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 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 Extra 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 need assistance, we can give you an additional 30 days to return the form to us.

Social Security Administration

Enclosures

Social Security Administration Resources and Income Summary

Name

Spouse Name



sources and income. Please review the
completing the enclosed form (SSA-10
Value
\$
\$
· · · · · · · · · · · \$

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	\$ \$
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	Φ
Yours	
Your spouse's	Ф
Net loss from self-employment	¢.
Yours	\$ \$
Disability Or Blind Work Expenses (see question 10)	Monthly Amount

KEEP THIS PAGE FOR YOUR RECORDS

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

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

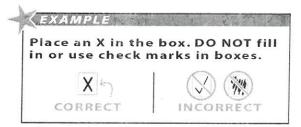


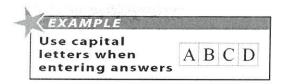
If You Are Assisting Someone Else With This Form

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.





Completing Your Form

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

Social Security Administration
Wilkes-Barre Direct 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**.



Statement for Continuing Eligibility for Extra He	IP FOR OFFICIAL USE ONLY
with Medicare Prescription Drug Plan Costs	
THIS DOES NOT ENROLL YOU IN A MEDICARE PRESCRIPTION DRUG PLAN.	State WBDOC Exception:
1. Name (Print each letter in a separate box.)	
	9
FIRST NAME MI	
LAST NAME	SUFFIX (JR., SR., ETC.)
SOCIAL SECURITY NUMBER DATE OF B	
(MM - DD -	YYYY)
EX	AMPLE
	January- September put a zero (0) in e first box. May 20, 1935 should read:
(This number is printed on your Medicare card)	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
	M - DD - YYYY)
SPOUSE'S MEDICARE CLAIM NUMBER	
3. If your marital status has not changed or you already reported If your marital status has changed and you did not report it to	
Married (living together)	
Divorced/Widowed/Separated/Annulled Date of chan	ge in marital status:



4.	If all of the information on the Resources and Income Summary is correct, place an $\overline{\mathbf{X}}$ in the box and go to question 11 on page 5, sign and return this form.			
	If any of the information on the <i>Resources and Inc</i> question 5.	come Summary is incorrect, continue to		
5.	We need to know about resources that you, your of you have. Instructions: Please look at the information we had Income Summary on the back of the enclosed lett. If the information has not changed, place an X in If the information has changed, fill in the new and If the information has changed, fill in the new and If the information has changed, fill in the new and If the information has changed, fill in the new and If the information has changed, fill in the new and If the information has changed.	ave about your resources on the <i>Resources and</i> er. the box and go to question 6.		
	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	s		
	Cash	\$		
	Value of real estate other than your home	\$		
6.	Will some money from the sources listed in question If YES, skip to question 7.	5 be used to pay for funeral or burial expenses?		
	If NO , place an X in the NO box, then go to question	7.		
	YOU: NO):		
	SPOUSE: NO);		



VISTRA					
7. For this question, a relative is someone related to you by blood, adoption, or marriage (but not including your spouse). How many relatives live with you and depend on you or your spouse for at least one-half of their financial support? **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.					
	se in the number you enter. If your household lace an X in the ZERO box. Place an X in only				
ZERO 1 2 3 4	5 6 7 8 9 or more				
Instructions: Please look at the information we Resources and Income Summary on the back	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	v 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, unemployment, private or State disability payments, etc. (Specify):	s I				



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 $\overline{\mathbf{X}}$ in the box and go to question 10.				
		the information has changed, fill in the new amount in the boxes below.			
	Type of Earned Income	T	he Correct Annual Amount Is		
	Wages before taxes and deductions	YOU	\$		
		SPOUSE	\$		
	Net earnings from self-employment	YOU	\$		
	The carriage from soft employment	SPOUSE	\$		
	Net loss from self-employment	YOU	\$] ,]		
	The ross from sen-employment	SPOUSE	\$] ,] .		
	you to work (also known as disability o your earnings toward the income limit it a disability or blindness and you have w Examples of such expenses are: the cost depression or epilepsy; a wheelchair; pe	or blind work f you work ar ork-related e is of medical ersonal attend transportation	ant services; vehicle modifications, driver n needs; work-related assistive technology;		
	YOU: YES NO	SF	POUSE: YES NO		
	If you or your spouse (if married and liv month and year. Otherwise sign the form				
F	FXAMPLE for January – September, place a zero (0) in the lirst box. May 2017 hould read: MM YY	1 7 Y Y	YOU:		
- 1		YY	SPOUSE: 20		



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.

	K	Section A		·		
Your Signature:		Date:	Phone Num	ber:	_	
Spouse's Signature:		Date:			-	
Your Mailing Address:	(A 2 3 3 1 1 1 1	Apt. #:	
City:			State:	Zip	Code:	
If you changed your mailin	g address within	the last three month	ns, place an X in the b	ox:		
If you would prefer that we person's name and a daytim			ditional questions, ple	ase provi	ide the	
Print First Name: Print		Print Last Name:		Phone Number:		
		Section B		Par		
If you are assisting someone phone number and address.		in the box that des		nd provid	e your daytime	
Family Member	Attorney	Other Advo	cate Other Specify:		/s 	
Friend	Agency	Social Work	cer	0.0		
Print First Name: Print Last Nam		t Name:	Phone Numl	Phone Number: ()		
Address:					Apt. #:	
City:		7 - SS-ACCESS - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	State:	Zip	Code:	



Privacy Act / Paperwork Reduction Notice

See Revised Privacy

Act Statement
ation

Social Attached

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 the loss of your Extra Help with Medicare prescription drug plan costs. We may provide information collected on this form to another Federal, State, or local government agency to assist us in determining your 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.



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 Direct Operations Center P.O. Box 1080 Wilkes-Barre, PA 18767