Iowa Department of Human Services

Medicare Savings Programs Additional Information Request

Dear: Date:

The Social Security Administration (SSA) sent information from your "Application for Extra Help with Medicare Prescription Drug Plan Costs" to the Iowa Department of Human Services (DHS). On that application you indicated that you wanted to apply for the Medicare Savings Programs (MSP). The Medicare Savings Program helps qualifying people pay for Medicare premiums, co-payments, and/or deductibles.

The information that you gave SSA has been entered on the enclosed form. Please answer the remaining questions on the form, provide the requested information, and send support documentation. Please send copies and NOT the original support documents.

Return the completed form back in the enclosed postage-paid envelope to the following address:

Please note, your MSP application will be denied if you don't return the form by

Questions?? If you need help filling out this form, call your local DHS office.

Another option to help to complete the Medicare Savings Programs Additional Information Request form is to call the Senior Health Insurance Information Program (SHIIP) at 800-351-4664. SHIIP, a service from the state of Iowa, provides help for Iowans with Medicare and health insurance questions or problems. SHIIP services are free and confidential.

Determination of your eligibility for the Medicare Savings Program will be made by the Department of Human Services.

Keep the cover pages and Part E for your records.

How Do I Get Help?

Step 1. Complete this request for additional information.

Answer as many questions as you can. If you need help filling out the form, please ask. **Please finish and turn in the form by the date on the front of this letter.**

Please check to see that the information that SSA sent to the Department about you is correct. If the information is not correct, please change it.

Step 2. Return the form to us.

You can bring, mail, or fax it to a local DHS office. **The date we receive the form back starts the time DHS has to work on your application.**

Step 3. When you return the form, you may be asked to show us proof:

- Of the money you have gotten in the last 30 days. Proof can be things like check stubs, self-employment records or award letters.
- Of bank accounts, trust accounts, stocks or bonds, etc.

You may need to show other proof. If you are not able to get the proof right away, you will be given time to get the information. If you need help, ask DHS to help you get the information.

What Do Our Terms Mean?

We use these terms in this form. This is what they mean.

Eligible	Meeting all program guidelines.
Expanded-Specified Low-Income Medicare Beneficiary (E-SLMB)	A Medicare Savings Program that helps pay your Medicare Part B premium.
Household	A group of people who live together.
Medicaid	A state-run program that provides hospital and medical coverage for people with low income and little or no resources.
Medicare	A national health insurance program for people ages 65 and over, or younger individuals with certain disabilities.
Qualified Disabled and Working Persons (QDWP)	A Medicare Savings Program that helps pay your Medicare Part A premium.
Qualified Medicare Beneficiary (QMB)	A Medicare Savings Program that helps pay your Medicare Part A and Part B premiums, co-payments and deductibles.
Quality Control	A DHS unit that might review your case to see if you are getting the correct assistance.
Specified Low-Income Medicare Beneficiary (SLMB)	A Medicare Savings Program that helps pay your Medicare Part B premium.

Medicare Savings Programs Additional Information Request

Tell Us About You — Part A

If any of the information that is already filled in is incorrect, please correct it and then answer questions that are not filled in.

Name:	Case Number:
Birth Date:	Worker Number:
Telephone Number:	County:
Mailing Address:	DHS Telephone Number:
	MSP Application Date:
	DHS Received MSP Application On:

Address Where You Live (**if different than your Mailing Address above**)		Apt #
City	State	ZIP Code
Telephone Number Where We Can Reach You (**if different than your Telephone Number above**)		

Tell Us More About You — Part A

If any of the information that is already filled in is incorrect, please correct it and then answer questions that are not filled in.

Applying For?	Last Name	First Name	Birth Date	Social Security Number
Yes				

Relationship to You	Ethnicity (Optional)	Race (Optional)	U.S. Citizen?	Receive benefits in another state?
Self	❑ Hispanic or Latino ❑ Not Hispanic or Latino	❑ White ❑ Black ❑ Asian ❑ American Indian/Alaska Native ❑ Native Hawaiian/Pacific Islander ❑ Other	❑ Yes ❑ No If No, what is your immigration status? _____	❑ Yes ❑ No What state? _____

Tell Us About the People in Your Home — Part B

If any of the information that is already filled in is incorrect, please correct it and then answer questions that are not filled in.

