

**Worksheet for Extra Help with Medicare Prescription Drug Plan Costs**  
**THIS IS A WORKSHEET FOR EXTRA HELP AND DOES NOT ENROLL YOU IN A MEDICARE PRESCRIPTION DRUG PLAN.**

1. Applicant's Name: Print name as it appears on your Social Security card.

FIRST NAME

MI

LAST NAME

SUFFIX (Jr., Sr, etc.)

 -  - 

APPLICANT'S SOCIAL SECURITY NUMBER

 -  - 

APPLICANT'S DATE OF BIRTH  
(MM-DD-YYYY)

2. If you are **married and living with your spouse**, please provide the following information **as it appears on your spouse's Social Security card**. If you are not currently married, do not live with your spouse or are widowed, skip to question 3 and do not include any information about your spouse on this worksheet.

FIRST NAME

MI

LAST NAME

SUFFIX (Jr., Sr, etc.)

 -  - 

APPLICANT'S SOCIAL SECURITY NUMBER

 -  - 

APPLICANT'S DATE OF BIRTH  
(MM-DD-YYYY)

If your spouse has Medicare, does he or she also wish to apply for the Extra Help?  Yes  No

3. If you are **married and living with your spouse**, do you have savings, investments or real estate worth more than \$27,250? If you are not married or do not live with your spouse is the value more than \$13,640? **Do NOT count the home you live in, vehicles, personal possessions, burial plots, irrevocable burial contracts or back payments from Social Security or SSI.**

YES      If you place a  in the YES box, you are not eligible for the Extra Help.

NO or NOT SURE      If you place a  in the NO or NOT SURE box, complete the rest of this worksheet and return it to us.

**If you placed an  in the NO or NOT Sure box in question 3, answer all the following questions. If you are married and living with your spouse, you must answer all of the questions for both of you.**

4. Enter below money amounts of all bank accounts, investments or cash that you, your spouse, if married and living together, or both of you own. Also include items that either of you own with another person. Include only dollar figures not account numbers. If you or your spouse do not own any item listed, alone or with another person, place an  in the **NONE** box. Do **NOT** include a back payment from Social Security or SSI received in the last 10 months.

- Combined total of all bank accounts (checking, savings and certificates of deposit)  NONE \$  ,  .
- Combined total of all stocks, bonds, savings bonds, mutual funds, Individual Retirement Accounts or other similar investments  NONE \$  ,  .
- Any other cash at home or anywhere else  NONE \$  ,  .

5. Will some money from the sources listed in **question 4** be used to pay for funeral or burial expenses?

**If YES, skip to question 6.**

If **NO**, place an  in the **NO** box, then go to question 6.

**You:**  **NO**

**SPOUSE:**  **NO**

6. Other than your home and the property on which it is located, do you or your spouse, if married and living together, own any real estate? Examples of other real estate are summer homes, rental properties or undeveloped land you own which is separate from your home.

**YES**

**NO**

7. Not counting your spouse if you are married, how many other relatives live in your household and receive **at least one-half** of their financial support from you or your spouse? We count relatives related to you by blood, marriage or adoption.

**Place an  in only one box. Do not include yourself or your spouse in the number you enter.** If your household consists only of you or you and your spouse, place an  in the **NONE** box.

<b>NONE</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9 or more</b>
<input type="checkbox"/>									

8. If you or your spouse, if married and living together, receive **income** from any of the sources listed below, you must answer the questions for both of you. Please enter the total amount you receive each month. **If the amount changes from month to month or you do not receive it every month, enter the average monthly income for the past year for each type** in the appropriate boxes. Do not list wages and self-employment, interest income, public assistance, medical reimbursements or foster care payments here. If you or your spouse do not receive income from a source listed below, place an  in the **NONE** box for that source.

		Monthly Benefit			
<ul style="list-style-type: none"> <li>• Social Security benefits <b>before deductions</b></li> </ul>	You <input type="checkbox"/> None	\$	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Spouse <input type="checkbox"/> None	\$	<input type="text"/>	<input type="text"/>	<input type="text"/>
<ul style="list-style-type: none"> <li>• Railroad Retirement benefits <b>before deductions</b></li> </ul>	You <input type="checkbox"/> None	\$	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Spouse <input type="checkbox"/> None	\$	<input type="text"/>	<input type="text"/>	<input type="text"/>
<ul style="list-style-type: none"> <li>• Veterans benefits <b>before deductions</b></li> </ul>	You <input type="checkbox"/> None	\$	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Spouse <input type="checkbox"/> None	\$	<input type="text"/>	<input type="text"/>	<input type="text"/>
<ul style="list-style-type: none"> <li>• Other pensions or annuities <b>before deductions</b>. Do not include money you receive from any item you included in question 4.</li> </ul>	You <input type="checkbox"/> None	\$	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Spouse <input type="checkbox"/> None	\$	<input type="text"/>	<input type="text"/>	<input type="text"/>
<ul style="list-style-type: none"> <li>• Other income not listed above, including alimony, net rental income, workers compensation, private or state disability payments, etc. (Specify): _____</li> </ul>	You <input type="checkbox"/> None	\$	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Spouse <input type="checkbox"/> None	\$	<input type="text"/>	<input type="text"/>	<input type="text"/>

