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DOH-4328 (8/17)

NEW YORK STATE DEPARTMENT OF HEALTH

Office of Health Insurance Programs

Medicare Savings Program Application

Please print clearly and do not write in the dark shaded area.

APPLICANT

First Name _____

Middle Initial _____

Last Name _____

Home Phone _____

Home Address

Street _____

Apt. No. _____

City _____

State _____

Zip Code _____

County _____

Is this a shelter?

Yes

No

Mailing Address (If Different from Above)

Street/P.O. Box _____

Apt. No. _____

City _____

State _____

Zip Code _____

County _____

NAMES

List your name first. Include aliases and maiden name. If necessary, attach an extra sheet to list all children.

Self

First Name _____

Middle Initial _____

Last Name _____

Date of Birth (MM/DD/YY) _____

Sex _____

Social Security Number _____

Race/Ethnic Group (*See Codes Below*) _____

Spouse

First Name _____

Middle Initial _____

Last Name _____

Date of Birth (MM/DD/YY) _____

Sex _____

Social Security Number _____

Race/Ethnic Group (*See Codes Below*) _____

Child*

First Name _____

Middle Initial _____

Last Name _____

Date of Birth (MM/DD/YY) _____

Sex _____

Social Security Number _____

Race/Ethnic Group (*See Codes Below*) _____

Child*

First Name _____

Middle Initial _____

Last Name _____

Date of Birth (MM/DD/YY) _____

Sex _____

Social Security Number _____

Race/Ethnic Group (*See Codes Below*) _____

**If under 18 years of age.*

Race/Ethnic Affiliation Codes:

B: Black, Not of Hispanic Origin

W: White, Not of Hispanic Origin

H: Hispanic

A: Asian or Pacific Islander

I: American Indian or Alaskan Native

U: Unknown

O: Other

CITIZENSHIP INFORMATION

Are you a U.S. citizen?

Yes

No

If No, do you have satisfactory immigration status?

Yes

No

Include alien number, date of status, and date entered country, if applicable.

Alien Number _____

Date of Status (DOS) _____

Date Entered Country (DEC) _____

Is your spouse a U.S. citizen?

Yes

No

If No, does your spouse have satisfactory immigration status?

Yes

No

Include alien number, date of status, and date entered country, if applicable.

Alien Number _____

Date of Status (DOS) _____

Date Entered Country (DEC) _____

MEDICARE INFORMATION

Applicant's Medicare Number (From Red and Blue Medicare Card) _____

Do you have Medicare Part A?

Yes

No

Effective Date _____

Do you have Medicare Part B?

Yes

No

Effective Date _____

Spouse's Medicare Number (From Red and Blue Medicare Card) _____

Does your spouse have Medicare Part A?

Yes

No

Effective Date _____

Does your spouse have Medicare Part B?

Yes

No

Effective Date _____

Would you like us to consider providing retroactive reimbursement of your Medicare premium?

Yes

No

Do you or your spouse pay any health insurance premiums other than Medicare?

Yes

No

Who? _____

Monthly Amount \$_____

Do you or your spouse pay child/spousal support?

Yes

No

Who? _____

Monthly Amount \$_____

Do you or your spouse receive payments from or are named beneficiary of a trust?

Yes

No

Who? _____

Value \$_____

INCOME

List below all available income such as: salary, wages, pension, social security, severance pay, rental or business income, etc. If necessary, attach an extra sheet to list all sources of income.

Name of Applicant, Spouse, or Child Under 18 _____

Who Provides the Money? (Name/Source of Income) _____

What Amount? _____

How Often? (Weekly, Every Two Weeks, Monthly, Other)

Name of Applicant, Spouse, or Child Under 18 _____
Who Provides the Money? (Name/Source of Income) _____
What Amount? _____
How Often? (Weekly, Every Two Weeks, Monthly, Other)

Name of Applicant, Spouse, or Child Under 18 _____
Who Provides the Money? (Name/Source of Income) _____
What Amount? _____
How Often? (Weekly, Every Two Weeks, Monthly, Other)

Do you want to receive notices in:

English Only

Spanish and English

CONSENT

I understand that by signing this application/certification form I agree to any investigation made by the Department of Social Services to verify or confirm the information I have given or any other investigation made by them in connection with my request for Medicaid. If additional information is requested, I will provide it.

SIGNATURES

Applicant/Representative Signature _____

Date _____

Spouse Signature _____

Date _____

Representative Address _____

City _____

State _____

Zip Code _____

Phone Number _____

Relationship _____

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INSTRUCTIONS

COMPLETE THE APPLICATION

Be sure to answer all the questions. If you are married and living with your spouse, you must complete both the “Self” and “Spouse” questions on the application (even if the spouse is not applying for the MSP).

