# 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, Medicare 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.**


**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 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**.

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 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
**M M D D Y Y Y Y**

**2.** Spouse's Name (If you are married **AND** living together, print your spouse's name **as it appears on your spouse's Social Security card**. If you are **NOT** currently married, do **NOT** live with your spouse or if you **ARE** widowed, **skip to Question 3.)**

☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ☐
**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 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?

**Instructions**: If **YES, skip to question 7.**

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

Do **NOT** place an X in the spouse **NO** box if you did not provide spouse information in Question 2.

**YOU:** ☐ **NO**

**SPOUSE:** ☐ **NO**

**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.

☐

**Please 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 ZERO box. Place an X in only one box.

| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
|---|---|---|---|---|---|---|---|---|---|
| **ZERO** | **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. If you or your spouse receive zero income from a source listed below, place an X in the NONE box for that source.

| | | **The Correct Monthly Amount Is** |
|---|---|---|
| Social Security benefits **before deductions** | ☐ **NONE** | $ ☐☐ , ☐☐☐ . ☐☐ |
| Railroad Retirement benefits **before deductions** | ☐ **NONE** | $ ☐☐ , ☐☐☐ . ☐☐ |
| Veteran's benefits **before deductions** | ☐ **NONE** | $ ☐☐ , ☐☐☐ . ☐☐ |
| Other pensions or annuities **before deductions.** Do not include money you receive from any item you included in question 5. | ☐ **NONE** | $ ☐☐ , ☐☐☐ . ☐☐ |
| Other income not listed above, including alimony, net rental income, workers compensation, unemployment, private or State disability payments, etc. (Specify):_____ | ☐ **NONE** | $ ☐☐ , ☐☐☐ . ☐☐ |

**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.

**Instructions**: If **NO**, skip to question 11. If **YES**, place an X in the YES box then go to question 11.

Do **NOT** fill in the boxes next to **SPOUSE** if you did not put spouse information in Question 2.

**YOU:** ☐ **YES** **SPOUSE:** ☐ **YES**

**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.

Do **NOT** fill in the boxes next to **SPOUSE** if you did not put spouse information in Question 2.

**EXAMPLE**

**For January – September, put a zero (0) in the first box. May 2021 should read:** 0 5 (M M) 2 0 2 1 (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: |
|---|---|---|

See Revised Privacy Act & PRA Statements attached

# ~~Privacy Act / Paperwork Reduction Notice~~

~~Section 1860 D-14 of the *Social Security Act* authorizes the collection of information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may affect your eligibility for the Medicare Prescription Drug Plan (Part D) subsidy.~~

~~We will use the information to review and re-determine your eligibility for the Medicare Part D subsidy. We may also share your information for the following purposes, called routine uses:~~

1. ~~To applicants, claimants, prospective applicants, or claimants (other than the data subjects and their authorized representatives) to the extent necessary for the purpose of pursuing Medicare Part D and Part D subsidy entitlement or appeal rights; and~~

2. ~~To the Centers for Medicare and Medicaid Services, for the purpose of administering Medicare Part D enrollment and premium collection and Medicare Advantage Part C premium collections, as well as Medicare Part B income-related monthly adjustment amounts.~~

~~In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.~~

~~A list of additional routine uses is available in our Privacy Act System of Records Notice (SORN) 60-0321, entitled Medicare Database File. Additional information and a full listing of all our SORNs are available on our website at www.ssa.gov/privacy/sorn.html.~~

~~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**

***SSA will insert the following revised Privacy Act & PRA Statements into the form as soon as possible:***

**Privacy Act Statement**
**Collection and Use of Personal Information**

Section 1860D-14 of the Social Security Act, as amended, allows us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may affect your eligibility for the Medicare Prescription Drug Plan (Part D) subsidy.

We will use the information you provide to review and re-determine your eligibility for the Medicare Part D subsidy. We may also share the information for the following purposes, called routine uses:

- To applicants, claimants, prospective applicants or claimants (other than the data subjects and their authorized representatives) to the extent necessary for the purpose of pursuing Medicare Part D and Part D subsidy entitlement or appeal rights; and

- To the Centers for Medicare and Medicaid Services, for the purpose of administering Medicare Part D enrollment and premium collection and Medicare Advantage Part C premium collections, as well as Medicare Part B income-related monthly adjustment amounts.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORNs) 60-0310, entitled Medicare Savings Programs Information System, as published in the Federal Register (FR) on March 31, 2004, at 69 FR 17019; and 60-0321, entitled Medicare Database (MDB) File, as published in the FR on July 25, 2006, at 71 FR 42159. Additional information, and a full listing of all of our SORNs, is available on our website at www.ssa.gov/privacy.

**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. We estimate that it will take about 18 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments regarding this burden estimate or any other aspect of this collection, including suggestions for reducing this burden to*****:** *SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.*