TO: Local District Commissioners, Medicaid Directors, Third Party Supervisors

FROM: Judith Arnold, Director, Division of Coverage & Enrollment
Office of Health Insurance Programs

SUBJECT: Elimination of Face-to-Face Interview For Medicare Savings Program

EFFECTIVE DATE: Immediately

CONTACT PERSON: Local District Support Unit
Upstate (518)474-8887 NYC (212)417-4500

In an effort to simplify the application process for the Medicare Savings Program (MSP), the face-to-face interview is no longer required for all potentially eligible MSP applicants. For individuals applying for the Qualified Medicare Beneficiary (QMB), Specified Low Income Medicare Beneficiary (SLIMB), Qualified Individual-1 (QI-1) or Qualified Disabled and Working Individual (QDWI) programs, the application process may now be completed through the mail.

When an individual contacts the local department of social services (LDSS) and asks to apply for the Medicare Savings Program, the one page revised DOH-4328 (copy attached) is to be mailed. Also attached is a sample cover letter that can be sent along with the application and a Medicare Savings Program fact sheet (copy attached). Any other enclosures that are usually sent to applicants must also be included in the mailing. All applicants must provide photocopies of the necessary documentation which must be kept in the case record with a notation of the date received. The date of application will be the date a signed and dated application is received in the Medicaid office. District staff should contact the A/R if additional information is needed to process the application. All other requirements for processing applications for the MSP remain unchanged.

The elimination of the face-to-face interview requirement may only be used when the applicant indicates that they only want to apply for the Medicare Savings Program. If an applicant indicates that they want to apply for Medicaid, Medicaid with a spenddown, or they do not know what program they want to apply for, they must complete the full application and appear for a face-to face interview according to current procedures.

As a reminder, eligibility for QMB begins the first of the month following the date of the application. Authorization for SLIMB and QI-1 may be three months retroactive to the date of the application. However, the QI-1 program may only be three months retroactive in the current calendar year.

NEW YORK STATE DEPARTMENT OF HEALTH | Office of Health Insurance Programs

MEDICARE SAVINGS PROGRAM
APPLICATION/RENEWAL

(Please Print Clearly And Do Not Write In Dark Shaded Area)

APPLICANT	*(First Name)*	*M.I.*	*(Last Name)*				HOME PHONE
HOME ADDRESS Is this a Shelter? Yes No	Street	Apt.	City	State	Zip Code	County	
MAILING ADDRESS *(If different from above)*	Street/P.O. Box	Apt.	City	State	Zip Code	County	

NAMES (List your name first. Include aliases and maiden name)

	First	M.I.	Last	Date Of Birth	Sex	Social Security Number	Race/Ethnic Code
SELF							
SPOUSE							
CHILD*							

*If under 18 years of age, use attachment if necessary to list additional children.

Race/Ethnic affiliation codes: **B -** Black, not of Hispanic origin; **W -** White, not of Hispanic origin; **H -** Hispanic; **U -** Unknown; **A -** Asian or Pacific Islander; **I -** American Indian/Alaskan Native; **O -** Other

Are you a U.S. Citizen or do you have satisfactory immigration status? Include Alien Number and Date of Entry, if applicable. __Yes __ No

Signature of Applicant: _____

Alien Number_____ Date of Entry_____

Is your spouse a U.S. Citizen or have satisfactory immigration status? Include Alien Number and Date of Entry, if applicable. __Yes __ No

Signature of Spouse: _____

Alien Number_____ Date of Entry_____

APPLICANT'S MEDICARE INFORMATION Do you have Medicare Part A? __Yes __ No Effective Date: _____

Medicare # _____ Do you have Medicare Part B? __Yes __ No Effective Date: _____

SPOUSE'S MEDICARE INFORMATION, if applying Does spouse have Medicare Part A? __Yes __ No Effective Date: _____

Medicare # _____ Does spouse have Medicare Part B? __Yes __ No Effective Date: _____

Do you or your spouse pay any health insurance premiums other than Medicare? __Yes __ No Monthly Amount: _____

Do you or your spouse pay child/spousal support? __Yes __ No Monthly Amount: _____

Are you requesting retroactive reimbursement of your Medicare premium? __Yes __ No

Do you or your spouse receive payments from or are named beneficiary of a trust? __ Yes __ No Who? _____ Value: $ _____

Do you or your spouse expect to receive a trust fund, lawsuit settlement, or income from other source? __ Yes __ No Who? _____ Value: $ _____

List below all available income such as: salary, wages, pension, social security, severance pay, rental or business income, etc.

