NEW YORK STATE DEPARTMENT OF HEALTH | Office of Health Insurance Programs

MEDICARE SAVINGS PROGRAM
APPLICATION/RENEWAL

(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
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? Include Alien Number and Date of Entry, if applicable. __Yes __ No

Signature of Applicant: _____

Alien Number_____ Date of Entry_____

Is your spouse a U.S. Citizen or have satisfactory immigration status? Include Alien Number and Date of Entry, if applicable. __Yes __ No

Signature of Spouse: _____

Alien Number_____ Date of Entry_____

APPLICANT'S MEDICARE INFORMATION Do you have Medicare Part A? __Yes __ No Effective Date: _____

Medicare # _____ Do you have Medicare Part B? __Yes __ No Effective Date: _____

SPOUSE'S MEDICARE INFORMATION, if applying Does spouse have Medicare Part A? __Yes __ No Effective Date: _____

Medicare # _____ Does spouse have Medicare Part B? __Yes __ No Effective Date: _____

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? __Yes __ No Monthly Amount: _____

Are you requesting retroactive reimbursement of your Medicare premium? __Yes __ No

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: $ _____

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?**
			$
			$
			$

DEPENDING ON YOUR INCOME, THE AMOUNT OF YOUR RESOURCES MIGHT NOT BE USED TO DETERMINE YOUR ELIGIBILITY FOR THE MEDICARE SAVINGS PROGRAM.

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 other than your primary residence, including income-producing, and non-income producing property, burial space, burial trust/fund, IRA, Keogh, 401-K, and annuity.

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

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

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 and 360-1.2; 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.

Applicant/Representative
Signature X _____ Date _____

Spouse Signature X _____ 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 _____

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