Medicare Savings Program (MSP) Application Instructions

Use this application to see if you or you and your spouse qualify for the state to pay your Medicare premiums and/or cost-sharing. This is NOT an application for other benefits such as long-term services and supports. If you would like to apply for other Medicaid coverage or need help completing any part of this form, contact your local Medicaid office - https://www.medicaid.gov/about-us/beneficiary-resources/index.html#statemenu

There are three types of Medicare Savings Programs (MSPs):

Qualified Medicare Beneficiary (QMB): the state pays your Medicare Part A and/or Part B premiums and cost sharing (deductibles, co-insurance and copays). If you qualify for QMB, you automatically qualify for Extra Help to pay your Medicare Part D drug coverage costs.

Specified Low-Income Medicare Beneficiary (SLMB): the state pays your Medicare Part B premiums, and you automatically qualify for Extra Help to pay your Medicare Part D drug coverage costs.

Qualifying Individual (QI): the state pays your Medicare Part B premiums, and you automatically qualify for Extra Help to pay your Medicare Part D drug coverage costs.

The state will decide if you qualify (and if your spouse qualifies, if your spouse is applying too). If you're approved for an MSP, your Part B premium will no longer be deducted from your Social Security, Railroad or Civil Service retirement benefits, and you'll automatically be enrolled in Extra Help to pay your Medicare Part D premiums and cost sharing for covered prescription drugs. Contact your Medicaid office if you are not enrolled in the Extra Help benefit.

Estate recovery does not apply to any help you get for payment of Medicare premiums or cost-sharing. That means you will NOT need to pay back any help you receive through a Medicare Savings Program.

What you may need to apply

You may need to provide copies of documents to confirm some information, including:

- Proof of income (like retirement or disability benefits or pay stubs)
- Proof of assets (like bank statements or life insurance policies)
- Proof of Medicare
- For non-citizens, proof of eligible immigration status (like a, green card, passport or other documentation from the Department of Homeland Security)
- Proof of where you live (like a rent receipt, utility bill, or state issued ID card)

If you need more room to write, attach additional pages.

Ways you can apply

- Complete an online application at_____
- Mail this paper application to _____
- Fax this application to _____
- Visit your [state agency] office at _____
- Call your [state agency] for assistance at _____

Keep a copy of the application for your records.

What happens next?

Your Medicaid agency will review your application. You should get a response about your eligibility within 45 days. If you don't get a response within 45 days, contact your Medicaid agency.

Get help with questions about Medicare Savings Programs

For questions about Medicare Savings Programs or your Medicare benefits, contact your local State Health Insurance Assistance Program (SHIP). Find their contact information by calling 877-839-2675 or visiting https://www.shiphelp.org/.

Application for Medicare Savings Programs

Personal Information

Applicant – List your name as it appears on your Medicare card

Last name	First name	Middle name

Address where you live	City	State	ZIP code

Mailing address (if different)	City	State	ZIP code

Primary phone:	Alternate phone (optional):
Email address (optional)	Marital status: ☐ Not married (single/divorced/widowed) ☐ Married, living with spouse ☐ Married but separated from spouse

Citizenship status:

Are you a U.S. citizen? ☐ Yes ☐ No

If not, do you have eligible immigration status? ☐ Yes (Please complete the information below) ☐ No

Alien number, I-94 number or document ID number and document type	Date status was granted	Date you entered the U.S.	Country of origin

Are you, or your spouse or parent, a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

Is your spouse a U.S. citizen (if your spouse is also applying for an MSP)? ☐ Yes ☐ No
If not, do they have eligible immigration status? ☐ Yes (Please complete the information below) ☐ No

Alien number, I-94 number or document ID number and document type	Date status was granted	Date you entered the U.S.	Country of origin

Household Members

Include your spouse living in the same household. Include relatives living in the same household who are dependent on either you or your spouse for at least half of their financial support. If you need more room to write, attach additional pages.

Name (last, first, middle)	Relationship to you	Date of birth	Applying for MSP benefits?	Social Security number (if applying for MSPs)
	Self		☐ Yes ☐ No	`
	Spouse		☐ Yes ☐ No	
	Other (specify)		N/A	Optional
	Other (specify)		N/A	Optional

Medicare Coverage Information			
Do you have Medicare?		Type of coverage	Medicare Number
Self	☐ Yes ☐ No	☐ Part A ☐ Part B	
Spouse	☐ Yes ☐ No	☐ Part A ☐ Part B	

Other Health Insurance Information **(such as employer, Medigap, Tricare, VA health benefits)**			
Policy holder	Insurer	Type of insurance	Policy number

Income

List any income you or your spouse receive. Provide the amount of income before any deductions such as taxes or insurance premiums are taken out. Types of income include, but are not limited to:

- Social Security Benefits
- Supplemental Security Income (SSI)
- Railroad Benefits
- Civil Service Retirement Benefits
- Public Assistance
- Unemployment Insurance
- Workers Compensation
- Veterans Benefits
- Alimony Payment
- Wages from a job
- Commissions
- Self-employment
- Dividends and Interest
- Rental Income

