- **If you need help understanding this notice, please call (202)724-5506. We will explain it to you in your preferred language. You can also Fax us at (202) 535-1663.**
- **ይህንን ማሳሰቢያ ለመረዳት እርዳታ የሚፈልጉ ከሆነ፣ እባኮን በ (202)724-5506 ይደውሉ። በሚመርጡት ቋንቋ እናብራራሎታለን :: በተጨማሪም፣ በ (202) 535-1663 ፋክስ ሊያደርጉልን ይችላሉ።**
- **Si necesita ayuda para entender este aviso, por favor llamar al (202)724-5506. Le explicaremos en el idioma de su preferencia. También puede enviar un fax al (202) 535-1663.**
- **Si vous avez des difficultés à comprendre cet avis, n'hésitez pas à appeler le (202)724-5506. Nous vous donnerons des explications dans votre langue préférée. Vous pouvez également nous atteindre par fax au (202) 535-1663.**
- **본 내용을 이해하는 데 도움이 필요하신 경우, (202)724-5506번으로 연락해 주십시오. 담 당직원이 원하시는 언어로 해당내용을 설명해드릴 것입니다. (202) 535-1663 번으로 팩스를 보내실 수도 있습니다.**
- **如果您需要帮助以理解本通知，请致电(202)724-5506。我们将采用您的首选语言向您解 释本通知。您还可向我们发送传真：(202) 535-1663**
- **如果您需要幫助以理解本通知，請致電 (202)724-5506。我們將採用您的首選語言 向您解釋本通知。 您還可向我們發送傳真：(202) 535-1663。**
- **Nếu cần được giúp đỡ để hiểu rõ thông báo này, xin gọi số (202)724-5506. Chún tôi sẽ giải thích thông báo này cho quý vị bằng ngôn ngữ quý vị chọn. Quý vị cũng có thể gởi điện sao (fax) đến chúng tôi theo số (202) 535-1663.**

Medicare Savings Program Application

Qualified Medicare Beneficiary Program (QMB) Only

INSTRUCTIONS:

This application is for individuals who would like to apply for assistance to help pay for **Medicare e**xpenses, including monthly premiums, coinsurance, annual deductibles and prescription drug costs. Medicare will continue to be your health insurance provider, so you can continue to work with the same physicians you use now.

This is **NOT** an application for Medicaid coverage other than assistance to help pay for Medicare, Cash Assistance or Food Stamps. If you want to apply for these programs, you must contact the Department of Human Services (DHS), Economic Security Administration(ESA) Call Center at 202.727.5355 to request information on how to apply for these programs.

If you need help applying or completing this application, you may contact the State Health Insurance Assistance Program (SHIP) D.C. Department of Aging for assistance:

- By email: ship.dacl@dc.gov
- By phone: 202.727.8370
- By fax: 202.741.5885

You may also submit your completed application and supporting documents:

- By Postal Mail

  SHIP - D.C. Department of Aging
  250 E Street SW; 6th Floor
  Washington, DC 20024

- In person at a Service Center near you

  To find out which Service Center is closest to you, call 202.724.5506

You will need to provide supporting documents for the following categories of information to process your application. Do not send originals. Send in copies of the documentation with your application. Some examples of supporting documents for each category are:

- Proof of DC residency
    - Some examples include: DC Driver's License, Utility Bill, Voter's Registration Card, Rent receipt, Lease agreement, signed letter from the shelter, or signed statement from your landlord that shows your current DC address
- Proof of Medicare Enrollment
    - Copy of Medicare Card (front and back)
- Proof of Income
    - Some examples include: Pension letter, Civil Service award letter, Annuity statement, Veterans Benefits letter, Social Security Award letter, Pay stubs, Self-employment record, Employer statement

      Important Note: Your bank statement showing your income deposit is not an acceptable verification of income.
- Proof of Other Health Insurance
    - Some examples include: Copy of Supplemental Insurance, Retiree Health Insurance, Private Insurance (front and back)

Complete all sections of the application

Section 1: PERSONAL INFORMATION

Name: As it appears on your Medicare Card		**Social Security Number:**
Date of Birth:	**Sex:** ☐ Male ☐ Female	**Marital Status:** ☐ Single ☐ Divorced ☐ Married ☐ Widowed
Street Address:		
City: **State:** **Zip Code:**		**Phone:**
Mailing Address, if different from above		

