

This document serves only as a model application for states to adapt to reflect their program rules. CMS recognize that states have flexibility in both their eligibility standards and that their application procedures may differ.

[State Agency] 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.

Who Should Apply

Those who need help paying Medicare premiums and/or cost-sharing.

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](tel: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: <input type="checkbox"/> Not married (single/divorced/widowed) <input type="checkbox"/> Married, living with spouse <input type="checkbox"/> Married, not living with spouse		
Citizenship status: Are you a U.S. citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, do you have eligible immigration status? <input type="checkbox"/> Yes (Please complete the information below) <input type="checkbox"/> 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
Is your spouse a U.S. citizen (if your spouse is also applying for an MSP)? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, do they have eligible immigration status? <input type="checkbox"/> Yes (Please complete the information below) <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Household Members				
Include your spouse living in the same household. Include relatives living in the same household who are <u>dependent on either you or your spouse for at least half of their financial support</u> . 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		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Spouse		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Other (specify)		N/A	Optional

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
		<input type="checkbox"/> Individual <input type="checkbox"/> Joint	\$
		<input type="checkbox"/> Individual <input type="checkbox"/> Joint	\$
		<input type="checkbox"/> Individual <input type="checkbox"/> Joint	\$
		<input type="checkbox"/> Individual <input type="checkbox"/> Joint	\$
		<input type="checkbox"/> Individual <input type="checkbox"/> Joint	\$
		<input type="checkbox"/> Individual <input type="checkbox"/> Joint	\$
		<input type="checkbox"/> Individual <input type="checkbox"/> Joint	\$
		<input type="checkbox"/> Individual <input type="checkbox"/> 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 by circling it:

Name of owner(s)	Ownership	Type of vehicle	Year	Make/Model	Value	Amount owed
	<input type="checkbox"/> Individual <input type="checkbox"/> Joint				\$	\$
	<input type="checkbox"/> Individual <input type="checkbox"/> Joint				\$	\$
	<input type="checkbox"/> Individual <input type="checkbox"/> Joint				\$	\$
	<input type="checkbox"/> Individual <input type="checkbox"/> Joint				\$	\$

Do you and/or your spouse have whole life insurance policies with a combined face value above \$1,500? If yes, please list cash value below or, if you do not know the cash value, indicate that you need help finding it:

Insured Person	Name of insurance company and policy number	Need help finding the cash value of policy?	Cash value
		<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
		<input type="checkbox"/> Yes <input type="checkbox"/> No	\$

Read Carefully Before Signing

I understand that:

- I must report any changes from what I wrote on this application 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](https://www.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 and enter additional details in the spaces below

What is your race and/or ethnicity?

☐ **American Indian or Alaska Native** –

Enter, for example, Navajo Nation, Blackfeet Tribe of the Blackfeet Indian Reservation of Montana, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, Aztec, Maya, etc.

☐ **Asian** – Provide details below.

- | | | |
|-------------------------------------|---------------------------------------|-----------------------------------|
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Filipino |
| <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Korean | <input type="checkbox"/> Japanese |

Enter, for example, Pakistani, Hmong, Afghan, etc.

☐ **Black or African American** – Provide

details below.

- | | | |
|---|------------------------------------|----------------------------------|
| <input type="checkbox"/> African American | <input type="checkbox"/> Jamaican | <input type="checkbox"/> Haitian |
| <input type="checkbox"/> Nigerian | <input type="checkbox"/> Ethiopian | <input type="checkbox"/> Somali |

Enter, for example, Trinidadian and Tobagonian, Ghanaian, Congolese, etc.

☐ **Hispanic or Latino** – Provide details below.

- | | | |
|----------------------------------|---------------------------------------|-------------------------------------|
| <input type="checkbox"/> Mexican | <input type="checkbox"/> Puerto Rican | <input type="checkbox"/> Salvadoran |
| <input type="checkbox"/> Cuban | <input type="checkbox"/> Dominican | <input type="checkbox"/> Guatemalan |

Enter, for example, Columbian, Honduran, Spaniard, etc.