Applying For?	Last Name	First Name	Birth Date	Social Security Number
❑ Yes ❑ No				

Relationship to You	Ethnicity (Optional)	Race (Optional)	U.S. Citizen?	Receive benefits in another state?
❑ Spouse ❑ Child ❑ Other	❑ Hispanic or Latino ❑ Not Hispanic or Latino	❑ White ❑ Black ❑ Asian ❑ American Indian/Alaska Native ❑ Native Hawaiian/Pacific Islander ❑ Other	❑ Yes ❑ No If No, what is your immigration status? _____	❑ Yes ❑ No What state? _____

Applying For?	Last Name	First Name	Birth Date	Social Security Number
❑ Yes ❑ No				

Relationship to You	Ethnicity (Optional)	Race (Optional)	U.S. Citizen?	Receive benefits in another state?
❑ Spouse ❑ Child ❑ Other	❑ Hispanic or Latino ❑ Not Hispanic or Latino	❑ White ❑ Black ❑ Asian ❑ American Indian/Alaska Native ❑ Native Hawaiian/Pacific Islander ❑ Other	❑ Yes ❑ No If No, what is your immigration status? _____	❑ Yes ❑ No What state? _____

Did you or anyone in your home receive medical care in the past three months? ❑ Yes ❑ No

If yes, who? _____ What months? _____

Does anyone have other health insurance besides Medicare? ❑ Yes ❑ No

If yes, who is covered? _____

Health Insurance Company? _____

Tell Us About Your Household Income Part C

If any of the information that is already filled in is incorrect, please correct it and then answer questions that are not filled in.

Please tell us about all of the money the people in your household get. If you leave a space blank, we will take that to mean there is no money of this kind. Please use an additional sheet of paper, if needed.

Unearned Income	Name of Person Who Gets This Income	Amount Per Month
Social Security or SSI		
Railroad Benefits		
Veteran's Benefits		
Pensions or Retirement		
Interest or Dividends		
Unemployment or Worker's Compensation		
Child Support or Alimony		
Money from friends or relatives		
Other Unearned Income		

Earned Income	Name of Person Who Gets This Income	Amount Per Month
Money from work – You		
Money from work – Spouse		
Self-employment or Odd Jobs – You		
Self-employment or Odd Jobs – Spouse		
Tips, Bonuses, Commissions		
Other Earned Income		

Tell Us About Your Resources (Assets) Part D

If any of the information that is already filled in is incorrect, please correct it and then answer questions that are not filled in.

Please tell us about all of the resources the people in your household have. If you leave a space blank, we will take that to mean there is no resource of this kind. Please use an additional sheet of paper, if needed.

List all cars, trucks, boats, campers, motorcycles or other licensed or unlicensed vehicles that anyone owns or is buying:

Year	Make	Model	Value or Worth	Amount Owed

Money Resources (Assets)	Name of Person Who Has This Resource	Amount
Bank or Credit Union Accounts		
Stocks or Bonds		
Cash		
Real Estate (other than the home you live in)		
Annuities		
Savings Certificates		
Keoghs or Other Assets		

Does anyone have a conservatorship or trust? ❑ Yes ❑ No

If yes, who? _____

Does anyone have a life or death benefit insurance? ❑ Yes ❑ No

If yes, who? _____

List the total money anyone has in:

Burial Contract $ _____ Who? _____

Burial Spaces $ _____ Who? _____

Does anyone expect to get a one-time payment, such as an inheritance or insurance settlement, or did anyone get one in the past 3 months? ❑ Yes ❑ No

If yes, who? _____

Addendum to Application and Review Forms for Release of Information

OPTIONAL Release of Information

Help Us Help You!

You do not have to sign this, but it will help us get information we need to help you, without having to get your signature on specific requests.

You should know that:

- We may need more information to decide if you can get assistance.
- If more information is needed from you, you will get a letter telling you what we need and the date you must get it to us.
- You are responsible to get the information or to ask us for help to get it.
- If you do not give us the information or ask for help by the due date, your application may be denied or your assistance may stop.
- We may be able to use the release below to get the information we need. **But you still have to provide information we request or ask us for help.**
- We may attach a copy of this release to a form that asks other people or organizations (like your employer) for specific information needed about you or others in your household.

Print and sign your name below to give us permission to get needed information.

RELEASE OF INFORMATION

I hereby authorize any person or organization to give the Iowa Department of Human Services requested information about me or other members of my household.

