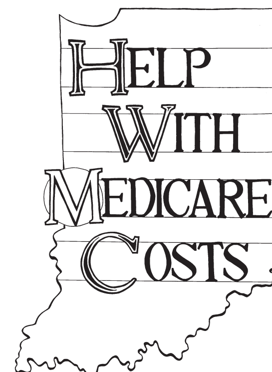
Thank you for your interest in the Medicare Savings Program.

This program can help to pay your Medicare costs.

- To apply, you just need to fill out both sides of the attached application. If there are parts that you don't understand, it is okay to leave them blank. However, you must complete section 1 and sign sections 13 and 14 on the back.
- All members of your household who have Medicare Part A can apply for assistance on this one application. This is true even if you do not currently have Medicare Part B. In section 1, be sure to place a ✓ in the last column for the persons who are applying. Read over the page entitled Rights and Responsibilities. It has important information. Keep that page for your records.
- You will have an interview that can take place over the telephone or in person. You can authorize a friend or family member to be interviewed on your behalf.
- You will need to provide papers that show proof of your income and resources (assets). A list of the papers you may need to provide is on the back of this page.
- We have to make a decision on your application within forty-five (45) days. You will receive a notice in the mail that tells you whether you are eligible.
- If you are eligible to have the State pay all of your Medicare Part B premium, your Social Security check will go up. This will take at least 3-4 months. However, you will receive a refund check for the full amount of premiums that we owe you.

If you wish, we will also check your eligibility for full-coverage Medicaid. Ask your interviewer for more information on full-coverage Medicaid.

If you received this application in the mail, you may return it to us after you fill it out. Send it to:



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State Form 49228 (R / 1-07) / FI 2033

What you need when you apply

You may need to bring the documents listed below to complete your application. If you have any of these documents, or can get them easily, please bring them with you to your interview. If you schedule an interview by telephone instead of in the office, your interviewer will make arrangements with you to get the necessary documents.

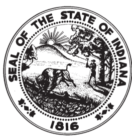
Here is what you will need:

- Your Medicare card, or other proof that you have Medicare
- Your *most recent* bank statements for all bank accounts
- Property deeds (for property that is not the home you are living in)
- Life insurance policies
- Funeral trust documents
- Proof of income
- Immigration documents for lawful immigrants
- Identification card for other health insurance such as a Medicare supplement

If you don’t have all of these documents

If you have these papers and can bring them with you to your interview, your application can be processed quicker. However, if you don’t have them we will help you get them.

Don’t delay in filing your application!



APPLICATION FOR MEDICARE SAVINGS PROGRAM (QMB, SLMB, QI)

State Form 49228 (R / 1-07) / FI 2033

For Office Use Only
Date of application (*month, day, year*)
Date received by DFR (*month, day, year*)

AUTHORIZATION

I, ______________________________, authorize ______________________________,

who is my ______________________________, to apply for the Medicare Savings Program on my behalf.

I understand that I may have to be contacted directly about some information on the application.

Signature of applicant	Date (*month, day, year*)

1. Tell us about the members of your household. Place a ✓ in the last column if that person is applying. List applicants, their spouse, their children under age 18, and their children age 18-21 who are students.

Name (*first, middle initial, last*)	Date of birth (*month, day, year*)	Social Security Number	Marital Status	Race	Sex	Relationship to you	Citizen of U.S. (Y / N / ?)	Applying for Benefits (✓)

2. Tell us your address and telephone number

Address (*number and street, city, state, and ZIP code*)	County	Telephone number ( )
Mailing address, if different (*number and street, city, state, and ZIP code*)	County	Other contact number ( )
Address of authorized representative, if applicable (*number and street, city, state, and ZIP code*)	County	Telephone number ( )

3. Are the applicants residents of Indiana? ☐ **Yes** ☐ **No**

4. Does any applicant have a court-appointed legal guardian? ☐ **Yes** ☐ **No**

If yes, who? ______________________________

In questions 5 and 6, please give information about the household members you listed in question 1, including the children.

5. Place a ✓ beside the types of income listed below that you and household members receive.

SSI		Unemployment		Cash from friends, relatives, etc.	
Social Security		Support (alimony or child support)		Worker's Compensation	
Veteran's Benefits		Sick benefits / Disability payments		Employment	
Railroad Retirement		Strike pay		Income from real estate (such as rent, land contract payments, farm cash rent payments)	
Pension		Interest Payments		Dividends	
Military Allotment		Black Lung Benefits		Other? Specify:	

6. Was the household income in the prior three (3) months the same as it is now? ☐ **Yes** ☐ **No**

If no, briefly explain: ______________________________

____

Questions 7, 8, and 9 are about resources (assets). Please give information for the applicants and their spouse. Include resources owned individually and those owned jointly with someone else.

