STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Richard F. Daines, M.D.
Commissioner

James W. Clyne, Jr.
Executive Deputy Commissioner

ADMINISTRATIVE DIRECTIVE

TRANSMITTAL: 10 OHIP/ADM-3

TO: Commissioners of Social Services

DIVISION: Office of Health Insurance Programs

DATE:

SUBJECT: Medicare Savings Program Enrollment under the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)

SUGGESTED DISTRIBUTION:

Local District Commissioners
Medicaid Staff
Temporary Assistance Staff
Staff Development Coordinators
Fair Hearing Staff

CONTACT PERSON:

Local District Liaison:
Upstate: (518)474-8887
New York City: (212)417-4500

ATTACHMENTS:

Attachment I. Medicare Savings Program Request for Information (DOH-4496)
Attachment II. Request for Information Cover Letter (OHIP-0035)
Attachment III. Notice of Denial for Medicare Savings Program (Application Received From SSA) (OHIP-0036)
Attachment IV. Option to Receive MSP Benefit (OHIP-0037)

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
05 OMM/ADM-5			P.L. 110-275, Section 113 of MIPPA		GIS 04 MA/013

I. PURPOSE

The purpose of this Administrative Directive (ADM) is to advise local departments of social services (LDSS) of the implementation of Section 113 of the Medicare Improvement for Patients and Providers Act of 2008 (MIPPA), which requires an application for the federal Low Income Subsidy (LIS) program to be considered an application for the Medicare Savings Program (MSP).

II. BACKGROUND

The LIS program, also known as "Extra Help", is administered by the Social Security Administration (SSA) to help low income Medicare beneficiaries pay for prescription drug costs associated with their Medicare Part D benefits. The MSP is a Medicaid benefit that helps eligible Medicare beneficiaries pay for costs associated with Medicare Part A and Part B. In an effort to decrease barriers to enrollment, Section 113 of the MIPPA states that an application to SSA for the LIS program for Medicare Part D benefits will also be used to initiate an application for benefits under the MSP. This statutory requirement is intended to improve enrollment in both the Medicare Part D LIS program, administered by SSA, and the MSP, administered by the states.

III. PROGRAM IMPLICATIONS

Beginning January 1, 2010, SSA must, with the consent of the applicant, transmit data received from the LIS "Extra Help" application to the State for consideration of the applicant's eligibility for the MSP. The State will receive this information via an electronic file from SSA each day that SSA makes LIS eligibility determinations. The State must act on this data as if the individual had applied for the MSP directly to the Medicaid program. The State requires further review of the file received from SSA before the planned automated procedure to process these applications can be implemented. Until further notice, however, districts must follow the procedures outlined in this ADM.

Upon receipt of the file from SSA, the Department will create two lists for each county containing names and addresses of individuals who have applied for the LIS through SSA. One list will contain information about applicants that do not have an active or pending Medicaid case in WMS. The second list will contain information about applicants with active or pending Medicaid cases.

Each upstate district's list will be placed in a folder on the Human Services Enterprise Network (HSEN). Each district has identified two individuals who will have access to these folders and must access the folders daily. The list for NYC will be provided to the Human Resources Administration (HRA) by the Downstate Division of Information Technology (DOIT) staff.

IV. REQUIRED ACTION

A. APPLICANTS WITHOUT AN ACTIVE OR PENDING MEDICAID CASE

For applicants who do not have an active or pending case in WMS, the State will create an electronic copy of DOH-4496, "Medicare Savings Program Request for Information," (Attachment I). This form will be pre-populated with the name, address, phone number, date of birth, and the last four digits of the social security number of the applicant. Information for a spouse will also be included if available. For upstate districts, the LDSS must register these applications in WMS and mail the "Medicare Savings Program Request for Information" to the applicant with OHIP-0035, "Request for Information Cover Letter", provided in this directive as Attachment II. For New York City residents, DOIT staff will register the application and mail the "Medicare Savings Program Request for Information" form to the applicant.

If the form is returned to the district, the application must be processed in the same manner as any other MSP application, including sending the appropriate acceptance or denial notice, and entry of MSP data, if applicable, in eMedNY.

