# Social Security Administration Review Of Your Eligibility For Extra Help

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

**What We Will Do To Review Your Case**

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

**What You Need To Do For This Review**

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

**If You Do Not Return This Form**

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

Regional Commissioner

Enclosures

# Social Security Administration
# Resources and Income Summary

Name
Spouse Name

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

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

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

| **Income Not From Work (see question 8)** | **Monthly Amount** |
|---|---|
| Social Security benefits before deductions | $ |
| Railroad Retirement benefits before deductions | $ |
| Veteran's benefits before deductions | $ |
| Other pensions or annuities before deductions | $ |
| Other income | $ |

| **Earned Income (see question 9)** | **Annual Amount** |
|---|---|
| Wages before taxes and deductions | |
| Yours | $ |
| Your spouse's | $ |
| Net earnings from self-employment | |
| Yours | $ |
| Your spouse's | $ |
| Net loss from self-employment | |
| Yours | $ |
| Your spouse's | $ |

| **Disability Or Blind Work Expenses (see question 10)** | **Monthly Amount** |
|---|---|
| Disability work expenses | $ |
| Blind work expenses | $ |

**KEEP THIS PAGE FOR YOUR RECORDS**

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

*Please go to the next page*

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

## If You Are Assisting Someone Else With This Form

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

## How To Complete This Form

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

**EXAMPLE**

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

CORRECT

INCORRECT

**EXAMPLE**

**Use capital letters when entering answers**

| A | B | C | D |
|---|---|---|---|

## Completing Your Form

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

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

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

## If You Have Questions Or Need Help Completing This Form

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

Form Approved
OMB No. 0960-0723

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

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

FOR OFFICIAL USE ONLY

State Code: ☐☐ WBDOC Exception: ☐

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

**FIRST NAME** **MI**

**LAST NAME** **SUFFIX (JR., SR., ETC.)**

**SOCIAL SECURITY NUMBER**

**DATE OF BIRTH (MM - DD - YYYY)**

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

**EXAMPLE**

**For January- September put a zero (0) in the first box. May 20, 1935 should read:**

0 5 2 0 1 9 3 5
MM DD YYYY

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

**FIRST NAME** **MI**

**LAST NAME** **SUFFIX (JR., SR., ETC.)**

**SPOUSE'S SOCIAL SECURITY NUMBER**

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

**SPOUSE'S MEDICARE CLAIM NUMBER**

**3.** If your marital status has **not** changed or you already reported the change to us, go to question 4.
If your marital status **has** changed and you did not report it to us, what is your current marital status?

☐ Married (living together)

☐ Divorced/Widowed/Separated/Annulled | Date of change in marital status: _____

4. If **all** of the information on the *Resources and Income Summary* is correct, place an X in the box and go to question 11 on page 5, sign and return this form.

☐

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

5. We need to know about **resources** that you, your spouse (if married and living together) or both of you have.

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

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

☐

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

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

6. Will some money from the sources listed in **question 5** be used to pay for funeral or burial expenses? **If YES, skip to question 7.**

If **NO**, place an X in the **NO** box, then go to question 7.

**YOU:** ☐ **NO**

**SPOUSE:** ☐ **NO**

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

*Instructions:* Please look at the information we have about your household size on the *Resources and Income Summary* on the back of the enclosed letter. If the information has **not** changed, place an X in the box and go to question 8.

☐

If the number of relatives **has** changed, how many relatives live with you now? Place an X in only one box. **Do not include yourself or your spouse in the number you enter.** If your household consists only of you or you and your spouse, place an X in the **NONE** box.

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

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

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

If the information has **not** changed, place an X in the box and go to question 9.

