ASSISTED APPLICATION FOR HELP WITH MEDICARE COSTS THROUGH THE MEDICARE SAVINGS PROGRAM

Dear Applicant:

This is your application for assistance from the Department of Health and Human Services (DHHS).

- Please read the front and back of this page before completing the application.
- Fill out all pages as best you can. Do not fill out any questions you do not understand. Ask the person assisting with this application to help you.

Qualified Medicare Beneficiary Program (QMB)

This federal program was set up to help people who are covered by Medicare Part A. If you are eligible for this program, DHHS will pay the Social Security Administration (SSA) directly for the cost of your Medicare premiums for Part A (if any) and Part B. DHHS will also pay for your out-of-pocket Medicare co-insurance and deductible costs if:

- your provider is enrolled in the Medicaid Program, and
- your provider accepts Medicare assignment.

Specified Low-Income Medicare Beneficiary Programs (SLMB and SLMB135)

These federal programs were set up to help people who would be eligible for the QMB program, except that their income is too high. If you are eligible for either of these programs, DHHS will pay SSA directly for the cost of your monthly Medicare Part B premium. DHHS will not pay any other Medicare costs for you.

Qualified Disabled Working Individuals Program (QDWI)

This federal program was set up to help working people with disabilities. If you are disabled and lose Medicare Part A due to your earnings, you may be eligible for this program. With this program, DHHS will pay SSA directly for the cost of your monthly Medicare Part A premium to help you keep working.

Timeframes for Decisions on Your Application

DHHS will figure out your eligibility within 45 days of getting your signed application and your proof at the DHHS District or ServiceLink Office.

Other Programs Available Through DHHS

You may also be able to get the following help:

- **Food Stamps:** to help you buy food.
- **Medical Assistance:** to help you with health care costs (Individuals receiving help from the SLMB135 program cannot receive assistance from this program at the same time).
- **Financial Assistance**: cash payments.

If you want to apply for any of these other programs, contact your local DHHS District Office. YOU CANNOT USE THIS APPLICATION FORM TO APPLY FOR OTHER PROGRAMS.

PLEASE TURN OVER — IMPORTANT INFORMATION IS ON THE BACK OF THIS PAGE

YOUR RIGHTS AND RESPONSIBILITIES

Your Right to Not be Discriminated Against

It is against the law to discriminate against anyone because of race, color, national origin, gender, age, disability, religion, or political beliefs. To file a complaint of discrimination, write the Ombudsman, NH DHHS, 129 Pleasant St., Concord, NH 03301-3857, or call (603) 271-6941/1-800-852-3345, ext 16941. TDD Access: Relay NH 1-800-735-2964 or 7-1-1. There can be no retaliation against you for having made this contact.

Your Right to an Administrative Appeal

You or someone representing you may request an Administrative Appeal if you are not satisfied with any decision regarding eligibility made by DHHS. You may be represented by an attorney or other person at an Administrative Appeal. DHHS will not pay for the cost of any legal services, but there are free and reduced cost legal services available in NH. An Administrative Appeal may be requested either verbally or in writing by contacting a District Office or DHHS, 105 Pleasant St., Concord, NH 03301-6521. Phone (603) 271-4292 or 1-800 852-3345, ext 14292; TDD Access: Relay NH 1-800-735-2964 or 7-1-1.

Your Right to Choice of Medical Program

If you are eligible for more than one DHHS program, such as medical assistance and SLMB135, you have the right to choose the program that best suits your circumstances.

Social Security Numbers (SSN)

Section 2651 of PL 98-369, 42 CFR 435.910, and Section 1137 of the SSA [42 USC 1302b-7], require that we ask for the SSN of each person asking for medical assistance. Giving us an SSN is optional for persons who are not applying for assistance. Giving us an SSN can save you time and money getting needed verifications. We use the SSNs to verify earned and unearned income and resource information you give us. It will be shared with the Social Security Administration, various offices within DHHS as allowed by federal law, New Hampshire Employment Security, the Internal Revenue Service, contracted third parties, financial institutions, and other computer matching programs. The information will be used to confirm income, figure out eligibility for and/or amount of benefits, identify or verify any errors in your eligibility and benefits, and in an investigation of suspected abuse of program law or rules.

Reporting Changes

You must tell us about any changes that might affect your eligibility, such as changes of address or shelter costs, changes in the members of your household, getting a lump sum payment or settlement, or changes in the source or amount of money your household gets or in what is owned. You must tell us about changes as soon as possible, but no later than 10 calendar days after they happen.

Quality Control Reviews

Your case may be chosen for a quality control or other governmental review. Such a review means that there will be an in-depth study of your household's financial or medical situation, living arrangements and other circumstances. We will contact banks, employers, companies, merchants, and other appropriate sources, about your household and statements you made or information you gave to DHHS. If you do not help us in these reviews, your benefits could stop.

