

Dear Medicare Beneficiary:

Here is the application for extra help with Medicare costs. If you have questions, you can call us at **(202) 739-0668**, or call D.C. Medicaid at one of the offices listed on the back of this letter.

You can take the completed application to your local Medicaid office and **get a receipt** when you give them the application, or you can mail it to HICP at 2136 Pennsylvania Ave. NW, Washington, DC 20052. If you send it to HICP, we will keep a copy and send it to Medicaid by certified mail so there is proof that it was submitted.

### APPLICATION CHECKLIST

To speed up your application, be sure to include a COPY of all the following documents;

- Proof of D.C. residence:** (for example, D.C. Income Tax Return, Utility bill, Rent Receipt, Driver's License, Voter Registration)
- Proof of income** (a Social Security benefit letter, Civil Service Annuity benefit letter, pay stubs, etc)
- Proof of Medicare** (A Copy of Your Medicare Card)
- Signed and Dated Application**

DO NOT SEND ORIGINAL DOCUMENTS, Only SEND COPIES

See the other side for addresses of local Medicaid offices



*Part of the District's Senior Service Network Supported by the D.C. Office on Aging*

2136 Pennsylvania Avenue, NW • Washington, DC 20052 • 202-739-0668 • FAX 202-293-4043

GOVERNMENT OF THE DISTRICT OF COLUMBIA  
DEPARTMENT OF HUMAN SERVICES



**INCOME MAINTENANCE ADMINISTRATION  
SERVICE CENTERS**

**Anacostia Service Center**

2100 Martin Luther King Avenue, SE  
Washington, DC 20020  
Phone: (202) 645-4614  
Fax: (202) 727-3527

**H Street Service Center**

645 H Street, NE  
Washington, DC 20002  
Phone: (202) 698-4350  
Fax: (202) 724-8964

**Congress Heights Service Center**

4001 South Capitol Street, SW  
Washington, DC 20032  
Phone: (202) 645-4546  
Fax: (202) 645-4524

**Fort Davis Service Center**

3851 Alabama Ave., SE  
Washington, DC 20020  
Phone: (202) 645-4500  
Fax: (202) 645-6205

**Taylor Street Service Center**

1207 Taylor Street, NW  
Washington, DC 20011  
Phone: (202) 576-8000  
Fax: (202) 576-8740

*Customers may call IMA at (202) 724-5506  
to learn which Service Center serves their address.*

Questions? ¿Preguntas? ຖ້າມີບັນຫາ?

有問題嗎? Có thắc mắc gì không?

 **(202) 724-5506**



# Medicare Savings Program Application

## 1. INSTRUCTIONS:

This is an application for Qualified Medicare Beneficiary /Medicare Savings Program benefits. This program can help you with your **Medicare** expenses, including monthly premiums, coinsurance, annual deductibles and prescription drug costs. **Medicare** will continue to be your health insurance provider, so you can continue to work with the same physicians you use now.

This is **NOT** an application for Cash Assistance, Food Stamps, or other Medical Assistance programs. If you want to apply for these programs, you must complete a Combined Application for D.C. Medical Assistance, Food Stamps, Cash Assistance.

If you live in D.C., you can use this form to apply for Qualified Medicare Beneficiary /Medicare Savings Program benefits. If you need help with this form, just ask your worker or another IMA employee. You can also contact the organization listed at the bottom of this page.

