

# 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 សូមទាក់ទងមកករិយាល័យជំនួយប្រចាំប្រទេស, CAO ។ ចំពោះជំនួយខាងផ្នែកភាសានិងត្រូវបានផ្តល់ជូនលោកអ្នកដោយពុំគិតថ្លៃ ។

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、共负保险额和白负额的申请书。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 appointments) 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

## 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.

| PROVIDER USE ONLY                       |                                     |                                    |                |          |
|---|-------------------------------------|------------------------------------|----------------|----------|
| PROVIDER NAME                           |                                     | PROVIDER NUMBER                    |                |          |
| <input type="checkbox"/> INPATIENT      | <input type="checkbox"/> OUTPATIENT | <input type="checkbox"/> EMERGENCY |                |          |
| <input type="checkbox"/> NON-APPLICABLE |                                     |                                    |                |          |
| COUNTY ASSISTANCE OFFICE USE            |                                     |                                    |                |          |
| <input type="checkbox"/> MAIL           | <input type="checkbox"/> 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<br>PM |
| <input type="checkbox"/> APPLICATION    |                                     | <input type="checkbox"/> RENEWAL   |                |          |
| AUTHORIZED                              |                                     | NOT AUTHORIZED                     |                |          |
| DATE                                    |                                     |                                    |                |          |
| BY                                      |                                     |                                    |                |          |
| CAT                                     |                                     |                                    |                |          |
| REASON CODE                             |                                     |                                    |                |          |

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<br><input type="checkbox"/> M <input type="checkbox"/> F | Social Security Number |
| Medicare Claim Number  | Are you a U.S. Citizen?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  | Non-Citizen Registration ID   | Do You Have a PA Access Card?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  | <b>SELF</b>            |
| <b>RACE</b><br><i>(Optional)</i>   | Individuals may fit more than one group. Check all groups that apply. Your benefits will not be affected if you do not answer. |   |   |  |                        |
| <span style="margin-right: 20px;">1 Black or African American</span> <span style="margin-right: 20px;">2 Hispanic</span> <span style="margin-right: 20px;">3 American Indian or Native Alaskan</span> <span style="margin-right: 20px;">4 Asian</span> <span style="margin-right: 20px;">5 White (Not Hispanic)</span> |  |   |   |  |                        |
| <span style="margin-right: 20px;">6 Other</span> <span style="margin-right: 20px;">7 Native Hawaiian or Pacific Islander</span>  |  | <b>Marital Status</b> <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Married <input type="checkbox"/> Common-law Marriage <input type="checkbox"/> Divorced <input type="checkbox"/> 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<br><input type="checkbox"/> M <input type="checkbox"/> F | Social Security Number | Medicare Claim Number |
| Is Spouse a U.S. Citizen?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  | Non-Citizen Registration ID        | Does Spouse Have a PA Access Card?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |                       | Relationship<br><b>SPOUSE</b>                                |                        |                       |
| <b>RACE (Optional)</b> Individuals may fit more than one group. Check all groups that apply. Your benefits will not be affected if you do not answer. <input type="checkbox"/> 1 Black or African American <input type="checkbox"/> 2 Hispanic <input type="checkbox"/> 3 American Indian or Native Alaskan <input type="checkbox"/> 4 Asian <input type="checkbox"/> 5 White (Not Hispanic) <input type="checkbox"/> 6 Other <input type="checkbox"/> 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<br><input type="checkbox"/> M <input type="checkbox"/> F | Social Security Number | Medicare Claim Number |
| Is this Person a U.S. Citizen?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   | Non-Citizen Registration ID        | Relationship |                       |  |                        |                       |
| <b>RACE (Optional)</b> Individuals may fit more than one group. Check all groups that apply. Your benefits will not be affected if you do not answer. <input type="checkbox"/> 1 Black or African American <input type="checkbox"/> 2 Hispanic <input type="checkbox"/> 3 American Indian or Native Alaskan <input type="checkbox"/> 4 Asian <input type="checkbox"/> 5 White (Not Hispanic) <input type="checkbox"/> 6 Other <input type="checkbox"/> 7 Native Hawaiian or Pacific Islander |                                    |              |                       |  |                        |                       |

|  |                                    |              |                       |  |                        |                       |
|--|------------------------------------|--------------|-----------------------|--|------------------------|-----------------------|
| Office Use Line #  | Name (Last, First, Middle Initial) | JR/SR/etc.   | Birth Date (MM/DD/YY) | Sex<br><input type="checkbox"/> M <input type="checkbox"/> F | Social Security Number | Medicare Claim Number |
| Is this Person a U.S. Citizen?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   | Non-Citizen Registration ID        | Relationship |                       |  |                        |                       |
| <b>RACE (Optional)</b> Individuals may fit more than one group. Check all groups that apply. Your benefits will not be affected if you do not answer. <input type="checkbox"/> 1 Black or African American <input type="checkbox"/> 2 Hispanic <input type="checkbox"/> 3 American Indian or Native Alaskan <input type="checkbox"/> 4 Asian <input type="checkbox"/> 5 White (Not Hispanic) <input type="checkbox"/> 6 Other <input type="checkbox"/> 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 are not registered to vote where you live now, would you like to apply to register to vote here today?  Yes  No  
**IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED 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.**

**Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.**

If you would like help filling out the voter registration application 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 would like help. If you believe that someone has interfered with your right to register 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.)

### COUNTY ASSISTANCE OFFICE STAFF WILL COMPLETE THIS BOX BASED UPON YOUR RESPONSE ABOVE

|  |  |  |
|--|--|--|
| <input type="checkbox"/> Given to Client __/__/__          | <input type="checkbox"/> Sent to voter registration __/__/__ | <input type="checkbox"/> Mailed to Client __/__/__             |
| <input type="checkbox"/> Declined, not interested __/__/__ | <input type="checkbox"/> Not a U.S. citizen __/__/__         | <input type="checkbox"/> 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 Non-resident property (98)     
  Yes  NO Stocks or Bonds (05)  
 Yes  NO Savings Account (02)     
  Yes  NO Burial Spaces, Reserves or Trusts (97)     
  Yes  NO Trust Fund (06)  
 Yes  NO Checking Account (03)     
  Yes  NO U.S. Savings Bonds (05)     
  Yes  NO IRA, KEOGH, or other retirement plan (27)  
 Yes  NO Certificate of Deposit (26)     
  Yes  NO Christmas or Vacation Club (04)

| 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 |
|----------------|----------------------|--|-------------|
|                |                      | <input type="checkbox"/> Yes <input type="checkbox"/> NO | \$          |
|                |                      | <input type="checkbox"/> Yes <input type="checkbox"/> NO | \$          |
|                |                      | <input type="checkbox"/> Yes <input type="checkbox"/> 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:

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**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                |   |
|---|---|
| <b>Identification</b><br>(Only One Source)        | Driver's License, Passport, Photo ID.   |
| <b>Alien Status</b><br>(Only if non-U.S. Citizen) | Most current immigration documents.   |
| <b>Income</b>                                     | 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. |
| <b>Resources</b>                                  | 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