

State of Maryland
Department of Human Resources

Mail-In Application for Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary (SLMB) Programs

Dear Applicant:

In this packet is the mail-in application to apply for the Qualified Medicare Beneficiary (QMB) and the Specified Low-Income Medicare Beneficiary (SLMB) Programs. To apply for these benefits, you will need to do the following things:

- Fill out this form
- Collect and copy the documents that you need to provide as proof (see yellow page).
- Mail pages 1, 2, 3, and 4 of your completed form and the copies of your documents to the local department of social services in the county (or Baltimore City) where you live. You will find their addresses on the inside back cover.

You can use this form if you are an individual or married couple who receives or has applied for Medicare benefits. Families with children that want to apply for Medical Assistance or Food Stamps must contact the local department of social services in their area.

There are instructions for each section of the application. If you want help, you may wish to ask a family member, friend, or neighbor. You may also call the Senior Health Insurance Assistance Program (SHIP) Coordinator for your area. Their phone numbers are on the last page of the document you keep for your records.

When you mail in this form, you are requesting QMB or SLMB benefits through the Maryland Medical Assistance Program. Once you are found eligible, each year your local department of social services will mail you a case information form (CIF) to be reviewed and returned so your eligibility for continued QMB/SLMB benefits can be redetermined. If you do not return the form by the due date, your benefits will end. Benefits for these programs are listed below.

Qualified Medicare Beneficiary Program (QMB)

The QMB Program helps eligible Maryland residents by paying the full amount of your monthly Medicare premiums and your Medicare co-pays and deductibles. You will receive a gray and white QMB card by mail.

Specified Low-Income Medicare Beneficiary Program (SLMB)

If you are eligible for SLMB, we will pay only your monthly Medicare Part B medical insurance premium. You will receive a letter to tell you if you are eligible, but you will not receive a card.

Keep this page for your records

RIGHTS and RESPONSIBILITIES

PRIVACY STATEMENT:

The Medical Assistance Program will use my personal information (Name, Address, Social Security Number, Date of Birth, Employment History, etc.) to see if I am eligible for benefits. If I do not provide the information, my application may be denied. I have the right to review, change, or correct any information. By law, the state may use my information only for purposes directly related to the administration of the programs for which I apply.

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

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 that may be liable to pay for my medical care and services. I understand that I must report to the local department of social services any payments received for medical care within 10 days.

REPORT CHANGES:

I understand that I must tell the local department of social services about any changes in my income, assets (savings and checking accounts, life insurance policies, etc.), address, or living arrangements within 10 days after the change happens.

APPLICANT'S STATEMENT OF UNDERSTANDING AND AGREEMENT:

I agree to the release of my personal and financial information to any agent of the state who will evaluate and determine my eligibility for Medical Assistance benefits.

I understand that the state may verify all information on this form. Social Security Numbers will be used for identification to verify information for program reviews or audits and computer matches with other agencies, such as the Social Security Administration or the Internal Revenue Service.

I have the right to appeal any decision, action, or inaction made concerning my eligibility. I understand that my application will be considered without regard to race, color, sex, age, disability, religion, national origin, or political belief.

I certify that everyone requesting benefits on this application form is a U.S. citizen or lawfully admitted alien. Proof of lawful immigration status is required.

Keep this page for your records

Maryland Department of Human Resources
Mail-In Application for Qualified Medicare Beneficiary (QMB) and Specified
Low-Income Medicare Beneficiary (SLMB) Programs

INSTRUCTIONS FOR COMPLETING APPLICATION

- Read all instructions for each part before filling out. Print clearly. Answer all questions. Do not leave any blank spaces. Put "NA" in each space that does not apply. Use the yellow QMB/SLMB Documentation Reminder checklist to make sure you send all information that applies to you.
- Send copies of your records only. Original documents will not be returned.
- When finished, remove and mail the application (pages 1, 2, 3, and 4) and proofs. Sign, date, and mail the application to the local department of social services in your area. A list of the social service offices is included.

Section 1. Information about you.

Your Name: _____
First Middle Last

Address: _____
Street Address Apt. No.

City State Zip Code

Daytime Telephone: (____) _____ - _____ Evening Telephone: (____) _____ - _____

Date of Birth: _____ Sex: Male Female Race (optional): _____

Your Social Security Number: _____ - _____ - _____

Your Medicare Number: _____ - _____ - _____ - _____

Marital Status: Never Married Married and living with spouse Separated Divorced Widowed

Are you a Maryland resident? Yes No Are you a citizen of the U.S.? Yes No

If not a citizen, most recent date of arrival in the U.S.: _____ INS ID Number _____

Which language do you speak the most? English Spanish Other: _____

Section 2. Information about your spouse.

