PENNSYLVANIA

Application for Payment of Medicare Premiums, Coinsurance and Deductibles

If you have a disability and need this form in large print or another format, please call our helpline at 1-800-692-7462. TDD services are available at 1-800-451-5886.

This is an application for payment of your Medicare premiums, Coinsurance and Deductibles. If you need this application in a different language or someone to interpret, please contact your local county assistance office, CAO. Language assistance will be provided free of charge.

នេះគឺជាពាក្យសុំសំរាប់ការបង់ប្រាក់ចំណាយលើថ្លៃធានារ៉ាប់រង Medicare ធានារ៉ាប់រងរួមគ្នា និង ការដកហូតយកធានារ៉ាប់រង ។ ប្រសិនបើ លោកអ្នកត្រូវការពាក្យសុំ នេះជាភាសាផ្សេង ឬ ត្រូវការនរណាម្នាក់ឱ្យជួយបកប្រែជូនលោកអ្នក សូមទាក់ទងមកការិយាល័យជំនួយប្រចាំប្រទេស, CAO ។ ចំពោះជំនួយខាងផ្នែកភាសានឹងត្រូវបានផ្តល់ជូនលោកអ្នកដោយពុំគិតថ្លៃ ។

Esta es una solicitud para el pago de su Cobertura de Salud y/o primas de Medicare. Si necesita esta solicitud en otro idioma o servicios de interpretación, comuníquese con su oficina de asistencia del condado (CAO, por sus siglas en inglés) local. La asistencia para comunicarse en otro idioma se proporcionará gratuitamente.

Данный документ является заявлением на оплату страховых премий программы Medicare, совместного страхования и нестрахуемого минимума. Если это заявление необходимо вам на другом языке, или если вам требуются услуги переводчика, обратитесь в местный окружной отдел поддержки в вопросах социального обеспечения (County assistance office, CAO). Услуги переводчика будут предоставлены вам бесплатно.

Đây là một đơn xin thanh toán phí bảo hiểm, đồng bảo hiểm và các khoản khấu trừ của chương trình Medicare của quý vị. Nếu quý vị cần đơn xin này bằng một ngôn ngữ khác hoặc cần người phiên dịch, vui lòng liên hệ văn phòng hỗ trợ của hạt tại địa phương (CAO). Việc hỗ trợ về ngôn ngữ sẽ được cung cấp miễn phí.

这是用于支付您医疗(**Medicare)**保险费用、共负保险额和自负额的申请书。如果您需要另一语言版本的申请书，或者需要他人加以解释，请与您当地的县援助办公室（COA）联
系。将免费提供语言援助。

Information about your Health Care Coverage

Should I apply?

Yes, you should apply. Everyone has the right to and is encouraged to apply.

What are the benefits?

There are several different benefits. Depending on your income and resources you may be eligible for benefits in one of the following categories.

Qualified Individuals (QI) benefits

- Pays your Medicare Part B premium. Monthly income cannot exceed 135% of the Federal Poverty Income Guideline. Resource limits are higher than most other Medical Assistance programs. Contact the local CAO or Customer Service Center (CSC) at 1-877-395-8930 for current limits. Philadelphia residents please call 1-215-560-7226.

Specified Low Income Medicare Beneficiaries (SLMB)

- Pays your Medicare Part B premium. Monthly income cannot exceed 120% of the Federal Poverty Income Guideline. Resource limits are higher than most other medical programs. Contact the local CAO or Customer Service Center (CSC) at 1-877-395-8930 for current limits. Philadelphia residents please call 1-215-560-7226.

Qualified Medicare Beneficiaries (QMB)

- Pays for your Medicare Part A premium. (if you have to pay the premium yourself), Medicare Part B premiums, Medicare deductibles and coinsurance (co-payment) costs. Monthly income cannot exceed 100% of the Federal Poverty Income Guideline. Resource limits are higher than most other Medical Assistance programs. Contact the local CAO or Customer Service Center (CSC) at 1-877-395-8930 for current limits. Philadelphia residents please call 1-215-560-7226.