Names of Applicant, Spouse, or Child under 18 (attach an extra sheet if necessary)	**Who Provides the Money?** (Name/source of Income)	**How Often?** (Weekly, two weeks, monthly)	**What Amount?**
			$
			$
			$

DEPENDING ON YOUR INCOME, THE AMOUNT OF YOUR RESOURCES MIGHT NOT BE USED TO DETERMINE YOUR ELIGIBILITY FOR THE MEDICARE SAVINGS PROGRAM.

List all resources available to you or your spouse. Resources include but are not limited to all cash on hand, checking, savings, and credit union accounts, safe deposit box, life insurance**,** stocks, bonds, savings bonds, certificates, or mutual funds. Also include any real estate other than your primary residence, including income-producing, and non-income producing property, burial space, burial trust/fund, IRA, Keogh, 401-K, and annuity.

		Life Insurance	
Cash on Hand: $	Real Estate: $	Face Value	Cash Value
Checking Account: $	Savings Account: $	$	$
Other Bank Account: $	Other Resource Value: $	Other Resource Value: $	

Do you want to receive notices in ___ **English Only** : ___ **Spanish and English**

PAYMENT OF YOUR MEDICARE PREMIUM IS A MEDICAID BENEFIT

PENALTIES: I understand that my application may be investigated, and I agree to cooperate in such an investigation. Federal and State laws provide for penalties of fine, imprisonment or both if you do not tell the truth when you apply for Medicaid benefits or at any time when you are questioned about your eligibility, or cause someone else not to tell the truth regarding your application or your continuing eligibility. Penalties also apply if you conceal or fail to disclose facts regarding your initial and continuing eligibility for Medicaid or if you conceal or fail to disclose facts that would effect the right of someone for whom you have applied to obtain or continue to receive Medicaid benefits; and such benefits must be used by the other person and not for yourself.

CHANGES: I agree to inform the agency **promptly** of any change in my needs, income, property, living arrangements or address to the best of my knowledge or belief.

SOCIAL SECURITY NUMBER (SSN): If you are applying for the Medicare Savings Program, you must report your SSN, unless you are a pregnant woman. The laws requiring this are: 18NYCRR Sections 351.2 and 360-1.2; 42USC 1320b-7. SSNs are used in many ways, both within the local social services districts and also between local social services districts and federal, state, and local agencies, both in New York and in other jurisdictions. Some uses of SSNs are: to check identity, to identify and verify earned and unearned income, to see if absent parents can get health insurance for applicants, to see if applicants can get child support and to see if applicants can get money or other help.

CERTIFICATION OF CITIZENSHIP & IMMIGRATION STATUS: I certify, under the penalty of perjury, by signing my name on this application, that I, and/or any person for whom I am signing is a U.S. citizen or national of the United States or has satisfactory immigration status. I understand that information about me will be submitted to the United States Citizenship and Immigration Services (USCIS) for verification of my immigration status, if applicable. I further understand that the use or disclosure of information about me is restricted to persons and organizations directly connected with the verification of immigration status and the administration and enforcement of the provisions of the Medicaid program.

NON-DISCRIMINATION NOTICE: This application will be considered without regard to race, color, sex, disability, religious creed, national origin, or political belief.

CERTIFICATION: In signing this application, I swear and affirm that the information I have given or will give to the Department of Social Services as a basis for Medicaid is correct. I also assign to the Department of Social Services any rights I have to pursue support from persons having legal responsibility for my support and to pursue other third-party resources. I understand that Medicaid paid on my behalf may be recovered from persons who had legal responsibility for my support at the time medical services were obtained.

CONSENT: I understand that by signing this application/certification form I agree to any investigation made by the Department of Social Services to verify or confirm the information I have given or any other investigation made by them in connection with my request for Medicaid. If additional information is requested, I will provide it.

Applicant/Representative
Signature X _____ Date _____

Spouse Signature X _____ Date _____

Representative Address, Phone Number and Relationship _____

If after reading and completing this form, you decide that you DO NOT want to apply for the Medicare Savings Program please sign on the following line.

I consent to withdraw my application _____ Date _____

SIGNATURE OF PERSON WHO OBTAINED ELIGIBILITY INFORMATION: x	DATE:	EMPLOYED BY:
Eligibility Determined By Worker: _____ (DATE)		Eligibility Approved By: _____ (DATE)

CENTRAL/OFFICE	APPLICATION DATE	UNIT ID	WORKER ID	CASE TYPE	CASE NO	REUSE IND.

CASE NAME	DISTRICT	REGISTRY NO.	VER.

Effective Date _____ MA Disp. Denial Withdrawal	REASON CODE	PROXY: Yes No

Dear Medicare Savings Program Applicant:

Enclosed is an application to apply for the Medicare Savings Program. Individuals applying for the Medicare Savings Program may apply through a mail-in process. A personal interview is not required. The following documentation must be submitted along with your signed application form. Also enclosed is information regarding the income and resource requirements for the Medicare Savings Program for the current year.

