

# Louisiana Medicaid Medicare Savings Program Application



Use this application to apply for Medicaid to pay your Medicare premiums, co-pays, and/or deductibles. **You must have or be eligible to get Medicare Part A to get this type of Medicaid.** If you are married, your spouse who also has or is eligible to get Medicare Part A may apply on this form. This is a free program. It does not cover medicine.

## To apply, you need to do these things:

1. **Fill out and sign this application.** Please print and use a black pen.
2. **Get the documents of proof.** Look on the last page for things you need to send us. Please trust that the information you give us on your application and everything you send us will be kept confidential. We are required by law to keep it private.
3. **Get this application form to us right away.** We will give you extra time to send in the proofs.

What language do you speak best?  English  Spanish  Vietnamese  Other \_\_\_\_\_  
What language do you write best?  English  Spanish  Vietnamese  Other \_\_\_\_\_

## 1. Where did you get this application form?

- Medicaid Office  Hospital  Pharmacy  Doctor's Office  Friend/Relative  
 Internet  Food Stamps Office  Health Unit  Social Security Office  
 Business (Store, Work)  Festival/Health Fair  Other \_\_\_\_\_

## 2. Tell us about you (the person applying).

Name (first, middle initial, last) \_\_\_\_\_

Male  Female Parish You Live In \_\_\_\_\_

Social Security Number \_\_\_\_\_ Maiden Name \_\_\_\_\_

Date of Birth (month, day, year) \_\_\_\_\_

Married and living with spouse  Single  Divorced  Widow/Widower

Race/Ethnic Background: (You do not have to answer. Mark one or more.)

- White  Black  Asian  American Indian or Alaska Native  Hispanic or Latino  
 Native Hawaiian or Pacific Islander

If you are not a U.S. citizen, are you a permanent resident?  Yes – Fill Out Below  No – Go to Question 3

Permanent Resident Card (green card) Number: A# \_\_\_\_\_

Date came to the U.S.: \_\_\_\_\_

**Call us toll free if you need help with this application at  
1-888-544-7996. If you are deaf or hard of hearing and  
have a TTY text telephone, call 1-800-220-5404.**

**3. Tell us how to reach you.**

Mailing Address \_\_\_\_\_ Apt/Lot \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home Address (if different) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Cell Phone ( \_\_\_\_\_ ) \_\_\_\_\_  
Message Phone ( \_\_\_\_\_ ) \_\_\_\_\_ E-mail Address \_\_\_\_\_  
Best Day and/or Time to Call Between Hours of 7 a.m. and 5 p.m. \_\_\_\_\_

**4. If you are married and living with your spouse, tell us about them in the spaces below.  No Spouse Lives With You - Go to Question 5**

Name (first, middle initial, last) \_\_\_\_\_  Male  Female  
Date of Birth (month, day, year) \_\_\_\_\_ Social Security Number \_\_\_\_\_

**Does your spouse want to apply for the Medicare Savings Program?  Yes - Fill Out Below  No - Go to Question 5** (They must have or be eligible to get Medicare Part A to get this type of Medicaid.)

Spouse’s Race/Ethnic Background: (You do not have to answer. Mark one or more.)

- White  Black  Asian  American Indian or Alaska Native
- Hispanic or Latino  Native Hawaiian or Pacific Islander

If your spouse is not a U.S. citizen, are they a permanent resident?  Yes – Fill Out Below  
 No – Go to Question 5

Permanent Resident Card (green card) Number: A# \_\_\_\_\_  
Date came to the U.S.: \_\_\_\_\_

**5. Medicare**

Your Medicare Claim Number (on Medicare card) \_\_\_\_\_  
Your Spouse’s Medicare Claim Number (on Medicare card) \_\_\_\_\_



**6. If anyone applying has health insurance or a Medicare supplement, answer the questions below.  No Insurance - Go to Question 7**

