State of Connecticut
Department of Social Services

Medicare Savings Programs Application/Redetermination (QMB, SLMB, ALMB)

W-1QMB
(Rev. 4/10)

Do you need a reasonable accommodation or special help to complete your application/redetermination because you have a disability? ☐ Yes ☐ No If you checked yes, please see page 4 about how we can help.
If you need a reasonable accommodation or special help, what kind of help do you need?

_____

Please give us the following information about you:

Your Name: _____
First M.I. Last

Your Address: _____

Your Mailing Address (if different): _____

Your Telephone Number: _____ A Message Number: _____

Your Marital Status: ☐ Never Married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

This application is for ☐ Yourself only ☐ Yourself and your spouse

Your Spouse's Name: _____
First M.I. Last

	Date of Birth	Place of Birth	Social Security Number	Sex	Do you have Medicare? Part A? (check one)	Part B? (check one)
Yourself					☐ Yes ☐ No	☐ Yes ☐ No
Your Spouse					☐ Yes ☐ No	☐ Yes ☐ No

Please tell us about your medical insurance:

Add separate pages if you need them.

Insurance for Yourself	Insurance for Your Spouse
Medicare Claim #: _____	Medicare Claim #: _____
Other Insurance, if any	Other Insurance, if any
Company Name: _____	Company Name: _____
Address: _____	Address: _____
Customer Service Phone: _____	Customer Service Phone: _____
Policy Number: _____	Policy Number: _____
Group Number: _____	Group Number: _____
Please check off all the services that are covered: ☐ Hospital ☐ Doctor/Hospital/Surgical ☐ Prescription ☐ Vision/Optical ☐ Dental ☐ Long Term Care	Please check off all the services that are covered: ☐ Hospital ☐ Doctor/Hospital/Surgical ☐ Prescription ☐ Vision/Optical ☐ Dental ☐ Long Term Care
Policy Start Date: _____ Stop Date: _____	Policy Start Date: _____ Stop Date: _____
Policy Premium Amount: _____ per _____	Policy Premium Amount: _____ per _____
When you started paying this premium: _____	When you started paying this premium: _____

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 the federal civil rights law. If you do not want to give us this information, it will not affect your application.

Are you Hispanic or Latino? ☐ Yes ☐ No

What is your racial origin? (check all that apply) ☐ White ☐ Black or African Descent

☐ Native American or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander

Please give us information about your citizenship:

	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 appropriate)
Yourself	☐ Yes ☐ No					
Your Spouse	☐ Yes ☐ No					

Please give us information about your Income:

Please list all income that you and your spouse receive. Please 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		
Name and Address of Employer, if any:			Name and Address of Employer, if any:		
Name of Pension Company:			Name of Pension Company:		
Where does the money come from?	How much do you receive?	How often do you receive it? (Weekly, Monthly or Quarterly)	Where does the money come from?	How much do you receive?	How often do you receive it? (Weekly, Monthly or Quarterly)
Social Security	$		Social Security	$	
SSI	$		SSI	$	
Pension	$		Pension	$	
Wages	$		Wages	$	
Interest	$		Interest	$	
Other (describe):	$		Other (describe):	$	
Other (describe):	$		Other (describe):	$	

I authorize the Department of Social Services to verify any information about anyone's non-citizen status with the United States Citizenship and Immigration Services (USCIS). I understand that the department will not share the information I give on this form with USCIS. I also understand that USCIS cannot use this application to deny admission to the U.S., harm permanent resident status or deport me.

I give the Department of Social Services permission to share my name and other information with programs that help with energy costs for my home. These programs will use this information only to decide if I qualify for these benefits and to offer me the benefits.

I give permission to the Department of Social Services, the Connecticut Medicaid Agency, 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 that all the statements made on this form are true and complete to the best of my knowledge. If I have knowingly given incorrect information, I may be subject to the penalties for false statements as specified in Connecticut General Statute Sections 53a-157b and 17b-97 and to penalties for larceny as specified in sections 53a-122 and 53a-123. I may also be subject to penalties for perjury under federal law.

Signature of Applicant Date

Signature of Spouse Date

Signature of Conservator or Other Representative Date

Please be sure to read the important information on the back page of this form.

This information is available in alternate formats. Phone (800) 842-1508 OR TDD/TTY (800) 842-4524.

