LDSS- 4592 (Rev. 5/02)

MEDICARE SAVINGS PROGRAM
APPLICATION

NEW YORK STATE *(Please Print Clearly And Do Not Write In Dark Shaded Area)* DEPARTMENT OF HEALTH

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
SELF							
SPOUSE							
CHILD*							

*If under 18 years of age. Use attachment if necessary to list additional children.

Race/Ethnic affiliation codes: **B -** Black, not of Hispanic origin **W -** White, not of Hispanic origin **H -** Hispanic **U -** Unknown **A -** Asian or Pacific Islander **I -** American Indian/Alaskan Native **O -** Other

Are you a U.S. Citizen or do you have satisfactory immigration status? Yes No Applicant Signature: _____

Is your spouse a U.S. Citizen or have satisfactory immigration status? Yes No Spouse Signature: _____

Do you have Medicare Part B? Yes No HIC number _____

Do you or your spouse pay any health insurance premiums other than Medicare? Yes No Monthly amount $ _____

Do you or your spouse pay child/spousal support or pay for child care? Yes No Monthly amount $ _____

Are you requesting retroactive reimbursement of your Medicare premium? Yes No

COMPLETE THIS SECTION ONLY IF YOU ARE APPLYING FOR THE SPECIFIED LOW INCOME MEDICARE BENEFICIARY PROGRAM (SLIMB).

List all resources available to you or your spouse. Resources include but are not limited to all cash on hand, checking, savings, and credit union accounts, safe deposit box, life insurance**,** stocks, bonds, savings bonds, certificates, or mutual funds. Also include any real estate including home, income-producing, and non-income producing property, burial space, burial trust/fund, IRA, Keogh, 401-K, and annuity.

Cash on Hand	Checking Account	Saving Account	Other Bank Account	Real Estate	Life Insurance	
					Face	Cash
$	$	$	$	$	$	$
Other Resource	Value	Other Resource	Value	Other Resource	Value	
	$		$		$	
Other Resource	Value	Other Resource	Value	Other Resource	Value	
	$		$		$	

Do you or your spouse receive payments from or are named beneficiary of a trust? Yes No Who? _____ Value: _____

Do you or your spouse expect to receive a trust fund, lawsuit settlement, or income from other source? Yes No Who? _____ Value: _____

Have you or your spouse ever served in the military? Yes No Who? _____

Are you a dependent of a military veteran? Yes No Who? _____

List below all available income such as: salary, wages, pension, social security, severance pay, rental or business income, etc.

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

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

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 MA 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 MA 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 MA 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 and 360-1.2; 42USC 1320b-7. SSNs are used in many ways, both within DSS and also between DSS 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/ALIEN 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 immigration and naturalization service 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 medical assistance 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 MA 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 MA 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 MA. If additional information is requested, I will provide it.

Applicant/Representative
Signature X _____ Date _____

Spouse Signature X _____ Date _____

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 _____

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