If you are living with your spouse, please complete the following information about him or her.

Name: _____
First Middle Last

Date of Birth: _____ Race: (optional): _____

Are you applying for QMB/SLMB benefits for this person? Yes No If yes, complete the following:

Social Security Number: _____ - _____ - _____

Medicare Number: _____ - _____ - _____ - _____

Citizenship: Is this person a citizen of the U.S.? Yes No

If not a citizen, most recent date of arrival in the U.S.: _____ INS ID Number _____

Which language does your spouse speak the most? English Spanish Other _____

Section 3. Assets. To show proof of the assets listed below, send copies of all current statements for you and your spouse. See the yellow pullout page for copies needed.

Type of Assets	Current Value (as of the 1 st day of this month)	Owner:		Account Number	Name of bank, institution, or location
		Applicant	Spouse		
Savings	\$	<input type="checkbox"/>	<input type="checkbox"/>		
Checking	\$	<input type="checkbox"/>	<input type="checkbox"/>		
Stock Certificates	\$	<input type="checkbox"/>	<input type="checkbox"/>		
Certificates of Deposit (CD's) or Money Market					
Bonds	\$	<input type="checkbox"/>	<input type="checkbox"/>		
Real Estate (except where you live)	\$	<input type="checkbox"/>	<input type="checkbox"/>		
Trust Fund	\$	<input type="checkbox"/>	<input type="checkbox"/>		
IRA, Keogh, 401-K,	\$	<input type="checkbox"/>	<input type="checkbox"/>		
Cash	\$	<input type="checkbox"/>	<input type="checkbox"/>		
Other:	\$	<input type="checkbox"/>	<input type="checkbox"/>		

Section 4. Income. For your income listed below, send in proof of how much you and your spouse receive (example: Social Security and Veterans' benefits letters, 1 month's worth of your latest pay stubs).

Type of Income	Amount (before taxes and other deductions)	How Often? (monthly, weekly, bi-weekly)?	Received by:	
			Applicant	Spouse
Social Security	\$		<input type="checkbox"/>	<input type="checkbox"/>
Social Security Disability	\$		<input type="checkbox"/>	<input type="checkbox"/>
Supplemental Security Income (SSI)	\$		<input type="checkbox"/>	<input type="checkbox"/>
Veterans' Benefits	\$		<input type="checkbox"/>	<input type="checkbox"/>
Railroad Retirement	\$		<input type="checkbox"/>	<input type="checkbox"/>
Civil Service Annuity	\$		<input type="checkbox"/>	<input type="checkbox"/>
Pension, Retirement, or Disability Income	\$		<input type="checkbox"/>	<input type="checkbox"/>
Rental Income	\$		<input type="checkbox"/>	<input type="checkbox"/>
Mortgage Income	\$		<input type="checkbox"/>	<input type="checkbox"/>
Dividends or Interest Earnings	\$		<input type="checkbox"/>	<input type="checkbox"/>
Job Earnings (Last 4 Weeks)	\$		<input type="checkbox"/>	<input type="checkbox"/>
Alimony	\$		<input type="checkbox"/>	<input type="checkbox"/>
Self Employment Income	\$		<input type="checkbox"/>	<input type="checkbox"/>
Unemployment	\$		<input type="checkbox"/>	<input type="checkbox"/>
Worker's Compensation	\$		<input type="checkbox"/>	<input type="checkbox"/>
Annuity Income	\$		<input type="checkbox"/>	<input type="checkbox"/>
Other:	\$		<input type="checkbox"/>	<input type="checkbox"/>

Section 5. Vehicles. List any boats, airplanes, or other recreational vehicles that you own.

Type of Vehicle	Make	Year	Model

Section 6. Life Insurance

Do you or your spouse own a life insurance policy? Yes No If yes, please complete the following information and send a copy of your policy.

Policy Owner	Insurance Company	Policy Number	Original Face Value	Current Cash Value

Section 7. Other Health Insurance

Do you and your spouse have health insurance other than Medicare? Yes No If yes, complete the section below. Send a copy of the front and back of your health insurance card for you and your spouse. Do not write in your Medicare information.

Insured Person	Insurance Company	Policy Number

Section 8. Authorized Representative. This section is optional. Complete it only if you want someone else to represent you in your application process for the QMB/SLMB Programs.