Please bring this form to your area Service Center. To find out which Center is closest to you, call (202) 724-5506. You may also mail this form to 645 H Street NE, Washington, DC 20002. If you mail this application, enclose a copy (not your original copy) of these documents:

- a. D.C. Drivers License (or other proof of residency like a utility bill showing your name and address)
- b. Medicare Card
- c. Proof of Income for the past 30 days (check stubs, Civil Service statement)
- d. Other Health Insurance cards

| For help completing this form, you can contact the Organization listed below | Phone Number                                       |
|--|--|
| George Washington, Health Insurance Counseling Project (HICP)                | Main Number: (202) 739-0668<br>TTY: (202) 973-1079 |

# QMB Application

## 1. PERSONAL INFORMATION

|   |  |                         |  |
|---|--|-------------------------|--|
| Name: <b>As it appears on your Medicare Card</b>  |  | Social Security Number: |  |
| Date of Birth:  | Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female | Marital Status:         | <input type="checkbox"/> Single <input type="checkbox"/> Married<br><input type="checkbox"/> Divorced <input type="checkbox"/> Widowed |
| Street Address:   |  |                         |  |
| City:   | State:   | Zip:                    | Phone:   |
| Mailing Address, if different from above  |  |                         |  |
| Are you homeless? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Do you plan to stay in the District of Columbia? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Do you want to apply for QMB benefits for your spouse also? <input type="checkbox"/> Yes <input type="checkbox"/> No |  |                         |  |

## 2. INFORMATION ON SPOUSE: Complete this information even if you are not applying for your spouse

|                                       |  |                         |  |
|---------------------------------------|--|-------------------------|--|
| Name (First, Middle Initial, Last)    |  | Social Security Number: |  |
| Date of Birth:                        | Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female |                         |  |
| Address (if different from applicant) |  |                         |  |

## 3. MEDICARE INFORMATION (from your Medicare Card)

|  |   |                  |                                    |
|--|---|------------------|------------------------------------|
| Do you have Medicare?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                  | Type of Coverage<br><input type="checkbox"/> Part A <input type="checkbox"/> Part B | Medicare Claim # | Effective Date<br>Part A<br>Part B |
| Does your <b>spouse</b> have Medicare?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | Type of Coverage<br><input type="checkbox"/> Part A <input type="checkbox"/> Part B | Medicare Claim # | Effective Date<br>Part A<br>Part B |

For Agency use only

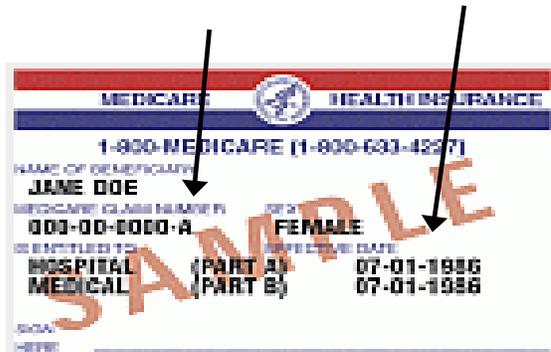
Case Name \_\_\_\_\_

Case No. \_\_\_\_\_

Date Received \_\_\_\_\_

Disposition:  Approved  Denied

Date of Disposition \_\_\_\_\_



# QMB Application

## 4. OTHER HEALTH INSURANCE

Do you have other health insurance?  Yes  No

Does your spouse have other health insurance?  Yes  No

If you or your spouse have other insurance, including a Medicare supplement policy, please complete the boxes below, and attach a copy (front and back) of the insurance card(s):

|        | Health Insurance Company - Name and Address | Monthly Premium | Policy Number | Type of Coverage (Medigap, Retiree, Rx) |
|--------|---|-----------------|---------------|---|
| Self   |   | \$              |               |   |
| Spouse |   | \$              |               |   |

**5. INCOME:** List the types and amounts of earnings and income that you and/or your spouse receive. List the amount of income before deductions, like taxes, are taken out.