*If there is more than one insurance, use another sheet of paper.*

Who is covered?  You  Spouse  Both Policyholder’s Name \_\_\_\_\_  
Coverage Start Date \_\_\_\_\_ How much does it cost for the month? \_\_\_\_\_  
Insurance Company Name and Phone Number \_\_\_\_\_  
Insurance Company Address \_\_\_\_\_  
Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_  
What does it cover?  Hospital  Doctor  Medicine  Dental  Ambulance

7. Do you or your spouse work or are self-employed?  Yes - Fill Out below  
 No - Go to Question 8

Name of Working Person	Employer's Name _____	How much is paid (show gross, not take home pay)? \$ _____  How often? <input type="checkbox"/> weekly <input type="checkbox"/> every 2 weeks <input type="checkbox"/> twice a month <input type="checkbox"/> monthly
	Employer's Phone Number ( _____ ) _____	
	<input type="checkbox"/> Self-employed	
Name of Working Person	Employer's Name _____	How much is paid (show gross, not take home pay)? \$ _____  How often? <input type="checkbox"/> weekly <input type="checkbox"/> every 2 weeks <input type="checkbox"/> twice a month <input type="checkbox"/> monthly
	Employer's Phone Number ( _____ ) _____	
	<input type="checkbox"/> Self-employed	

8. Does anyone get income (money) from:

- Social Security • SSI • Veterans' Benefits • Retirement • Pension • Royalties
- Annuities • Rent from Property Owned • Alimony • Worker's Comp
- Unemployment • Money from Friends/Relatives • Other (tell us what it is)

Yes - Fill Out Below  No - Go to Question 9

Name	Type of Income	How much is received? \$ _____	How often? <input type="checkbox"/> weekly <input type="checkbox"/> every 2 weeks <input type="checkbox"/> twice a month <input type="checkbox"/> monthly	For Veterans' benefits or Railroad Retirement, tell us the claim number.
Name	Type of Income	How much is received? \$ _____	How often? <input type="checkbox"/> weekly <input type="checkbox"/> every 2 weeks <input type="checkbox"/> twice a month <input type="checkbox"/> monthly	For Veterans' benefits or Railroad Retirement, tell us the claim number.
Name	Type of Income	How much is received? \$ _____	How often? <input type="checkbox"/> weekly <input type="checkbox"/> every 2 weeks <input type="checkbox"/> twice a month <input type="checkbox"/> monthly	For Veterans' benefits or Railroad Retirement, tell us the claim number.

9. Has anyone applied for income such as Social Security or Veterans' benefits, but they did not get it, yet?  Yes - Fill Out Below  No - Go to Question 10

Who? \_\_\_\_\_ What is it? \_\_\_\_\_

10. If anyone who gets Social Security benefits ever received SSI benefits, but no longer gets SSI, now, give us their name. \_\_\_\_\_

**11. Tell us if you or your spouse have any of the things listed below.**

**A. Checking/Savings account(s)?**  Yes – Fill Out Below  No – Go to B

*If there are more than 3 accounts, use another sheet of paper.*

What is it?  Checking  Savings Who does it belong to?  You  Spouse  Both

Name of the Bank \_\_\_\_\_

Account Number \_\_\_\_\_ How much is in the account? \_\_\_\_\_

What is it?  Checking  Savings Who does it belong to?  You  Spouse  Both

Name of the Bank \_\_\_\_\_

Account Number \_\_\_\_\_ How much is in the account? \_\_\_\_\_

What is it?  Checking  Savings Who does it belong to?  You  Spouse  Both

Name of the Bank \_\_\_\_\_

Account Number \_\_\_\_\_ How much is in the account? \_\_\_\_\_

**B. Money set aside in a bank account(s) for burial, or a pre-need (burial contract) with a funeral home?**  Yes – Fill Out Below  No – Go to C

