Washington State Health Care Authority

Washington State Department of Social & Health Services

Transforming lives

Application for Medicare Savings Programs

Please 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. For some, the MSP can pay Medicare premiums and other Medicare costs not paid by Medicare. These include Medicare deductibles, coinsurance, and copayments.

You will need to answer all questions before we will know if we can help you. If you need help completing any part of this form, call your local Community Services Office.

Please print.

1. First name	Middle initial	Last name		
2. Residence address		City	State	ZIP code
3. Mailing address (if different)		City	State	ZIP code
4. Telephone number Primary: _____ Other: _____				
5. Do you have trouble speaking, reading, or writing English? ☐ YES ☐ NO Do you need an interpreter? ☐ YES ☐ NO If yes, we will provide one. What language do you speak? _____				

GENERAL INFORMATION

List self and all others living with you. Use legal names.

Name (First, MI, Last)	Relationship to you	Date of birth	Applying for benefits? Yes No	Social Security Number	Sex M or F
	SELF				
	SPOUSE				

MEDICAL COVERAGE INFORMATION

Check which applies				Medicare number
Eligible for or receiving: Medicare Part A	Self	YES ☐	NO ☐	
	Spouse	YES ☐	NO ☐	
	Other	YES ☐	NO ☐	
Check which applies				Medicare number
Eligible for or receiving: Medicare Part B	Self	YES ☐	NO ☐	
	Spouse	YES ☐	NO ☐	
	Other	YES ☐	NO ☐	

I/we have other medical coverage. YES ☐ NO ☐

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? YES ☐ NO ☐

If so, please tell us which months _____

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
- SSU/Public Assistance
- Pensions/Retirement
- Dividends and Interest
- Other

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

ASSETS

A. List all assets. Assets include bank accounts, certificates of deposit, savings bonds, IRAs, stocks and bonds, mutual funds, cash, and property other than your home or automobile.

If yes, please list below:

Name of owner	Type/account number of the asset	Current value

B. Do you or your spouse own or are you buying a car or other vehicle (truck, boat, motor home, motorcycle, camper and/or trailer?) YES ☐ NO ☐

If yes, please list below:

Name of owner	Item	Year	Make/model	Is vehicle used to get to medical appointments?	Value	Amount owed
				YES ☐ NO ☐		
				YES ☐ NO ☐		
				YES ☐ NO ☐		
				YES ☐ NO ☐		

C. Do you or your spouse have a whole life insurance policy with cash value over $1,500? Also list any burial insurance or burial plans.	Yes ☐ No ☐

If yes, please list below:

Policy owner	Name of insurance company/policy number	Face value	Cash value	Who is covered?

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? ☐ Yes ☐ No

2. Do you want your authorized representative to receive notices related to your application and account? ☐ Yes ☐ No

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

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

Authorized Representative Name / Organization

Phone Number

Mailing Address of Authorized Representative

E-mail Address

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: Washington State Elections Office PO Box 40229, Olympia, WA 98504-0229 (1-800-448-4881)

Do you want to register to vote or update your voter registration? ☐ YES ☐ NO

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? ☐ YES ☐ NO

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.

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 authorize the Washington State Health Care Authority (HCA) and Department of Social and Health Services (DSHS) to conduct asset verification to establish my eligibility and to verify the accuracy of my financial information. I understand the HCA and DSHS may investigate and contact any financial institution, state or federal agency, or private database, as part of the asset verification process. I understand this authorization ends when a final adverse decision is made on my application, 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 Medicaid program.

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.

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	Organization	Date

VOLUNTARY INFORMATION

We ask you to voluntarily tell us your race or ethnic background. This information will not be used in considering your eligibility for benefits.

☐ Caucasian ☐ Hispanic ☐ Black ☐ Native American/Alaskan Native

☐ Vietnamese/Laotian/Cambodian ☐ Tribe: _____

☐ Other Asian or Pacific Islander ☐ Other: _____

Sign and date your application and return it to your local Community Services Office or by mail to:

DSHS
CSD Customer Service Center
PO Box 11699
Tacoma, WA 98411-6699

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.