☐

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

| | **The Correct Monthly Amount Is** |
|---|---|
| Social Security benefits **before deductions** | $ ☐☐,☐☐☐.☐☐ |
| Railroad Retirement benefits **before deductions** | $ ☐☐,☐☐☐.☐☐ |
| Veteran's benefits **before deductions** | $ ☐☐,☐☐☐.☐☐ |
| Other pensions or annuities **before deductions.** Do not include money you receive from any item you included in question 5. | $ ☐☐,☐☐☐.☐☐ |
| Other income not listed above, including alimony, net rental income, workers' compensation, private or state disability payments, etc. (Specify): _____ | $ ☐☐,☐☐☐.☐☐ |

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

*Instructions:* Please look at the information we have about your earned income on the *Resources and Income Summary* on the back of the enclosed letter.
If the information has **not** changed, place an X in the box and go to question 10.

☐

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

| Type of Earned Income | The Correct Annual Amount Is |
|---|---|
| Wages **before taxes and deductions** | **YOU** $ ☐☐☐,☐☐☐.☐☐ |
| | **SPOUSE** $ ☐☐☐,☐☐☐.☐☐ |
| Net earnings from self-employment | **YOU** $ ☐☐☐,☐☐☐.☐☐ |
| | **SPOUSE** $ ☐☐☐,☐☐☐.☐☐ |
| Net loss from self-employment | **YOU** $ ☐☐☐,☐☐☐.☐☐ |
| | **SPOUSE** $ ☐☐☐,☐☐☐.☐☐ |

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

**YOU:** ☐ **YES** ☐ **NO** **SPOUSE:** ☐ **YES** ☐ **NO**

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

**EXAMPLE**

**For January – September, put a zero (0) in the first box. May 2010 should read:** 0 5 (M M) 2 0 1 0 (Y Y Y Y)

**YOU:** ☐☐ – 2 0 ☐☐ (M M) (Y Y Y Y)

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

## Signatures

## IMPORTANT INFORMATION - PLEASE READ CAREFULLY

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

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

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

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

### Section A

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

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

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

| Print First Name: | Print Last Name: | Phone Number: ( ) – |
|---|---|---|

### Section B

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

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

☐ Friend ☐ Agency ☐ Social Worker _____

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

# Privacy Act / Paperwork Reduction Notice

Section 1860 D-14 of the *Social Security Act* authorizes the collection of information requested on this form. The information you provide will be used to enable the Social Security Administration (SSA) to determine if you continue to be eligible for help paying your share of the cost of a Medicare prescription drug plan. You do not have to give us the information requested. However, if you do not provide the information, we will be unable to make an accurate and timely decision on your continuing eligibility for benefits and could result in th Help with Medicare prescription drug plan costs. We may provide ed on this form to another Federal, State, or local government agenc rmining your initial or continuing eligibility for the Extra Help or if a Federal law requires the release of the information. We also may need to share the information with other SSA programs if SSA needs to determine your eligibility in those programs.

Please see revised Privacy Act Statement below.

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

Paperwork Reduction Act Statement — This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the *Paperwork Reduction Act of 1995.* You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 18 minutes to read the instructions, gather the facts, and answer the questions. You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. **Send only comments relating to our time estimate to this address, not the completed form.**

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

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

## Privacy Act Statement

Section 1860 D-14 of the Social Security Act, as amended, authorizes us to collect this information. We will use the information you provide in determining your continuing eligibility for Medicare prescription drug plan benefits.

The information you furnish on this form is voluntary. However, failure to provide all or part of the information could prevent an accurate and timely decision on continuing benefit eligibility and could result in the loss of Extra Help with Medicare prescription drug plan costs.

We rarely use the information you supply for any purpose other than for establishing benefit eligibility. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following:

1. To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage;

2. To comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and Department of Veterans' Affairs);

3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and,

4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of Social Security programs (e.g., to the Bureau of the Census and private concerns under contract to Social Security).

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

A complete list of routine uses for this information is available in our Systems of Records Notices entitled, Medicare Database File, 60-0321. This notice, additional information regarding this form, and information regarding our programs and systems, are available on-line at www.socialsecurity.gov or at your local Social Security office.