- Qualified Medicare Beneficiaries also may be eligible for full Medical Assistance benefits (includes transportation to medical appoint ments) and payment of Medicare premiums. Resource limits are $2,000 individual/ $3,000 married couple.

Even if your earned and unearned income and resources are above the limits, you should apply because not all income is counted. Certain resources, such as the house you live in, are not counted. The income limits may change every year.

Your application will be reviewed for payment of your Medicare Part B premiums for the previous three months.

Client Rights and Responsibilities

Right to Nondiscrimination
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, or disability. To file a complaint of discrimination, contact HHS. Write HHS, Director, Office of Civil Rights, Room 506-F, 200 Independence Avenue, S. W. Washington, D.C. 20201 or call (202) 619-0403 (Voice) or (202) 619-3257 (TTD). HHS is an equal opportunity provider and employer.

Right to Confidentiality
We keep information you give confidential and use it only to administer the programs you apply for and/or may be eligible for.

Right to a Written Notice
We will give you a written notice explaining your benefits. If we deny, change, suspend, or stop benefits, we will explain the reason on the notice. You have 30 days from the date of the notice to ask for a hearing if you disagree with the action taken and/or the reasons given.

Right to Appeal and Right to an Agency Conference
You have the right to ask for a Department of Public Welfare (DPW) hearing to appeal a decision or failure to act by the Department, which affects your benefits or that you believe is unfair or incorrect. You may file the appeal at the county assistance office (CAO.) At the appeal hearing, you may represent yourself, or someone else, such as a lawyer, friend, or relative, may represent you. If you appeal, you may have an agency conference before the hearing. Every decision we make about your coverage must be sent to you in writing and can be appealed. All written decisions will include instructions on how to appeal. Local legal services can assist in your appeal.

Responsibility to provide Social Security Numbers
You must provide a Social Security Number (SSN) for each person for whom you are applying. If you do not have an SSN, we will help you apply for one. Refusal or failure to provide an SSN may result in ineligibility. We will also ask you to supply an SSN to verify identity and administer our programs. We will use your SSN to prevent duplication in state and federal programs and to get information about income to determine eligibility for benefits.

Responsibility to Provide Information
You must give true, correct and complete information. You must cooperate in documenting or proving the information you give. If you cannot provide proof, you should ask the CAO to help. You must cooperate fully with persons or investigators of DPW or Office of Inspector General conducting investigations.

Responsibility to Report Changes
You must report changes in the number of people in your household, address, new unearned income, real property or other resources (such as bank accounts or life insurance). You must report any plans to move out of the state, even temporarily. You must report if your gross monthly earned income increases by more than $100. If you have unearned income, you must report if your gross monthly unearned income increases by more than $50. **Changes must be reported within the first 10 days of the month following the month of the change.**

Application for Payment of Medicare Premiums Coinsurance and Deductibles

PROVIDER USE ONLY	
PROVIDER NAME	PROVIDER NUMBER
☐ INPATIENT ☐ OUTPATIENT ☐ EMERGENCY	
☐ NON-APPLICABLE	

COUNTY ASSISTANCE OFFICE USE

☐ MAIL ☐ WALK-IN		FILE CLEAR BY DATE	SCREEN BY DATE	
COUNTY	DISTRICT	APPLICATION REG #	DATE STAMP	CAT
WORKER I.D.	CASELOAD	RECORD NUMBER	2ND DATE	CAT
NAME				
APPOINTMENT DATE/TIME				AM PM
☐ APPLICATION		☐ RENEWAL		

	AUTHORIZED				NOT AUTHORIZED			
DATE								
BY								
CAT								
REASON CODE								

How do I apply?

Complete this application. Read the entire application form including the instructions. Please print your responses on the application. If you need help answering the questions, call your local county assistance office, or CAO, or the **HELPLINE at 1-800-842-2020 (if you are hearing impaired, call TDD 1-800-451-5886).**

You can apply online at **www.compass.state.pa.us.** by mail, or by visiting your county assistance office.

Where do I send the application?

When you have completed the application, send it to your CAO. Contact the CSC at **1-877-395-8930** for the correct address. Philadelphia residents please call 1-215-560-7226.

How long will it take to learn whether I have been found eligible? It should take 30 days. If additional information is needed, it could take up to 45 days.

Do you need an interpreter? ☐ YES ☐ NO **If yes, in what language?** ____________

Please Print All Information

Question 1 - Tell us about you, the applicant: We need to gather information about you, the person applying for benefits.

Office Use Line #	Name (Last, First, Middle Initial)	JR/SR/etc.	Birth Date (MM/DD/YY)	Sex ☐ M ☐ F	Social Security Number
Medicare Claim Number	Are you a U.S. Citizen? ☐ Yes ☐ No	Non-Citizen Registration ID	Do You Have a PA Access Card? ☐ Yes ☐ No	Relationship SELF	
RACE (Optional)	Individuals may fit more than one group. Check all groups that apply. Your benefits will not be affected if you do not answer.	1 ☐ Black or African American	2 ☐ Hispanic	3 ☐ American Indian or Native Alaskan	4 ☐ Asian; 5 ☐ White (Not Hispanic)
6 ☐ Other	7 ☐ Native Hawaiian or Pacific Islander	Marital Status	☐ Single ☐ Separated ☐ Married	☐ Common-law Marriage	☐ Divorced ☐ Widowed
Home Address (Include Street, Apt. Number, City, State & Zip Code+4)				Phone Number	
Mailing Address (Include Street, Apt. Number, City, State & Zip Code+4)					
Township or Municipality			School District		

Question 2 - Tell us about your spouse if he or she lives with you. To determine if you qualify, we need to know about your spouse living with you.

Are you applying for your spouse? ☐ YES ☐ NO

Office Use Line #	Name (Last, First, Middle Initial)	JR/SR/etc.	Birth Date (MM/DD/YY)	Sex ☐ M ☐ F	Social Security Number	Medicare Claim Number
Is Spouse a U.S. Citizen? ☐ Yes ☐ No	Non-Citizen Registration ID	Does Spouse Have a PA Access Card? ☐ Yes ☐ No	Relationship SPOUSE			

RACE *(Optional)* Individuals may fit more than one group. Check all groups that apply. Your benefits will not be affected if you do not answer. 1 ☐ Black or African American 2 ☐ Hispanic 3 ☐ American Indian or Native Alaskan 4 ☐ Asian 5 ☐ White (Not Hispanic) 6 ☐ Other 7 ☐ Native Hawaiian or Pacific Islander

Question 3 - Children Under 21. We need to know if there are any children under 21 living with you.

Do you have children under 21 living with you? ☐ YES ☐ NO

Office Use Line #	Name (Last, First, Middle Initial)	JR/SR/etc.	Birth Date (MM/DD/YY)	Sex ☐ M ☐ F	Social Security Number	Medicare Claim Number
Is this Person a U.S. Citizen? ☐ Yes ☐ No	Non-Citizen Registration ID		Relationship			

RACE *(Optional)* Individuals may fit more than one group. Check all groups that apply. Your benefits will not be affected if you do not answer. 1 ☐ Black or African American 2 ☐ Hispanic 3 ☐ American Indian or Native Alaskan 4 ☐ Asian 5 ☐ White (Not Hispanic) 6 ☐ Other 7 ☐ Native Hawaiian or Pacific Islander

Office Use Line #	Name (Last, First, Middle Initial)	JR/SR/etc.	Birth Date (MM/DD/YY)	Sex ☐ M ☐ F	Social Security Number	Medicare Claim Number
Is this Person a U.S. Citizen? ☐ Yes ☐ No	Non-Citizen Registration ID		Relationship			

RACE *(Optional)* Individuals may fit more than one group. Check all groups that apply. Your benefits will not be affected if you do not answer. 1 ☐ Black or African American 2 ☐ Hispanic 3 ☐ American Indian or Native Alaskan 4 ☐ Asian 5 ☐ White (Not Hispanic) 6 ☐ Other 7 ☐ Native Hawaiian or Pacific Islander

Question 4 - U.S. Military Service.

