THE GEORGE WASHINGTON UNIVERSITY LAW SCHOOL
WASHINGTON DC

The Jacob Burns Community Legal Clinics

Health Insurance Counseling Project

Dear Medicare Beneficiary:

Here is the application for extra help with Medicare costs, the Qualified Medicare Beneficiary Program. If you have questions you can call us at **(202) 994-6272**, or contact D.C. Medicaid at one of the offices listed on the following page.
You can take the completed application to your local Economic Security Administration office and ***get a receipt***, or you can mail or deliver it to HICP at 2136 Pennsylvania Ave. NW, Washington, DC 20052. HICP will ensure your application is complete and submit it to the Economic Security Administration on your behalf with verification of delivery.

APPLICATION CHECKLIST

To speed up your application, be sure to include a COPY of all the following documents;

☐ **Proof of D.C. residence:** (for example, D.C. Income Tax Return, Utility bill, Rent Receipt, Driver's License, Voter Registration)

☐ **Proof of income** (a Social Security benefit letter, Civil Service Annuity benefit letter, pay stubs, etc)

☐ **Proof of Medicare** (A Copy of Your Medicare Card)

☐ **Signed and Dated Application**

DO NOT SEND ORIGINAL DOCUMENTS, Only SEND COPIES

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HUMAN SERVICES

ECONOMIC SECURITY ADMINISTRATION SERVICE CENTERS

Anacostia Service Center
2100 Martin Luther King Avenue, SE
Washington, DC 20020
Phone: (202) 645-4614
Fax: (202) 727-3527

Congress Heights Service Center
4001 South Capitol Street, SW
Washington, DC 20032
Phone: (202) 645-4546
Fax: (202) 645-4524

H Street Service Center
645 H Street, NE
Washington, DC 20002
Phone: (202) 698-4350
Fax: (202) 724-8964

Fort Davis Service Center
3851 Alabama Ave., SE
Washington, DC 20020
Phone: (202) 645-4500
Fax: (202) 645-6205

Taylor Street Service Center
1207 Taylor Street, NW
Washington, DC 20011
Phone: (202) 576-8000
Fax: (202) 576-8740

*Customers may call ESA at **(202) 724-5506***
to learn which Service Center serves their address.

Questions? ¿Preguntas? ጥያቄዎች?
有問題嗎？Có thắc mắc gì không?
☎ (202) 724-5506.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HUMAN SERVICES
INCOME MAINTENANCE ADMINISTRATION

Medicare Savings Program Application

1. INSTRUCTIONS:

This is an application for the Qualified Medicare Beneficiary program. This benefit can help you with your **Medicare** expenses, 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, Cash Assistance or Food Stamps. If you want to apply for these programs, you must complete the D.C. Combined Application.

There are three ways that you can submit this application. You can bring this form and the supporting documents to your area Service Center. To find out which Center is closest to you, call 202-724-5506. You may also mail this form to 645 H St. NE, Washington, DC 20002. If you mail this application, enclose copies (not your original copy) of the documents below.

You may also contact the *Health Insurance Counseling Project* (HICP) at George Washington University for assistance. HICP will help you to complete the application and can also submit the forms for you. Below are examples of the types of documents you will need to submit with your application. Call HICP if you have questions,

Examples of Supporting Documents:

1. D.C. Residency: e.g. D.C. Drivers License, Utility Bill, or Voter's Registration Card
2. Medicare Eligibility: Copy of Medicare Card
3. Income: Proof of Income for the past 30 days - check stubs, Civil Service and Social Security statements, Veterans Benefits letter, etc.
4. Other Health Insurance: Copy of Supplemental or Retiree Health Insurance Card

For help completing or submitting this application, contact the organization listed below	Phone Number
George Washington University Health Insurance Counseling Project (HICP) DCHICP@gmail.com	**Main Number**: 202-994-6272 Fax: 202-994-6441 TTY: 202-994-6656

Print Form Reset Form

1. PERSONAL INFORMATION

Name: **As it appears on your Medicare Card**		Social Security Number:
Date of Birth:	Sex: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Street Address:		
City: State: Zipcode:		Phone:
Mailing Address, if different from above		
Are you homeless? ☐ Yes ☐ No Do you plan to stay in the District of Columbia? ☐ Yes ☐ No Do you want to apply for QMB benefits for your spouse also? ☐ Yes ☐ No		