- Social Security
- Veterans Benefits
- Unemployment
- SSI
- Annuities
- Civil Service
- Wages/Self-Employment
- Pension/Retirement benefits
- Other (tell us what it is)

|  |                |                                   |   |
|--|----------------|-----------------------------------|---|
| <input type="checkbox"/> Self<br><input type="checkbox"/> Spouse | Type of Income | How much is received?<br>\$ _____ | How Often?<br><input type="checkbox"/> weekly <input type="checkbox"/> every 2 weeks<br><input type="checkbox"/> twice a month <input type="checkbox"/> monthly |
| <input type="checkbox"/> Self<br><input type="checkbox"/> Spouse | Type of Income | How much is received?<br>\$ _____ | How Often?<br><input type="checkbox"/> weekly <input type="checkbox"/> every 2 weeks<br><input type="checkbox"/> twice a month <input type="checkbox"/> monthly |
| <input type="checkbox"/> Self<br><input type="checkbox"/> Spouse | Type of Income | How much is received?<br>\$ _____ | How Often?<br><input type="checkbox"/> weekly <input type="checkbox"/> every 2 weeks<br><input type="checkbox"/> twice a month <input type="checkbox"/> monthly |
| <input type="checkbox"/> Self<br><input type="checkbox"/> Spouse | Type of Income | How much is received?<br>\$ _____ | How Often?<br><input type="checkbox"/> weekly <input type="checkbox"/> every 2 weeks<br><input type="checkbox"/> twice a month <input type="checkbox"/> monthly |

## 6. AUTHORIZED REPRESENTATIVE

Do you want someone else to act for or represent you?  Yes  No

Name of Your Authorized Representative \_\_\_\_\_

Address of Representative \_\_\_\_\_

Phone # of Representative \_\_\_\_\_

What do you want them to do?  Complete interviews  Report changes

**7. VOLUNTARY QUESTIONS**

Your Ethnicity:  Hispanic/Latino  Not Hispanic/Latino

Your Race:  Black/African-American  American Indian or Alaskan Native  
 White  Asian  Native Hawaiian or Other Pacific Islander

Your Language Preference:  English  Cantonese  Mandarin  Vietnamese  
 Amharic  Korean  French  Spanish  Other

Note: You may check more than one race. Also, you do not have to provide this information. None of this information will affect your benefits. We only ask for this information to make sure that we do not discriminate

**8. SIGNATURE**

- By signing below, I give my permission to DHS to get information about me. DHS can get this from my employer, landlord, bank and utility company. I give all of these people my permission to give information about me to DHS. I believe that all of my information on this application is correct. I know if I give false information, I may be breaking the law. I know that state and federal officials will check this information. I agree to help with their investigations.
- I have received a copy of my rights and responsibilities. I understand my responsibilities and agree to cooperate as required.
- I understand that if I need help with other medical expenses, or if I need to apply for food stamps, I must file a separate application at the Income Maintenance Administration office in my area.
- I certify that everyone requesting benefits on this application form is a U.S. citizen or lawfully admitted alien. I have provided proof of lawful immigration status.

**↓ You Must Sign Below ↓**

If you are married and your spouse is applying, he/she will also need to sign below

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Applicant's Spouse

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Authorized Representative

\_\_\_\_\_  
Date

# Notice of Rights and Responsibilities

## *General Rules*

You must give true and complete information. If you lie or give false information, you may lose your benefits. You could also be fined and go to prison. We may verify your information to make sure it is correct. We may check on your income, your Social Security information, and your immigration information. We verify this information through computer matching programs. We may also interview you and do a home visit.

Your case may be chosen for a Quality Control review. This is a detailed review of all of your information. It may include some personal interviews and a review of your medical records. By applying, you agree to cooperate with the state or federal reviewers. If you refuse to cooperate, you may lose all or part of your benefits. If you are under investigation or are fleeing to avoid the law, we may share your information with federal and local agencies.

Under federal and District law, you must provide your Social Security Number (if you have one) if you are in the assistance unit. (See 42 CFR 435.910, 7 CFR 273.6, DC Code §4-204.07, §4-205.05a, and §4-217.07) Your SSN will be used to verify your identity, prevent receipt of duplicate benefits, and make required program changes. The DHS computer system uses your SSN to verify your income by using records from the Internal Revenue Service, the Social Security Administration, and the DC Child Support Services Division (CSSD).

