



W-1QMB
(Rev 8/16)

State of Connecticut Department of Social Services Application for Medicare Savings Programs (QMB, SLMB, ALMB)

Use this form to **apply** for Medicare Savings Program benefits. If you currently receive these benefits, please renew using the Renewal Form for Medicare Savings Programs (W-1QMBR).

Do you need a reasonable accommodation or special help to complete your application because you have a disability? Yes No If yes, complete the next question and see page 3 about how we can help.

If you need a reasonable accommodation or special help, tell us what kind of help you need:

Tell us about yourself

Name (first, middle, last)		Sex (M or F)	Social Security #	Date of Birth
Home Street Address		City	State	Zip Code
Mailing Address (if different)		City	State	Zip Code
Best phone # to reach you	Marital Status (check one): <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
This application is for (check one): <input type="checkbox"/> Yourself only <input type="checkbox"/> Yourself and your spouse		Spouse's Name (first, middle, last)		
		Spouse's Social Security #	Spouse's Date of Birth	

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

Are you of Hispanic, Latino/a, or Spanish origin? No Yes (if yes, check all that apply)

Mexican, Mexican-American or Chicano/a Cuban Puerto Rican Other Hispanic, Latino/a or Spanish

Racial Heritage (check all that apply): White Black or African American American Indian or Alaska Native
 Asian Indian Chinese Filipino Japanese Korean Vietnamese Other Asian
 Native Hawaiian Samoan Guamanian or Chamorro Other Pacific Islander

Tell us about your citizenship status

	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 applicable)
Yourself	<input type="checkbox"/> Yes <input type="checkbox"/> No					
Your Spouse	<input type="checkbox"/> Yes <input type="checkbox"/> No					



Tell us about your medical insurance

Check if you have Medicare Part A or Part B . Check if your spouse has Medicare Part A or Part B .

Insurance for You	Insurance for Your Spouse
Medicare Claim #: _____	Medicare Claim #: _____
Insurance other than Medicare, if any: _____	Insurance other than Medicare, if any: _____
Company name: _____	Company name: _____
Policy number: _____	Policy number: _____
Group number: _____	Group number: _____
Check off all the services that are covered:	Check off all the services that are covered:
<input type="checkbox"/> Hospital <input type="checkbox"/> Doctor/Surgical <input type="checkbox"/> Dental	<input type="checkbox"/> Hospital <input type="checkbox"/> Doctor/Surgical <input type="checkbox"/> Dental
<input type="checkbox"/> Prescription <input type="checkbox"/> Vision/Optical <input type="checkbox"/> Long Term Care	<input type="checkbox"/> Prescription <input type="checkbox"/> Vision/Optical <input type="checkbox"/> Long Term Care
Policy start date: _____ Stop date: _____	Policy start date: _____ Stop date: _____
Policy premium amount: \$ _____ per _____	Policy premium amount: \$ _____ per _____
Date you started paying this premium: _____	Date you started paying this premium: _____

Tell us about your income

List all income that you and your spouse receive. 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		
Where does the money come from?	How much do you receive?	How often do you receive it? (hourly, weekly, every other week, monthly, yearly)	Where does the money come from?	How much do you receive?	How often do you receive it? (hourly, weekly, every other week, monthly, yearly)
Wages (employer name):	\$		Wages (employer name):	\$	
Interest:	\$		Interest:	\$	
Social Security (type):	\$		Social Security type:	\$	
Pension (company name):	\$		Pension (company name):	\$	
IRA (name of bank):	\$		IRA (name of bank):	\$	
Other (describe):	\$		Other (describe):	\$	



Important information for you to know about your application

- This application 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 and will only be disclosed as permitted by law.
- The Social Security numbers of everyone receiving or requesting assistance will be used to verify identity and eligibility. Social Security numbers will be checked against government databases, as permitted by law.
- Information provided on this form may be verified to the extent permitted by law, including by checking government computer databases or directly with third parties such as employers or banks.

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. For example, we may be able to complete your application over the telephone if you cannot come into the office, help you get certain proofs, or give you extra time to provide information. Contact DSS at 1-855-626-6632 to request a reasonable accommodation or special help. If we do not agree to give you a reasonable accommodation or special help based on your disability, you can complain to the department's Americans with Disabilities Act (ADA) coordinator. See the Non-Discrimination Statement on page 4.

Please read carefully and sign below

- I give permission to DSS, 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 under penalty of perjury that all the statements made on this form are true and complete to the best of my knowledge. I understand that I can be criminally or civilly prosecuted under state or federal law if I knowingly give incorrect information or fail to report something I should report.

Any person who helped you complete this form or completed this form for you must also sign.

Applicant's Signature	Date	Spouse's Signature	Date
Helper or Representative's Signature	Date	Relationship To Applicant	

Permission to Share Information

To permit the Department of Social Services to share information about your application, please identify the authorized individuals, agencies, or institutions that DSS may communicate with, and sign in the box.			
1	Name:	Phone #	
	Address:		
2	Name:	Phone #	
	Address:		
Applicant's Signature or Signature of Authorized Representative			Date



NON-DISCRIMINATION STATEMENT

You may file discrimination complaints or request reasonable accommodations as follows:

You have the right to make a discrimination complaint if you think we have taken action against you because of your race, color, religion, sex, gender identity or expression, marital status, age, national origin, ancestry, political beliefs, sexual orientation, intellectual disability, mental disability, learning disability, or physical disability, including, but not limited to, blindness.

An individual with a disability may request and receive a reasonable accommodation or special help from the Department of Social Services when it is necessary to allow the individual to have an equal and meaningful opportunity to participate in programs administered by the Department.

If you asked for an accommodation or special help and we refused to provide it, you may make a complaint to the Department's Affirmative Action Division Director or any of the agencies listed:

Commissioner of Social Services Attn: Affirmative Action Division Director/ADA Coordinator

55 Farmington Avenue, Hartford, CT 06105
Ph: 1-860-424-5040 Toll free: 1-800-842-1508
TDD: 1-800-842-4524 Fax: 1-860-424-4948

Connecticut Commission on Human Rights and Opportunities

25 Sigourney Street, Hartford, CT 06106
Ph: 1-860-541-3400 Toll free: 1-800-477-5737
TDD: 1-860-541-3459 Fax: 1-860-246-5265
Web: <http://www.ct.gov/chro/site/default.asp>

U.S. Dept. of Health and Human Services Office for Civil Rights

JFK Federal Building, Room 1875, Boston, MA 02203
Ph: 1-617-565-1340 Toll free: 1-800-368-1019
TDD: 1-800-537-7697 Fax: 1-617-565-3809
Web: <http://www.hhs.gov/ocr/office/file/index.html>

Persons who are deaf or hard of hearing and have a TTD/TTY device can contact DSS at 1-800-842-4524. Persons who are blind or visually impaired can contact DSS at 1-860-424-5040.

