



## Medicare Savings Program Renewal Form

This form is used to continue getting Medicaid payment for certain Medicare costs, such as the premiums, coinsurance, and deductibles. If you need help filling out this form call your local Medicaid office or call us toll free at 1-888-342-6207. If you are deaf or have hearing problems call the TTY number at 1-800-220-5404. **You may call your local Medicaid Office to answer the questions on this form over the phone.** If you want to apply for other health coverage (such as nursing facility, waiver services, or Medically Needy coverage), mark (x) this box (). We will send you information about applying for other coverage and tell you what you have to do to protect your application date.

What language do you speak best?  English  Spanish  Vietnamese  Other (specify) \_\_\_\_\_  
 What language do you write best?  English  Spanish  Vietnamese  Other (specify) \_\_\_\_\_

**"We can provide an interpreter at no cost to you, if you do not speak English."**

1. Tell us about the person who gets help:

Name (First, Middle Initial, Last) \_\_\_\_\_  
 Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Parish \_\_\_\_\_ Home Phone # ( ) \_\_\_\_\_ Daytime Phone # ( ) \_\_\_\_\_

2. Have there been any changes in the family members living in your home since your last application or renewal?  No  Yes **(If No, go to Question 3.)**

**Tell us about the new family members who have moved into your home.** Also show spouse and any children under age 18. You do not have to give Social Security numbers for those who are not applying. If you do, they will only be used to verify income.

Name - first, middle initial, last (If applying, mark (x) the <input type="checkbox"/> )	Relation to You (husband, wife, etc.)	Social Security Number	Date of Birth month/ day/ year	U.S. Citizen	Does this person have Medicare?
<input type="checkbox"/>				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Tell us the name of any family members who have moved out or no longer live in your home since your last application or renewal? \_\_\_\_\_

3. Do you still have Medicare?  Yes  No If No, tell us when you lost Medicare. \_\_\_\_\_  
 Give us the name(s) of anyone else living in your home who has Medicare. \_\_\_\_\_

4. Do you or anyone applying have private health insurance that covers doctor and hospital visits?  Yes  No If Yes, answer the following. **(Send proof of coverage.)**

Insurance Company Name, Address, & Phone	Group/Policy Number	Person(s) Covered	Policy Covers: (✓)		
			hospital maternity	doctor drugs	ambulance dental

5. Does anyone work or is self-employed?  Yes  No If **Yes**, tell us about **each** full-time job, part-time job, or business. Show gross income before any deductions - **not** take-home pay.

(For **each** job, send copies of **all pay check stubs** or other proof of earnings for last month. For self-employment, send copies of the most recent federal tax form with **all schedule attachments**, or other proof if you do not have tax forms.)

A. Give us the name, address, & phone # of the company or person you work for <u>or</u> B. Self-employment information	Name of the Person Working	Amount Paid Per Hour	Number of Hours Worked/Week	How often paid?
		\$		
		\$		

6. Tell us about anyone getting **any** other money, like the kinds listed below. (Send proof of the income that is received. You **do not** have to send proof of Social Security/SSI income or Unemployment Compensation.)

Types of Income	Source Name, Address, & Phone	Who gets this money?	How much?	How often?
Social Security/SSI <input type="checkbox"/> Yes <input type="checkbox"/> No			\$	
Retirement/Pension/Annuities/ Veteran's Benefits <input type="checkbox"/> Yes <input type="checkbox"/> No			\$	
Interest/Dividends/Royalties <input type="checkbox"/> Yes <input type="checkbox"/> No			\$	
Money from friends/relatives <input type="checkbox"/> Yes <input type="checkbox"/> No			\$	
Other (unemployment compensation, rental income, workman's comp, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No			\$	

Has anyone applied for but not yet received money from any of these sources?  Yes  No  
If **Yes**, who and from what source? \_\_\_\_\_

7. Tell us about anyone having **any** of the things listed below. (Send proof of ownership and the value of each.)

Item (resource or asset)	Company Name, Address, & Phone; Account/Policy Number; and/or Description	To whom does this belong?	Bank Account Balance	Value	Amount Owed
Bank Accounts <input type="checkbox"/> Yes <input type="checkbox"/> No			\$		\$
Stocks/Bonds/Trust Funds <input type="checkbox"/> Yes <input type="checkbox"/> No				\$	\$
Property other than your home <input type="checkbox"/> Yes <input type="checkbox"/> No				\$	\$
Life/Burial insurance <input type="checkbox"/> Yes <input type="checkbox"/> No				\$	\$
Funeral/Burial Plans (bank account, pre-need, burial contract with funeral home, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No			\$	\$	\$
Vehicles (make, model, year) <input type="checkbox"/> Yes <input type="checkbox"/> No				\$	\$
Other (CDs, Mineral Rights, IRAs, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No			\$	\$	\$

\_\_\_\_\_  
Signature of Applicant or Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Spouse, if applicable

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Agency or AC Representative, if applicable

\_\_\_\_\_  
Date