State of Rhode Island

MEDICARE PREMIUM PAYMENT (MPP) FORM

This form asks for information necessary to determine whether you are eligible for initial or continuing eligibility for the Medicare Premium Payment. Please answer all of questions and provide the documentation requested in each section. Be sure to put your name and the last four digits of your Social Security Number at the top of all the documents and information you send us. Please send all documents to: State of Rhode Island, P.O. Box 8709, Cranston RI 02920-8787.

DO NOT FORGET TO SIGN AND DATE THE FORM AT THE BOTTOM OF THE LAST PAGE.

Information about You

Name	Social Security #	D.O.B.	Tel No.

Home Address

Street City Zip

Name and Address of Nursing Home/Assisted Living /or other Residence or Facility if Applicable	Address

Please indicate if there is a guardian, power of attorney, conservator, authorized representative, or person who we should contact on your behalf if needed and provide the contact information requested below**:**

Guardian	Power of Attorney	Conservator	Authorized Representative	Relative	Friend

Name	Tel. No

Address

Street City Zip

1. Do you have your name on any account like a savings or checking account, a certificate of deposit, a money market funds, IRA, Keough plan, annuity plan, or do you own a burial contract?

YES□ NO□

If YES, complete the following using additional paper if necessary**.**

Source / Bank	Account Type	Account Number	Amount in Account
			$
			$
			$
			$
			$

2. Has there been any change in your Life Insurance**?**

YES□ NO□

If YES, please complete below and include a copy of the last statement if the total face value of your non-term, whole life insurance policy(s) exceeds **$4,000**.

Life Insurance Co.	Policy Number	Face Value	Cash Value
		$	$
		$	$

3. Complete the following, if you or your spouse have cashed in, exchanged, transferred to another account, or otherwise received any funds from an item of value in which you or your spouse are named as a sole or joint owner since your initial application or last renewal. Include items such as any inheritance, insurance settlement, IRA distribution, burial contract, stock portfolio, trust fund, annuity plan, brokerage account, insurance settlement, the sale of property and the like.

YES□ NO□

If YES, please complete section below and send in documentation showing the action you took on your each item.

Describe the item	Date of Action	Amount of Funds

4. Have you or your spouse established or transferred any item of value such as an inheritance, property, insurance settlement, IRA distribution, burial contract, stock portfolio, trust fund, annuity plan, brokerage account, insurance settlement, or the like into a trust within the last sixty (60) months?

YES□ NO□

If YES, complete the following:

Describe the item	Date of Action	Value/Amount of item placed in Trust

5. Do you own property?

If YES, and not previously reported, please submit a copy of deed and provide the address below. **YES□ NO□**

Address

5a. Do you have a Life Estate in any property? **YES □ NO□**

If YES, and not previously reported, please submit a copy of deed and provide the address below.

Address

5b. Does the property generate rental income? **YES □ NO□**

If YES, complete the following and please submit proof of the income and your mortgage, homeowner's insurance, taxes, water, sewer, and utility bills for property.

Amount of Rent Received	How Often Received?

6. Do you receive, or expect to receive income such as Supplemental Security Income (SSI), Social Security benefits, insurance awards, Veteran's or work-related retirement benefits or pensions, gifts over $ 240 this year, lottery winnings, worker's compensation, wages from employment, or dividends, interest or other income on any accounts in which you are the sole or joint owner?

YES□ NO□

If YES, please complete the section below and provide copies of documents showing the gross and net amounts of income by source.

Source of Income	Gross Amount	How Often

7. Do you have any form of health coverage such as Medicare, an employer health plan, or a private health insurance plan or supplemental health insurance coverage?

YES□ NO□

If YES, please complete the section below and provide a copy of your health insurance plan or medical card(s).

Health Coverage	Policy Number	Amount paid	How Often

8. Complete this section if you have a spouse. Check here if you do not have a spouse □

8a. Does your spouse live at home, in the home of another person, or in a residential setting like assisted living, an apartment or supportive housing? **YES□ NO□**

If YES, complete the section below:

Spouse's Name	Social Security #.	Source of Income, if any	Gross Amount	How Often Received?

Please submit proof of amounts currently in effect for: the mortgage payment, home owner's insurance, taxes, water, sewer and utility bills that are paid.

9. **Complete this section** if you have any dependent children under age 21 or a child 21 years of age or older who has a disability. Check here if no dependent or disabled children ☐

9a. Does your child live at home, in the home of another, or in a residential setting like a group home, or shared living??

If YES, please complete the section below and provide documentation for your responses.

Child's Name	Social Security #	Source of Income	Gross Amount	How Often Received

RIGHTS AND RESPONSIBILITIES

I am renewing Medicare Premium Payment Program funded through the Executive Office of Health and Human Services. I understand that all the information in this form and my Social Security Administration records will be used in deciding my eligibility for these benefits. I agree to provide a valid Social Security Number for me and my spouse. I understand that these Social Security Numbers may be used in electronic data matches with state and federal agencies to obtain and/or verify information that pertains directly to my Medicaid eligibility and give the state my permission to use it for these purposes. I agree to provide accurate information to the state when applying for and renewing benefits and assistance. I understand and agree to report any changes in the information I have provided within 10 days of the date the change takes effect. I understand that under state and federal law, there are penalties for making false and misleading statements. I agree to cooperate fully with the state and federal personnel conducting quality control reviews.

I know that Medicaid does not pay for health care expenses that are the responsibility of a third-party, including Medicare, the Veteran's Administration, or another commercial health or insurance plan. I understand that by signing below, I am assigning my rights to any third-party payment to the EOHHS, including payment for lawsuits, or other insurance policies. I also understand that EOHHS has a potential lien against my estate for Medicaid paid for on my behalf if I am 55 years of age or older. This lien does not extend to Medicare benefits or Payments under federal law.

I know that the information I have given is confidential and is used only for administration of the Medicaid program. The EOHHS, and its eligibility agent the DHS, will not release information about me without my consent except as provided in federal and state laws, rules and regulations. If I am determined no longer eligible, I understand that I may reapply at any time. I know that I have the right to appeal any agency decision or delays, and receive a hearing before an EOHHS administrative fair hearing officer.

LIMITED ENGLISH PROFICIENCY NOTICE

Upon request, the DHS will schedule an interpreter or bilingual staff member to help you read English language notices, letters or other written information about your Medicaid eligibility. If you have problems obtaining an interpreter or bilingual staff services at a DHS office, please contact the Limited English proficiency Coordinator at the telephone number on the first page of this notice.

______________________________________ ______________________

Signature of Customer or Authorized Representative Date