NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs

Medicare Savings Program Application

Please print clearly and do not write in the dark shaded area.

APPLICANT

First Name, Middle Initial, Last Name			Home Phone Number ( )		
Home Address Street Apt. No.	City		State	Zip Code	County

Is this a shelter? ☐ Yes ☐ No

Mailing Address Street/P.O. Box (If Different from Above) Apt. No.	City	State	Zip Code	County

NAMES

List your name first. Include aliases and maiden name. If necessary, attach an extra sheet to list all children.

First Name, Middle Initial, Last Name	Date of Birth (MM/DD/YY)	Sex M, F, X	Gender Identity** (Optional)	Social Security Number	Race/Ethnicity Group (See codes below)
Self	/ /			– –	
Spouse	/ /			– –	
Child*	/ /			– –	
Child*	/ /			– –	

*If under 18 years of age

**Gender Identity: Gender identity is how you perceive yourself and what you call yourself. Your gender identity can be the same as or different from your sex assigned at birth.

Gender Identity Codes: **M**-Male, **F**-Female, **N**-Non-Binary or Non-Conforming, **X**-X, **T**-Transgender, **D**-Different Identity: Describe your Identity in space provided.

Race/Ethnic Group Codes: **B**-Black or African American, **W**-White, **H**-Hispanic or Latino, †**A**-Asian or Pacific Islander, **I**-American Indian or Alaskan Native, †**P**-Native Hawaiian or other Pacific Islander, **U**-Unknown, **O**-Other.

†If you have selected **A**-Asian, or **P**-Native Hawaiian or Pacific Islander please see below information on Other AAPI.

‡Other Asian American/Pacific Islander (optional) - Please identify your AAPI subgroup. Subgroups within this community include, but are not limited to: Chinese, Japanese, Filipino, Korean, Vietnamese, Cambodian, Indonesian, Pakistani, Sri Lankan, Taiwanese, Native Hawaiian, Samoan, Tongan, Guamanian or Chamorro, Marshallese, Fijian, and other.

CITIZENSHIP INFORMATION

Are you a U.S. citizen? ☐ Yes ☐ No

If No, do you have satisfactory immigration status? ☐ Yes ☐ No Include alien number, date of status, and date entered country, if applicable.

Alien Number	Date of Status (DOS)	Date Entered Country (DEC)

Is your spouse a U.S. citizen? ☐ Yes ☐ No

If No, does your spouse have satisfactory immigration status? ☐ Yes ☐ No Include alien number, date of status, and date entered country, if applicable.

Alien Number	Date of Status (DOS)	Date Entered Country (DEC)

MEDICARE INFORMATION

Applicant's Medicare Number (From Red and Blue Medicare Card)			
Do you have Medicare Part A? ☐ Yes ☐ No	Effective Date	Do you have Medicare Part B? ☐ Yes ☐ No	Effective Date

Spouse's Medicare Number (From Red and Blue Medicare Card)			
Does your spouse have Medicare Part A? ☐ Yes ☐ No	Effective Date	Does your spouse have Medicare Part B? ☐ Yes ☐ No	Effective Date

Would you like us to consider providing retroactive reimbursement of your Medicare premium? ☐ Yes ☐ No

Do you or your spouse pay any health insurance premiums other than Medicare? ☐ Yes ☐ No

Who?	Monthly Amount $

Do you or your spouse pay child/spousal support? ☐ Yes ☐ No

Who?	Monthly Amount $

Do you or your spouse receive payments from or are named beneficiary of a trust? ☐ Yes ☐ No

Who?	Value $

INCOME

List below all available income such as: salary, wages, pension, social security, severance pay, rental or business income, etc. If necessary, attach an extra sheet to list all sources of income.

Name of Applicant, Spouse, or Child Under 18	Who Provides the Money? (Name/Source of Income)	What Amount?	How Often? (Weekly, Every Two Weeks, Monthly, Other)

Do you want to receive notices in: ☐ English Only ☐ Spanish and English?

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.

SIGNATURES

Applicant/Representative Signature	Date
Spouse Signature	Date

Representative Address			Relationship
City	State	ZIP Code	Phone Number ( )

INSTRUCTIONS

PLEASE TYPE OR PRINT LEGIBLY

COMPLETE THE APPLICATION

Be sure to answer all the questions. If you are married and living with your spouse, you must complete both the "Self" and "Spouse" questions on the application (even if the spouse is not applying for the MSP).

SIGN AND DATE THE APPLICATION

If both spouses are applying, both must sign the MSP application.

INCLUDE THE FOLLOWING VERIFICATION DOCUMENTS

Please review this list and submit the documents that you will need to provide in order for the Medicaid Program to determine if you are eligible for MSP. If you are requesting retroactive reimbursement of your Medicare premiums, you must send proof of income for the previous three-months. If there is an applying spouse, the spouse must also provide documentation.

- A photocopy of the front and back of your **Medicare card**.
- **Proof of income:** Paycheck stubs, letter from employer, income tax return, award letter for any unearned income benefit such as social security, unemployment, or veteran's benefit, or letter from renter, boarder or tenant.
- **Health insurance premiums that you pay other than Medicare:** Letter from employer, premium statement, or pay stub.
- **Proof of date of birth:** State driver's license, U.S. birth certificate, permanent resident card ("green card"), or NYS Benefit Identification Card.
- **Proof of residence:** Lease/letter/rent receipt with your home address from your landlord, driver's license (if issued in the past 6 months), utility bill (gas, electric, phone, cable, fuel or water), government ID card with address, property tax records or mortgage statement, or postmarked envelope or postcard (cannot use if sent to a P.O. Box).
- If you are not a U.S. citizen, you must provide documents indicating your current immigration status.

Mail the application and required documentation to your local Department of Social Services (LDSS) or Human Resource Administration (HRA). To find the address in your county: http://www.health.ny.gov/health_care/medicaid/ldss.htm.

TERMS, RIGHTS AND RESPONSIBILITIES

By completing and signing this form, I am applying for the Medicare Savings Program. **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.

CHANGES

I agree to immediately report any changes to the information on this application.

SOCIAL SECURITY NUMBER (SSN)

If you are applying for the Medicare Savings Program, you must report your SSN. The laws requiring this are: 18NYCRR Sections 351.2, 360-1.2, and 360-3.2(j)(3); 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.

If after reading and completing this form, you decide that you DO NOT want to apply for the Medicare Savings Program, please sign your name below:

I consent to withdraw my application:

Applicant Signature	Date

Signature of Person Who Obtained Eligibility Information			Date	Employed By		
Date Eligibility Determined By Worker				Date Eligibility Approved By		
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	