7. Does anyone own life insurance? ☐ **Yes** ☐ **No**

8. Does anyone own a car or other vehicles? ☐ **Yes** ☐ **No**

9. Place a ✓ beside each type of resource below that anyone owns.

Savings account		Bonds		Credit Union		Certificates of Deposit		Mobile home	
Checking account		Trust fund		Funeral plan / trust		Stocks		Camper	
Cash		Stocks		IRA / retirement fund		Keogh / 401 plan		Real Estate	
Life estate in property		Mineral Rights		Livestock		Farm Equipment		Other	

10. Give us information about the applicants' Medicare coverage.

Name	Medicare Number	Part A Effective Date (*month, day, year*)	Part B Effective Date (*month, day, year*)	Part D (Yes or No)

11. Do any of the applicants have other health insurance, such as Medicare Supplement policy? ☐ **Yes** ☐ **No**

12. Do any of the applicants pay child support for children living out of the household? ☐ **Yes** ☐ **No**

13. Medical Assignment. I hereby assign to the State of Indiana, my rights to medical support and payments for medical care which I have on behalf of myself and other persons under this application whose rights I can legally assign. (*All adults applying must sign*.)

Signature of applicant

Signature of applicant

14. Please read the statement below and sign your application.

CERTIFICATION

I certify under penalty of perjury, that all of the information I have provided is complete and correct to the best of my knowledge and belief, and that I have received the Notice entitled "Rights and Responsibilities under the Medicaid Program."

Signature	Date (*month, day, year*)

Signature of witness if signed with "X"

RIGHTS AND RESPONSIBILITIES UNDER THE MEDICAID PROGRAM

Please read this information carefully. Ask your interviewer about anything that you don't understand.

1. The information you provide is confidential. (42 CFR 431.300, 470 IAC 1-2-7, 470 IAC 1-3-1, 470 IAC 6-1-1, 405 IAC 1-1-12.)

2. We will ask you for papers that confirm certain information on your application. If you cannot get the necessary papers, you can sign a consent for release of information and we will get them for you.

3. Eligibility is considered without regard to race, color, creed, sex, age, disability, national origin, or political belief.

4. The Office of Family Resources will send you a notice that tells you whether your application was approved or denied. You may request a fair hearing if you disagree with any decision about your eligibility, or if your application is not processed within forty-five (45) days.

5. We ask about your racial-ethnic heritage to show compliance with the Federal Civil Rights Law. However you are not required to tell us this information.

6. You must give accurate and complete information on your application. A person who receives assistance by giving false information or by misrepresenting the truth is committing a crime and can be prosecuted under the law. The value of benefits received by a person who was not entitled to receive them must be repaid to the Medicaid program.

7. The immigration status of lawful immigrants may be verified by the Immigration and Naturalization Service.

8. You must tell us your Social Security Number. We will use it to check information of other state and federal agencies, such as the Social Security Administration. (Section 1137 of the Social Security Act)

9. You must file for any benefits you may be entitled to such as Social Security or disability benefits.

10. If any of the information you give on your application changes, you must tell the Office of Family Resources within ten (10) days.

11. You must assign your rights to medical support and payment for medical care to the State. This assignment does not apply to Medicare payments. You will be required to cooperate in obtaining medical support or third party payments as explained on the back of this notice.

12. The State has the right to file a claim against your estate after your death. However, amounts paid for your Medicare premiums will not be recovered. More information about estate recovery is on the back of this notice.

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WHAT IS MEANT BY MEDICAL SUPPORT COOPERATION?

A. Cooperation means telling us about:
- Medical insurance coverage that you have now or that you get in the future;
- Any court orders which provide for the payment of any of your medical bills;
- Any legal action you take or will take against a third party for any injuries you sustain in an accident.

B. Cooperation also means:
- Helping to obtain medical payments that may be available to you under a court or administrative order;
- Paying to the Family and Social Services Administration, money you receive from any third party that is for medical services which were paid (or are to be paid) by the Medicaid program.

WHAT IS MEANT BY GOOD CAUSE FOR NOT COOPERATING?

You may be excused from the above requirements if you can show that cooperating would cause you physical or emotional harm. You should tell your caseworker if you think you have a good cause for not cooperating with a medical support requirement. If you claim good cause, you will receive a notice explaining the good cause circumstances and the type of information you must submit to support your claim. You may ask for the good cause notice to help you decide if you want to claim good cause.

A NOTE ABOUT ESTATE RECOVERY

Upon your death, the State may file a claim against your estate in the amount of medical services paid on your behalf after age 55. IMPORTANT EXCEPTION: The State will not recover the amount that it paid for your Medicare premiums.

There are some instances in which the State will not recover from your estate. These are:

- There is a surviving spouse, or dependent children.
- Pursuing recovery would cause an undue hardship upon the heirs.
- You had protected your assets by purchasing and using an Indiana Partnership long term care insurance policy, prior to receiving Medicaid benefits.

If you have any questions regarding estate recovery, please discuss them with your caseworker.