For individuals who are determined eligible for the Specified Low Income Medicare Beneficiary (SLIMB) program or the Qualified Individual (QI) program, eligibility may begin three months prior to the date of application. However, for the QI program, the retroactive coverage cannot precede the current calendar year. For the Qualified Medicare Beneficiary program (QMB), eligibility begins the month following the month of application. Eligibility for MSP can never begin earlier than the first month of Medicare eligibility, regardless of the date of application for MSP benefits.

Applicants may indicate on the "Medicare Savings Program Request for Information" that they would like to apply for full Medicaid benefits. In such cases, the applicants must be sent and must complete the Access NY Health Care application and comply with all current procedures for applying for Medicaid benefits.

If an applicant does not return the "Medicare Savings Program Request for Information" by the requested date, OHIP-0036, "Notice of Denial for the Medicare Savings Program (Application Received by SSA)" provided as Attachment III must be sent.

The only address information provided by SSA is the mailing address of the individual, which is not necessarily the home address. If after receiving a completed "Medicare Savings Program Request for Information" form it becomes apparent that the applicant lives in another district, the individual's information should be transferred to the appropriate LDSS following current protocols.

B. APPLICANTS WITH AN ACTIVE OR PENDING MEDICAID

Districts will also receive a list of individuals who currently have an active or pending Medicaid or MSP case. Active cases will be annotated with "AC", and pending cases will be annotated with "AP". Active recipients will have their Client Identification Number (CIN) entered on their record. The list will include the information received from SSA for each of these individuals.

No action is required to be taken on the case, if the individual currently has an active MSP case.

An eligibility determination must be made for cases where the individual is not on MSP, but has an active Medicaid case and is participating in the Excess Income Program, or is only eligible for Medicaid with no spenddown by using the Medicare premium as a deduction. If the applicant is eligible for MSP, the LDSS must send OHIP-0037, "Option to Receive Medicare Savings Program (MSP) Benefit," (Attachment IV) and allow the individual to indicate his/her choice between spenddown and MSP eligibility. This form should be sent with the LDSS-4038, "Explanation of the Excess Income Program". This choice must be offered to the individual even if the individual previously stated his/her selection. If the individual fails to return the "Option to Receive Medicare Savings Program (MSP) Benefit", the case is to remain open and benefits continued unchanged. It is not necessary to send an MSP denial notice for failure to return this form since the form already includes this information.

An MSP denial notice must be sent to the individual if, after reviewing the case record, it is determined the applicant is not eligible for MSP.

Some individuals may be fully eligible for Medicaid without using the Medicare premium as a deduction from income. If the person is also eligible for MSP, the individual must be enrolled in the correct MSP category and the Buy-In information must be entered in eMedNY. The appropriate Client Notice System (CNS) acceptance notice must be sent to the individual. If it is determined that the applicant is not eligible for MSP, a MSP denial notice must be sent.

If the individual is currently enrolled in the Family Health Plus program and the district finds that the individual is enrolled in Medicare, the district should follow current protocol for disenrolling the individual from Family Health Plus, and determining eligibility for other programs such as MSP and/or Medicaid.

For individuals appearing on the district's LIS list that also have a pending application for MSP with the LDSS, the application date for MSP eligibility purposes shall be the earlier of the two application dates, if individual is otherwise eligible during that time.

C. ADDITIONAL INFORMATION

1. Application Date for MSP Eligibility

The application date for MSP eligibility for records sent to the LDSS from the LIS file is the date the individual applied for LIS at SSA. For records with no active or pending Medicaid or MSP case, the LIS application date will be pre-populated on the "Medicare Savings Program Request for Information" form in the upper right hand corner of the form. If the record has an active or pending Medicaid or MSP case, the LIS application date can be obtained from the LIS list in the field labeled, "APP DATE". If determined eligible, benefits under the MSP may begin on the date the person applied for LIS, or three months prior to that date if otherwise eligible. As stated above, benefits under the QMB category can only be provided the month following the month of application.

2. Application Date for Case Processing

The LDSS must determine eligibility for all applications promptly, generally within 45 days of the date of application. Under certain circumstances, additional time for an eligibility determination may be required, for example, due to a delay on the part of the applicant to provide information, or due to an administrative or other emergency beyond the district's control. The reason for the delay shall be noted in the case record. The 45-day time limit for processing applications sent to the State from SSA begins the date the State receives the file from SSA.

