If you have new information, you must contact us. We cannot accept additional information over the Internet. Please contact Social Security if the information you submitted is wrong or you want to report a change in:

- Address or phone number
- Marital status
- Income
- Money, investments, or real estate

To contact Social Security, call our toll-free number, **1-800-772-1213**. If you are deaf or hard of hearing, call our toll-free TTY number, **1-800-325-0778**. Representatives are available Monday through Friday from 7 a.m. to 7 p.m.



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

## How The Online Application Works

This application does not have to be completed all at once. After you fill in your name and address, you will get a Reentry Number. You will be able to stop working on the application whenever you want, and then use this Reentry Number to come back. Each application has its own Reentry Number that can only be used for that application on the web site.

When you have completed the application, you will get a full summary of the information you entered. You can make any necessary changes prior to submission. After you send the application to us electronically, you will be able to print or save a receipt, and your submitted application.

Please read the following information about using this online application:

- Select Continue to move forward, or Previous to move backward. Both options are located at the bottom of the page. Do **NOT** use the Back button on your browser to move backward.
- **IMPORTANT:** Do not use the Enter key to move around in the application or to select from the drop-down lists.
- Additional buttons, other than Continue and Previous, may appear at the bottom of a page. These buttons allow you to take an action such as returning to the Review page.
- You must complete all required information before you can send us the application. After the data entry pages, you will see a list of the pages with missing information. You will not be able to sign and submit the application to us until you fix all the errors and provide the missing information.
- If you Sign Out of the application before completing this basic information, when you return to the application we will return you to the page where you left off.
- Additional information may appear in a pop-up window. Close this window to return to the application.
- Keyboard commands, hotkeys or access keys will vary based upon browser and the version of that browser that you are using. A list of these commands can be found in the Help section of your browser. The Help feature can be located on the Menu bar of your browser or by using the F1 function key on the keyboard. Any assistive devices that you may be using will also have a list of these shortcut keys in the Help section. Also see our [Keyboard Commands](#) web page.



- [Special Instructions for Blind Users.](#)

## **Time Limits**

There are time limits for your work on each page. You will receive a warning after 25 minutes and you can extend your time on that page. After the third warning on a page, you must move to another page or your time will run out and all your work on that page will be lost. If you have turned JavaScript off in your browser, you will not receive these warnings and, after 30 minutes on a page, you must go to another page or your application session will end, and your work on that page will be lost.

Close this window to return to the application.



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

## Special Instructions For Users Who Are Blind

The following instructions are for users of screen readers such as JAWS and Window-Eyes and browser-based readers such as Home Page Reader. Filling out this application is best accomplished in a Forms or MSAA mode that allows you to tab to controls and fill in input boxes, radio buttons, check boxes and list boxes. Instructional text usually occurs at the beginning of these screens and can be accessed in non-MSAA or virtual-cursor mode. Tab indices have also been added to allow for tabbing through text. Additionally, consistent headers have been set up to access questions and examples/instructions more easily. The screen reader will indicate which questions have additional help or instructional text. You can then tab to the additional help or continue tabbing to the next question to bypass this help.

Unless you have turned JavaScript off in your browser, you will receive a warning after 25 minutes and you can extend your time on the page. After the third warning, you must move to another page, or your time will run out and your work on that page will be lost.

This application contains hotkeys to improve navigation and provide information. On many screens there is a continue button at the end of the screen to allow you to go to the next page or a previous button to return to the prior page. The hotkey ALT + C is associated with the Continue button and ALT + P for the Previous button. Press ALT + C or ALT + P to move forward or back in Internet Explorer. There is also a non-interactive progress indicator (ALT + G) which lets you know the step of the application in which you are currently working. However, the use of this hotkey forces you to leave your current position on the page as it moves focus to the top, where the progress indicator is located.

Other keyboard commands, hotkeys or access keys will vary based upon browser and the version of that browser that you are using. A list of these commands can be found in the Help section of your browser. The Help feature can be located on the Menu bar of your browser or by using the F1 function key on the keyboard. Any assistive devices that you may be using will also have a list of these shortcut keys in the Help section. Also see our [Keyboard Commands](#) web page.

When you attempt to advance through the application with erroneous data or missing information, the page will redisplay with a list of links at the top for each error. Selecting these error links will take you directly to the field in question, placing focus at the specific error control. The fixed error will not be deleted from the list of links or error messages at the field until the page is re-submitted. To navigate to the next error, invoke the screen reader or screen magnifier's links list or simply tab through the fields and listen to the screen reader to hear when there is an error message.

There are instances where link and button names are repeated in an application like the following:

- More Info
- Edit
- Details

These links usually have a title attribute that describes the link in more detail. In order for screen readers to speak this additional information, the screen reader must be set up to speak the title attribute instead of the screen text. Depending on the screen reader used, this can be a verbosity setting, configuration setting, set file, etc. Please refer to the documentation for specific screen readers or browser readers if this procedure is unknown.

Close this window to return to the application.



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

## **Your Session Has Expired**

If you would like to continue completing the application, you may try again by selecting Return To Application below.

Select Exit to leave this application. You will be taken to the Social Security home page.



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

## We Cannot Process Your Request

We have not been able to match the information you entered with our records. If the information you provided is correct, then it may be necessary to correct your information with Social Security.

To resolve this problem, call our toll-free number, **1-800-772-1213**. If you are deaf or hard of hearing, call our toll-free TTY number, **1-800-325-0778**. Representatives are available Monday through Friday from 7 a.m. to 7 p.m.

Select Exit to leave this application. You will be taken to the Social Security home page.



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

## We Cannot Process Your Request At This Time

If you still wish to complete the application, you may:

- Try again later,
- Call our toll-free number, **1-800-772-1213**. If you are deaf or hard of hearing, call our toll-free TTY number, **1-800-325-0778**. Representatives are available Monday through Friday from 7 a.m. to 7 p.m.

Select Exit to leave this application. You will be taken to the Social Security home page.



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

## **We Cannot Process Your Request**

Please try again during business hours.

This service is available during the following hours (Eastern Time):

Monday through Friday: 5:00 AM - 1:00 AM

Saturday: 5:00 AM - 11:00 PM

Sunday: 8:00 AM - 10:00 PM

Holidays: 5:00 AM - 11:00 PM

Select Exit to leave this application. You will be taken to the Social Security home page.



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

## **You Have Reached The Limit On The Number Of Requests To Reenter The Application Already Started**

You have reached the limit on the number of tries to reenter the Internet Application For Help With Medicare Prescription Drug Plan Costs already started. You can start a new application or call us to help you complete this application.

To ensure privacy, the prior application is now locked. If you start a new application, you will have to reenter any information that was already entered.

To contact Social Security, call our toll-free number, **1-800-772-1213**. If you are deaf or hard of hearing, call our toll-free TTY number, **1-800-325-0778**. Representatives are available Monday through Friday from 7 a.m. to 7 p.m.





# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

## **We Are Processing This Request**

Please wait a moment before selecting Continue.



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

## Limit On The Number Of New Applications Started

You have reached the limit on the number of requests you can make to start a new application.

Please contact Social Security to make other arrangements to complete an application. Be sure to tell the representative that you tried the online application and received this message.

To contact Social Security, call our toll-free number, **1-800-772-1213** . If you are deaf or hard of hearing, call our toll-free TTY number, **1-800-325-0778** . Representatives are available Monday through Friday from 7 a.m. to 7 p.m.

Select Exit to leave this application. You will be taken to the Social Security home page.



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

## **Limit On The Number Of Tries To Start The Application**

You have reached the limit on the number of tries to start this application.

Please contact Social Security to make other arrangements to complete this application. To contact Social Security, call our toll-free number, **1-800-772-1213**. If you are deaf or hard of hearing, call our toll-free TTY number, **1-800-325-0778**. Representatives are available Monday through Friday from 7 a.m. to 7 p.m.

Select Exit to leave this application. You will be taken to the Social Security home page.



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

## **Warning: System Will Shut Down**

This application for Help With Medicare Prescription Drug Plan Costs is scheduled to shut down for the day within two hours.

This application is available during the following hours (Eastern Time):

Monday through Friday: 5:00 AM - 1:00 AM

Saturday: 5:00 AM - 11:00 PM

Sunday: 8:00 AM - 10:00 PM

Holidays: 5:00 AM - 11:00 PM

If you choose to start the application now and the system shuts down before you finish it, you will only lose the information on the page you are working on at the time of the shutdown.

You may want to consider starting the application at another time to avoid losing any information. If you decide to start this application later, you should write down this web site so that you can return to it: <http://www.socialsecurity.gov/prescriptionhelp>

If you decide to leave this application, select Exit. You will be taken to the Social Security home page.



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

## Please Confirm

You said earlier **you are not under 65 years old**, and now you would like to change your answer.

To confirm, please answer the question below.

**Note:** Changing your answer may delete information you have provided about this question or require you to provide additional information.

Are you **UNDER 65 years old**? [More](#)

[Info](#)

**No**

**Yes**



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

## Please Confirm

You said earlier **your spouse is not under 65 years old**, and now you would like to change your answer.

To confirm, please answer the question below.

**Note:** Changing your answer may delete information you have provided about this question or require you to provide additional information.

Is your spouse **UNDER 65 years old**? [More](#)

[Info](#)

**No**

**Yes**



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

## Please Confirm

You said earlier **you have worked in this calendar year**, and now you would like to change your answer.

To confirm, please answer the question below.

**Note:** Changing your answer may delete information you have provided about this question or require you to provide additional information.

Have you worked in this calendar year? [More](#)

[Info](#)

No

Yes



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

## Please Confirm

You said earlier **your spouse has not worked in this calendar year**, and now you would like to change your answer.

To confirm, please answer the question below.

**Note:** Changing your answer may delete information you have provided about this question or require you to provide additional information.

Has your spouse worked in this calendar year? [More](#)

[Info](#)

No

Yes





# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

## Please Confirm

You said earlier **you have worked in 2006 or 2007**, and now you would like to change your answer.

To confirm, please answer the question below.

**Note:** Changing your answer may delete information you have provided about this question or require you to provide additional information.

Have you worked in 2006 or 2007? [More](#)

[Info](#)

No

Yes



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

## Please Confirm

You said earlier **your spouse has worked in 2006 or 2007**, and now you would like to change your answer.

To confirm, please answer the question below.

**Note:** Changing your answer may delete information you have provided about this question or require you to provide additional information.

Has your spouse worked in 2006 or 2007? [More](#)

[Info](#)

No

Yes



# Help With Medicare Prescription Drug Plan Costs

**1-800-772-1213** or TTY **1-800-325-0778**, 7am-7pm Monday-Friday

## Other Ways To Apply

If you prefer not to fill out this application on the Internet, you can call our toll-free number, **1-800-772-1213** for a paper application or to make an appointment. If you are deaf or hard of hearing, call our toll-free TTY number, **1-800-325-0778**. Representatives are available Monday through Friday from 7 a.m. to 7 p.m. Tell the representative that you want to apply for the Help with Medicare Prescription Drug Costs.

Close this window to return to the application.



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

## How To Print/Save/View This Application

### **To print this application:**

Choose the Print button on your browser button bar or choose Print from the File menu. Make sure the correct printer is selected and choose OK.

### **To save this application:**

Choose Save As from the File menu. We recommend that you save as an HTML file. Provide a file name and location, if needed, and choose OK.

### **To view the saved page:**

Open your browser. Choose Open from the File menu. Click Browse and locate the file name and location you used. (When you reopen this HTML file, none of the buttons or links on the page will work.)

Close this window to return to the application.



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

## **If You Are Not Eligible For Medicare**

You must have Medicare or be eligible for Medicare in order to participate in the prescription drug plan. If you have a state-issued medical assistance card (Medicaid), you should contact your state agency.

Select Exit to leave this application. You will be taken to the Social Security home page.



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

## Check The Information You Entered

The information you entered does not match our records.

- If you typed the wrong information, you will need to correct it before continuing.
- If the information is correct, please confirm it by reentering the same information.
- To do either of the above, select Previous.

If you prefer, you can contact Social Security to make other arrangements to complete an application. Be sure to tell the representative that you tried completing the online application and received this message.

To contact Social Security, call our toll-free number, **1-800-772-1213**. If you are deaf or hard of hearing, call our toll-free TTY number, **1-800-325-0778**. Representatives are available Monday through Friday from 7 a.m. to 7 p.m.



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

## We Cannot Process Your Request

We have not been able to match the information you entered with our records. If the information you provided is correct, then it may be necessary to correct your information with Social Security.

To resolve this problem, call our toll-free number, **1-800-772-1213**. If you are deaf or hard of hearing, call our toll-free TTY number, **1-800-325-0778**. Representatives are available Monday through Friday from 7 a.m. to 7 p.m.

Select Exit to leave this application. You will be taken to the Social Security home page.



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

## What You Will Need

To determine if you could be eligible for help with prescription drug plan costs, Social Security needs information about your (and your spouse's, if married and living together) income and resources.

Documents that may help you prepare include:

- Social Security card;
- bank account statements, including checking, savings, and certificates of deposit;
- Individual Retirement Accounts (IRA), stocks, bonds, savings bonds (including book entry securities\*), mutual funds, other investment statements;
- tax returns;
- payroll slips;
- your most recent Social Security benefits award letters or statements for Railroad Retirement income, Veterans benefits, pensions and annuities; and
- the cash value and face value of any life insurance policies you have. Check with your insurance agent for the exact amount you would get if you cashed in your life insurance policies today.