2. INFORMATION ON SPOUSE: Complete this information even if you are not applying for your spouse

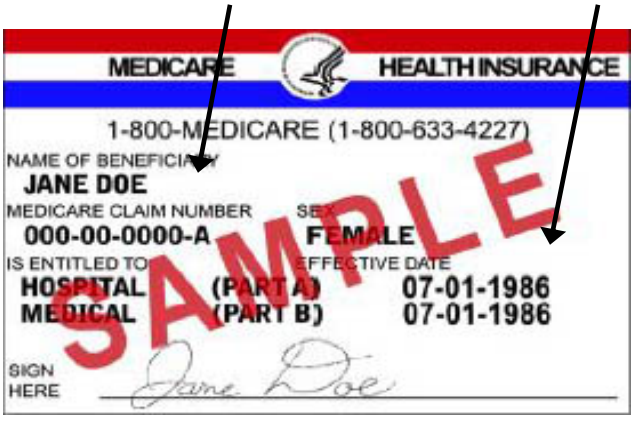
Name (First, Middle Initial, Last)		Social Security Number:
Date of Birth:	Sex: ☐ Male ☐ Female	Address (if different from applicant)

3. MEDICARE INFORMATION (from your Medicare Card)

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

For Agency use only

Case Name _____
Case No. _____
Date Appl. Received _____
Disposition:
On-going Benefits ☐ Approved ☐ Denied
Retro Benefits ☐ Approved ☐ Denied
Date of Disposition _____



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):

	Company Name and Address	Monthly Premium	Policy Number	Type of Coverage (Medigap, Retiree, Rx)
Self		$		
Spouse		$		

5. INCOME: List in the boxes below the types and amounts of earnings and income that you and/or your spouse receive. List the amount of GROSS income before deductions like taxes or premiums are taken out.

- Social Security
- Veterans Benefits
- Unemployment
- SSI
- Annuities
- Civil Service
- Wages/Self-Employment
- Pension/Retirement benefits
- Other (tell us what it is)

☐ **Self** ☐ **Spouse**	**Type of Income**	**Amount received?** $__________	**How Often?** ○ weekly ○ every 2 weeks ○ twice a month ○ monthly
☐ **Self** ☐ **Spouse**	**Type of Income**	**Amount received?** $__________	**How Often?** ○ weekly ○ every 2 weeks ○ twice a month ○ monthly
☐ **Self** ☐ **Spouse**	**Type of Income**	**Amount received?** $__________	**How Often?** ○ weekly ○ every 2 weeks ○ twice a month ○ monthly
☐ **Self** ☐ **Spouse**	**Type of Income**	**Amount received?** $__________	**How Often?** ○ weekly ○ every 2 weeks ○ twice a month ○ monthly

6. AUTHORIZED REPRESENTATIVE

Do you want someone else to act for or represent you? ☐ Yes ☐ No

Name of Your Authorized Representative __________ Address of Representative __________ Phone # of Representative __________

What do you want them to do? ☐ Complete interviews ☐ Report changes

7. RETROACTIVE COVERAGE

Did you live in D.C. during the last 3 months? ☐ Yes ☐ No

Has your income changed during the last 3 months? ☐ Yes ☐ No

8. 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

Your Language Preference: ☐ English ☐ Cantonese ☐ Mandarin ☐ Vietnamese
☐ Amharic ☐ Korean ☐ French ☐ Spanish ☐ Other _____

Note: You may check more than one race. Also, you do not have to provide this information. None of this information will affect your benefits. We only ask for this information to make sure that we do not discriminate

9. SIGNATURE

- By signing below, I give my permission to DHS to get information about me. DHS can get this from my employer, landlord, bank, utility company and others who may have information about me that DHS needs. I give all of these people my permission to give information about me to DHS. I believe that all of my information on this application is correct. I know if I give false information, I may be breaking the law. I know that state and federal officials will check this information. I agree to help with their investigations.
- I have received a copy of my rights and responsibilities. I understand my responsibilities and agree to cooperate as required.
- I understand that if I need help with other medical expenses, or if I need to apply for food stamps or cash assistance, I must file a separate application at the Income Maintenance Administration office in my area.
- I certify that everyone requesting benefits on this application form is a U.S. citizen or lawfully admitted alien.

⬇ You Must Sign Below ⬇

If you are married and your spouse is applying, he/she will also need to sign below

_____ _____
Signature of Applicant Date

_____ _____
Signature of Applicant's Spouse Date

_____ _____
Signature of 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 435.910, 7 CFR 273.6, DC Code §4-204.07, §4-205.05a, and §4-217.07) Your SSN will be used to verify your identity, prevent receipt of duplicate benefits, and make required program changes. The 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 DHS must determine if you are disabled). If you do not get a notice within this period, please call your IMA 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 1121 12th Street, NW, Washington, DC 20005.

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 DHS. 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, 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 DHS 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 DHS. In addition, you also give DHS permission to look at your motor vehicle records, wage data, tax information, and other government records. Of course, DHS keeps all of your information confidential. DHS 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 DHS 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 above to talk to a lawyer or counselor.

Free Legal Help

Neighborhood Legal Services
3101 M.L. King Jr. Ave, SE
(202) 678-2000

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

Health Insurance Counseling Project
2136 Pennsylvania Ave., NW
(202) 994-6272

Signature (sign below to show that you got this form)

_____ Applicant

_____ Date