PROOF OF INCOME (provide the documentation that applies to you)

Earned Income from Employer.....	Current paycheck/stubs (4 consecutive weeks) or letter from employer
Self-Employment Income	Current signed income tax return or record of earnings and expenses
Rental/Roomer-Boarder Income.....	Letter from roomer, boarder, tenant or check stub
Unemployment Benefits	Award letter/certificate, benefit check, correspondence from NYS Dept. of Labor
Private Pensions/Annuities	Statement from pension/annuity
Social Security	Award letter/certificate, benefit check, correspondence from Social Security Administration
Child Support/Alimony.....	Letter from person providing support, letter from court, child support/alimony check stub
Worker's Compensation	Award letter, check stub
Veteran's Benefits.....	Award letter, benefit check stub, correspondence from Veterans Administration
Military Pay	Award letter, check stub
Support from other Family Members	Signed statement and/or letter from family member
Income from a trust.....	Trust document

IDENTITY AND CITIZENSHIP OR CURRENT IMMIGRATION STATUS

Identity	Copy of front and back of your and your spouse's Medicare cards
Citizenship	A copy of your Medicare card also serves as documentation of U.S citizenship
Lawful Permanent Resident (LPR)/Immigrant	Immigration documentation such as USCIS form I-551 "Green Card"

RESIDENCY / HOME ADDRESS (provide one of the following for each applicant)

ID card with address .....

Driver's license issued within past 6 ..... Months

School Record showing address .....

Letter/lease/rent receipt with home address from landlord

Postmarked non-window envelope, postcard, or magazine label with name, address and date

Utility bill within last six months (gas, electric, cable), or correspondence from a government agency

Property tax records or mortgage statement

HEALTH INSURANCE PREMIUMS (Provide, if applicable.)

Letter from employer Premium statement Pay stub

Please mail the signed and dated application, along with all necessary documentation to:

If you are applying for full Medicaid or Medicaid with a spenddown, you will need to contact your local Medicaid office to schedule an appointment to apply for Medicaid.

Medicaid and the Medicare Savings Programs

New York State Department of Health
Office of Health Insurance Programs
2008

THE FOLLOWING PROGRAMS ADMINISTERED BY LOCAL DEPARTMENTS OF SOCIAL SERVICES AND THE HUMAN RESOURCES ADMINISTRATION IN NEW YORK CITY CAN ASSIST INDIVIDUALS/COUPLES IN PAYING FOR THEIR MEDICARE PREMIUMS.

The income below, except for full Medicaid, includes a $20 exemption.

Full Medicaid for dual eligibles (Individuals eligible for both Medicare and Medicaid): This program pays for a wide range of medical care, services and supplies as well as premiums, coinsurance and deductible payments for Medicare beneficiaries. The 2008 income and resource requirements for those applicants who are aged or certified blind or disabled are:

	Income Below	**Resources Below**
Single:	$ 725 per month	$4,350
Couple	$1,067 per month	$6,400

Qualified Medicare Beneficiary Program (QMB): This program can pay for the Medicare Part A and/or Part B premium. An individual can be eligible for QMB only or for QMB and Medicaid. This program also pays for the Medicare Parts A and B coinsurance and deductibles. The 2008 income and resource requirements for this program are:

	Income Below	**Resources Below**
Single	$ 887 per month	$4,000
Couple	$1,187 per month	$6,000

Specified Low Income Medicare Beneficiary Program (SLIMB): This program pays for the Medicare Part B premium only. Individuals can be eligible for SLIMB only or for SLIMB and Medicaid (with a spenddown). The applicant must have Medicare Part A in order to be eligible for the program. The 2008 income and resource requirements for this program are:

	Income Below	**Resources Below**
Single	$1,060 per month	$4,000
Couple	$1,420 per month	$6,000

Qualified Individual-1 (QI-1): This program pays for the Medicare Part B premium only. Individuals cannot be eligible for QI-1 and Medicaid. The applicant must have Medicare Part A. States are allotted money for this program on a yearly basis. There is no resource test for this program. The 2008 income requirements for this program are:

	Income Below
Single	$1,190 per month
Couple	$1,595 per month

Qualified Disabled and Working Individual (QDWI): This program pays for the Medicare Part A premium **only,** not Part B. The applicant must be a disabled worker under age 65 who lost Part A benefits because of return to work. The 2008 income and resource requirements for this program are:

	Income Below	**Resources Below**
Single	$1,754 per month	$4,000
Couple	$2,354 per month	$6,000

ESTIMATED FIGURES

Applications for all of these programs may be obtained from the Medicaid office at the local (county) department of social services. The phone number for the local department of social services may be found in the government pages of the telephone book. Within New York City, the phone number to call for the Medicaid Helpline is 1-888-692-6116. Outside of New York City call 212-639-9675.