Is anyone in the U.S. military, or has been in the U.S. military? ☐ YES ☐ NO

Is anyone a widow, spouse, or child (under age 18) of anyone in the U.S. military, or anyone who has been in the U.S. military? ☐ YES ☐ NO

PERSON WHO SERVED	BRANCH (Example: Army, Navy, Marine Corps, Air Force, Coast Guard)	DATES OF SERVICE

Question 5 - Voter Registration.

Voter Registration (Optional)

If you or any other adult in your household is not registered to vote where you live now, would you like to register to vote?___Yes___No If yes, enter the names below. IF YOU DO NOT CHECK 'YES' OR 'NO', OR RETURN THE FORM, YOU ARE CHOOSING NOT TO REGISTER TO VOTE AT THIS TIME.

To register, you must: 1) Be at least 18 on the day of the next election; 2) Be a citizen of the United States for at least one month PRIOR TO THE NEXT ELECTION; 3) Reside in Pennsylvania and the voting district at least 30 days prior to the next election.

LINE NO CAO ONLY	LAST NAME	FIRST NAME	LINE NO CAO ONLY	LAST NAME	FIRST NAME

YOUR BENEFITS WILL NOT BE AFFECTED IF YOU REGISTER OR DO NOT REGISTER.

If you need help filling out the voter registration form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private. Please contact the Central Unit if you need help. If you believe that someone has interfered with your right to vote, or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Secretary of the Commonwealth, PA Department of State, Harrisburg, PA 17120.
(Toll-free telephone number 1-877-VOTESPA.)

DO NOT COMPLETE: COUNTY ASSISTANCE OFFICE USE ONLY

☐ Given to Client __/__/__
☐ Declined, not interested __/__/__
☐ Sent to voter registration __/__/__
☐ Not a U.S. citizen __/__/__
☐ Mailed to Client __/__/__
☐ Declined, already registered __/__/__

Question 6 - Income.

We want to know about your income and the income of your spouse. Include income of children under 21. Not all income is counted. For example, we disregard at least $20 of income and have other deductions that may be made. List the amount of income before deductions (such as taxes or insurance) are taken out. (Attach additional paper if necessary).

Does anyone including a spouse or child, have income? ☐ Yes ☐ NO

If YES, list any income you have already received this month or expect to receive this month.

WAGES • UNION PAY • SICK BENEFITS • UNEMPLOYMENT OR WORKERS COMPENSATION • RENT • ROOM & BOARD • MONEY FOR TRAINING • COMMISSIONS • SSI • SELF EMPLOYMENT • DIVIDENDS OR INTEREST • CHILD SUPPORT • SOCIAL SECURITY • PENSIONS • OTHER • (Specify)

NAME	TYPE/SOURCE OF INCOME	HOW MUCH	HOW OFTEN?
		$	
		$	
		$	
		$	
		$	

Question 7 - Income Expenses. Some people must pay expenses to receive their income. This question is asking whether any individual's had to pay for such things as Impairment Related Work Expenses, Attorneys Fees, Court Costs, or Transportation to receive the income that was listed in Question #6.

Does anyone including a spouse or child, pay expenses such as attorneys' fees, bank fees, court costs, transportation costs and impairment related work expenses in order to receive their income? ☐ YES ☐ NO

If anyone pays for such expenses, list them here.

WHOSE EXPENSE?	TYPE OF EXPENSE	AMOUNT?	HOW OFTEN?
		$	
		$	
		$	

Question 8 - Resources. In this question, we want to know each individual's resources. Resources are assets or savings that you may have. Please know that not all resources are counted in determining eligibility. For example, we do not count the home that you live in. Check yes or no for each resource listed. For each yes, where you have indicated that you or another individual has the listed resource, use the space in the chart to tell us more about that resource.

Does anyone including a spouse or child have any of the following resources?