## *Medical Assistance Rules*

After you apply, you will get a decision about your Medical Assistance within 45 days (or 90 days if DHS must determine if you are disabled). If you do not get a notice within this period, please call your IMA worker or (202) 727-5355. To get free legal help with Medicaid, call Terris, Pravlik, and Millian on (202) 682-0578 or write to them at 1121 12th Street, NW, Washington, DC 20005.

If you get Medical Assistance, then you must recertify each year when we send you a recertification notice. There is no time limit for getting Medical Assistance.

*Estate Recovery:* The District will seek recovery for the bills we pay if you are in a nursing home or other medical institution. Also, if you are age 55 or older, the District will seek recovery for services that you get. This means that we may put a lien or claim on your property or estate. If you have questions, call (202) 442-9075.

*Lawsuits:* If you sue or enter into settlement negotiations with a third party for a medical claim or injury, you must provide written notice of the action (either by personal service or certified mail) within 20 calendar days to the Medical Assistance Administration, Third Party Liability Section, 825 N. Capitol St., NE, 4th Floor, Washington, DC 20002. If you have questions, call (202) 442-9075.

## *Recertification*

We will send you a recertification notice in the mail. If you get Medical Assistance, just complete the form and send it back to DHS. If you do not recertify, then you will lose your benefits. Also, please let us know if you move. Just call **(202) 727-5355** to report your new address

## Reporting Changes

You must report changes in your income, Medicare status, and who lives with you. To report a change, call **(202) 727-5355**. You must call us before the 10th day of the month after the change.

## Confidentiality

By applying, you give DHS permission to talk with your employer, your landlord, your bank, your doctor, and other people who have information about you. You also give these people your permission to give information about you to DHS. In addition, you also give DHS permission to look at your motor vehicle records, wage data, tax information, and other government records. Of course, DHS keeps all of your information confidential. DHS does not release your records without your permission (except when required by law).

## Equality and Non-Discrimination

In accordance with Federal law and U.S. Department of Health and Human Services (HHS) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write HHS, Director, Office for Civil Rights, Room 506-F, 200 Independence Ave., SW, Washington, DC 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TDD). HHS is an equal opportunity provider and employer.

In accordance with the DC Human Rights Act of 1977, as amended, DC Official Code § 2-1401.01 et seq., (Act) the District of Columbia does not discriminate on the basis of actual or perceived: race, color, religion, national origin, sex, age, marital status, personal appearance, sexual orientation, gender expression, familial status, family responsibilities, matriculation, political affiliation, genetic information, disability, source of income, and place of residence or business. Sexual harassment is a form of sex discrimination, which is prohibited by the Act. In addition, harassment based on any of the above protected categories is prohibited by the Act. Discrimination in violation of the Act will not be tolerated. Violators will be subject to disciplinary action.

## Fair Hearings

If you think that DHS has made a mistake, then you can get a Fair Hearing. Call 202-698-4650 to find out more. You can also call (202) 727-8280. At a Fair Hearing, you can ask someone else to speak for you. This could be an attorney, a friend, a relative, or someone else. You can also bring witnesses. We will pay for transportation to the Fair Hearing for you and your witnesses. We may also pay for some of your other costs. You can also get free legal help for a Fair Hearing. Call one of the agencies above to talk to a lawyer or counselor.

## Free Legal Help

Neighborhood Legal Services  
1213 Good Hope Rd., SE  
(202) 678-200

Legal Aid Society  
666 11<sup>th</sup> St., NW  
Suite 800  
(202) 628-1161

Legal Counsel for the Elderly  
601 E St., NW  
Building A, 4<sup>th</sup> Floor  
(202) 434-2120

*Signature (sign below to show that you got this form)*

\_\_\_\_\_  
Applicant

\_\_\_\_\_  
Date