NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs

Application Date: _____

Medicare Savings Program
Request for Information

(Please print clearly and do not write in dark shaded area)

APPLICANT	First Name	M.I.	Last Name			HOME PHONE
HOME ADDRESS Is this a Shelter? Yes __ No__	Street	Apt.	City	State	Zip Code	County
MAILING ADDRESS *(If different from above)*	Street/P.O. Box	Apt.	City	State	Zip Code	County

NAMES (*List your name first. Include aliases and maiden name*)

	First	M.I.	Last	Date Of Birth	Sex	Social Security Number	Race/Ethnic Code (Optional)
SELF							
SPOUSE							
CHILD*							

**If under 18 years of age. Attach extra sheet if necessary to list additional children.*

Race/Ethnic Affiliation Codes: (You may pick more than one.)
A- Asian **B –** Black or African American **H –** Hispanic or Latino **I -** Native American or Alaskan Native
W - White **P** – Native Hawaiian or other Pacific Islander **U -** Unknown

APPLICANT'S MEDICARE INFORMATION Medicare # _____(*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 INFORMATION, if applying Medicare # _____(*From red and blue Medicare card*)

Does spouse have Medicare Part A? __Yes __No Effective Date _____

Does 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 wish to apply for full Medicaid benefits? ___ Yes ___No

List below all available income such as: salary, wages, pension, social security, severance pay, rental or business income, etc. List amount received before any taxes or other deductions.

Names of Applicant, Spouse, or Child under 18 (*Attach an extra sheet if necessary*)	**Who Provides the Money?** (*Name/source of Income*)	**What Amount?**	**How Often?** (*weekly, two weeks, monthly*)

Do you want to receive notices in: __ **English Only** __ **Spanish and English**

By signing this form, I understand that each person listed will be enrolled in the appropriate program, if eligible. I have also read and understand the Terms, Rights and Responsibilities on the following page. I certify under penalty of perjury that everything on this application is the truth as best I know.

_____ _____
Signature of Applicant or Representative Date

_____ _____
Signature of Spouse Date

_____
Representative Address, Phone Number and Relationship

If after reading and completing this form, you decide that you DO NOT want to apply for the Medicare Savings Program please sign on the following line.

I consent to withdraw my application _____ Date _____

DOCUMENTATION: You must send proof of income and proof of any health insurance premiums that you pay. 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 additional benefits. If you are requesting retroactive reimbursement of your Medicare premiums, you must send proof of income for the three month period before the "Application Date" listed in the upper right corner of this form.

- **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.

To avoid a delay in processing, remember to sign and date this application in the space indicated above.

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. Penalties also apply if you conceal or fail to disclose facts regarding your initial and continuing eligibility for Medicaid or if you conceal or fail to disclose facts that would effect the right of someone for whom you have applied to obtain or continue to receive Medicaid benefits; and such benefits must be used by the other person and not for yourself.

CHANGES: I agree to inform the agency **promptly** of any change in my needs, income, property, living arrangements or address to the best of my knowledge or belief.

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.

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.

<table>
<tr><td colspan="3">SIGNATURE OF PERSON WHO OBTAINED ELIGIBILITY INFORMATION:
x</td><td>DATE:</td><td colspan="4">EMPLOYED BY:</td></tr>
<tr><td colspan="4">Eligibility Determined By Worker: _____ (DATE)</td><td colspan="4">Eligibility Approved By: _____ (DATE)</td></tr>
<tr><td>CENTRAL/OFFICE</td><td>APPLICATION DATE</td><td>UNIT ID</td><td>WORKER ID</td><td>CASE TYPE</td><td colspan="2">CASE NO</td><td>REUSE IND.</td></tr>
<tr><td colspan="2">CASE NAME</td><td colspan="2">DISTRICT</td><td colspan="3">REGISTRY NO.</td><td>VER.</td></tr>
<tr><td colspan="4">Effective Date _____ MA Disp. Denial Withdrawal</td><td colspan="2">REASON CODE</td><td colspan="2">PROXY:
Yes No</td></tr>
</table>