Verifying What You Told Us

The information that you tell us and give in this application will be verified by federal, state and local officials and computer matching with other agencies. We do this to confirm your eligibility for our programs and determine your benefits. If any information is found to be wrong, your benefits could stop and you may be subject to criminal prosecution for knowingly providing false information.

AGENCY USE ONLY

This is your record of application. When your completed and signed application is received by a DHHS District Office, this page will be filled out by a Department of Health and Human Services worker and returned to you.

I have received from _____

a completed application for help with Medicare costs on ____/____/____

_____ _____

District Office **Signature of Worker**

ASSISTED APPLICATION FOR HELP WITH MEDICARE COSTS THROUGH THE MEDICARE SAVINGS PROGRAM

AGENCY USE ONLY	RFA#:		Filing Date:	/ /

GENERAL INFORMATION

Applicant's Name (Last, First, Middle)	Home Telephone	Work Telephone		
Mailing Address (Street, RR, Box #, Apt.)	**City**	**Cty**	**State**	**ZIP Code**
Home Address (if different)	**City**	**Cty**	**State**	**ZIP Code**

Email Address: ☐ **I do not have an E-Mail address**

Have you ever used another name? ☐ Yes ☐ No
If you answered "Yes", list other names:

Are you currently receiving any other assistance from the Department? ☐ Yes ☐ No

If Yes, check all that apply: ☐ Financial Assistance ☐ Medicaid ☐ Food Stamps

FAMILY MEMBERS: You, your spouse, and children living with you who need help with Medicare costs.

Name (Last, First, Middle)	Relation to You	Date of Birth (mm/dd/yy)	Social Security Number
	SELF		

MEDICAL INSURANCE: List any health insurance currently held by each applicant, INCLUDING MEDICARE PART A, PART B, and PART D. List each type separately, even if held by the same person.

Name (Last, First, Middle)	Insurance Type	Effective Date	Claim Number

RESOURCES: List all resources owned by you or your spouse. Resources include bank accounts, certificates of deposit, stocks, bonds, burial plots, life insurance, real property, and other assets.

Type of Resource	Owner	Current Value	Identifying Information (Bank, Acct. Number, etc.)

PLEASE TURN OVER — MORE QUESTIONS ARE ON THE BACK OF THIS PAGE

INCOME: List all income received by you and your spouse and any children requesting help with Medicare costs.

Source of Income	Person Receiving	Amount	Frequency (Monthly, Weekly, etc.)
		$	
		$	
		$	
		$	
		$	

Do you expect any income or resource changes in the near future? ☐ Yes ☐ No

If you answered "Yes, " describe: _____

_____

_____

APPLICATION FOR RETROACTIVE ASSISTANCE: Individuals may qualify for up to three months of SLMB or SLMB135 coverage before the application month. This is called "Retroactive Assistance."

Do you wish to apply now for SLMB or SLMB135 Retroactive Assistance? ☐ Yes ☐ No

If yes, for how many prior months? Check any or all: ☐ 1 month ☐ 2 months ☐ 3 months

IMPORTANT — PLEASE READ CAREFULLY! SIGNING YOUR NAME BELOW INDICATES YOU FULLY UNDERSTAND EACH OF THE FOLLOWING STATEMENTS.

- **I UNDERSTAND** that I have to give DHHS documents to prove what I have written on the application. I also understand that if I deliberately hide or do not tell DHHS any information which affects my right to any benefit or payment or its conversion to the use by someone else, or if I give false information or withhold information related to my receipt of assistance, now or in the future, I may be prosecuted for fraud.
- **I UNDERSTAND** that DHHS will keep any information on this application confidential and only people involved in administering DHHS programs or as otherwise permitted by Federal regulations or State law will see it.
- **I UNDERSTAND** that DHHS will contact other people or organizations to get additional proofs of my eligibility, that the information I have provided will be used in computer matching with other agencies, and that information from the matching programs may be used to determine or redetermine eligibility for and/or amount of my benefits.
- **I UNDERSTAND** that my signature below authorizes the Department and any contracted third party to get verification and authorizes release of such information to DHHS. My authorization to release information remains in effect until the time of my next redetermination of eligibility.
- **I CERTIFY** that I have read the **YOUR RIGHTS AND RESPONSIBILITIES** section and that the statements contained in that section have been explained to me and all of my questions have been answered.

I CERTIFY, under penalty of perjury, that the information I have provided on this application is true and complete to the best of my knowledge.

_____ _____

Signature of Applicant or Authorized Representative **Date**

I CERTIFY that I have completely explained to the individual completing the application the RIGHTS AND RESPONSI-BILITIES and all STATEMENTS on this page AND that I have seen proof of that person's identity.

_____ _____ _____

Signature of Individual Assisting with Application **Agency** **Date**