\* **Book Entry Securities** In addition to traditional U.S. Savings Bonds, individuals now may go to the Treasury Department's Internet site and make online purchases of electronic savings bonds. Electronic savings bonds are also called "book entry securities." With book entry securities, the individual's investment is recorded electronically by the Treasury Department and a paper savings bond is not issued. If you have book entry securities, they are counted as resources and should be reported on this application.

If you do not have these documents, provide us with your best estimate so that we can tell you whether you are likely to qualify for extra help with your prescription drug costs. This information is to help you complete the application. You will not have to submit the documents unless contacted by a Social Security representative.

Close this window to return to the application.







# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

[Need Help?](#)

Step:  **Find Out If You Qualify**

 Complete Application

 Review  Submit

 Print Receipt

## Find Out If You And Your Spouse Qualify: Part 1

The next few pages provide a tool that can tell you if you are likely to qualify for extra help to pay for your prescription drug costs so that you do not have to go through the entire application process unnecessarily. If this tool suggests that it is unlikely you will qualify, you may still apply. We will save your answers only if you decide to apply now. You may change your answers at any time until you submit your application.

Have you or your spouse worked in this calendar year? [More Info](#)

You

No  Yes

Spouse

No  Yes

Are you or your spouse UNDER age 65? [More Info](#)

You

No  Yes

Spouse

No  Yes

Not counting your spouse, how many other relatives live in your household and receive at least one-half of their financial support from you or your spouse? Do NOT include yourself or your spouse in the number you enter. If your household consists only of you and your spouse, enter "0." [More Info](#)

We ask this because your household size may affect the amount of help you can get. We count relatives related to you by blood, marriage or adoption.

Do you count on anyone to help pay for any of the following household expenses? [More Info](#)

- . Food
- . Heating Fuel or Gas

- **Mortgage**
- **Electricity and Water**
- **Rent**
- **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.

**No**

**Yes, they provide: \$** \_\_\_\_\_ **per month**


(If the amount changes from month to month or you do not receive it every month, enter the average monthly amount for the past year.)



# Help With Medicare Prescription Drug Plan Costs


1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

[Need Help?](#)

**Step:**  **Find Out If You Qualify**

 Complete Application

 Review

 Submit

 Print Receipt

## Find Out If You And Your Spouse Qualify: Part 1

The next few pages provide a tool that can tell you if you are likely to qualify for extra help to pay for your prescription drug costs so that you do not have to go through the entire application process unnecessarily. If this tool suggests that it is unlikely you will qualify, you may still apply. We will save your answers only if you decide to apply now. You may change your answers at any time until you submit your application.

**Have you or your spouse worked in this calendar year?** [More Info](#)

**You**    **No**  
          **Yes**

**Spouse**    **No**  
              **Yes**

**Are you or your spouse UNDER age 65?** [More Info](#)

**You**    **No**  
          **Yes**

**Spouse**    **No**  
              **Yes**

**Not counting your spouse, how many other relatives live in your household and receive at least one-half of their financial support from you or your spouse? Do NOT include yourself or your spouse in the number you enter. If your household consists only of you and your spouse, enter "0."** [More Info](#)

We ask this because your household size may affect the amount of help you can get. We count relatives related to you by blood, marriage or adoption.

**Do you count on anyone to help pay for any of the following household expenses?** [More Info](#)

- Food
- Heating Fuel or Gas
- Mortgage
- Electricity and Water

**. Rent**

**. 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.

**No**

**Yes, they provide: \$** \_\_\_\_\_ **per month**

(If the amount changes from month to month or you do not receive it every month, enter the average monthly amount for the past year.)



# Help With Medicare Prescription Drug Plan Costs


1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

[Need Help?](#)

**Step:**  **Find Out If You Qualify**

 Complete Application

 Review

 Submit

 Print Receipt

## Find Out If You Qualify: Part 1

The next few pages provide a tool that can tell you if you are likely to qualify for extra help to pay for your prescription drug costs so that you do not have to go through the entire application process unnecessarily. If this tool suggests that it is unlikely you will qualify, you may still apply. We will save your answers only if you decide to apply now. You may change your answers at any time until you submit your application.

**Have you worked in this calendar year?** [More Info](#)

No

Yes

**Are you UNDER age 65?** [More Info](#)

No

Yes

**How many relatives live in your household and receive at least one-half of their financial support from you? Do NOT include yourself in the number you enter. If your household consists only of you, enter "0."** [More Info](#)

We ask this because your household size may affect the amount of help you can get. We count relatives related to you by blood, marriage or adoption.

**Do you count on anyone to help pay for any of the following household expenses?** [More Info](#)

- Food
- Heating Fuel or Gas
- Mortgage
- Electricity and Water
- Rent
- 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.

No

**Yes, they provide: \$**                      **per month**

(If the amount changes from month to month or you do not receive it every month, enter the average monthly amount for the past year.)



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

[Need Help?](#)

Step: **Find Out If You Qualify**

Complete Application

Review Submit  
 Print Receipt

## Find Out If You And Your Spouse Qualify: Part 3 Of 3

Please continue to enter the information below so that we can tell you if you are likely to qualify for extra help.

You told us that you **worked this calendar year**. If this is not correct, please

You told us that your spouse **worked this calendar year**. If this is not correct, please

**Do you or your spouse have to pay for things related to a disability or blindness that enable you to work?** [More Info](#)

We will only count part of your earnings towards 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 modification, driver assistance, or other special work-related transportation needs; work-related assistive technology; guide dog expenses; sensory and visual aids; and Braille translations.

**You**    **No**  
**Yes, for blindness**  
**Yes, for a disability**

**Spouse**    **No**

**Yes, for blindness**

**Yes, for a  
disability**

**What do you or your spouse expect to earn in wages before taxes and deductions this calendar year? [More Info](#)**

**You**    **None**    **Wages of: \$**                      **this**  
**year**

**Spouse**    **None**    **Wages of: \$**                      **this**  
**year**

**What do you or your spouse expect your net earnings from self-employment to be this calendar year? [More Info](#)**

**You**    **None**  
**Net EARNINGS of: \$**                      **this**  
**year**  
**Net LOSS**

**Spouse**    **None**  
**Net EARNINGS of: \$**                      **this**  
**year**  
**Net LOSS**

**Have you or your spouse stopped working in 2006 or 2007, or plan to stop working in 2007 or 2008? [More Info](#)**

**You**    **No**  
**Yes, stopped/plan to stop:**

**Spouse**    **No**  
**Yes, stopped/plan to stop:**





# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

[Need Help?](#)

Step: **Find Out If You Qualify**

Complete Application

Review Submit  
 Print Receipt

## Find Out If You Qualify: Part 3 Of 3

Please continue to enter the information below so that we can tell you if you are likely to qualify for extra help.

You told us that you **worked this calendar year**. If this is not correct, please

**Do you have to pay for things related to a disability or blindness that enable you to work?**

[More Info](#)

We will count only a part of your earnings towards 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 modification, driver assistance, or other special work-related transportation needs; work-related assistive technology; guide dog expenses; sensory and visual aids; and Braille translations.

No

Yes, for blindness

Yes, for a disability

**What do you expect to earn in wages before taxes and deductions this calendar year?** [More Info](#)

None

Wages of: \$

this

**year**

**What do you expect your net earnings from self-employment to be this calendar year? [More Info](#)**

**None**

**Net EARNINGS of: \$                      this**

**year**

**Net LOSS**

**Have you stopped working in 2006 or 2007, or plan to stop working in 2007 or 2008? [More Info](#)**

**No**

**Yes, stopped/plan to stop:**



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

[Need Help?](#)

Step: **Find Out If You Qualify**



Complete Application



Review



Submit



Print Receipt

## Find Out If You Qualify: Part 3 Of 3

Please continue to enter the information below so that we can tell you if you are likely to qualify for extra help.

You told us that you **worked this calendar year**. If this is not correct, please

What do you expect to earn in wages before taxes and deductions this calendar year? [More Info](#)

None Wages of: \$ this year

What do you expect your net earnings from self-employment to be this calendar year? [More Info](#)

None Net EARNINGS of: \$ this year

Net LOSS

Have you stopped working in 2006 or 2007, or plan to stop working in 2007 or 2008? [More Info](#)

No


**Yes, stopped/plan to stop:**



# Help With Medicare Prescription Drug Plan Costs


1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

[Need Help?](#)

**Step:**  **Find Out If You Qualify**

 Complete Application

 Review

 Submit

 Print Receipt

## Find Out If You Qualify: Part 2 Of 2

Please continue to enter the information below so that we can tell you if you are likely to qualify for extra help.

If you or your spouse 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 fields.

Do NOT list wages and self-employment, interest income, public assistance, medical reimbursements or foster care payments here. If you do not receive income from a source listed below, select **No** for that source.

If you need help adding your pensions or annuities, select Add Pensions Or Annuities. If you need help adding your other income, select Add Other Income. The total dollar amount calculated will appear in the dollar amount field on this page when Add And Use Total is selected on the page calculating the totals.

Do you or your spouse receive Social Security benefits? [More Info](#)

You  No  Yes, \$ \_\_\_\_\_ per month (**before deductions**)

Spouse  No  Yes, \$ \_\_\_\_\_ per month (**before deductions**)

Do you or your spouse receive Railroad Retirement income? [More Info](#)

You  No  Yes, \$ \_\_\_\_\_ per month (**before deductions**)

Spouse  No  Yes, \$ \_\_\_\_\_ per month (**before deductions**)

Do you or your spouse receive Veterans benefits? [More Info](#)

You  No  Yes, \$ \_\_\_\_\_ per month (**before deductions**)

**Spouse**

**No**    **Yes, \$**                      per month **(before deductions)**

**Do you or your spouse receive income from other pensions or annuities?** [More Info](#)

**You**

**No**    **Yes, \$**                      per month **(before deductions)**

(Do NOT include annuities from certificates of deposit, stocks, bonds, mutual funds, IRAs or any other investments.)

**Spouse**

**No**    **Yes, \$**                      per month **(before deductions)**

**Do you or your spouse receive other income not listed above, including alimony, net rental income, workers' compensation, etc.?**

[More Info](#)

(Do NOT include help with rent or utilities, money you have in bank accounts, stocks, bonds, savings bonds, mutual funds, IRAs or any similar investments, or any other cash at home or anywhere else.)

**You**

**No**    **Yes**

**If Yes, specify monthly amount and type(s):**

**Amount: \$**                      per month

**Type:**

**Spouse**

**No**    **Yes**

**If Yes, specify monthly amount and type(s):**

**Amount: \$**                      per month


**Type:**




# Help With Medicare Prescription Drug Plan Costs


1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

[Need Help?](#)

**Step:**  **Find Out If You Qualify**

 Complete Application

 Review

 Submit

 Print Receipt

## Find Out If You Qualify: Part 2 Of 3

Please continue to enter the information below so that we can tell you if you are likely to qualify for extra help.

If you 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 fields.

Do NOT list wages and self-employment, interest income, public assistance, medical reimbursements or foster care payments here. If you do not receive income from a source listed below, select **No** for that source.

If you need help adding your pensions or annuities, select Add Pensions Or Annuities. If you need help adding your other income, select Add Other Income. The total dollar amount calculated will appear in the dollar amount field on this page when Add And Use Total is selected on the page calculating the totals.

**Do you receive Social Security benefits?** [More Info](#)

**No**    **Yes, \$**                      per month (**before deductions**)

**Do you receive Railroad Retirement income?** [More Info](#)

**No**    **Yes, \$**                      per month (**before deductions**)

**Do you receive Veterans benefits?** [More Info](#)

**No**    **Yes, \$**                      per month (**before deductions**)

**Do you receive income from other pensions or annuities?** [More Info](#)

(Do NOT include annuities from certificates of deposit, stocks, bonds, mutual funds, IRAs or any other investments.)

**No**      **Yes, \$**                      per month **(before deductions)**

**Do you receive other income not listed above, including alimony, net rental income, workers' compensation, etc.?** [More Info](#)

(Do NOT include help with rent or utilities, money you have in bank accounts, stocks, bonds, savings bonds, mutual funds, IRAs or any similar investments, or any other cash at home or anywhere else.)

**No**      **Yes**

**If Yes, specify monthly amount and type(s):**

**Amount: \$**                      per month

**Type:**








# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

[Need Help?](#)

Step:  **Find Out If You Qualify**

 Complete Application

 Review  Submit  
 Print Receipt

## Find Out If You Qualify: Results - You Should Apply

Based on the answers you provided, **you probably qualify** for the extra help with prescription drug costs.

### What You Can Do Next

1. You may begin the application process by selecting Apply Now,
2. You may go back to make changes by selecting Previous, or
3. You may select Start Over to reenter your information.

If you select Apply Now, you will get a Reentry Number after you fill in your name and address. If you choose to Sign Out of this application before it is complete, you may use your Reentry Number at any time to come back. You will also be able to change your answers later.

### What You Will Need To Apply

If you decide to complete this application, we will ask about your income (and your spouse's income, if married and living together) and the things that you and your spouse own. Documents that may help you prepare include:

- Social Security card;
- bank account statements, including checking, savings, and certificates of deposit;
- Individual Retirement Accounts (IRAs), stocks, bonds, savings bonds, mutual funds, other

- investment statements;
- tax returns;
- payroll slips;
- your most recent award letters or statements for Railroad Retirement income, Veterans benefits, pensions and annuities; and
- the cash and face values of any life insurance policies you have. Check with your insurance agent for the exact amount you would get if you cashed in your life insurance policies today.