Are you homeless?	☐ Yes	☐ No
If you are homeless, do you plan to stay in the District of Columbia?	☐ Yes	☐ No
Do you have a spouse?	☐ Yes	☐ No
Do you want to apply for QMB benefits for your spouse?	☐ Yes	☐ No

Section 2: Spouse Information: *Spouse needs to complete if applying for QMB program. If your spouse is not applying, providing his/her information, including his/her SSN is strictly voluntary. Your spouse's SSN would be used only to verify his/her income to determine your eligibility for QMB. Please note that we may need your spouse's SSN to verify his/her income to help us process your application timely.*

Name: As it appears on Spouse's Medicare Card		**Spouse's Social Security Number:**
Spouse's Date of Birth:	**Spouse's Sex:** ☐ Male ☐ Female	**Spouse Address, if different from above**

Section 3: MEDICARE INFORMATION (from your Medicare Card)

Do you have Medicare? ☐ Yes ☐ No	Type of Coverage ☐ Part A ☐ Part B	Medicare Claim #	Part A: Effective Date Part B: Effective Date
Does your spouse have Medicare? ☐ Yes ☐ No	Type of Coverage ☐ Part A ☐ PartB	Medicare Claim #	Part A: Effective Date Part B: Effective Date

Section 4: OTHER HEALTH INSURANCE

Do you have other health insurance? ☐ Yes ☐ No

Does your spouse have other health insurance? ☐ Yes ☐ No

If you or your spouse have other insurance, please complete the boxes below and attach a copy (front and back) of the insurance card(s):

Insured's Name	Company Name and Address	Monthly Premium	Policy Number	Type of Coverage
		$		
		$		
		$		
		$		

Section 5: INCOME:

Tell us about any income that you and/or your spouse currently receives or have applied for. List the amount of GROSS income before taxes and other deductions.

Type of Benefit/Income	Receiving Income or Benefits	Person(s) Receiving Income or Benefits	Amount	Application Status	If applied, Application or Denial Date
	☐ YES ☐ NO	☐ Self ☐ Spouse	$	☐ Receiving ☐ Applied For ☐ Denied	
	☐ YES ☐ NO	☐ Self ☐ Spouse	$	☐ Receiving ☐ Applied For ☐ Denied	
	☐ YES ☐ NO	☐ Self ☐ Spouse	$	☐ Receiving ☐ Applied For ☐ Denied	

Section 6: AUTHORIZED REPRESENTATIVE Do you want someone else to act for or represent you? ☐ Yes ☐ No

Person's Name	Relationship	Address	Contact Number

Section 7: Voluntary Questions

Your Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Your Race: ☐ Black/African-American ☐ American Indian or Alaskan Native ☐ White ☐ Asian

☐ Native Hawaiian or Other Pacific Islander

Preferred Language: ☐ English ☐ Spanish ☐ Amharic ☐ Other _____

Section 8: SIGNATURE (All boxes must be checked)

☐ By signing below, I give my permission to Department of Human Services (DHS) to get information about me and my spouse. DHS can get this information from those officials or institutions that have knowledge of my situation. I give these parties my permission to give information about me to DHS. I have reviewed the information in my application and I believe that all the information on this entire application is true and correct. I know if I give false information, I may be breaking the law and I could be at risk of criminal prosecution and penalties. I know that state and federal officials will check this information. I agree to help and cooperate with their potential investigations.

☐ I attest that I received a copy of my rights and responsibilities. I understand my rights and responsibilities and agree to cooperate as required.

☐ I understand that this application is not an application for Medicaid coverage other than assistance to help pay for Medicare, Food stamps, or cash assistance. I understand that if I would like to apply for these benefits, I must contact ESA at 202.727.5355 to request an application and/or information.

Applicant's Signature: _____ Date: _____

Authorized Representative: _____ Date: _____

Notice of Rights and Responsibilities

General Rules

You must give true and complete information. If you lie or give false information, you may lose your benefits. You could also be fined and go to prison. We may verify your information to make sure it is correct. We may check on your income, your Social Security information, and your immigration information. We verify this information through computer matching programs. We may also interview you and do a home visit.

