Medicare Savings Programs (MSP) Model Application

APPLICATION
FOR MEDICARE PREMIUM ASSISTANCE

Please read the following before completing the application. You will need to answer all questions before we will know if we can help you. If you need help completing any part of this form, call your local Medicaid office.

Applicant

Last Name	First Name	Middle Initial

Address Where You Live	City	State	ZIP Code

Mailing Address (If Different)	City	State	ZIP Code

Telephone Numbers:	Interpretative Services:
Home: Cell: Other:	Do you have trouble speaking, reading or writing in English? Yes □ No □
Marital Status: Single □ Married □ Widowed □ Divorced □	If you need an interpreter, we will provide one. Tell us the language you speak.

Representative/Sponsor

Last Name	First Name	Middle Initial

Address Where You Live	City	State	ZIP Code

Mailing Address (If Different)	City	State	ZIP Code

Relationship to Applicant:	Telephone Number(s): Home: Cell: Other:

Household Members

List all household members. Use legal names (as listed on Medicare card or birth certificate).

Name (Last, First, MI)	Relationship to You	Date of Birth	Applying for Benefits?	Social Security Number	Sex M or F
	Self		Yes □ No □		
	Spouse		Yes □ No □		
	Other (Specify)		Yes □ No □		

Medicare Coverage Information

Medicare Coverage	Beneficiary	Receiving?	Medicare Number
Medicare Part A	Self	Yes □ No □ Don't Know □	
	Spouse	Yes □ No □ Don't Know □	
	Other:	Yes □ No □ Don't Know □	
Medicare Part B	Self	Yes □ No □ Don't Know □	
	Spouse	Yes □ No □ Don't Know □	
	Other:	Yes □ No □ Don't Know □	
Medicare Part C	Self	Yes □ No □ Don't Know □	
	Spouse	Yes □ No □ Don't Know □	
	Other:	Yes □ No □ Don't Know □	
Medicare Part D	Self	Yes □ No □ Don't Know □	
	Spouse	Yes □ No □ Don't Know □	
	Other:	Yes □ No □ Don't Know □	

Other Insurance Information

Type of Insurance	Carrier	Beneficiary	Claim/Policy Number

Income

For each person that you included on this application who has income, list the income below. List the income amount before deductions (such as taxes or insurance) are taken out. Income includes, but is not limited to:

- Social Security Benefits
- Supplemental Security Income (SSI)
- Railroad Benefits
- Veterans Benefits
- Public Assistance
- Unemployment Insurance
- Workers Compensation
- Pensions/Retirement
- Alimony Payment
- Wages
- Self-Employment
- Commissions
- Dividends and Interest
- Rental Income

Name	Employer or Source of Income	Amount Before Deductions	How Often Received

Assets

For each person that you included on this application who has assets, list the asset below. List the type of asset, who owns the asset and if the asset is owned in individually or jointly. Assets include, but are not limited to:

- Cash
- Checking
- Savings
- Money Market Accounts
- Mutual Funds
- Savings Bonds
- Stocks
- Certificates of Deposit (CD)
- Individual Retirement Accounts (IRAs)
- Real Property (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:

Name of Owner(s)	Ownership	Type of Vehicle	Year	Make/Model	Value	Amount Owed
	Individual □ Joint □				$	$
	Individual □ Joint □				$	$
	Individual □ Joint □				$	$
	Individual □ Joint □				$	$

Do you or your spouse have a whole life insurance policy with a cash value? If yes, please list below:

Policy Owner	Name of Insurance Company/Policy Number	Individual(s) Covered	Face Value	Cash Value
			$	$
			$	$

Read Carefully Before Signing

I understand that:

- I must report immediately to the Medicaid office, in writing, or by telephone, any changes in my situation. Late reporting may cause incorrect benefits.
- My situation is subject to verification by the Medicaid office or other State or Federal agencies.
- I must provide proof if I am eligible for help. The Medicaid office may help me obtain the proof or contact other persons or agencies for it.
- 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.

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.

Signature of Applicant		Date
Signature of Spouse (If Applicable)		Date
Signature of Person Helping Applicant	Organization	Date