Who does it belong to?  You  Spouse  Both

Name of the Bank or Funeral Home \_\_\_\_\_

How much is it worth? \_\_\_\_\_

If a pre-need, how was it funded?  Cash  Life Insurance  Both

Is the pre-need paid in full?  Yes  No Can it be canceled or revoked?  Yes  No

**C. Certificates of deposit (CDs)?**  Yes – Fill Out Below  No – Go to D

Who does it belong to?  You  Spouse  Both

Name of the Bank \_\_\_\_\_

Account number(s) \_\_\_\_\_

How much is it worth? \_\_\_\_\_

**D. Bonds?**  Yes – Fill Out Below  No – Go to E

Who does it belong to?  You  Spouse  Both

What is the bond(s) worth? \_\_\_\_\_

Bond Number(s) \_\_\_\_\_

What type of bond is it? \_\_\_\_\_

**E. Stocks?**  Yes – Fill Out Below  No – Go to F

Who does it belong to?  You  Spouse  Both

How much is the stock(s) worth? \_\_\_\_\_

What is the name of the company? \_\_\_\_\_

**F. Annuities and/or retirement accounts (IRA, Keogh, 401-K)?**  Yes – Fill Out Below  No – Go to G

Who does it belong to?  You  Spouse  Both

Account Number(s) \_\_\_\_\_

How much is in it? \_\_\_\_\_

Are regular payments being received?  Yes  No

If **yes**, how much? \$ \_\_\_\_\_ How often? \_\_\_\_\_

If **no**, are such payments available?  Yes  No  Don't Know

Can a lump-sum withdrawal of these funds be made?  Yes  No  Don't Know

**G. Safety Deposit Box(es)?**  Yes – Fill Out Below  No – Go to H

Who does it belong to?  You  Spouse  Both

Name of the Bank \_\_\_\_\_

What is inside the box or boxes? \_\_\_\_\_

What are the things inside the box worth? \_\_\_\_\_

**H. Life or burial insurance?**  Yes – Fill Out Below  No – Go to I

Tell us about each policy. *If there are more than 8, use another sheet of paper.*

Policy Covers	Owner of Policy	Insurance Company	Face Value	Policy Number
<input type="checkbox"/> You <input type="checkbox"/> Spouse				
<input type="checkbox"/> You <input type="checkbox"/> Spouse				
<input type="checkbox"/> You <input type="checkbox"/> Spouse				
<input type="checkbox"/> You <input type="checkbox"/> Spouse				
<input type="checkbox"/> You <input type="checkbox"/> Spouse				
<input type="checkbox"/> You <input type="checkbox"/> Spouse				
<input type="checkbox"/> You <input type="checkbox"/> Spouse				
<input type="checkbox"/> You <input type="checkbox"/> Spouse				

- I. **Cars, trucks, boats, campers, motorcycles, ATVs?**  Yes – Fill Out Below  
 No – Go to J

Tell us about each below. *If there are more than 3, use another sheet of paper.*

Owner	What is it?	Make, Model, Year	What is it worth?	How much owed on it?

- J. **Property (not your home), like a second house, land, out of state property, or inherited property (can be undivided)?**  Yes – Fill Out Below  No – Go to K

Who does it belong to?  You  Spouse  Both

How much is it worth? \_\_\_\_\_

How much is owed on it? \_\_\_\_\_

Tell us about it (location, lot size, number of acres, buildings). \_\_\_\_\_

\_\_\_\_\_

- K. **Have you or your spouse ever created a trust, placed any items in trust, or has a trust set up for them?**  Yes – Fill Out Below  No – Go to L

Date the trust was created. \_\_\_\_\_ Can it be revoked or canceled?  Yes  No

Was the trust set up by a Last Will and Testament?  Yes  No

Was the trust set up for a disabled person under age 65?  Yes  No

Who created the trust? \_\_\_\_\_

Who is the trustee? \_\_\_\_\_

- L. **Anything else?**  Yes – Fill Out Below  No – Sign Application on Next Page

Who does it belong to?  You  Spouse  Both

What is it? \_\_\_\_\_

How much is it worth? \_\_\_\_\_

Tell us about it. \_\_\_\_\_

**This is the end of the application. You must sign the application on the next page.**

# YOUR RIGHTS AND RESPONSIBILITIES

## WHAT MEDICAID HAS THE RIGHT TO EXPECT OF YOU

**CITIZENSHIP AND IMMIGRATION STATUS:** You state that the information about citizenship and immigration given at the beginning of this application form is true and correct.

