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

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):	Spouse's Name (first, middle, last)	
☐ Yourself only		
☐ Yourself and your spouse	Spouse's Social Security #	Spouse's Date of Birth

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

	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					

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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 ☐.

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.

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):	$	

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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.

Applicant's Signature	Date	Spouse's Signature	Date
Helper or Representative's Signature	Date	Relationship To Applicant	

Permission to Share Information

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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