Social Security Administration
Office of Quality Review

(Address of Office)
Date:
Beneficiary Name:
SSN:

(Address)

The Social Security Administration is contacting a few people who have applied for extra help with Medicare prescription drug plan costs. We are doing a quality review to make sure we made the correct decision on these applications. We picked (**fill-in 1**) name by chance, **NOT** for any other reason. To make sure we made the correct decision on (**fill-in 2**) application, I would like to telephone you on (**fill-in 3**). For general information about Social Security or to verify that this is an official communication, you can call our national toll-free number at 1-800-772-1213.

IMPORTANT INFORMATION
You do not have to give us the requested information. However, if you do not provide the information, we will not be able to evaluate if the denial of your request for extra help with Medicare prescription drug plan costs was correct. The Social Security law that allows us to ask you questions is explained in the enclosed page, Privacy Act and the Paper Reduction Act Notice.

WHAT WILL HAPPEN WHEN I CALL
I will identify myself by name as shown at the bottom of this letter. I will ask you some questions about the information on (**fill-in 4**) application for help with Medicare prescription drug plan costs.

HOW YOU CAN GET READY FOR YOUR CALL
I have enclosed a page that shows the kinds of information you should have ready. I have checked the things I would like to talk about. If you do not have all of the information that I am requesting, I can help you get the information you do not have. If you would like to have a friend or relative help you, please tell that person to be there when I call.

PLEASE RETURN THE ENCLOSED FORM
I have enclosed an acknowledgement form for you to complete, sign and mail back to me in the envelope I have provided. You do not need to put a stamp on the envelope. This form is to let me know you received this letter and whether or not you will be available when I plan to call you.

If you have any questions, please call me at my office between 8:00 a.m. and 4:00 p.m., Monday through Friday. My toll-free number is 1-800- ______. Thank you for your help.

Sincerely,

Social Insurance Specialist

Enclosures

PRIVACY ACT AND PAPER REDUCTION ACT NOTICE

COLLECTION AND USE OF PERSONAL INFORMATION

Section 1860 D-14 of the Social Security Act, as amended, allows us to collect this information. We will use the information you provide to determine your continued eligibility for help paying your share of the cost of a Medicare Prescription Drug Plan.

Furnishing us this information is voluntary. However, failing to provide us with all or part of the information could result in a change or termination of your subsidy.

We rarely use the information you supply for any purpose other than what we state above, however, we may use the information for the administration of our programs including sharing information:

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

2. To facilitate statistical research, audit, or investigative activities necessary to ensure the integrity and improvement of our programs (e.g., to the Bureau of the Census and to private entities under contract with us).

A complete list of when we may share this information with others, called routine uses, is available in our Privacy Act Systems of Records Notice 60-0321, entitled Medicare Database. Additional information about this and other system of records notices and our programs are available from our Internet website at www.socialsecurity.gov or at your local Social Security office.

We may share the information you provide to other health agencies through computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. We use the information from these programs to establish or verify a person's eligibility for federally funded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

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 (OMB) control number. The OMB control number for this collection is 0960-0707. We estimate that it will take 15 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments relating to our time estimate above*** *to*: *SSA, 6401 Security Blvd, Baltimore, MD 21235-6401*

FORM APPROVED
OMB No. 0960-0707

ACKNOWLEDGEMENT FORM
(*RETURN THIS SHEET IMMEDIATELY*)

Beneficiary's Name	Beneficiary's SSN
______________________________	______________

1. Will you be available at the time requested? □ Yes □ No

2. What telephone number can we use to reach you, including area code? ( )_________________

3. If you will not be available at the time requested, we can reschedule your appointment. If you would like to reschedule, please let us know when you will be available at that number.
____

4. **Is your address shown correctly on this letter? □ Yes □ No**
If "NO," please show the appropriate address below:

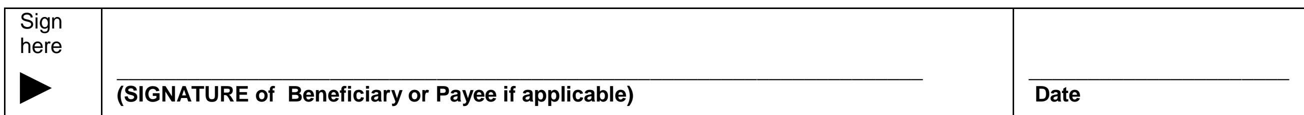
____
____

5. **If you need assistance with the telephone interview due to a hearing impairment, please check/complete the appropriate box(es) shown below:**

□ I am deaf or hard of hearing. I will have a person to assist me with this telephone interview. His/her name is ______________________. He/she is my ___________________ (indicate your relationship).
□ I am deaf or hard of hearing. SSA may call me with the assistance of a Telephone State Relay System operator.

6. **If you need assistance with the telephone interview due to language problems, please check and complete the appropriate box(es) shown below:**

□ I need a language interpreter. I speak___________________ (indicate language).
□ I will provide a qualified language interpreter for this telephone interview. His/her name is ______________________. He/she is my ___________________ (indicate your relationship). (Your interpreter should be 18 years of age or older).
□ I want SSA to provide a qualified language interpreter for this phone interview at no cost to me.



Sign here ▶	**(SIGNATURE of Beneficiary or Payee if applicable)**	**Date**

QRA________________________