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| W-1QMB(Rev 8/16) | State of Connecticut Department of Social Services  **Application for Medicare Savings Programs (QMB, SLMB, ALMB)**  *Use this form to* ***apply*** *for Medicare Savings Program benefits. If you currently receive these*  *benefits, please renew using the Renewal Form for Medicare Savings Programs (W-1QMBR).* |

Do you need a reasonable accommodation or special help to complete your application because you have a disability?  Yes  No If yes, complete the next question and see page 3 about how we can help*.*

If you need a reasonable accommodation or special help, tell us what kind of help you need:

**Tell us about yourself**

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| Name (first, middle, last) | | | | | | Sex (M or F) | Social Security # | | | | Date of Birth |
| Home Street Address | |  |  | | City | | | | State | Zip Code | |
| Mailing Address (if different) | |  |  | | City | | | | State | Zip Code | |
| Best phone # to reach you | Marital Status (check one):  Never Married  Married  Separated  Divorced  Widowed | | | | | | | | | | |
| This application is for (check one):  Yourself only  Yourself and your spouse | | | | Spouse’s Name (first, middle, last) | | | | | | | |
| Spouse’s Social Security # | | | | Spouse’s Date of Birth | | | |
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| Title VI of the Civil Rights Act of 1964 allows us to ask for race and ethnic origin information. You do not have to give it to us. The information helps to make sure that we are following federal civil rights law. If you do not want to give us this information, it will not affect your application. |
| Are you of Hispanic, Latino/a, or Spanish origin?  No  Yes (if yes, check all that apply)  Mexican, Mexican-American or Chicano/a  Cuban  Puerto Rican  Other Hispanic, Latino/a or Spanish |
| Racial Heritage (check all that apply):  White  Black or African American  American Indian or Alaska Native  Asian Indian  Chinese  Filipino  Japanese  Korean  Vietnamese  Other Asian  Native Hawaiian  Samoan  Guamanian or Chamorro  Other Pacific Islander |

**Tell us about your citizenship status**

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| --- | --- | --- | --- | --- | --- | --- |
|  | Are you a U.S. citizen?  (check one) | If no, what is your non-citizen status? (refugee, entrant, permanent resident, etc.) | What is your alien registration number? | What is your country of origin? | What are the date and place that you came into the country? | What is your sponsor’s name? (if applicable) |
| Yourself | Yes  No |  |  |  |  |  |
| Your Spouse | Yes  No |  |  |  |  |  |

**Tell us about your medical insurance**

Check if you have Medicare Part A  or Part B . Check if your spouse has Medicare Part A  or Part B .

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| **Insurance for You** | **Insurance for Your Spouse** |
| Medicare Claim #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Insurance other than Medicare, if any:  Company name:  Policy number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Group number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Check off all the services that are covered:  Hospital  Doctor/Surgical  Dental  Prescription  Vision/Optical  Long Term Care  Policy start date: Stop date:  Policy premium amount: $\_\_\_\_\_\_\_\_ per \_\_\_\_\_\_\_\_\_\_\_\_\_  Date you started paying this premium: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Medicare Claim #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Insurance other than Medicare, if any:  Company name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Policy number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Group number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Check off all the services that are covered:  Hospital  Doctor/Surgical  Dental  Prescription  Vision/Optical  Long Term Care  Policy start date: Stop date:  Policy premium amount: $\_\_\_\_\_\_\_ per \_\_\_\_\_\_\_\_\_\_\_  Date you started paying this premium: \_\_\_\_\_\_\_\_\_\_\_\_ |

**Tell us about your income**

List all income that you and your spouse receive. List the amounts of income before any deductions are made.

Examples of income are: Social Security, Supplemental Security Income (SSI), wages, pensions, disability benefits, worker’s compensation, unemployment compensation, interest, dividends, rental property income, alimony, and child support.

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| **Income for Yourself** | | | **Income for Your Spouse** | | |
| **Where does the money come from?** | **How much**  **do you receive?** | **How often do you receive it?**  (hourly, weekly, every other week, monthly, yearly) | **Where does the money come from?** | **How much do you receive?** | **How often do you receive it?**  (hourly, weekly, every other week, monthly, yearly) |
| Wages (employer name): | $ |  | Wages (employer name): | $ |  |
| Interest: | $ |  | Interest: | $ |  |
| Social Security (type): | $ |  | Social Security type): | $ |  |
| Pension (company name): | $ |  | Pension (company name): | $ |  |
| IRA (name of bank): | $ |  | IRA (name of bank): | $ |  |
| Other (describe): | $ |  | Other (describe): | $ |  |

**Important information for you to know about your application**

* This application is a request for help from the Medicare Savings Programs only.
* All the information given on this form is confidential and will only be used to administer the programs and will only be disclosed as permitted by law.
* The Social Security numbers of everyone receiving or requesting assistance will be used to verify identity and eligibility. Social Security numbers will be checked against government databases, as permitted by law.
* Information provided on this form may be verified to the extent permitted by law, including by checking government computer databases or directly with third parties such as employers or banks.