If you do not have these documents, provide us with your best estimate so that we can tell you whether you are likely to qualify for extra help with your prescription drug costs. This information is to help you complete the application. You will not have to submit the documents unless contacted by a Social Security representative.






# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

[Need Help?](#)

Step:  **Find Out If You Qualify**

 Complete Application

 Review  Submit  
 Print Receipt

## Find Out If You Qualify: Results - You Probably Do Not Qualify

Based on the answers you provided, **you probably do not qualify** for extra help. You do not need to complete this application. However, if there is any doubt about your entries or you need a letter stating you are not eligible, complete the application. Whether or not you qualify for the extra help, you may still enroll in an approved Medicare prescription drug plan for coverage. For information about enrolling in a prescription drug plan, call **1-800-MEDICARE** (TTY **1-877-486-2048**) or visit [www.medicare.gov](http://www.medicare.gov).

### What You Can Do Next

1. You may begin the application process by selecting Apply Now,
2. You may go back to make changes by selecting Previous,
3. You may select Start Over to reenter your information, or
4. You may Exit the application.

If you select Apply Now, you will get a Reentry Number after you fill in your name and address. If you choose to Sign Out of this application before it is complete, you may use your Reentry Number at any time to come back. You will also be able to change your answers later.

### What You Will Need To Apply

If you decide to complete this application, we will ask about your income (and your spouse's income, if married and living together) and the things that you and your spouse own. Documents that may

help you prepare include:

- Social Security card;
- bank account statements, including checking, savings, and certificates of deposit;
- Individual Retirement Accounts (IRAs), stocks, bonds, savings bonds, mutual funds, other investment statements;
- tax returns;
- payroll slips;
- your most recent award letters or statements for Railroad Retirement income, Veterans benefits, pensions and annuities; and
- the cash and face values of any life insurance policies you have. Check with your insurance agent for the exact amount you would get if you cashed in your life insurance policies today.

If you do not have these documents, provide us with your best estimate so that we can tell you whether you are likely to qualify for extra help with your prescription drug costs. This information is to help you complete the application. You will not have to submit the documents unless contacted by a Social Security representative.



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

[Need Help?](#)

**Step:**  Complete Application  **Review**  Submit  Print Receipt

## Review Your Information

Review the items you completed below before you submit this application. If you need to make changes, select the Edit button in the margin just left of the section where the changes are necessary. Changes on one page may require additional information to be entered or changed on subsequent pages. You can print this summary before you submit it. Once you submit it, you will be able to print a receipt that shows exactly what is on your application.

## About the Form Completer

**Name:** Form Completer  
**Relationship:** Family Member

**Phone:** (111) 111-1111  
**Address:** 123 Main Street, Anywhere, SC 34567

## About You and Your Spouse

**Applicants:** Both my spouse and I are applying.

### Work

**Status:** I did not work in 2006 or 2007.

My spouse

did not work in 2006 or 2007. We do not have combined savings, investments, and real estate worth more than \$23,410.

<b>My Information:</b>	<b>My Spouse:</b>
John Doe	Jane Doe
743-99-6047	743-99-1047
Date of birth: January 1, 1900	Date of birth: February 2, 1901

**Mailing Address/Phone:**  
123 Main Street  
Anywhere, SC 34567  
(540) 555-9876

We have not changed our address within the last three months.

**Contact Person:**  
None given

## About You And Your Spouse's Living Situation

**Number of dependents:**

0

**Support:**

No one helps us pay for household expenses.

**Resources**

**Bank accounts, investments, cash:**

We have no bank accounts.

We have no stocks, bonds, savings bonds, mutual funds, Individual Retirement Accounts, or similar investments.

We have no cash at home or anywhere else.

**Life insurance policies:**

I do not have life insurance policies with a total face value of more than

\$1,500.  
My  
spouse  
does not  
have life  
insurance  
policies  
with a  
total face  
value of  
more  
than  
\$1,500.

**Burial  
expenses:**

Some  
money  
from the  
sources  
above will  
be used  
to pay for  
my  
funeral or  
burial  
expenses.

Some  
money  
from the  
sources  
above will  
be used  
to pay for  
my  
spouse's  
funeral or  
burial  
expenses.

**Real  
estate:**

We do  
not  
own  
any  
real  
estate  
other



than  
our  
home  
and the  
property  
on  
which it  
is  
located.

## Income Other Than Wages and Earnings

### **Income from pensions, annuities and other sources:**

I did not  
answer  
the  
question  
about  
receiving  
Social  
Security  
benefits.

I did not  
answer  
the  
question  
about my  
spouse  
receiving  
Social  
Security  
benefits.

I do not  
receive  
Railroad  
Retirement  
income.

My  
spouse  
does not  
receive  
Railroad  
Retirement  
income.

I do not receive Veterans benefits. My spouse does not receive Veterans benefits. I receive \$500.00 per month from other pensions or annuities.

My spouse does not receive other pensions or annuities. I receive \$500.00 per month from other income.

Type:  
Other  
Income

My spouse does not receive other income.

**Decrease  
in  
income  
other  
than  
wages  
and  
earnings:**

Our

income  
from  
these  
sources  
has not  
decreased  
in the last  
two years.



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

[Need Help?](#)

**Step:**  Complete Application  **Review**  Submit  Print Receipt

## Review Your Information

Review the items you completed below before you submit this application. If you need to make changes, select the Edit button in the margin just left of the section where the changes are necessary. Changes on one page may require additional information to be entered or changed on subsequent pages. You can print this summary before you submit it. Once you submit it, you will be able to print a receipt that shows exactly what is on your application.

## About You and Your Spouse

### Applicants:

I am applying.  
My spouse is not applying.

### Work

#### Status:

I worked in 2006 or 2007.  
My spouse worked in 2006 or 2007.  
We do not have combined savings, investments, and real estate

worth more than \$23,410.

<b>My Information:</b>	<b>My Spouse:</b>
John Doe	Jane Doe
743-99-3047	743-99-1047
Date of birth:	Date of birth:
January 1, 1960	February 2, 1901

**Mailing Address/Phone:**

123 Main Street  
Anywhere, SC  
34567  
(540) 555-9876


We have not changed our address within the last three months.

**Contact Person:**

None given

## About You And Your Spouse's Living Situation

**Number of dependents:**

 You did not enter the number of dependents.

**Support:**

 You

did not answer whether anyone helps you or your spouse pay for household expenses.

## Resources

### **Bank accounts, investments, cash:**

You did not give us information about your bank accounts.

You did not answer whether you have any stocks, bonds, savings bonds, mutual funds, Individual Retirement Accounts, or similar investments.

You did not answer whether you have any other cash at home or anywhere else.

