Georgia Application for Medicare Savings for Qualified Beneficiaries

(QMB - payment of premiums, coinsurance, and deductibles;
SLMB - payment of Part B premium; **and QI-1** - payment of Part B premium**)**

INSTRUCTIONS:

1. Read the application carefully and answer each question accurately. Attach additional pages if needed.
2. **Sign and mail application to:** (Mail or deliver application to the DFCS office in your county of residence)

_____ County DFCS
_____
_____
_____
ATTN: _____

3. An interview is not required for these programs.
4. The DFCS Medicaid Specialist will review this application. If it appears that you may be eligible for full Medicaid coverage, the Medicaid Specialist will contact you for more information.

PERSONAL INFORMATION: You may have a friend, relative, or someone else help you complete this application.

Applicant's Name (Last, First, Middle Initial)	If someone else (guardian, representative, friend, relative, etc.) is completing this form, Name (Last, First, Middle Initial)
Street Address	Street Address
City State Zip	City State Zip
Phone County	Phone
Nursing Facility (if applicable)	Relationship to Individual

COMPLETE THIS INFORMATION FOR YOU AND YOUR SPOUSE.

Name (Self)	Birthdate	Sex	Race	U.S. Citizen (Yes or No)	Social Security Number	Marital Status
Name (Spouse)					(Optional, if spouse is not applying)	

Are you applying for Medicare savings for your spouse, too? ☐ **Yes** ☐ **No**

LIVING ARRANGEMENT: Check the one box that best describes your current living situation.

In Own Home	Renting	Nursing Facility	In Other's Home	Hospital	Assisted Living	Other (ex. Shelter)
		Date admitted:		Date admitted:		

HEALTH INSURANCE:

Do you have Medicare? ☐ **Yes** ☐ **No** ❒ Are you enrolled in a Medicare HMO? ☐ **Yes** ☐ **No**	Type of Coverage ☐❒**Part A** (hospital) ☐❒**Part B** (doctor)	Effective Date	Medicare Number
Does your spouse have Medicare? ☐ **Yes** ☐ **No**	Type of Coverage ☐❒**Part A** ☐❒**Part B**	Effective Date	Medicare Number

Do you have other health insurance? ❒☐ **Yes** ☐ **No**

Does your spouse have other health insurance? ❒☐ **Yes** ☐ **No**

If you answered yes to either of these questions, please complete the following information:

	Health Insurance Company Name, Address, and Telephone Number	Type of Coverage (Hospital, Medicare Supplement, Drugs, Major Medical,)	Effective Date	Policy Number
Self				
Spouse				

Attach copies (front and back) of Medicare and insurance cards if applicable.

REAL PROPERTY: Do you own all or part of any real estate in which you do not live?☐ **Yes** ☐ **No**

If yes, please complete the following for each piece of real estate. **Do not list the house or mobile home in which you live.**

Address	Value	Amount Owed

Do you or your spouse own a boat, camper, utility trailer, etc.? ☐ **Yes** ☐ **No**

If yes, please complete the following information about each vehicle. **Cars and trucks are not counted – do not list.** Attach additional pages if needed.

Type	Year	Make	Model	Value	Amount Owed

RESOURCES: Check all resources (assets) owned by you, your spouse, or jointly owned with someone else. Include any accounts or properties on which your name(s) appear. Attach additional pages if necessary.

Do you or your spouse have any of the following resources?					
Checking account	☐ **Yes**	☐ **No**	Funeral plans/ prepaid burial items	☐ **Yes**	☐ **No**
Savings account	☐ **Yes**	☐ **No**	Burial plots	☐ **Yes**	☐ **No**
Government bonds	☐ **Yes**	☐ **No**	Stocks and bonds	☐ **Yes**	☐ **No**
Trust funds	☐ **Yes**	☐ **No**	Other (IRA, CD, etc.)	☐ **Yes**	☐ **No**

If you answered yes to any of these questions, please describe below.

Type of Resource	Account/ Policy Number	Value	Name of Bank, Insurance Company, Etc.

Do you or your spouse have a life insurance policy? ☐ **Yes** ☐ **No**

If yes, please complete the following information. Attach additional pages if necessary.

Policy Owner	Insurance Company	Policy Number	Face Value	Cash Value

INCOME AND EARNINGS: List all types of earnings and income that you or your spouse receives. List the income amount before deductions (such as taxes, insurance, or Medicare premiums) are taken out. Attach additional pages if necessary. Income includes, but is not limited to:

Social Security	SSI	Wages/ Self-Employment
Railroad Retirement Benefits	Veterans' Benefits	Trust or Annuity Payments
Pensions/ Retirement Benefits	Rental Income Paid to You	Oil Royalties/ Mineral Rights

Name of Person Who Receives Income	Type of Income	Source of Income or Name of Employer	Amount	How Often Received? (weekly, monthly, etc.)	Claim Number (if applicable)

PRIVACY STATEMENT:

Federal and state laws and regulations limit the use and disclosure of confidential information concerning applicants and recipients of all agency programs to purposes directly related to the administration of these programs.

ASSIGNMENT OF RIGHTS OF PAYMENT FOR MEDICAL SUPPORT AND OTHER MEDICAL CARE:

(If you are applying on behalf of another individual and do not have the power to execute an assignment for that individual, the individual will need to execute an assignment of the rights described below, as a condition of his or her eligibility for the benefits covered by this application.) As a condition of my eligibility, I assign to the state any rights to medical support and to payment for medical care from any third party. I agree to cooperate with the state in identifying and providing information to assist the state in pursuing any third party who may be liable to pay for care and services. I understand that I must report any payments received for medical care within ten days.

APPLICANT'S STATEMENT OF UNDERSTANDING AND AGREEMENT:

I understand that, by signing this application, I am agreeing to a full investigation or review of my eligibility by state and/or federal officials. This may include inquiries of employers, medical providers, financial institutions, and other business and professional persons and review of any agency records. I also agree that my application authorizes these agencies to release to this agency the information needed to determine my eligibility. I agree to provide the documents necessary to establish eligibility. If documents are not available, I agree to give the name of the person or organization from which this agency may obtain the necessary proof.

I understand that each individual who receives assistance must provide or apply for a Social Security Number. I authorize the use of my (our) Social Security Number for such purposes as identification, program reviews or audits, and computer matching with other agencies and institutions such as banks, saving and loan associations, and other government agencies, including Internal Revenue Service, to verify eligibility for assistance.

I understand that my application will be considered without regard to race, color, sex, age, handicap, religion, national origin, or political belief. I understand that I may request a fair hearing if I disagree with an agency decision in my case and that I may be represented by any person I choose.

I certify that I (or if filing for my spouse, my spouse and I) am a U.S. citizen, national, or alien in qualified alien status. If this application is being filed on behalf of another individual or individuals, the actual applicant(s) will need to make this certification.

APPLICANT(S) OR REPRESENTATIVE MUST READ AND SIGN:

State and federal law provide for fine, imprisonment, or both for any person who withholds or gives false information to obtain assistance to which he is not entitled. I understand the questions on this application and I certify, under penalty of perjury, that the information given by me on this form is correct and complete to the best of my knowledge. I agree to notify this agency of changes in my income, resources, or living arrangements, which might affect my right to receive assistance.

Signature of Applicant or Representative:	**Date:**
Signature of Applicant's Spouse or Representative:	**Date:**