RHODE ISLAND
DEPARTMENT OF HUMAN SERVICES

APPLICATION FOR THE MEDICARE PREMIUM PAYMENT PROGRAM

Please complete this application if you are applying ONLY for Medicare Premium Payment Program benefits to help pay for some of your Medicare expenses. Return the signed and dated application form to your local DHS office (see insert). For information about this or other EOHHS/DHS programs, call your local DHS office or visit the DHS website at www.dhs.ri.gov.

APPLICANT INFORMATION

1. **I am applying** _____
Last Name *First Name* *MI*

2. **Primary Language** _____ 3. **Telephone number**_____

4. **Social Security Number** __ __ __-__ __-__ __ __ __ 5. **Date of Birth** _____-_____-_____

6. **Residence Address** _____
Street *City/Town* *State* *ZIP*

7. **Mailing Address** _____
(If different from Residence) *Street* *City/Town* *State* *ZIP*

8. **I am entitled to Medicare**: Part A *Yes*____ *No*____ Part B *Yes*____ *No*____

9. **My Medicare Claim Number is**: __ __ __-__ __-__ __ __ __-___
(From your red, white, and blue card)

10. **My Other Medical Insurance is**: _____
Company (Blue Cross, etc.) *Policy Number*

SPOUSE INFORMATION

(Complete if Living Together)

11. **Spouse's Name** _____
Last Name *First Name* *MI*

12. **Spouse is applying**: *Yes*___ *No*___

13. **Social Security Number**__ __ __-__ __-__ __ __ __ 14. **Date of Birth** _____-_____-_____

15. **Entitled to Medicare**: **Part A** *Yes*____ *No*____ **Part B** *Yes*____ *No*____

16. Medicare Claim Number is: __ __ __-__ __-__ __ __ __-___

17. **Other Medical Insurance** _____

18. **INCOME**

Tell us about all gross income (before any deductions for Medicare premiums, taxes, etc.) received by you and your spouse. Please tell us the type and amount of income received.

TYPE OF INCOME (*Monthly*)	**YOURS**	**SPOUSE**
Social Security Income	$_____	$_____
Veteran's Benefits	$_____	$_____
Pension Income	$_____	$_____
Employment Income	$_____	$_____
Rental Income	$_____	$_____
Other_____	$_____	$_____
_____	$_____	$_____

19. **RESOURCES**

Tell us about all resources owned by you and your spouse, separately or jointly. Resources include but are not limited to cash, bank accounts, life insurance, stocks, bonds, mutual funds, certificates of deposit, and property other than the home you live in. List the bank, account number and balance of all bank accounts.

Bank Accounts:

_____ _____ $_____
Bank *Account Number*

_____ _____ $_____
Bank *Account Number*

_____ _____ $_____
Bank *Account Number*

Stocks, Bonds, Mutual Funds $_____
(Total Amount)

Property Other Than Home You Live In $_____
(Equity Value)

Life Insurance – Yours – (Do Not Include Term Insurance):

_____ _____ $_____ $_____
Company *Policy Number* *(Face Value)* *(Cash Value)*

Life Insurance – Spouse – (Do Not Include Term Insurance):

_____ _____ $_____ $_____
Company *Policy Number* *(Face Value)* *(Cash Value)*

Other resources (please describe)_____

_____

_____

20. In the last three months, has there been a substantial change in income or resources for you or your spouse? Yes____ No_____

DECLARATIONS OF APPLICANT, RIGHTS AND RESPONSIBILITIES:

I hereby apply to the RI Executive Office of Health and Human Services/Department of Human Services for the Medicare Premium Payment Program. I understand that the information contained in this application, along with my Social Security Administration records will be used in the determination of my eligibility for these benefits.