☐ **Middle Eastern or North African** – Provide details below.

- | | | |
|-----------------------------------|----------------------------------|-----------------------------------|
| <input type="checkbox"/> Lebanese | <input type="checkbox"/> Iranian | <input type="checkbox"/> Egyptian |
| <input type="checkbox"/> Syrian | <input type="checkbox"/> Iraqi | <input type="checkbox"/> Israeli |

Enter, for example, Moroccan, Yemeni, Kurdish, etc..

☐ **Native Hawaiian or Pacific Islander** – Provide details below.

- | | | |
|--|---------------------------------|--------------------------------------|
| <input type="checkbox"/> Native Hawaiian | <input type="checkbox"/> Somoan | <input type="checkbox"/> Chamorro |
| <input type="checkbox"/> Tongan | <input type="checkbox"/> Fijian | <input type="checkbox"/> Marshallese |

Enter, for example, Chuukese, Palauan, Tahitian, etc.

☐ **White** – Provide details below.

- | | | |
|----------------------------------|---------------------------------|--------------------------------|
| <input type="checkbox"/> English | <input type="checkbox"/> German | <input type="checkbox"/> Irish |
|----------------------------------|---------------------------------|--------------------------------|

☐ Italian ☐ Polish ☐ Scottish

Enter, for example, French, Swedish, Norwegian, etc.

Choose the best response.

Gender (what is your gender?)

☐ Woman ☐ Man ☐ Non-binary ☐ I use a different term _____ ☐ Prefer not to answer

Sex assigned at birth (what was your sex assigned at birth? for example, on your original birth certificate?)

☐ Female ☐ Male ☐ I don't know

Sexual Orientation (which of the following best represents how you think of yourself?)

☐ Lesbian or gay ☐ Straight, that is not lesbian or gay ☐ Bisexual ☐ I use a different term _____ ☐ Prefer not to answer

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

SPOUSE: check all that apply and enter additional details in the spaces below

What is your race and/or ethnicity?

☐ **American Indian or Alaska Native** –

Enter, for example, Navajo Nation, Blackfeet Tribe of the Blackfeet Indian Reservation of Montana,
Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, Aztec, Maya, etc.

☐ **Asian** – Provide details below.

☐ Chinese ☐ Asian Indian ☐ Filipino
☐ Vietnamese ☐ Korean ☐ Japanese

Enter, for example, Pakistani, Hmong, Afghan, etc.

☐ **Black or African American** – Provide

details below.

☐ African American ☐ Jamaican ☐ Haitian
☐ Nigerian ☐ Ethiopian ☐ Somali

Enter, for example, Trinidadian and Tobagonian, Ghanaian, Congolese, etc.

☐ **Hispanic or Latino** – Provide details below.

☐ Mexican ☐ Puerto Rican ☐ Salvadoran
☐ Cuban ☐ Dominican ☐ Guatemalan

Enter, for example, Columbian, Honduran, Spaniard, etc.

☐ **Middle Eastern or North African** – Provide details below.

☐ Lebanese ☐ Iranian ☐ Egyptian
☐ Syrian ☐ Iraqi ☐ Israeli

Enter, for example, Moroccan, Yemeni, Kurdish, etc..

☐ **Native Hawaiian or Pacific Islander** – Provide details below.

☐ Native Hawaiian ☐ Samoan ☐ Chamorro
☐ Tongan ☐ Fijian ☐ Marshallese

Enter, for example, Chuukese, Palauan, Tahitian, etc.

☐ **White** – Provide details below.

☐ English ☐ German ☐ Irish

☐ Italian

☐ Polish

☐ Scottish

Enter, for example, French, Swedish, Norwegian, etc.

Choose the best response.

Gender (what is your gender?)

☐ Woman ☐ Man ☐ Non-binary ☐ I use a different term _____ ☐ Prefer not to answer

Sex assigned at birth (what was your sex assigned at birth? for example, on your original birth certificate?)

☐ Female ☐ Male ☐ I don't know

Sexual Orientation (which of the following best represents how you think of yourself?)

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