You may have another person, such as a relative, friend or attorney represent you in your application for benefits. If you would like that person to speak to the Department about your case and receive copies of all letters about your eligibility, please fill in the following:

Name of representative: _____

Address of representative: _____

Daytime telephone: (_____) _____ - _____ Evening telephone: (_____) _____ - _____

Representative's relationship to you: _____

I would like the representative above to: (check all that apply)

- Receive copies of all letters about my eligibility and discuss my eligibility with the Local Department of Social Services and the Department of Health and Mental Hygiene.
- Receive and complete my yearly applications for me.
- Receive my identification cards for me.

Section 9. Signature Section

- I have received a copy of my rights and responsibilities. I understand my responsibilities and agree to cooperate with the State as required.
- I understand that if I need help with other medical expenses, or if I need to apply for food stamps, I must file a separate application at the Local Department of Social Services in my area.
- I certify that everyone requesting benefits on this application form is a U.S. citizen or lawfully admitted alien. I have provided proof of lawful immigration status.

By signing this application form, I certify under penalty of perjury that everything on the form is the truth, as best I know it. 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 or she is not entitled.

Signature of Applicant

Date

Signature of Applicant's Spouse

Date

RIGHTS and RESPONSIBILITIES

PRIVACY STATEMENT:

The Medical Assistance Program will use my personal information (Name, Address, Social Security Number, Date of Birth, Employment History, etc.) to see if I am eligible for benefits. If I do not provide the information, my application may be denied. I have the right to review, change, or correct any information. By law, the state may use my information only for purposes directly related to the administration of the programs for which I apply.

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

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 that may be liable to pay for my medical care and services. I understand that I must report to the local department of social services any payments received for medical care within 10 days.

REPORT CHANGES:

I understand that I must tell the local department of social services about any changes in my income, assets (savings and checking accounts, life insurance policies, etc.), address, or living arrangements within 10 days after the change happens.

APPLICANT'S STATEMENT OF UNDERSTANDING AND AGREEMENT:

I agree to the release of my personal and financial information to any agent of the state who will evaluate and determine my eligibility for Medical Assistance benefits.

I understand that the state may verify all information on this form. Social Security Numbers will be used for identification to verify information for program reviews or audits and computer matches with other agencies, such as the Social Security Administration or the Internal Revenue Service.

I have the right to appeal any decision, action, or inaction made concerning my eligibility. I understand that my application will be considered without regard to race, color, sex, age, disability, religion, national origin, or political belief.

I certify that everyone requesting benefits on this application form is a U.S. citizen or lawfully admitted alien. Proof of lawful immigration status is required.

When you finish filling in this application, mail pages 1, 2, 3, and 4 to the Local Department of Social Services for your area, listed below. Complete the following and keep this page for your records:

I mailed my application form on:

_____ (Date)

Circle the office where you mailed your application.

LOCAL DEPARTMENTS OF SOCIAL SERVICES

<p>Allegany County DSS P.O. Box 1420 Cumberland, MD 21502-1420 (301) 784-7000</p> <p>Anne Arundel County DSS 80 West Street Annapolis, MD 21401 (410) 269-4500</p> <p>Baltimore City DSS c/o Sylvia McLean Central Medical Assistance 1920 N. Broadway Baltimore, MD 21213 (443) 423-6100</p> <p>Baltimore County DSS</p> <p>Catonsville District c/o Melissa Caldwell 910 Frederick Road Baltimore, MD 21228 (410) 853-3475</p> <p>Essex District c/o Rose Cunningham 439 Eastern Avenue Baltimore, MD 21221 (410) 853-3806</p> <p>Reistertown District c/o Betty Foster 130 Chartley Drive Reisterstown, MD 21136 (410) 853-3050</p> <p>Towson District c/o Shirlene Dodd Drumcastle Center 6401 York Road Baltimore, MD 21212 (410) 853-3353</p>	<p>Calvert County DSS 200 Duke Street Prince Frederick, MD 20678 (410) 286-2100</p> <p>Caroline County DSS P.O. Box 100 Denton, MD 21629 (410) 819-4500</p> <p>Carroll County DSS 10 Distillery Drive Suite 10 Westminster, MD 21157 (410) 386-3300</p> <p>Cecil County DSS P.O. Box 1160 Elkton, MD 21922 (410) 996-0100</p> <p>Charles County DSS P.O. Box 1010 LaPlata, MD 20646 (301) 392-6400</p> <p>Dorchester County DSS P.O. Box 217 Cambridge, MD 21613-0217 (410) 901-4100</p> <p>Frederick County DSS P.O. Box 237 Frederick, MD 21705 301-694-4555</p>	<p>Garrett County DSS 12578 Garrett Highway Oakland MD 21550 (301) 533-3000</p> <p>Harford County DSS 2 S. Bond Street Bel Air, MD 21014 (410) 836-4700</p> <p>Howard County DSS 7121 Columbia Gateway Drive Columbia, MD 21046 (410) 872-4200</p> <p>Kent County DSS P.O. Box 670 Chestertown, MD 21620 (410) 810-7600</p> <p>Montgomery County DHHS c/o Kate Garvey 401 Hungerford Road 5th Floor Rockville, MD 20850 (240) 777-1245</p> <p>Prince George's Co. DSS 805 Brightseat Road Landover, MD 20875 (301) 909-7000</p> <p>Queen Anne's County DSS 125 Comet Drive Centreville, MD 21617 (410) 758-8000</p>	<p>Talbot County DSS P.O. Box 1479 Easton, MD 21601 (410) 822-1612</p> <p>Saint Mary's County DSS c/o Nicki Sacks P.O. Box 509 Leonardtown, MD 20650 (240) 895-7000</p> <p>Somerset County DSS P.O. Box 359 Princess Anne, MD 21853 (410) 677-2100</p> <p>Washington County DSS 122 N. Potomac Street Hagerstown, MD 21741 (240) 420-2100</p> <p>Wicomico County DSS 201 Baptist Street Suite 27 Salisbury, MD 21601 (410) 543-6900</p> <p>Worcester County DSS 299 Commerce Street Snow Hill, MD 21863 (410) 677-6800</p>
--	--	--	--