**REPORTING THE TRUTH:** You state that the information you give on the application form is true and correct. You understand if you on purpose give information that is not true OR if you on purpose do not tell information that you are supposed to, you and/or the person(s) applying may get health benefits that you or they should not get. If that happens, you can by law be punished for fraud. Also, you may have to pay money back to Medicaid for the bills it paid by mistake.

**VERIFICATION OF INFORMATION:** You understand that the information you give about you and/or the person(s) applying will be checked. You agree to help do that and let Medicaid get information it needs from government agencies, employers, medical providers, and others.

**SOCIAL SECURITY NUMBERS:** You understand Social Security numbers will only be used to get information from other government agencies to make a decision on eligibility for you and/or the person(s) applying for Medicaid.

**PAYMENT OF MEDICAL CARE BY A THIRD PARTY:** You understand by accepting Medicaid, the Department has the right to get money received by you and/or the person(s) applying from other sources like insurance payments or lawsuit settlements for services that Medicaid has paid for you and/or the person(s) applying.

**REPORTING CHANGES:** You agree to tell Medicaid within 10 days of these changes: 1) if anyone getting Medicaid moves out of state; 2) changes in mailing or home address; 3) when someone moves in or out of the home; 4) changes in health insurance and premiums; 5) changes in income; and 6) changes in things owned by anyone who gets Medicaid who is disabled or over age 64.

## WHAT YOU HAVE THE RIGHT TO EXPECT FROM MEDICAID

**RIGHT TO A FAIR HEARING:** You understand that you can ask for a Fair Hearing if you think any decision made on the case is unfair, incorrect, or made too late.

**NO DISCRIMINATION:** You understand Medicaid cannot treat you differently because of race, color, sex, age, disability, religion, nationality, or political belief. If you think it has, you can call the U.S. DHHS Regional Office for Civil Rights in Dallas, TX at 1-800-368-1019 or write to Louisiana's Department of Health & Hospitals, Human Resources at P. O. Box 4818 Baton Rouge, LA 70821-4818.



## YOU MUST SIGN BELOW



 Sign Your Name Here: \_\_\_\_\_ Date \_\_\_\_\_

*If you are married and your spouse is applying, he/she will sign below.*

 Spouse Signs Here: \_\_\_\_\_ Date \_\_\_\_\_

*If someone from Medicaid filled out this application for you, they will sign below.*

\_\_\_\_\_ Date \_\_\_\_\_

**Please mail, bring, or fax the application and proofs to your local Medicaid office right away. If you need the address or toll free fax number, call 1-888-342-6207. If you are deaf or hard of hearing and have a TTY text telephone, call 1-800-220-5404.**

## Send Us These Things

These things are needed to help us see if you qualify. Some of these things will not apply to you and your spouse. For the things that do apply, let us know if you do not have or cannot get any of these things, because we may be able to get them ourselves or help you get them.

**To help you decide what to send, enter a check  next to each for the things that apply to you or your spouse.**

Copies of health insurance and Medicare Supplement cards (front and back) - for anyone applying

- Copy of Permanent Resident Card (green card) or other forms from U.S. Citizenship and Immigration Services - **for anyone applying who is not a U.S. citizen**
- If you or your spouse work, send pay stubs for the last month showing gross pay (before taxes) or letter from employer. If self-employed, send copies of tax return and all schedule attachments.
- Copy of Veterans' Benefit Award letter - **for you and spouse**
- Proof of any income such as retirement, pension, mineral rights, royalties, and any other income - **for you and spouse**
- If you or spouse own property that is rented out, send proof of the amount of rental income received (letter from renters or cancelled check).