### **Life**

**insurance policies:**

● You did not answer whether you have life insurance policies with a total face value of more than \$1,500.

● You did not answer whether your spouse has life insurance policies with a total face value of more than \$1,500.

**Burial expenses:**

Some money from the sources above will be used to pay for my funeral or burial expenses. Some money from the

sources above will be used to pay for my spouse's funeral or burial expenses.

**Real estate:**

You did not answer whether you own any real estate other than your home and the property on which it is located.

## Income Other Than Wages and Earnings

**Income from pensions, annuities and other sources:**

I did not answer the question about receiving Social Security benefits.



I did not answer the question about my spouse receiving Social Security benefits. I do not receive Railroad Retirement income. My spouse does not receive Railroad Retirement income. I do not receive Veterans benefits. My spouse does not receive Veterans benefits. I do not receive other pensions or annuities. My spouse does not receive other pensions or annuities. I do not receive

other  
income.  
My  
spouse  
does not  
receive  
other  
income.

**Decrease  
in  
income  
other  
than  
wages  
and  
earnings:**

Our  
income  
from  
these  
sources  
has not  
decreased  
in the last  
two years.

## Wages and Earnings

**Pre-tax  
wages  
this  
calendar  
year:**

I do not  
expect  
to earn  
wages  
this  
calendar  
year.

My  
spouse  
does  
not  
expect  
to earn  
wages  
this  
calendar

year.

**Self-employment net earnings this calendar year:**

I expect to earn \$1,200.00. My spouse expects to earn \$1,300.00.

**Decrease in wages and/or net self-employment earnings:**

Our income from wages and/or net self-employment earnings has not decreased in the last two years.

**Work plans:**

I did not stop working in 2006 or 2007, and do not plan to stop in 2007 or

2008.  
My  
spouse  
did not  
stop  
working  
in  
2006  
or  
2007,  
and  
does  
not  
plan to  
stop in  
2007  
or  
2008.

**Disability-  
related  
expenses:**

I do not  
pay for  
things  
related to  
disability  
or  
blindness  
that  
enable  
me to  
work.

*You must provide the missing information before you can continue to submit this application.*



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

[Need Help?](#)

Step:  Complete Application  Review  **Submit**  Print Receipt

## Ready To Submit?

If you are ready to submit your Application for Help With Medicare Prescription Drug Plan Costs, read the statements below. Checking the box next to your name means that you agree with the statements and have signed your application.

I, **John Doe**, understand that the Social Security Administration (SSA) will check my 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 authorizing SSA to obtain and disclose information related to my income, resources, and assets, foreign and domestic, consistent with applicable privacy laws. This information may include, but is not limited to, information about my wages, account balances, investments, insurance policies, benefits, and pensions.

[I declare under penalty of perjury that I have examined all the information on this form, and it is true and correct to the best of my knowledge.](#)

I, **Jane Doe**, understand that the Social Security Administration (SSA) will check my 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 authorizing SSA to obtain and disclose information related to my income, resources, and assets, foreign and domestic, consistent with applicable privacy laws. This information may include, but is not limited to, information about my wages, account balances, investments, insurance policies, benefits, and pensions.

[I declare under penalty of perjury that I have examined all the information on this form, and it is true and correct to the best of my knowledge.](#)



**Important: After you submit this application, you will not be able to come back to it. Check the box next to your name to indicate that you have read and are signing the statement below.**

**I, John Doe, read and agree with the above.**

**I, Jane Doe, read and agree with the above.**



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

[Need Help?](#)

Step:  Complete Application  Review  **Submit**  Print Receipt

## Ready To Submit?

If you are ready to submit your Application for Help With Medicare Prescription Drug Plan Costs, read the statements below. Checking the box next to your name means that you agree with the statements and have signed your application.

I, **John Doe**, understand that the Social Security Administration (SSA) will check my 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 authorizing SSA to obtain and disclose information related to my income, resources, and assets, foreign and domestic, consistent with applicable privacy laws. This information may include, but is not limited to, information about my wages, account balances, investments, insurance policies, benefits, and pensions.

[I declare under penalty of perjury that I have examined all the information on this form, and it is true and correct to the best of my knowledge.](#)

I, **Jane Doe**, understand that by signing this application, I am authorizing Social Security to obtain and disclose information related to my income, resources, and assets, foreign and domestic, consistent with applicable privacy laws. This information may include, but is not limited to, information about my wages, account balances, investments, insurance policies, benefits, and pensions.



**Important: After you submit this application, you will not be able to come back to it. Check the box next to your name to indicate that you have read and are signing the statement below.**

**I, John Doe, read and agree with the above.**

**I, Jane Doe, read and agree with the above.**



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

[Need Help?](#)

**Step:**  Complete Application  Review  **Submit**  Print Receipt

## Ready To Submit?

If you are ready to submit your Application for Help With Medicare Prescription Drug Plan Costs, read the statement below. Checking the box next to your name means that you agree with the statement and have signed your application.

I, **John Doe**, understand that the Social Security Administration (SSA) will check my 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 authorizing SSA to obtain and disclose information related to my income, resources, and assets, foreign and domestic, consistent with applicable privacy laws. This information may include, but is not limited to, information about my wages, account balances, investments, insurance policies, benefits, and pensions.

[I declare under penalty of perjury that I have examined all the information on this form, and it is true and correct to the best of my knowledge.](#)



**Important: After you submit this application, you will not be able to come back to it. Check the box next to your name to indicate that you have read and are signing the statement below.**

**I, John Doe, read and agree with the above.**





# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

[Need Help?](#)

Step:



Complete Application



Review



Submit



Print Receipt

## Ready To Submit?

If you are ready to submit your Application for Help With Medicare Prescription Drug Plan Costs, read the statement below. Checking the box next to your name means that you agree with the statement and have signed your application.

I, **Form Completer**, am assisting **John Doe and Jane Doe** in submitting this application. I understand that the Social Security Administration (SSA) will check my 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 authorizing SSA to obtain and disclose information related to the applicant's income, resources, and assets, foreign and domestic, consistent with applicable privacy laws. This information may include, but is not limited to, information about the applicant's wages, account balances, investments, insurance policies, benefits, and pensions.

[I declare under penalty of perjury that I have examined all the information on this form, and it is true and correct to the best of my knowledge.](#)



**Important: After you submit this application, you will not be able to come back to it. Check the box next to your name to indicate that you have read and are signing the statement below.**

**I, Form Completer, read and agree with the above.**



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

[Need Help?](#)

**Step:**  Complete Application  Review  **Submit**  Print Receipt

## Ready To Submit?

If you are ready to submit your Application for Help With Medicare Prescription Drug Plan Costs, read the statement below. Checking the box next to your name means that you agree with the statement and have signed your application.