3. Exceptions

Individuals may apply for Medicare and LIS three months prior to their 65th birthday. If the individual indicates on the "Medicare Savings Program Request for Information" form that their Medicare effective date is within the next three months and an award letter from SSA is provided, districts may register the application and determine eligibility. Prospective Medicare information may be entered in eMedNY. However, Medicare Buy-In information may not be entered more than one month prior to the Buy-In effective date. The Buy-In effective date may never precede the Medicare coverage effective date.

If the individual has lost Medicare eligibility or will not become Medicare eligible within the next three months, a denial notice must be sent.

Most individuals who are eligible for Medicare Part B are also eligible for premium free Part A coverage. However, there are some individuals who are eligible for Medicare Part B who do not have credit for sufficient work quarters to qualify for free Medicare Part A. An "M" suffix on the

Health Insurance Claim Number (HICN) indicates an individual does not have sufficient work credit for premium free Medicare Part A. Some individuals are eligible for Medicaid payment of their Medicare Part A premium through the Part A Buy-In program. Refer to GIS 04 MA/013 for more information on Medicare Part A Buy-In procedures. If an applicant on the LIS file qualifies for payment of their Medicare Part A premium through the Part A Buy-In program, a QMB case should be opened and an acceptance notice sent. If the applicant is not eligible for payment of their Part A premium, the case should be denied for MSP and a denial notice sent.

The LDSS must print the "Request for Information Cover Letter" (Attachment II) and the "Option to Receive Medicare Savings Program (MSP) Benefit" (Attachment IV), on its own letterhead and must indicate the date by which the information must be returned by the individual.

English and Spanish versions of the attached forms are available on the Department of Health's Intranet website.

VII. EFFECTIVE DATE

The provisions of this directive are effective January 1, 2010.

Donna Frescatore
Deputy Commissioner
Office of Health Insurance Programs

NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs

Application Date: _____

Medicare Savings Program
Request for Information

(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 (Optional)
SELF							
SPOUSE							
CHILD*							

**If under 18 years of age. Attach extra sheet if necessary to list additional children.*

Race/Ethnic Affiliation Codes: (You may pick more than one.)
A- Asian **B –** Black or African American **H –** Hispanic or Latino **I -** Native American or Alaskan Native
W - White **P** – Native Hawaiian or other Pacific Islander **U -** Unknown

APPLICANT'S MEDICARE INFORMATION Medicare # _____(*From red and blue Medicare card*)

Do you have Medicare Part A? __Yes __No Effective Date _____

Do you have Medicare Part B? __Yes __No Effective Date _____

SPOUSE'S MEDICARE INFORMATION, if applying Medicare # _____(*From red and blue Medicare card*)

Does spouse have Medicare Part A? __Yes __No Effective Date _____

Does spouse have Medicare Part B? __Yes __No Effective Date _____

Would you like us to consider providing retroactive reimbursement of your Medicare premium? __Yes __No

Do you or your spouse pay any health insurance premiums other than Medicare? ___ Yes ___No Who? _____ Monthly Amount $_____

Do you or your spouse pay child/spousal support? ___ Yes ___No Who? _____ Monthly Amount $_____

Do you wish to apply for full Medicaid benefits? ___ Yes ___No

List below all available income such as: salary, wages, pension, social security, severance pay, rental or business income, etc. List amount received before any taxes or other deductions.

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

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

By signing this form, I understand that each person listed will be enrolled in the appropriate program, if eligible. I have also read and understand the Terms, Rights and Responsibilities on the following page. I certify under penalty of perjury that everything on this application is the truth as best I know.

_____ _____
Signature of Applicant or Representative Date

_____ _____
Signature of Spouse 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 _____

DOCUMENTATION: You must send proof of income and proof of any health insurance premiums that you pay. Please review this list and submit the documents that you will need to provide in order for the Medicaid Program to determine if you are eligible for additional benefits. If you are requesting retroactive reimbursement of your Medicare premiums, you must send proof of income for the three month period before the "Application Date" listed in the upper right corner of this form.

- **Proof of income:** Paycheck stubs, letter from employer, income tax return, award letter for any unearned income benefit such as social security, unemployment, or veteran's benefit, or letter from renter, boarder or tenant.
- **Health Insurance premiums that you pay other than Medicare**: Letter from employer, premium statement, or pay stub.

To avoid a delay in processing, remember to sign and date this application in the space indicated above.