Keep this page for your records

TURN PAGE OVER

If you need help to complete your application, call the coordinator for the Senior Health Insurance Assistance Program (SHIP) in your area, listed below.

SHIP COORDINATORS

COUNTY	PHONE NUMBER
Allegany	(301) 777-5970 x 110
Anne Arundel	(410) 222-4464
Baltimore City	(410) 396-2273
Baltimore County	(410) 887-2059
Calvert	(301) 855-1170 (410) 535-4606
Caroline	(410) 479-2535
Carroll	(410) 876-3363
Charles	(301) 934-0118 (301) 870-3388 x 5118
Cecil	(410) 996-5295
Dorchester	(410) 376-3662, x 106
Frederick	(301) 631-3522
Garrett	(301) 334-9431 1-888-877-8403
Harford	(410) 638-3025
Howard	(410) 313-7392
Kent	(410) 778-2564
Montgomery	(301) 590-2819
Prince George's	(301) 265-8456
Queen Anne's	(410) 758-0848
Somerset	(410) 742-0505 x 106
St. Mary's	(301) 475-4200 x 1064
Talbot	(410) 822-2869
Washington	(301) 790-0275 x 208
Wicomico	(410) 742-0505, x 106
Worcester	(410) 742-0505, x 106

Keep this page for your records

QMB/SLMB DOCUMENTATION REMINDER

- Along with my application, I need to mail copies of proof of income, assets (savings and checking accounts, life insurance, etc.) and health insurance listed on my application.
- If I cannot send the papers now, I will mail them at a later date. However, I understand that my eligibility for the QMB/SLMB Programs cannot be decided until I send all information. I understand that the local department of social services may ask me to submit more information.

Please be sure to include a copy of all that apply to you. Do not send original records. They will not be returned to you.

Place a √ beside each item that you must send with your application	<u>What</u>
	Health Insurance Card(s) – front and back (not your Medicare card)
	Lawful Permanent Resident form, I-94 Card, or other forms from Immigration and Naturalization Services (Department of Homeland Security)
	Checking Account Statement – last 3 statements
	Savings Book/Statement showing the balance at the first of this month
	Divorce/Separation Papers
	Alimony Papers
	If employed, pay stubs for last month or 4 weeks, W-2, or letter from employer or proof of self-employment income (quarterly tax forms, receipts)
	Retirement / Pension Verification of gross income you get (before taxes, etc. are deducted)
	Life Insurance Policy (copy of original policy)
	Whole Life Insurance (cash value table from the life insurance policy or cash value letter from insurance carrier)
	Social Security Award Letter
	Veterans Administration Award Letter
	Civil Service Annuity Award Letter
	Stock, bonds, 401-Ks, etc.– statements for last 3 months
	Trust Fund document(s) for trusts you have had in the last 60 months (copy of trust & last 3 statements)
	Burial or Funeral Account, Fund, or Plan Statement
	Mortgage Contract for rental or business property for which you are the lender or are receiving money
	Rental/Lease Income Statements for property you rent or lease to someone else
	IRA or Keogh – last statement
	Annuities- copy of annuity & last 3 statements
	Copy of letter or statement showing amount for any other income or asset.

Keep this page for your records