W-1QMBR
(New 6/16)

State of Connecticut Department of Social Services

Renewal Form for Medicare Savings Programs (QMB, SLMB, ALMB)

*Use this form to **renew** your Medicare Savings Program benefits. If you do not currently receive these benefits, please apply using the Application Form for Medicare Savings Programs (W-1QMB).*

Do you need a reasonable accommodation or special help to complete your renewal because you have a disability? ☐ Yes ☐ No If yes, please see page 2 about how we can help.

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

_____

Tell us about yourself:

First Name	Middle Name	Last Name	(Maiden Name)	Best Phone #	Other Phone #

Home Street Address	City	State	Zip Code

Mailing Address (if different)	City	State	Zip Code

DSS Client ID Number	Marital Status (check one): ☐ Never Married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

This renewal is for (check one):	Spouse's Name (first, middle, last):
☐ Yourself only ☐ Yourself and your spouse	Spouse's Social Security Number:

Tell us about your medical insurance:

Has there been a change in your medical insurance in the past year? ☐ Yes ☐ No

If you checked yes, please complete the section below. If you checked no, please skip this section and complete the income section on page 2.

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

Return to:
PO Box 1320, Manchester, CT 06045

W-1QMBR

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.

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		
Name of employer, if any:			Name of employer, if any:		
Address of employer:			Address of employer:		
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	$		Wages	$	
Interest	$		Interest	$	
Social Security (describe):	$		Social Security (describe):	$	
Pension (describe):	$		Pension (describe):	$	
IRA (describe):	$		IRA (describe):	$	
Other (describe):	$		Other (describe):	$	

Important information for you to know about your renewal:

- 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.
- This renewal is a request for help from the Medicare Savings Programs only.
- 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 renewal 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 3.

Return to:
PO Box 1320, Manchester, CT 06045

W-1QMBR

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.

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 renewal, please identify the authorized individuals, agencies or institutions and sign in the box:

1	Name:	
	Address:	Phone #
2	Name:	
	Address:	Phone #

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

Return to:
PO Box 1320, Manchester, CT 06045

W-1QMBR

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.