Washington State Health Care Authority

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?

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 benefit, 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

RELEASE OF INFORMATION

I authorize the Agency or the Agency's designee to release information about my application for the Medicare Savings Programs to the person assisting with completion of this application or representative from that person's organization.

SIGNATURE OF APPLICANT	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

Discrimination is prohibited in all programs and activities administered by the Agency or the Agency's designee. No one shall be excluded from these programs and activities on the basis of race, color, creed, political beliefs, national origin, religion, sex, or disability.