I, **Form Completer**, am assisting **John Doe** in submitting this application. I understand that the Social Security Administration (SSA) will check my 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 authorizing SSA to obtain and disclose information related to the applicant's income, resources, and assets, foreign and domestic, consistent with applicable privacy laws. This information may include, but is not limited to, information about the applicant's wages, account balances, investments, insurance policies, benefits, and pensions.

[I declare under penalty of perjury that I have examined all the information on this form, and it is true and correct to the best of my knowledge.](#)



**Important: After you submit this application, you will not be able to come back to it. Check the box next to your name to indicate that you have read and are signing the statement below.**

**I, Form Completer, read and agree with the above.**



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

Step: Complete Application Review Submit **Print Receipt**

## Successful Submission - Print Or Save Your Receipt

We recommend that you print or save this page for your records. We have included the exact details of your submitted application. For instructions on how to print, save, or view the saved file, please refer to the [Print/Save/View Guide](#).

Select this link to [print this page or save](#) it to your computer.

The Application For Help With Medicare Prescription Drug Plan Costs was received by Social Security on August 23, 2007, 3:38:56 pm.

### About You and Your Spouse

	You	Spouse
Name:	John Doe	Jane Doe
Social Security Number:	743-99-5047	743-99-1047
What are your dates of birth?	January 1, 1900	February 2, 1901
Have you worked in 2006 or 2007?	Yes	No
Mailing Address:	123 Main Street Anywhere, SC 34567 We have not changed our address within the last three months.	
Telephone Number:	(540) 555-9876	

If your spouse has Medicare (or expects to have it in the next three months), does he or she also wish to apply?	<b>Yes</b>
Do you have combined savings, investments, and real estate worth more than \$23,410?	<b>No</b>
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:	<b>None Provided</b>

Not counting your spouse, how many other relatives live in your household and receive at least one-half of their financial support from you or your spouse?	<b>0</b>
Do you count on anyone to help pay for any of the following household expenses-food, mortgage, rent, heating fuel or gas, electricity, water or property taxes?	<b>No</b>

<b>You</b>	<b>Spouse</b>
------------	---------------

Do you or your spouse have any of the following resources:

Combined total of all bank accounts (checking, savings and certificates of deposit)	<b>No</b>	
Combined total of all stocks, bonds, savings bonds, mutual funds, Individual Retirement Accounts or other similar investments	<b>No</b>	
Any other cash at home or anywhere else	<b>No</b>	
Do you or your spouse own life insurance policies with a total face value of more than \$1,500?	<b>No</b>	<b>No</b>
Will some money from any of these sources be used to pay for funeral or burial expenses?		
Other than your home and the property on which it is located, do you or your spouse own any real estate?	<b>No</b>	

<b>You</b>	<b>Spouse</b>
------------	---------------

Do you or your spouse receive income from any of the sources listed below:

Social Security benefits
--------------------------

Railroad Retirement income	No	No
Veterans benefits	No	No
Other pensions and annuities	Yes, \$500.00 per month	No
Other income not listed, including alimony, net rental income, workers' compensation, etc.	Yes, \$500.00 per month from Other Income	No
Has any of the income from these sources decreased in the last two years?	No	

	You	Spouse
What do you or your spouse expect to earn in wages, before taxes and deductions this calendar year?	Yes, \$1,000.00 this year	
What do you or your spouse expect your net earnings from self-employment to be this calendar year?	Yes, net earnings of \$1,000.00 this year	N/A
Have these wages or self-employment earnings decreased in the last two years?	No	
Have you or your spouse stopped working in 2006 or 2007, or plan to stop working in 2007 or 2008?	No	



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

Step:  Complete Application  Review  Submit  **Print Receipt**

## Successful Submission - Print Or Save Your Receipt

We recommend that you print or save this page for your records. We have included the exact details of your submitted application. For instructions on how to print, save, or view the saved file, please refer to the [Print/Save/View Guide](#).

Select this link to [print this page or save](#) it to your computer.

The Application For Help With Medicare Prescription Drug Plan Costs was received by Social Security on August 23, 2007, 3:38:07 pm.

### About You

Name:	John Doe
Social Security Number:	743-99-1047
What is your date of birth?	January 1, 1900
Have you worked in 2006 or 2007?	Yes
Mailing Address:	123 Main Street Anywhere, SC 34567 I did not change my address within the last three months.
Telephone Number:	(540) 555-9876
Do you have combined savings, investments, and real estate worth more than \$11,710?	No

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:	<b>None Provided</b>
--	----------------------

How many relatives live in your household and receive at least one-half of their financial support from you?	<b>0</b>
--	----------

Do you count on anyone to help pay for any of the following household expenses-food, mortgage, rent, heating fuel or gas, electricity, water or property taxes?	<b>No</b>
---	-----------

Do you have any of the following resources:	
---	--

Combined total of all bank accounts (checking, savings and certificates of deposit)	<b>No</b>
---	-----------

Combined total of all stocks, bonds, savings bonds, mutual funds, Individual Retirement Accounts or other similar investments	<b>No</b>
---	-----------

Any other cash at home or anywhere else	<b>No</b>
---	-----------

Do you own life insurance policies with a total face value of more than \$1,500?	<b>No</b>
--	-----------

Will some money from any of these sources be used to pay for funeral or burial expenses?	
--	--

Other than your home and the property on which it is located, do you own any real estate?	<b>No</b>
---	-----------

Do you receive income from any of the sources listed below:	
---	--

Social Security benefits	
--------------------------	--

Railroad Retirement income	<b>No</b>
----------------------------	-----------

Veterans benefits	<b>No</b>
-------------------	-----------

Other pensions and annuities	<b>No</b>
------------------------------	-----------

Other income not listed, including alimony, net rental income, workers' compensation, etc.	<b>No</b>
--	-----------

Has any of the income from these sources decreased in the last two years?	<b>No</b>
---	-----------



<p>What do you expect to earn in wages before taxes and deductions this calendar year?</p>	<p><b>Yes, \$1,500.00 this year</b></p>
<p>What do you expect your net earnings from self-employment to be this calendar year?</p>	<p><b>No</b></p>
<p>Have these wages or self-employment earnings decreased in the last two years?</p>	<p><b>No</b></p>
<p>Have you stopped working in 2006 or 2007, or plan to stop working in 2007 or 2008?</p>	<p><b>Yes, stopped/plan to stop February, 2007</b></p>





# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

**Step:**  Complete Application  Review  Submit  **Print Receipt**

## Unsuccessful Submission

We cannot process your request at this time. If you still wish to complete the application, you may:

- Try again later,
- Call our toll-free number, **1-800-772-1213**. If you are deaf or hard of hearing, call our toll-free TTY number, **1-800-325-0778**. Representatives are available Monday through Friday from 7 a.m. to 7 p.m.

Select Exit to leave this application. You will be taken to the Social Security home page.



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

## Next Steps

### What you just did:

You completed the Application for Help With Medicare Prescription Drug Plan Costs.