I agree to give EOHHS/DHS accurate information to prove the statements I have made, and I give EOHHS/DHS permission to get such proof. I know that I must inform EOHHS/DHS at the time any of this information changes and I agree to do so. I understand that under Public Assistance Law in Rhode Island and under federal law, there is a penalty for making false and misleading statements. I agree to furnish a valid Social Security number for myself and my spouse. My social security number and the social security number of my spouse will be used in computer matching with the Department of Labor and Training, the Social Security Administration, the Internal Revenue Service, the Food and Nutrition Services and other governmental and non-governmental entities authorized by law or contract, and they will be subject to verification by Federal, State, and local officials. I agree to cooperate fully with State and federal personnel conducting quality control reviews.

I know that Medical Assistance does not pay medical expenses that a third party is supposed to pay. I understand that by signing below, I am assigning my rights to any third party payment to EOHHS/DHS. These payments may include payments from hospital and health insurance policies, or may result from a lawsuit or other claim. I understand that this application will serve as authorization to the RI Executive Office of Health and Human Services/Department of Human Services to obtain from medical providers information that is pertinent to me or any person included in this application.

I know that the information I have given is confidential. The Department uses information about you and other members of your household only for purposes directly related to the administration of the programs. The Department does not release information about you or other members of your household without your consent except as provided in Rhode Island General Laws 40-6-12 and 40-6-12.1, and regulations set forth in the EOHHS/DHS Policy Manuals. Any person found guilty of violating the provisions of Rhode Island General Laws 40-6-12 shall be deemed guilty of a misdemeanor. Violators are subject to a maximum fine of two hundred dollars ($200), or imprisonment of up to six (6) months, or both. I know that my eligibility will not be affected by my race, color, national origin, disability, gender, age, religion or sexual orientation except where this is restricted by law. I know that I have a right to request, and if found eligible, to receive Medicare Premium Payment Program benefits based on policies and standards established under State law. If ineligible, I may reapply at any time. I know that I have a right to appeal and receive a Hearing before a Hearing Officer of the Department if I am dissatisfied with any agency decision, or if the agency delays in making a decision.

EOHHS/DHS has my consent to use or disclose protected health information for the purposes of treatment, payment and health care operations in accordance with EOHHS/DHS notice of privacy practices.

I have read and understand these rights and responsibilities.

_____	_____	_____
Your Signature	*Spouse Signature(required if living together)*	*Date*
_____	_____	
Print Name	*Print Name*	

NON- DISCRIMINATION NOTICE

In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.); Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 794); Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.); Title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.); The Food Stamp Act; the Age Discrimination Act of 1975; the U.S. Department of Health and Human Services implementing regulations (45 C.F.R. Parts 80 and 84); the U.S. Department of Education implementing regulations (34 C.F.R. Parts 104 and 106); and the U.S. Department of Agriculture, Food and Nutrition Services (7 C.F.R. 272.6); the Rhode Island Executive Office of Health and Human Services and the Department of Human Services (DHS), does not discriminate on the basis of race, color, national origin, disability, political beliefs, age, religion or gender in acceptance for or provision of services, employment or treatment, in its educational and other programs and activities. Under other provisions of applicable law, EOHHS/DHS does not discriminate on the basis of sexual orientation.

For further information about these laws, regulations and EOHHS'/DHS' discrimination complaint procedures for resolution of complaints of discrimination, contact EOHHS/DHS at 57 Howard Avenue, Cranston, RI 02920, telephone number 462-2130 (TDD 462-6239 or 711). The Community Relations Liaison Officer is the coordinator for implementation of Title VI; the Office of Rehabilitation Services (ORS) Administrator or his/her designee is the coordinator for implementation of Title IX, Section 504, and ADA. The Director of EOHHS/DHS or his/her designee has the overall responsibility for EOHHS'/DHS' civil rights compliance.

AGENCY USE ONLY

CASE RECORD CLEARANCE FOR PARTICIPATION
PERS SEARCH

PREVIOUS CASE RECORD			STATUS DATE	RECORD LOCATION	REQUEST
RIW	Y	N			
SNAP	Y	N			
MA	Y	N			
GPA	Y	N			

DATE APPLICATION RECEIVED: _____