☐ Yes ☐ NO Cash-on-hand (01)
☐ Yes ☐ NO Savings Account (02)
☐ Yes ☐ NO Checking Account (03)
☐ Yes ☐ NO Certificate of Deposit (26)
☐ Yes ☐ NO Non-resident property (98)
☐ Yes ☐ NO Burial Spaces, Reserves or Trusts (97)
☐ Yes ☐ NO U.S. Savings Bonds (05)
☐ Yes ☐ NO Christmas or Vacation Club (04)
☐ Yes ☐ NO Stocks or Bonds (05)
☐ Yes ☐ NO Trust Fund (06)
☐ Yes ☐ NO IRA, KEOGH, or other retirement plan (27)

WHOSE RESOURCE?	TYPE AND LOCATION/FINANCIAL INSTITUTION	ACCOUNT NUMBER	CURRENT VALUE
			$
			$
			$
			$
			$

Question 9 - Vehicles. In this question, we want to know about any vehicles. Please know that not all vehicles are counted in determining eligibility. For example, we do not count the first car.

Does anyone including a spouse or child own or are buying a car, truck, or motorcycle? ☐ YES ☐ NO

WHOSE VEHICLE?	YEAR, MAKE AND MODEL	LICENSED	AMOUNT OWED
		☐ Yes ☐ NO	$
		☐ Yes ☐ NO	$
		☐ Yes ☐ NO	$

Question 10 - Life Insurance. In this question, we want to know about any life insurance policies and their face and cash value, to the extent that you know this information.

Does anyone including a spouse or child, have a life insurance policy?
If yes, please fill out this section to the best of your knowledge. It is okay if you do not have all the information.

☐ YES ☐ NO

WHOSE POLICY	INSURANCE COMPANY	POLICY NUMBER	FACE VALUE	CASH VALUE	WHO IS COVERED?
			$	$	
			$	$	
			$	$	

Question 11 - Medical Insurance. In this question, we want to know what other medical coverage you have, if any.

Does anyone including a spouse or child, have any other medical insurance, including Medicare or coverage purchased by someone else? If yes, complete the following and provide a copy of the card, and/or premium notice.

☐ YES ☐ NO

INSURANCE COMPANY	POLICY NUMBER	WHO IS COVERED?	PREMIUM	HOW OFTEN

Question 12 - Changes to Income or Resources. If you or your spouse paid Medicare Part B premiums in any of the previous three months you may receive a refund of those payments.

Please tell us if there was a change in income or resources within the last three months.

☐ NO, there was no change.

☐ YES, there was a change in income or resources. Please explain:

____

____

Question 13 - Verification. We will need proof of the information you have provided to process your application. If you are unable to obtain proof of the information, your CAO will help you.

☐ Check here if you need help getting proof of your address, income and/or resources.

Do you have copies of the information you provided? ☐ YES ☐ NO

PLEASE SEND COPIES - NOT ORIGINALS	
Identification (Only One Source)	Driver's License, Passport, Photo ID.
Alien Status (Only if non-U.S. Citizen)	Most current immigration documents.
Income	One Month's Current Pay Stubs, Proof of Pension, Financial Eligibility Notice for Unemployment Compensation, Tax Forms or Other Records of Self-employment Income, Copies of Check Stubs or Statements from the Source of Income.
Resources	Bank Statements, Insurance Policies, Tax Assessment Notices.

WHEN I SIGN THIS FORM I AGREE THAT:

I have read this application in full or someone has read it to me, and I understand the questions asked.

I received a copy of my rights and responsibilities, and have read them or someone has read them to me.

I understand, and agree with them.

I will provide or cooperate in getting any information needed to prove my statements.

I must report any changes in my circumstances to the CAO within the first 10 days of the month following the month of the change.

I am responsible for any fraudulent statements made on this application even if the application is submitted by someone acting on my behalf.

I certify that, subject to penalties provided by law, the information I gave is true, correct and complete to the best of my knowledge.

WHEN I SIGN THIS FORM, I UNDERSTAND THAT:

If I do not report changes as required, my benefits may be stopped.

If I purposely fail to give correct information or report changes, I may be fined and/or put in jail.

The State operates a fraud control program under which local, state and federal officials may verify the information I have given.

The State may obtain information about my circumstances from other persons or organizations, including computer matches and U.S. citizenship and immigration services.

My Social Security number will be used to verify my circumstances and eligibility.

Applicant #1 Signature | Date Signed

Applicant #2 Signature | Date Signed

Name and address of Authorized Representative | Date Signed

Signature and Name of Witness if Applicant Signed with an "X" | Date Signed

Witness Address | Witness Phone Number