### What we will do:

We will process your application as quickly as possible. We will contact you if we need more information. When we finish, we will send a letter to advise whether you qualify for extra help.

### What you need to do:

Carefully read the letter we provide. It will say what to do next. Please remember, if you or the person/people you are helping qualify for this extra help, enrollment in a Medicare prescription drug plan is required.

If you do not choose a Medicare prescription drug plan, Medicare will select one for you to be sure this benefit is received. However, if you wait for Medicare to choose, there may be months for which there is no prescription drug coverage.

For information about prescription drug plans in your area, you may call toll-free **1-800-MEDICARE** (1-800-633-4227) or visit [www.medicare.gov](http://www.medicare.gov). If you are deaf or hard of hearing, you may call the Medicare TTY number toll-free at **1-877-486-2048**.



# Help With Medicare Prescription Drug Plan Costs

1-800-772-1213 or TTY 1-800-325-0778, 7am-7pm Monday-Friday

[Need Help?](#)

Step:  **Complete Application**

Review

Submit

Print Receipt

## Missing Information

You must provide the missing information before you can submit this application. To review the information you entered, select the "Review All Information" button.

**[Missing Information: About You And Your Spouse's Living Situation](#)**

**[Missing Information: Resources](#)**

## Successful Submission - Print Or Save Your Receipt

The Application For Help With Medicare Prescription Drug Plan Costs was received by Social Security on August 23, 2007, 3:38:56 pm.

### About You and Your Spouse

	You	Spouse
Name:	John Doe	Jane Doe
Social Security Number:	743-99-5047	743-99-1047
What are your dates of birth?	January 1, 1900	February 2, 1901
Have you worked in 2006 or 2007?	Yes	No
Mailing Address:	123 Main Street Anywhere, SC 34567 We have not changed our address within the last three months.	
Telephone Number:	(540) 555-9876	
If your spouse has Medicare (or expects to have it in the next three months), does he or she also wish to apply?	Yes	
Do you have combined savings, investments, and real estate worth more than \$23,410?	No	
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:	None Provided	
Not counting your spouse, how many other relatives live in your household and receive at least one-half of their financial support from you or your spouse?	0	

Do you count on anyone to help pay for any of the following household expenses-food, mortgage, rent, heating fuel or gas, electricity, water or property taxes?	<b>No</b>
---	-----------

<b>You</b>	<b>Spouse</b>
------------	---------------

Do you or your spouse have any of the following resources:	
--	--

Combined total of all bank accounts (checking, savings and certificates of deposit)	<b>No</b>
---	-----------

Combined total of all stocks, bonds, savings bonds, mutual funds, Individual Retirement Accounts or other similar investments	<b>No</b>
---	-----------

Any other cash at home or anywhere else	<b>No</b>
---	-----------

Do you or your spouse own life insurance policies with a total face value of more than \$1,500?	<b>No</b>	<b>No</b>
---	-----------	-----------

Will some money from any of these sources be used to pay for funeral or burial expenses?	
--	--

Other than your home and the property on which it is located, do you or your spouse own any real estate?	<b>No</b>
--	-----------

<b>You</b>	<b>Spouse</b>
------------	---------------

Do you or your spouse receive income from any of the sources listed below:	
--	--

Social Security benefits	
--------------------------	--

Railroad Retirement income	<b>No</b>	<b>No</b>
----------------------------	-----------	-----------

Veterans benefits	<b>No</b>	<b>No</b>
-------------------	-----------	-----------

Other pensions and annuities	<b>Yes, \$500.00 per month</b>	<b>No</b>
------------------------------	--------------------------------	-----------

Other income not listed, including alimony, net rental income, workers' compensation, etc.	<b>Yes, \$500.00 per month from Other Income</b>	<b>No</b>
--	--	-----------

Has any of the income from these sources decreased in the last two years?	<b>No</b>
---	-----------

<b>You</b>	<b>Spouse</b>
------------	---------------

<p>What do you or your spouse expect to earn in wages, before taxes and deductions this calendar year?</p>	<p><b>Yes, \$1,000.00 this year</b></p>	
<p>What do you or your spouse expect your net earnings from self-employment to be this calendar year?</p>	<p><b>Yes, net earnings of \$1,000.00 this year</b></p>	<p><b>N/A</b></p>
<p>Have these wages or self-employment earnings decreased in the last two years?</p>	<p><b>No</b></p>	
<p>Have you or your spouse stopped working in 2006 or 2007, or plan to stop working in 2007 or 2008?</p>	<p><b>No</b></p>	

Close this window to return to the application.

## Successful Submission - Print Or Save Your Receipt

The Application For Help With Medicare Prescription Drug Plan Costs was received by Social Security on August 23, 2007, 3:38:07 pm.

About You	
Name:	John Doe
Social Security Number:	743-99-1047
What is your date of birth?	January 1, 1900
Have you worked in 2006 or 2007?	Yes
Mailing Address:	123 Main Street Anywhere, SC 34567 I did not change my address within the last three months.
Telephone Number:	(540) 555-9876
Do you have combined savings, investments, and real estate worth more than \$11,710?	No
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:	None Provided
How many relatives live in your household and receive at least one-half of their financial support from you?	0
Do you count on anyone to help pay for any of the following household expenses-food, mortgage, rent, heating fuel or gas, electricity, water or property taxes?	No

Do you have any of the following resources:

Combined total of all bank accounts (checking, savings and certificates of deposit)	No
Combined total of all stocks, bonds, savings bonds, mutual funds, Individual Retirement Accounts or other similar investments	No
Any other cash at home or anywhere else	No
Do you own life insurance policies with a total face value of more than \$1,500?	No
Will some money from any of these sources be used to pay for funeral or burial expenses?	
Other than your home and the property on which it is located, do you own any real estate?	No

Do you receive income from any of the sources listed below:	
Social Security benefits	
Railroad Retirement income	No
Veterans benefits	No
Other pensions and annuities	No
Other income not listed, including alimony, net rental income, workers' compensation, etc.	No
Has any of the income from these sources decreased in the last two years?	No

What do you expect to earn in wages before taxes and deductions this calendar year?	<b>Yes, \$1,500.00 this year</b>
What do you expect your net earnings from self-employment to be this calendar year?	No
Have these wages or self-employment earnings decreased in the last two years?	No
Have you stopped working in 2006 or 2007, or plan to stop working in 2007 or 2008?	<b>Yes, stopped/plan to stop February, 2007</b>

Close this window to return to the application.



## Unsuccessful Submission

We cannot process your request at this time. If you still wish to complete the application, you may:

- Try again later,
- Call our toll-free number, **1-800-772-1213**. If you are deaf or hard of hearing, call our toll-free TTY number, **1-800-325-0778**. Representatives are available Monday through Friday from 7 a.m. to 7 p.m.