Who gets this income?	Type of income (such as employer or Social Security)	What amount?	How often is it received? (weekly, every two weeks, monthly)
		$	
		$	
		$	
		$	
		$	
		$	
		$	

Assets

If you or your spouse has assets, list the type of asset, who owns the asset and if the asset is owned individually or jointly. Assets include, but are not limited to:

- Cash
- Checking Account
- Savings Account
- Money Market Accounts
- Mutual Funds
- Savings Bonds
- Stocks
- Certificates of Deposit (CD)
- Individual Retirement Accounts (IRAs)
- Burial Funds
- Homes or lands that you own (excluding primary residence)

Type of asset	Name of owner(s)	Ownership	Current value
		☐ Individual ☐ Joint	$
		☐ Individual ☐ Joint	$
		☐ Individual ☐ Joint	$
		☐ Individual ☐ Joint	$
		☐ Individual ☐ Joint	$
		☐ Individual ☐ Joint	$
		☐ Individual ☐ Joint	$
		☐ Individual ☐ Joint	$

Do you or your spouse own any vehicles (car, truck, boat, motor home, motorcycle, camper, and/or trailer)?
If yes, please list below and indicate which is your primary vehicle:

Name of owner(s)	Ownership	Type of vehicle	Year	Make/Model	Value	Amount owed
	☐ Individual ☐ Joint				$	$
	☐ Individual ☐ Joint				$	$
	☐ Individual ☐ Joint				$	$
	☐ Individual ☐ Joint				$	$

Do you and/or your spouse have whole life insurance policies with a combined face value above $1,500? If yes, please list below:

Insured Person	Name of insurance company/policy number	Need help finding the value of policy?	Face value	Cash value
		☐ Yes ☐ No	$	$
		☐ Yes ☐ No	$	$

Read Carefully Before Signing

I understand that:

- I must report any changes in my situation to the Medicaid agency right away. Late reporting may cause incorrect benefits.
- My situation is subject to verification by the Medicaid agency or other state or federal agencies.
- The Medicaid agency may ask me to show proof if I'm eligible. The Medicaid agency may help me get the proof or contact other people or agencies for it.
- By submitting this application, I am authorizing the state Medicaid agency to contact my life insurance company on my behalf.
- By asking for and receiving medical care benefits, I assign to the state all rights to any medical support and to any third-party payments for medical care.
- If I'm found eligible for a Medicare Savings Program, I will **not** be subject to estate recovery for any help I get to pay my Medicare premiums, deductibles, or coinsurance.

You'll get an Eligibility Notice in the mail after we process your application. If you don't agree with what you qualify for, you can ask for an appeal. Review your Eligibility Notice to find appeals instructions specific to each person in your household who applies for coverage, including how many days you have to request an appeal. Here's important information to consider when requesting an appeal:

You can have someone request or participate in your appeal if you want to. That person can be a friend, relative, lawyer, or other individual. Or, you can request and participate in your appeal on your own.

To ask for an appeal, call us at 1-800-XXX-XXXX (TTY: 1-800-XXX-XXXX). Or, go to [medicaid.state.gov] to get an appeals form. Or, you can write your own letter and send or bring it to us at the State Medicaid Agency, 321 Any Road, Any City, Any State 00100.

Declaration and Signatures

I have read and understood the information in this application. I declare, under penalty of perjury, the information I have given in this application is true, correct, and complete to the best of my knowledge.

Applicant/representative signature:	Date:
Spouse signature (if applicable):	Date:

Representative name:	Representative phone number:	Relationship to applicant:
Representative mailing address:	Representative email address:	

You have the right to get your information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice, or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.

Optional: (Providing this information won't impact eligibility.)

SELF: check all that apply

If Hispanic/Latino ethnicity

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other_____

Race

☐ White ☐ American Indian or Alaska Native ☐ Filipino ☐ Vietnamese ☐ Guamanian or Chamorro
☐ Black or African American ☐ Asian Indian ☐ Japanese ☐ Other Asian ☐ Samoan
☐ Chinese ☐ Korean ☐ Native Hawaiian ☐ Other Pacific Islander
☐ Other_____

Choose one response.

Sex assigned at birth (may be found on your birth certificate)

☐ Female ☐ Male ☐ Other_____ ☐ Not sure ☐ Prefer not to answer

Current gender:

☐ Female ☐ Male ☐ Transgender female ☐ Transgender male ☐ A different term_____ ☐ Not sure ☐ Prefer not to answer

Sexual Orientation:

☐ Bisexual ☐ Lesbian or gay ☐ Straight (not lesbian or gay) ☐ A different term _____ ☐ Not sure ☐ Prefer not to answer

Optional: (Providing this information won't impact eligibility.)

SPOUSE: check all that apply

If Hispanic/Latino ethnicity

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other_____

Race

☐ White ☐ American Indian or Alaska Native ☐ Filipino ☐ Vietnamese ☐ Guamanian or Chamorro
☐ Black or African American ☐ Asian Indian ☐ Japanese ☐ Other Asian ☐ Samoan
☐ Chinese ☐ Korean ☐ Native Hawaiian ☐ Other Pacific Islander
☐ Other_____

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