A copy of this release is as valid as the original.

This release does not apply to protected health information.

This release is good for 12 months from the date signed.

_____	_____
Your Name (please print clearly)	Other Adult Name (please print clearly)
_____	_____
Signature or Mark	Signature or Mark
_____	
Date	

Keep this page for your records.

You Have the Right to Appeal — Part E

You, or the person helping you, may request an appeal hearing if you do not agree with any action taken on your case. For MSP, you must appeal in writing. To appeal in writing do **one** of the following:

- Complete an appeal electronically at https://hhs.iowa.gov/programs/appeals; **or**
- Write a letter telling us why you think a decision is wrong, **or**
- Fill out an Appeal and Request for Hearing form. You can get this form at your county DHS office.

Send or take your appeal to the Department of Human Services, Appeals Section, 5th Floor, 1305 E Walnut Street, Des Moines, Iowa 50319-0114. If you need help filing an appeal, ask your county DHS office.

You can represent yourself. Or, you can have a friend, relative, lawyer or someone else act on your behalf.

You may contact your county DHS office about legal services. You may have to pay for these legal services. If you do, your payment will be based on your income. You may also call Iowa Legal Aid at (800) 532-1275. If you live in Polk County, call (515) 243-1193.

You Will Not Be Discriminated Against — Part E

It is the policy of the Iowa Department of Human Services (DHS) to provide equal treatment in employment and provision of services to applicants, employees and clients without regard to race, color, national origin, sex, religion, age, disability, political belief or veteran status.

If you feel DHS has discriminated against or harassed you, you can send a letter of complaint to:
Iowa Department of Human Services, Hoover Building, 5th Floor – Bureau of Policy Coordination, 1305 E. Walnut, Des Moines IA 50319-0114 or via email inclusion@hhs.iowa.gov

You Need to Know — Part E

We Check What You Tell Us

The information you give us may be checked by federal, state, and local officials to make sure it is true. Things we might check are any listed person's: Social Security Number, job and pay, bank account amount, alien status, and amounts received from other sources like Social Security or unemployment. If any information you give us is not correct, we may deny your application.

We check and use computer systems like the state Income and Eligibility Verification System. If something you told us is different from what the computer system tells us, we will check to find out what is correct. We might check your information by contacting your employer, your bank or other people. To do this kind of checking with your employer, bank, or other people, we will ask you first.

Other Things You Need to Know Part E

The Quality Control unit or Investigations unit may review your case. They may contact other people or organizations to get proof of your information. By signing this application, you give permission to release confidential information to the Quality Control unit or Investigations unit. You must cooperate with them to keep your benefits.

You will have to pay back any benefits you got or that was paid to a third party on your behalf for which you were not eligible.

Section 1128B of the Social Security Act provides federal penalties for fraudulent acts and false reporting in connection with these programs.

Anyone who gets; tries to get, or helps any other person get assistance to which they are not entitled, is guilty of violating the laws of the state of Iowa. This includes, but is not limited to, Iowa Code Chapters 239B, 243, 249, and 249A.

Comm. 233 will be mailed to you. It will tell you about any additional rights and responsibilities not covered with this application.

Within 5 working days of the date the change happens, you must tell DHS about changes, such as:

- Income, including lump sum payments, such as past due child support, inheritances, or settlements
- Resources or assets, which includes getting an inheritance
- Someone moving in or out of your home
- Your health insurance coverage
- You file an insurance claim or get an attorney to recover bills paid by Medicaid
- Mailing or living address

If approved for QMB, you give up your rights to medical support payments while you get benefits. The state of Iowa will keep and use those payments to help pay for your medical coverage.

If you are eligible for QMB, payments on future unpaid medical services will be paid directly to the doctors and medical suppliers under the Medicare Insurance Program (Medicare Part B).

Estate recovery will not include Medicaid payments made for Medicare cost sharing for MSP benefits.

If you return this application, you give your permission for DHS to share:

- Your medical and other health care records with federal and state officials.
- You agree to assign medical payments from a third party to the Medicaid agency for yourself and others who are eligible for Medicaid for whom you legally can assign benefits. You also agree to cooperate in obtaining medical payments from third parties.

This permission ends when your Medicaid (Medicare Savings Programs) stops.

Insert this sheet, along with other documents in the enclosed return envelope.

DHS office address must be visible in envelope window.