Thank you for your interest in the Medicare Savings Program.

State Form 49228 (R6 / 4-19)

- To apply, please fill out both sides of the attached application. If there are parts that you do not understand, it is okay to leave them blank. However, you must complete section 1 and sign section 13.

- All members of your household who have Medicare Part A can apply for assistance on this one application. This is true even if you do not currently have Medicare Part B. In section 1, be sure to place a ✓ in the last column for the persons who are applying.

- You will need to provide copies of certain documents to help us determine your eligibility such as:

  Your Medicare card;
  Your most *recent* statements for all bank accounts, annuities, stocks, bonds, etc.;
  Property deeds (for property that is not the home you are living in);
  Life insurance policies;
  Funeral trust documents;
  Proof of income;
  Immigration documents for lawful immigrants;
  Identification card for other health insurance such as Medicare supplement.

  If you do not have all of the documents that we need, we will assist you in getting the information.

- If you are eligible for the Medicare Savings Program, it will take at least 3-4 months for the Social Security Administration to stop withholding the Part B premium from your check. However, you will receive a refund check for the full amount of premiums that we owe you.

If you received this application in the mail, you may return it to us after you fill it out. Send it to:
FSSA Document Center, PO Box 1810, Marion, IN 46952

RIGHTS AND RESPONSIBILITIES UNDER MEDICAID AND THE MEDICARE SAVINGS PROGRAM

Please read this information carefully.

1. The information you provide is confidential. (42 CFR 431.300, 470 IAC 1-2-7, 470 IAC 1-3-1, 470 IAC 6-1-1, 405 IAC 1-1-12.)

2. If you cannot get the papers needed to determine your eligibility, you must sign a consent for release of information and we will get them for you.

3. Eligibility is considered without regard to race, color, creed, sex, age, disability, national origin, or political belief.

(Keep this page.)

4. The Division of Family Resources County Office will send you a notice that tells you whether your application was approved or denied. You may request a fair hearing if you disagree with any decision about your eligibility, or if your application is not processed within forty five (45) days.

5. We ask about your racial-ethnic heritage to show compliance with the Federal Civil Rights Law. However, you are not required to tell us this information.

6. You must give accurate and complete information on your application. A person who receives assistance by giving false information or by misrepresenting the truth is committing a crime and can be prosecuted under the law and required to repay benefits received in error.

7. The immigration status of lawful immigrants may be verified by the Citizen and Immigration Service.

8. You must tell us your Social Security Number. We will use it to check information of other state and federal agencies, such as the Social Security Administration.

9. You must file for any benefits you may be entitled to such as Social Security or disability benefits.

10. If any of the information you give on your application changes, you must tell the Division of Family Resources County Office within ten (10) days.

11. Your rights to medical support and payment for medical care are assigned to the State if you are found eligible for the Medicare Savings Program. This assignment does not apply to Medicare payments. You will be required to cooperate in obtaining medical support or third party payments. This means that you must tell us about medical insurance coverage that you have now or that you obtain in the future, any court orders which provide for the payment of any or all of your medical bills, and any legal action you take or intend to take against a third party for any injuries you sustain in an accident.

    You may be excused from the above requirements if you can show that cooperating would cause you physical or emotion harm. If you claim good cause, you will receive a notice explaining the good cause circumstances and the type of information you must submit to support your claim. You may ask for the good cause notice to help you decide if you want to claim good cause.

12. Federal law does not permit the State to file a claim against your estate after your death to recover the amount of benefits that the Medicare Savings Program (MSP) pays for you. Estate recovery is a provision of the full coverage Medicaid program; however, it does not include benefits paid the MSP for services incurred on and after January 1, 2010.

13. If you believe you have been discriminated against in the determination of eligibility for benefits, you have the right to file a civil rights complaint by contacting the Department of Health and Human Services, Director of the Office of Civil Rights, Room 506F, 200 Independence Avenue, S.W., Washington, D.C., 20201. The telephone number is (202)619-0403, or TDD at (202)619-3257.

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Reset Form

APPLICATION FOR MEDICARE SAVINGS PROGRAM (QMB, SLMB, QI)

State Form 49228 (R6 / 4-19)

For Office Use Only
Date of application (*month, day, year*)
Date received by DFR (*month, day, year*)

1. Tell us about the members of your household. Place a ✓ in the last column if that person is applying. List applicants, their spouse, their children under age 18, and their children age 18-21 who are students.

Name (*first, middle initial, last*)	Date of Birth (*month, day, year*)	Social Security Number	Marital Status	Race	Sex	Relationship to you	Citizen of U.S. (Y / N / ?)	Applying for Benefits (✓)
								☐
								☐
								☐
								☐

2. Tell us your address and telephone number

Address (*number and street, city, state, and ZIP code*)	County	Telephone number ( )
Mailing address, if different (*number and street, city, state, and ZIP code*)	County	Other contact number ( )
Address of authorized representative, if applicable (*number and street, city, state, and ZIP code*)	County	Telephone number ( )

3. Are the applicants residents of Indiana? ☐ **Yes** ☐ **No**

4. Does any applicant have a court-appointed legal guardian? ☐ **Yes** ☐ **No**

If yes, who? _____

In questions 5 and 6, please give information about the household members you listed in question 1, including the children.

5. Place a ✓ beside the types of income listed below that you and household members receive.

SSI	☐	Unemployment	☐	Cash from friends, relatives, etc.	☐
Social Security	☐	Support (alimony or child support)	☐	Worker's Compensation	☐
Veteran's Benefits	☐	Sick benefits / Disability payments	☐	Employment	☐
Railroad Retirement	☐	Strike pay	☐	Income from real estate (such as rent, land contract payments, farm cash rent payments)	☐
Pension	☐	Interest Payments	☐	Dividends	☐
Military Allotment	☐	Black Lung Benefits	☐	Other? Specify:	☐

6. Was the household income in the prior three (3) months the same as it is now? ☐ **Yes** ☐ **No**

If no, briefly explain: _____

_____

Questions 7, 8, and 9 are about resources (assets). Please give information for the applicants and their spouse. Include resources owned individually and those owned jointly with someone else.

7. Does anyone own life insurance? ☐ **Yes** ☐ **No**

8. Does anyone own a car or other vehicles? ☐ **Yes** ☐ **No**

9. Place a ✓ beside each type of resource below that anyone owns.

Savings account		Bonds		Credit Union		Certificates of Deposit		Mobile home	
Checking account		Trust fund		Funeral plan / trust		Stocks		Camper	
Cash		Stocks		IRA / retirement fund		Keogh / 401 plan		Real Estate	
Life estate in property		Mineral Rights		Livestock		Farm Equipment		Other	

10. Give us information about the applicants' Medicare coverage.

Name	Medicare Number	Part A Effective Date (*month, day, year*)	Part B Effective Date (*month, day, year*)	Part D (Yes or No)

11. Do any of the applicants have other health insurance, such as Medicare Supplement policy? ☐ **Yes** ☐ **No**

12. Do any of the applicants pay child support for children living out of the household? ☐ **Yes** ☐ **No**

13. Please read the statement below and sign your application.

CERTIFICATION

I certify under penalty of perjury, that all of the information I have provided is complete and correct to the best of my knowledge and belief, and that I have received the "Rights and Responsibilities under the Medicaid and Medicare Savings Programs."

Signature	Date (*month, day, year*)

Signature of witness if signed with "X"

If this form is being signed by an authorized representative for the applicant, an Authorized Representative form must be included when filing this application. State Form 55366 can be downloaded from www.in.gov/iara.