Washington State Health Care Authority

Washington State Department of Social & Health Services
Transforming lives

Application for Medicare Savings Programs

Read the following before completing the application.

Depending on your income and resources, the Medicare Savings Program (MSP) can help pay your Medicare Part B premium. Other costs not paid by Medicare may also be covered, including deductibles, coinsurance, and copayments.

There are five ways to submit this application:

- **Mail:**
  DSHS
  CSD Customer Service Center
  PO Box 11699
  Tacoma, WA 98411-6699
- **Fax:** 1-888-338-7410
- **Online: washingtonconnection.org**
- **Phone:** 1-877-501-2233
- **In person:** Find a drop box at your local Community Services Office at **dshs.wa.gov/office-locations**

1 Primary applicant information

First name _____ M.I. _____ Last name and Suffix _____

Residence address _____ City _____ State _____ Zip Code _____

Mailing address (if different) _____ City _____ State _____ Zip Code _____

Primary phone number _____ Secondary phone number _____

Do you need help with speaking, reading, or writing English? ☐ No ☐ Yes

Do you need an interpreter? ☐ No ☐ Yes

If yes, we will provide one. What language do you speak (including American Sign Language)? _____

2 Information about you and your family

List yourself, spouse, and dependents living with you even if you are not applying for them (attach additional sheets, if necessary).

Name (First, Middle, Last)	Sex assigned at birth	Relation to you?	Date of birth
		SELF	

Social Security number (SSN)* Do you want coverage for this person? ☐ No ☐ Yes

Citizen or Non-citizen status: (check one)

U.S. citizen ☐ No ☐ Yes Washington resident ☐ No ☐ Yes

Are you Hispanic, Latino, or Spanish origin? (OPTIONAL)

☐ Cuban ☐ Mexican/Mexican-American/Chicano ☐ Not Spanish/Hispanic

☐ Other Spanish/Hispanic ☐ Puerto Rican

Race (OPTIONAL – select up to five that apply)

☐ American Indian or Alaska Native	☐ Chinese	☐ Korean	☐ Thai
☐ Asian	☐ Filipino	☐ Laotian	☐ Vietnamese
☐ Asian Indian	☐ Guamanian	☐ Other Pacific Islander	☐ White
☐ Black or African American	☐ Hawaiian	☐ Other Race	
☐ Cambodian	☐ Japanese	☐ Samoan	

Why we collect this – We use this information to help improve health equity and increase access to health care for all individuals. The information you provide will not affect your eligibility for health care coverage.

Name (First, Middle, Last)	Sex assigned at birth	Relation to you (e.g. spouse, child)	Date of birth

Social Security number (SSN)* Do you want coverage for this person? ☐ No ☐ Yes

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*HCA does not share this information with any immigration agency for immigration enforcement purposes. Leave this blank if you do not have an SSN.

3 Medical coverage information

Eligible for or receiving: Medicare Part A
Check which applies.

Self ☐ No ☐ Yes Medicare number _____

Spouse ☐ No ☐ Yes Medicare number _____

Other ☐ No ☐ Yes Medicare number _____

Eligible for or receiving: Medicare Part B
Check which applies.

Self ☐ No ☐ Yes Medicare number _____

Spouse ☐ No ☐ Yes Medicare number _____

Other ☐ No ☐ Yes Medicare number _____

I/we have other medical coverage ☐ No ☐ Yes

_____

If yes, what insurance and whom does it cover?

Did you pay Medicare premiums for Medicare Part A or Part B in the last 3 months? ☐ No ☐ Yes

_____

If yes, tell us which months

4 Income

For each person that you included on this application who has income, list the income below. List the income amount before deductions (such as taxes or insurance) are taken out. Income includes but is not limited to:

- Wages
- Self-employment
- Commissions
- Room and Board/Rent
- Railroad Benefits
- Social Security Benefits
- Veterans Benefits
- Alimony Benefits
- Unemployment or Worker Compensation
- SSI/Public Assistance
- Pensions/Retirement
- Dividends and Interest
- Other

Name	Employer or source of income	Amount before deductions	How often received?

5 Authorized representative information

An authorized representative is any adult who is aware of the household circumstances and is authorized by the household to act on behalf of the household for eligibility purposes.

By designating an authorized representative, you are giving permission for your authorized representative to:

- Sign the application on your behalf;
- Receive notices related to your application and account; and
- Act on your behalf for all matters related to the application and account.

1. Are you designating an authorized representative? ☐ No ☐ Yes

2. Do you want your authorized representative to receive notices related to your application and account?

☐ No ☐ Yes

3. Does this authorized representative have legal guardianship? ☐ No ☐ Yes If yes, who: _____

4. Does this authorized representative have power of attorney? ☐ No ☐ Yes If yes, who: _____

_____ _____

Authorized Representative Name / Organization Phone number

_____ _____

Mailing Address of Authorized Representative E-mail Address

6 Voter registration

The Department offers voter registration services, including automatic voter registration.

Applying to register or declining to register to vote will not affect the services or amount of benefits that you may receive from this agency. If you would like 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 voter registration form in private. 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

Washington State Election Division, PO Box 40229, Olympia, WA 98504, email **elections@sos.wa.gov**, or call 1-800-448-4881.

Do you want to register to vote or update your voter registration? ☐ No ☐ Yes

If you do not check either box, we will consider you to have decided not to register to vote at this time, unless you are eligible for, and do not decline, automatic voter registration.

Unless you checked "No" above, you may be eligible for automatic voter registration. You are eligible for automatic voter registration if you will be at least 18 years old by the next election, you are a citizen of the United States of America, and DSHS has your name, residential and mailing address, date of birth, verification of citizenship information, and your signature attesting to the truth of the information provided on this application.

Do you want to be automatically registered to vote? ☐ No ☐ Yes

If you checked the box marked "Yes," or do not check either box and you meet automatic voter registration eligibility requirements, DSHS will send your information to the Office of the Secretary of State and you will be automatically registered to vote.

7 Authorization

I understand the information I provide to apply for assistance will be subject to verification by federal and state officials to determine if it is correct. I understand this authorization ends when a final adverse decision is made on my application, if my eligibility for benefits ends, or if I revoke this authorization at any time by providing HCA or DSHS with written notice. Should I revoke or refuse to provide authorization, I understand that I will not be eligible for any Washington Apple Health Aged, Blind or Disabled (SSI-related) Medicaid program.

8 Read carefully before signing

I understand that:

- I must report immediately to the agency or the agency's designee, in writing, or by telephone, any changes in my situation. Late reporting may cause incorrect benefits.
- My situation is subject to verification by the agency or other state or federal agencies.
- To receive help, I must provide proof when asked. The agency or the agency's designee may help me obtain the proof or contact other persons or agencies for it.
- By asking for and receiving medical care benefits, I assign to the state of Washington all rights to any medical support, and to any third party payments for medical care.

To share comments or include more information, attach an additional sheet.

9 Declaration and signature(s)

I have read and understood the information in this application. I declare, under penalty of perjury, the information I have given in this application is true, correct, and complete to the best of my knowledge.

Signature of applicant	Date
Signature of spouse	Date
Signature of person assisting applicant (If applicable)	Organization / Date

HCA and DSHS comply with all applicable federal and Washington state civil rights laws and are committed to providing equal access to our services. If you need an accommodation, or require documents in another format or language, please call 1-877-501-2233.