Your case may be chosen for a Quality Control review. This is a detailed review of all of your information. It may include some personal interviews and a review of your medical records. By applying, you agree to cooperate with the state or federal reviewers. If you refuse to cooperate, you may lose all or part of your benefits. If you are under investigation or are fleeing to avoid the law, we may share your information with federal and local agencies.

Under federal and District law, you must provide your Social Security Number (if you have one) if you are in the assistance unit. (See 42 CFR 435.910and §4-217.07) Your SSN will be used to verify your identity, prevent receipt of duplicate benefits, and make required program changes. The OHS DHS computer system uses your SSN to verify your income by using records from the Internal Revenue Service, the Social Security Administration, and the DC Child Support Services Division (CSSD).

Medical Assistance Rules

After you apply, you will get a decision about your Medical Assistance within 45 days (or 90 days if ESA must determine if you are disabled). If you do not get a notice within this period, please call your ESA worker or (202) 727-5355. To get free legal help with Medicaid, call Terris, Pravlik, and Millian on (202) 682-0578 or write to them at the Thurgood Marshall Center, 1816 12th Street, NW, Suite 303, Washington, DC 20009.

If you get Medical Assistance, then you must recertify each year when we send you a recertification notice. There is no time limit for getting Medical Assistance.

Estate Recovery and the Qualified Medicare Beneficiary Program*:* Effective January 1, 2010, Section 115 of the Medicare Improvement for Patients and Provider Act (MIPPA) prohibits states from recovering Medicaid payments for Medicare cost sharing expenses made on behalf of Qualified Medicare Beneficiaries. The District cannot seek recovery of payments for Medicare cost sharing. If you have questions, call (202) 442-9075.

Lawsuits: If you sue or enter into settlement negotiations with a third party for a medical claim or injury, you must provide written notice of the action (either by personal service or certified mail) within 20 calendar days to the Medical Assistance Administration, Third Party Liability Section, 825 N. Capitol St., NE, 4th Floor, Washington, DC 20002. If you have questions, call (202) 442-9075.

Recertification

We will send you a recertification notice in the mail. If you get Medical Assistance, just complete the form and send it back to ESA. If you do not recertify, then you will lose your benefits. Also, please let us know if you move. Just call **(202) 727-5355** to report your new address.

Reporting Changes

You must report changes in your income, address, Medicare status, and who lives with you. To report a change, call **(202) 727-5355.** You must call us before the 10th day of the month after the change.

Confidentiality

By applying, you give ESA permission to talk with your employer, your landlord, your bank, your doctor, and other people who have information about you. You also give these people your permission to give information about you to ESA. In addition, you also give ESA permission to look at your motor vehicle records, wage data, tax information, and other government records. Of course, ESA keeps all of your information confidential. ESA does not release your records without your permission (except when required by law).

Equality and Non-Discrimination

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, age, or disability. To file a complaint of discrimination, write HHS, Director, Office for Civil Rights, Room 506-F, 200 Independence Ave., SW, Washington, DC 20201 or call (202) 619- 0403 (voice) or (202) 619-3257 (TDD). HHS is an equal opportunity provider and employer.

In accordance with the DC Human Rights Act of 1977, as amended, DC Official Code§ 2- 1401.01 et seq., (Act) the District of Columbia does not discriminate on the basis of actual or perceived: race, color, religion, national origin, sex, age, marital status, personal appearance, sexual orientation, gender expression, familial status, family responsibilities, matriculation, political affiliation, genetic information, disability, source of income, and place of residence or business. Sexual harassment is a form of sex discrimination, which is prohibited by the Act. In addition, harassment based on any of the above protected categories is prohibited by the Act. Discrimination in violation of the Act will not be tolerated. Violators will be subject to disciplinary action.

Fair Hearings

If you think that ESA has made a mistake, then you can get a Fair Hearing. Call 202-698-4650 to find out more. You can also call (202) 727-8280. At a Fair Hearing, you can ask someone else to speak for you. This could be an attorney, a friend, a relative, or someone else. You can also bring witnesses. We will pay for transportation to the Fair Hearing for you and your witnesses. We may also pay for some of your other costs. You can also get free legal help for a Fair Hearing. Call one of the agencies below to talk to a lawyer or counselor.

Free Legal Help

Neighborhood Legal Services
2811 Pennsylvania Ave, SE
(202) 678-2000
(202) 832-6577

Legal Aid Society
1331 H St., NW Suite 350
(202) 628-1161