TERMS, RIGHTS AND RESPONSIBILITIES

By completing and signing this form, I am applying for the Medicare Savings Program. **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, 360-1.2, and 360-3.2(j)(3); 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.

<table>
<tr><td colspan="3">SIGNATURE OF PERSON WHO OBTAINED ELIGIBILITY INFORMATION:
x</td><td>DATE:</td><td colspan="4">EMPLOYED BY:</td></tr>
<tr><td colspan="4">Eligibility Determined By Worker: _____ (DATE)</td><td colspan="4">Eligibility Approved By: _____ (DATE)</td></tr>
<tr><td>CENTRAL/OFFICE</td><td>APPLICATION DATE</td><td>UNIT ID</td><td>WORKER ID</td><td>CASE TYPE</td><td colspan="2">CASE NO</td><td>REUSE IND.</td></tr>
<tr><td colspan="2">CASE NAME</td><td colspan="2">DISTRICT</td><td colspan="3">REGISTRY NO.</td><td>VER.</td></tr>
<tr><td colspan="4">Effective Date _____ MA Disp. Denial Withdrawal</td><td colspan="2">REASON CODE</td><td colspan="2">PROXY:
Yes No</td></tr>
</table>

{*Request for Information Cover Letter*}

{County Address}

{County Telephone No.}

{Applicant's Name}
{Applicant's Address}

Date:

Dear Consumer:

You recently applied to the Social Security Administration for Extra Help with your Medicare Part D prescription drug coverage. At that time, you agreed to have your application sent to the New York State Medicaid office to apply for help with your Medicare costs through the Medicare Savings Program.

In order for us to determine if you are eligible for this benefit, we need some additional information. Please mail the following documents to the address listed above:

- A copy of the completed and signed "Request for Information" form.
- A photocopy of the front and back of your Medicare card (the red, white and blue card).
- Proof of income, such as paychecks stubs, a letter from employer, income tax return, award letter for any unearned income benefit such as social security, unemployment, or veteran's benefit, or letter from renter, boarder or tenant.
- Proof of any other health insurance premium that you pay other than Medicare, such as a letter from employer, premium statement or pay stub.
- If you are not a U. S. citizen, you must provide documents indicating your current immigration status.

If we do not receive the requested information by _____, we will assume that you do not want to receive benefits through the Medicare Savings Program and we will send you a notice informing you that you are not eligible for the Medicare Savings Program.

If you need help with this form, you may contact the Medicaid office listed above or contact the Health Insurance Information Counseling & Assistance Program (HIICAP) at 1-800-701-0501. TTY users should call 1-877-486-2048.

OHIP-0036 (01/10) Attachment III

Notice of Denial for the Medicare Savings Program (Application Received by SSA)

NOTICE DATE:		NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN/RID NUMBER	
CASE NAME (and C/O Name if Present) AND ADDRESS		GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____
		OR Agency Conference _____
		Fair Hearing Information and Assistance _____
		Record Access _____
		Legal Assistance Information _____

OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	TELEPHONE NO.

You recently applied to the Social Security Administration for Extra Help with your Medicare Part D prescription drug coverage. At that time, you agreed to have your application sent to the New York State Medicaid office to apply for the Medicare Savings Program. This program helps to pay for Medicare costs such as Medicare Part B premiums, and sometimes your Medicare deductibles, coinsurance, and co-payments.

We have denied your application for the Medicare Savings Program for the reason checked below for:

Name _____ Client I.D. # _____

Name _____ Client I.D. # _____

( ) You have failed to provide the following documentation: _____.

( ) You have chosen to participate in the Medicaid Excess Income Program instead of the Medicare Savings Program.

( ) You have told us that you do not want to enroll in the Medicare Savings Program.

( ) You do not qualify for the Medicare Savings Program because: _____
_____

_____.

( ) Other_____.

This decision is based on Social Services Law section 367-a(3)(a) and Regulation 18 NYCRR 360-7.7(g).

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

YOU HAVE THE RIGHT TO APPEAL THIS DECISION
BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION

RIGHT TO A CONFERENCE: You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made the wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the front page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing.*** If you ask for a conference you are still entitled to a fair hearing. Read below for fair hearing information.