**If you need a reasonable accommodation or special help**

If you cannot do something we ask you to do because you have a disability, you may request a reasonable accommodation or special help. For example, we may be able to complete your application over the telephone if you cannot come into the office, help you get certain proofs, or give you extra time to provide information. Contact DSS at 1-855-626-6632 to request a reasonable accommodation or special help. If we do not agree to give you a reasonable accommodation or special help based on your disability, you can complain to the department’s Americans with Disabilities Act (ADA) coordinator. See the Non-Discrimination Statement on page 4.

**Please read carefully and sign below**

* I give permission to DSS, or any health insurer, provider, or any other entity providing services to me or my family under the Medicaid program, to release information about me or my family as necessary for the delivery of Medicaid program services and the administration of the Medicaid program, as permissible by federal or state law.
* I certify under penalty of perjury that all the statements made on this form are true and complete to the best of my knowledge. I understand that I can be criminally or civilly prosecuted under state or federal law if I knowingly give incorrect information or fail to report something I should report.

**Any person who helped you complete this form or completed this form for you must also sign.**

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| Applicant’s Signature Date | Spouse’s Signature Date |
| Helper or Representative’s Signature Date | Relationship To Applicant |

**Permission to Share Information**

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| To permit the Department of Social Services to share information about your application, please identify the authorized individuals, agencies, or institutions that DSS may communicate with, and sign in the box. | | |
| **1** | Name: | Phone # |
| Address: |  |
| **2** | Name: | Phone # |
| Address: |  |
| Applicant’s Signature or Signature of Authorized Representative | | Date |

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| **NON-DISCRIMINATION STATEMENT**  **You may file discrimination complaints or request reasonable accommodations as follows:**  You have the right to make a discrimination complaint if you think we have taken action against you because of your race, color, religion, sex, gender identity or expression, marital status, age, national origin, ancestry, political beliefs, sexual orientation, intellectual disability, mental disability, learning disability, or physical disability, including, but not limited to, blindness.  An individual with a disability may request and receive a reasonable accommodation or special help from the Department of Social Services when it is necessary to allow the individual to have an equal and meaningful opportunity to participate in programs administered by the Department.  If you asked for an accommodation or special help and we refused to provide it, you may make a complaint to the Department’s Affirmative Action Division Director or any of the agencies listed: | **Commissioner of Social Services**  **Attn: Affirmative Action Division Director/ADA Coordinator**  55 Farmington Avenue, Hartford, CT 06105  Ph: 1-860-424-5040 Toll free: 1-800-842-1508  TDD: 1-800-842-4524 Fax: 1-860-424-4948  **Connecticut Commission on Human Rights and Opportunities**  25 Sigourney Street, Hartford, CT 06106  Ph: 1-860-541-3400 Toll free: 1-800-477-5737  TDD: 1-860-541-3459 Fax: 1-860-246-5265  Web: http://www.ct.gov/chro/site/default.asp  **U.S. Dept. of Health and Human Services Office for Civil Rights**  JFK Federal Building, Room 1875, Boston, MA 02203  Ph: 1-617-565-1340 Toll free: 1-800-368-1019  TDD: 1-800-537-7697 Fax: 1-617-565-3809  Web: http://www.hhs.gov/ocr/office/file/index.html |

Persons who are deaf or hard of hearing and have a TTD/TTY device can contact DSS at 1-800-842-4524. Persons who are blind or visually impaired can contact DSS at 1-860-424-5040.

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| ED-682(Rev. 9/15) | **DO YOU WANT TO REGISTER TO VOTE?** |

Federal and state laws require the Department of Social Services (DSS) to give you the chance to register to vote. Please answer the questions below and print and sign your name in the space provided.

* Are you registered to vote?  Yes, I am already registered No
* If you are not registered to vote where you live now, would you like to apply to register to vote here today?  Yes No

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

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| Applying to register or declining to register to vote will notaffect the amount of assistance that you will be provided by this agency.  If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private. |

You can register online at https://voterregistration.ct.gov/OLVR, or you can complete a paper voter registration application form and leave it at DSS or mail it in. The form is included with DSS applications and renewals that we mail to you, and you can also get one at all DSS offices. You can mail your completed form to DSS in the enclosed envelope or send it directly to your Town Hall. If you need help, please call 1-855-626-6632.

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| Print Your Name | | Sign Here | | | | Date | |
| Your Address (#, Street, Apt #) |  | |  | City | State | | Zip Code |
|  | | | | | | | |
| For Worker’s Use Only  Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No boxes checked  Voter Registration Card Sent  Worker Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Worker Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |

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*(Tear Here and Keep)*

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose you own political party or other political preferences, you may file a complaint with: State Elections Enforcement Commission, 20 Trinity Street, Hartford, CT 06106; 860-256-2940, toll-free 866-733-2463, TDD: 1-800-842-9710; SEEC@ct.gov