

Medicare Savings Programs (MSP) Model Application  
**APPLICATION**  
**FOR MEDICARE PREMIUM ASSISTANCE**

*Please read the following before completing the application. You will need to answer all questions before we will know if we can help you. If you need help completing any part of this form, call your local Medicaid office.*

<b>Applicant</b>					
Last Name		First Name		Middle Initial	
Address Where You Live		City	State	ZIP Code	
Mailing Address (If Different)		City	State	ZIP Code	
Telephone Numbers:  Home: _____ Cell: _____ Other: _____		Interpretative Services:  Do you have trouble speaking, reading or writing in English? <div style="text-align: center;">             Yes <input type="checkbox"/>                      No <input type="checkbox"/> </div>			
Marital Status:  Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		If you need an interpreter, we will provide one. Tell us the language you speak.			
<b>Representative/Sponsor</b>					
Last Name		First Name		Middle Initial	
Address Where You Live		City	State	ZIP Code	
Mailing Address (If Different)		City	State	ZIP Code	
Relationship to Applicant:		Telephone Number(s):			
		Home:	Cell:	Other:	
<b>Household Members</b>					
List all household members. Use legal names (as listed on Medicare card or birth certificate).					
Name (Last, First, MI)	Relationship to You	Date of Birth	Applying for Benefits?	Social Security Number	Sex M or F
	Self		Yes <input type="checkbox"/> No <input type="checkbox"/>		
	Spouse		Yes <input type="checkbox"/> No <input type="checkbox"/>		
	Other (Specify)		Yes <input type="checkbox"/> No <input type="checkbox"/>		



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### Assets

For each person that you included on this application who has assets, list the asset below. List the type of asset, who owns the asset and if the asset is owned in individually or jointly. Assets include, but are not limited to:

- |  |   |  |
|--|---|--|
| <ul style="list-style-type: none"> <li>• Cash</li> <li>• Checking</li> <li>• Savings</li> <li>• Money Market Accounts</li> </ul> | <ul style="list-style-type: none"> <li>• Mutual Funds</li> <li>• Savings Bonds</li> <li>• Stocks</li> <li>• Certificates of Deposit (CD)</li> </ul> | <ul style="list-style-type: none"> <li>• Individual Retirement Accounts (IRAs)</li> <li>• Real Property (excluding Primary Residence)</li> </ul> |
|--|---|--|

Type of Asset	Name of Owner(s)	Ownership	Current Value
		Individual <input type="checkbox"/> Joint <input type="checkbox"/>	\$
		Individual <input type="checkbox"/> Joint <input type="checkbox"/>	\$
		Individual <input type="checkbox"/> Joint <input type="checkbox"/>	\$
		Individual <input type="checkbox"/> Joint <input type="checkbox"/>	\$
		Individual <input type="checkbox"/> Joint <input type="checkbox"/>	\$
		Individual <input type="checkbox"/> Joint <input type="checkbox"/>	\$
		Individual <input type="checkbox"/> Joint <input type="checkbox"/>	\$
		Individual <input type="checkbox"/> Joint <input type="checkbox"/>	\$

Do you or your spouse own any vehicles (car, truck, boat, motor home, motorcycle, camper, and/or trailer)? If yes, please list below:

Name of Owner(s)	Ownership	Type of Vehicle	Year	Make/Model	Value	Amount Owed
	Individual <input type="checkbox"/> Joint <input type="checkbox"/>				\$	\$
	Individual <input type="checkbox"/> Joint <input type="checkbox"/>				\$	\$
	Individual <input type="checkbox"/> Joint <input type="checkbox"/>				\$	\$
	Individual <input type="checkbox"/> Joint <input type="checkbox"/>				\$	\$

Do you or your spouse have a whole life insurance policy with a cash value? If yes, please list below:

Policy Owner	Name of Insurance Company/Policy Number	Individual(s) Covered	Face Value	Cash Value
			\$	\$
			\$	\$

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**Read Carefully Before Signing**

I understand that:

- I must report immediately to the Medicaid office, in writing, or by telephone, any changes in my situation. Late reporting may cause incorrect benefits.
- My situation is subject to verification by the Medicaid office or other State or Federal agencies.
- I must provide proof if I am eligible for help. The Medicaid office may help me obtain the proof or contact other persons or agencies for it.
- By asking for and receiving medical care benefits, I assign to the State all rights to any medical support and to any third party payments for medical care.

**Declaration and Signatures**

I have read and understood the information in this application. I declare, under penalty of perjury, the information I have given in this application is true, correct, and complete to the best of my knowledge.

Signature of Applicant		Date
Signature of Spouse (If Applicable)		Date
Signature of Person Helping Applicant	Organization	Date