RIGHT TO A FAIR HEARING: If you believe that the above action is wrong, you may request a State fair hearing by:

1) **Telephone:** You may call the state wide toll free number: 800-342-3334 (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL); **OR**

2) **Fax:** Send a copy of this notice to fax no. (518) 473-6735; **OR**

3) **On-Line:** Complete and send the online request form at: **http://www.otda.state.ny.us/oah/forms.asp; OR**

4) **Write:** Send a copy of this notice **completed**, to the Fair Hearing Section, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

☐ I want a fair hearing. The Agency's action is wrong because: _____

_____

_____

Print Name: _____ Case Number: _____

Address: _____ Telephone: _____

Signature of Client: _____ Date: _____

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, pay stubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the front of this notice.

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your case file. If you call or write to us, we will provide you with free copies of the documents from your file which we will give to the hearing officer at the fair hearing. Also, if you call or write to us, we will provide you with free copies of other documents from your file which you think you may need to prepare for your fair hearing. To ask for documents or to find out how to look at your file, call us at the Record Access telephone number listed at the top of the front of this notice or write us at the address printed at the top of the front of this notice.

If you want copies of documents from your case file, you should ask for them ahead of time. They will be provided to you within a reasonable time before the date of the hearing. Documents will be mailed to you only if you specifically ask that they be mailed.

INFORMATION: If you want more information about your case, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, call us at the telephone numbers listed at the top of the front of this notice or write to us at the address printed at the top of the front of this notice.

ATTENTION: Children under 19 years of age who are not eligible for Medicaid or other health insurance may be eligible for the Child Health Plus Insurance. The plan provides health care insurance for children. Call 1-800-522-5006 for information.

Option to Receive Medicare Savings Program (MSP) Benefit

{County Address}

{County telephone No.}

{Applicant's Name}
{Applicant's Address}

Date:

Dear Consumer:

You recently applied to the Social Security Administration for Extra Help with your Medicare Part D prescription drug coverage. At that time, you agreed to have your application sent to the New York State Medicaid office to apply for help with your Medicare costs.

This is to advise you that the New York State Medicaid Program has determined that you are eligible for the Medicare Savings Program. However, participation in the Medicare Savings Program may affect the benefits you are currently receiving. Please read the paragraph checked below.

☐ You are currently eligible for full Medicaid benefits as long as you continue to pay your Medicare Part B Premium. However, if you choose to join the Medicare Savings Program (MSP) and have your Medicare premium and other coinsurance payments paid by the Medicaid Program, you will only be eligible for Medicaid under the Medicaid Excess Income Program. Under the Medicaid Excess Income Program you can only receive Medicaid coverage in a month when paid or unpaid medical bills equal or exceed your monthly excess income amount of $_____. **You will have to provide proof that you have medical expenses each month at least equal to this amount before you can get Medicaid coverage for the remainder of the medical bills for that month.** See the enclosed form, "Explanation of the Excess Income Program," for information about that program.

☐ You are already enrolled in the Medicaid Excess Income Program. **If you choose to have the Medicare Savings Program pay your Medicare premium and possibly other coinsurance payments, your Medicaid monthly excess amount will increase from $_____ to $_____.** You will have to provide proof that you have medical expenses each month at least equal to this new amount before you can get Medicaid coverage for the remainder of the medical expenses for that month.

☐ You are already enrolled in the Medicaid Excess Income Program. You are also eligible to have your Medicare Part B premium paid through the Medicare Savings Program as a Qualified Individual (QI program). However, you may not receive both the QI program and the Medicaid Excess Income Program. You may only choose one. If you choose not to join the Medicare Savings Program, you will continue to be enrolled in the Medicaid Excess Income Program.

For many people, full Medicaid coverage through the Medicaid Excess Income Program is the more beneficial coverage. However, if you do not have a lot of medical bills each month that are not paid by Medicare, you may prefer to be enrolled in the Medicare Savings Program, which will pay your Medicare Part B premium every month that you remain eligible for the Medicare Savings Program.

NOTE: If you are currently receiving Food Stamps and you choose to join the Medicare Savings Program, your Food Stamp benefits may be reduced.

If you would like to join the Medicare Savings Program, print your name, sign and date the form, and return the form to the county address above by _____.

If you do not return this form by the date stated above, your Medicaid benefits will continue unchanged.

I understand the options available to me and I want to join the Medicare Savings Program.

_____

Print Name Date

_____

Sign Here