SIGN AND DATE THE APPLICATION

If both spouses are applying, both must sign the MSP application.

INCLUDE THE FOLLOWING VERIFICATION DOCUMENTS

Please review this list and submit the documents that you will need to provide in order for the Medicaid Program to determine if you are eligible for MSP. If you are requesting retroactive reimbursement of your Medicare premiums, you must send proof of income for the previous three-months. If there is an applying spouse, the spouse must also provide documentation.

- A photocopy of the front and back of your **Medicare card**.
- **Proof of income:** Paycheck stubs, letter from employer, income tax return, award letter for any unearned income benefit such as social security, unemployment, or veteran's benefit, or letter from renter, boarder or tenant.
- **Health insurance premiums that you pay other than Medicare:** Letter from employer, premium statement, or pay stub.
- **Proof of date of birth:** State driver's license, U.S. birth certificate, permanent resident card ("green card"), or NYS Benefit Identification Card.
- **Proof of residence:** Lease/letter/rent receipt with your home address from your landlord, driver's

license (if issued in the past 6 months), utility bill (gas, electric, phone, cable, fuel or water), government ID card with address, property tax records or mortgage statement, or postmarked envelope or postcard (cannot use if sent to a P.O. Box).

- If you are not a U.S. citizen, you must provide documents indicating your current immigration status.

Mail the application and required documentation to your local Department of Social Services (LDSS) or Human Resource Administration (HRA). To find the address in your county:

http://www.health.ny.gov/health_care/medicaid/ldss.htm

TERMS, RIGHTS AND RESPONSIBILITIES

By completing and signing this form, I am applying for the Medicare Savings Program. **PAYMENT OF YOUR MEDICARE PREMIUM IS A MEDICAID BENEFIT.**

PENALTIES

I understand that my application may be investigated, and I agree to cooperate in such an investigation. Federal and State laws provide for penalties of fine, imprisonment or both if you do not tell the truth when you apply for Medicaid benefits or at any time when you are questioned

about your eligibility, or cause someone else not to tell the truth regarding your application or your continuing eligibility.

CHANGES

I agree to immediately report any changes to the information on this application.

SOCIAL SECURITY NUMBER (SSN)

If you are applying for the Medicare Savings Program, you must report your SSN, unless you are a pregnant woman. The laws requiring this are: 18NYCRR Sections 351.2, 360-1.2, and 360-3.2(j)(3); 42USC 1320b-7. SSNs are used in many ways, both within the local social services districts and also between local social services districts and federal, state, and local agencies, both in New York and in other jurisdictions. Some uses of SSNs are: to check identity, to identify and verify earned and unearned income, to see if absent parents can get health insurance for applicants, to see if applicants can get child support and to see if applicants can get money or other help.

CERTIFICATION OF CITIZENSHIP & IMMIGRATION STATUS

I certify, under the penalty of perjury, by signing my name on this application, that I, and/or any person for whom I

am signing is a U.S. citizen or national of the United States or has satisfactory immigration status. I understand that information about me will be submitted to the United States Citizenship and Immigration Services (USCIS) for verification of my immigration status, if applicable. I further understand that the use or disclosure of information about me is restricted to persons and organizations directly connected with the verification of immigration status and the administration and enforcement of the provisions of the Medicaid program.

NON-DISCRIMINATION NOTICE

This application will be considered without regard to race, color, sex, disability, religious creed, national origin, or political belief.

CERTIFICATION

In signing this application, I swear and affirm that the information I have given or will give to the Department of Social Services as a basis for Medicaid is correct. I also assign to the Department of Social Services any rights I have to pursue support from persons having legal responsibility for my support and to pursue other third-party resources. I understand that Medicaid paid on my behalf may be recovered from persons who had legal

responsibility for my support at the time medical services were obtained.

If after reading and completing this form, you decide that you DO NOT want to apply for the Medicare Savings Program, please sign your name below:

I consent to withdraw my application:

Applicant Signature _____

Date _____

Signature of Person Who Obtained Eligibility Information

Date

Date Eligibility Determined By Worker

Central/Office

Application Date

Unit ID

Worker ID

Case Name

District

Effective Date

MA Disp.

Denial

Withdrawal

Employed By

Date Eligibility Approved By

Case Type

Case No.

Reuse Ind.

Registry No.

Ver.

Reason Code

Proxy

Yes

No