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. We can use different methods to complete your application or redetermination. For example, we may be able to complete your application or redetermination over the telephone if you cannot come into the office, we may be able to help you get certain proofs, or give you extra time to provide information. Contact your local regional office to request a reasonable accommodation or special help. If we do not agree to give you a reasonable accommodation or special help, you can complain to the department's Americans with Disabilities Act (ADA) coordinator. See the bottom of this page for how to make a complaint.

Important information for you to know about your application/redetermination:

- This application/redetermination 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 except for certain exceptions.
- The Social Security numbers of everyone receiving or requesting assistance will be used to verify identity and eligibility. Social Security numbers will also be matched against federal, state and local government files by computer. The department is allowed to request Social Security numbers based on the following statutes: for Medicaid, 42 USC sections 1320b-7(a)(1), (b)(2) and Connecticut General Statutes section 17b-77.
- The department will request information through the Income and Eligibility Verification System (IEVS). The information will be used to process this application/redetermination. Information will come from certain State and Federal agencies when allowed by law. We may directly verify information we receive with other sources such as banks and employers. Results from such verification may affect eligibility.

In accordance with Federal law and U.S. Department of Health and Human Services (HHS) policy, the Department of Social Services 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, 200 Independence Avenue, S.W., Room 509-F, HHH Building, Washington, D.C. 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TTY).

Under state law you have the right to make a discrimination complaint if you think we have taken actions against you because of your race, color, religious creed, sex, marital status, age, national origin, ancestry, criminal record, political beliefs, sexual orientation, mental retardation, mental disability, learning disability or physical disability, including but not limited to blindness. You or someone representing you may write to or call one or more of these agencies to make a discrimination complaint: **Commissioner of the Department of Social Services, Attention Affirmative Action Division Director/ADA Coordinator, 25 Sigourney Street, Hartford, CT 06106-5033**, or call 1-860-424-5040 (TDD: 1-800-842-4524); **Connecticut Commission on Human Rights and Opportunities, 21 Grand Street, Hartford, CT 06106**, or call 1-860-541-3400 (TDD: 1-860-541-3459).

The Department of Social Services Offers Voter Registration

The department wants you to have the chance to be active in the political process.

Congress passed the National Voter Registration Act (NVRA) of 1993 in order to make it easier for you to get and file an application to register to vote. The Department of Social Services can help you register to vote. That is why we ask you to answer the questions on the next page. These questions tell us about whether you are registered to vote. Please complete this form and return it to us with your application form.

If you are not registered to vote, you can apply to register with the department. You need to fill out an application to register. We sent an application to register to you with this application form or your worker gave you a form. If you did not receive an application to register to vote, please tell your worker. Your worker will get a form to you.

DECLINING TO REGISTER TO VOTE

Connecticut General Statutes Sec. 9-23o states that state offices administering SNAP, Medicaid, WIC, Temporary Family Assistance, and offices providing state-funded programs primarily engaged in providing services to persons with disabilities must provide individuals with the opportunity to register to vote. This form must be completed with each application for service or assistance, and with each recertification, renewal, or change of address form relating to such service.

If you are not registered to vote where you live now, would you like to apply to register to vote here today?

☐ Yes ☐ No ☐ I decline because I am already registered

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

Applying to register or declining to register will **not** affect the assistance this agency will provide.

If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours.

- If you are applying in person, you may fill out the application form in private.
- If you are applying by mail, call your worker. **A notice is included that has your worker's name and telephone number.**

If you fill out and sign the voter registration application, you can:

- leave it with your worker,
- mail it to us in the enclosed envelope or
- mail it directly to the registrar of voters in your Town Hall.

Declining to register to vote and the particular office at which you register to vote remain confidential and will be used only for voter registration purposes.

Name	Signature	Date

For Agency Use Only

Voter Registration Form Completed: ☐ Yes ☐ No ☐ Already Registered

☐ Voter Registration Form given to applicant for later mailing (at applicant's request)

Agency Staff Name	Agency Staff Signature	Date

(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 your own political party or other political preference, you may file a complaint with:

State Elections Enforcement Commission, 20 Trinity Street, Hartford CT 06106,
Phone: (860) 566-7106; TDD: 1-(800) 842-9710