9. Have any of the amounts you included in question 8 decreased during the last two years?  
 YES  NO

**If you have worked in the last two years, you need to answer questions 10-14. If you are married and living with your spouse and either one of you has worked in the last two years, you need to answer questions 10-14. Otherwise, skip to question 15.**

10. What do you expect to earn in wages before taxes and deductions **this calendar year?**

You  None \$

Spouse  None \$

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11. What do you expect your net earnings from self-employment to be **this calendar year**?

Place an  in the **NONE** box if you are not self employed and go to question 12.

You  None \$

Spouse  None \$

Place an  in the box(es) if you or your spouse expect a net loss. **YOU:**  **SPOUSE:**

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12. Have the amounts you included in questions 10 or 11 decreased in the last two years?  
 YES  NO

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13. If you or your spouse, stopped working in 2014 or 2015, or plan to stop working in 2014 or 2015, enter the month and year.



You:

Spouse:

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**If you are younger than age 65, answer question 14. If you are married and living with your spouse and either one of you is younger than age 65, continue to question 14. Otherwise, skip to question 15.**

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14. Do you or your spouse have to pay for things that enable you to work? We will count only a part of your earnings toward the income limit if you work and receive Social Security benefits based on a disability or blindness and you have work-related expenses for which you are not reimbursed. Examples of such expenses are: the cost of medical treatment and drugs for AIDS, cancer, depression or epilepsy; a wheelchair; personal attendant services; vehicle modifications, driver assistance or other special work-related transportation needs; work-related assistive technology; guide dog expenses; sensory and visual aids; and Braille translations.

**You:**  YES  NO

**SPOUSE:**  YES  NO

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15. **Information about Medicare Savings Programs:** You may be able to get help from your state with your Medicare costs under the Medicare Savings Programs. To start your application process for the Medicare Savings Programs, Social Security will send information from this form to your state unless you tell us not to. **If you want to get help from the Medicare Savings Programs, do not complete this question. Just sign and date the worksheet and your state will contact you.**

If you are **not** interested in filing for the Medicare Savings Programs, place an  in the box below.

**No, do not send the information to the state.**

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## SIGNATURES

### IMPORTANT INFORMATION – PLEASE READ CAREFULLY

I/We understand that the Social Security Administration (SSA) will check my/our statements and compare its records with records from Federal, State, and local government agencies, including the Internal Revenue Service (IRS) to make sure the determination is correct.

By submitting this worksheet, I am/we are authorizing SSA to obtain and disclose information related to my/our income, resources, and assets, foreign and domestic, consistent with applicable privacy laws. This information may include, but is not limited to, information about my/our wages, account balances, investments, benefits and pensions.

Unless I/we answered “No” to question 15, I am/we are authorizing SSA to disclose to the state the financial information listed above and other individually identifiable information from my/our file, such as my/our name(s), date of birth, gender and Social Security number(s) to start the application process for the Medicare Savings Programs. I/We declare under penalty of perjury that I/we have examined all the information on this form and it is true and correct to the best of my/our knowledge.

**Please complete Section A. If you cannot sign, a representative may sign for you. If someone assisted you, complete Section B as well.**

#### SECTION A

Your Signature:	Date:	Phone Number: (____) ____ - ____
Spouse's Signature:	Date:	
Your Mailing Address:		Apt. #
City:	State:	Zip Code:

If you changed your mailing address within the last three months, place an  here:

If you would prefer that we contact someone else if we have additional questions, please provide the person's name and a daytime phone number.

Print First Name:	Print Last Name:	Phone Number: (____) ____ - ____
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#### SECTION B

If someone assisted you, place an  in the box that describes that person and provide the rest of the information requested below.

Family Member       Attorney       Other Advocate       Other  
 Friend       Agency       Social Worker      Specify: \_\_\_\_\_

Print First Name:	Print Last Name:	Phone Number: (____) ____ - ____
Your Mailing Address:		Apt. #
City:	State:	Zip Code: