

Instructions for Completing a Medicare Savings Program (MSP) Application

The attached Department of Human Services (DHS) Health Services Application is used to apply for Medicare Savings Programs (MSP) benefits (QMB, SLMB, QI). You cannot apply for MSP through the DHS on-line application process.

To assure the application is handled in a timely manner there are **TWO** things to remember:

1. It is critical that all of the questions on this application be completed. Because the application is used for multiple services some of the questions don't seem to apply. You may have to explain this to the client. However, if any of the questions are NOT answered the application will be denied.
2. Copies of the documents listed below must accompany the application;
 - a. Copy of drivers license or birth certificate(proof of identity),
 - b. Copies of the client's last 3 months (most current) checking and savings account statements,
 - c. Copies of the most recent statements for any stocks, bonds, certificate of deposit, trusts
 - d. Copy of the declaration page from any life insurance policy.

The completed application with accompanying documents can be FAXed to the DHS Imaging Center that covers the client's county (IMAGING CENTER map attached).

Inform your client that DHS may contact them to clarify or request additional information either by mail or by phone. DHS has a limited time frame in which the client has to respond. If the client does not respond in time they will need to reapply.

Call the DHS Contact Center at 1-855-889-7985 to check the status of your client's application. Document the date and person you talk to just in case you have to follow up.

You can consider calling the DHS Contact Center and starting the application process over the phone. However, the client will be contacted and requested to supply the documents outlined above. If the client has trouble with the mail or follow through the application may not be successful. You would still need to help them collect and submit the required documents.

For information about MSP benefits, when benefits are effective, etc. refer to the following training module:

1. Go to the SHIP website, www.therightcalliowa.gov
2. Click on "Volunteers and Sponsors."
3. Login
4. Click on SHIP Training Modules
5. Click on Medicare Part D Extra Help - Understanding the Parts (Note: Even though this is a LIS training module, it includes an explanation of MSP.)

HOUSEHOLD INFORMATION – Complete for all programs				
First Name		Middle Name	Last Name	
Home Address		City	State	County Zip Code
Mailing Address (if different from above) OR Payee or Representative's Name & Address				
Home Phone Number ()		Message Number ()	Name of Message Contact Person	
Check the program(s) you would like to receive: <input type="checkbox"/> Medical Assistance (Title 19 or Medicaid) <input type="checkbox"/> Facility <input checked="" type="checkbox"/> Medicare Savings Program <input type="checkbox"/> Waiver <input type="checkbox"/> Maternal and Children Health Services <input type="checkbox"/> WIC				
<input type="checkbox"/> Breast and Cervical Cancer Treatment <input type="checkbox"/> Foster Care/Subsidized Adoption <input type="checkbox"/> State Supplementary Assistance <input type="checkbox"/> Iowa Family Planning Network (IFPN)				
IF YOU NEED MORE ROOM TO ANSWER ANY OF THE FOLLOWING QUESTIONS, ATTACH EXTRA PAGES.				

Starting with yourself, list all the people who live in your home and mark the box **yes** or **no** if you are applying for that person. If you choose no, you only need to list their name, relationship to you and their date of birth.

NAME (First, Middle, Last)	Are you applying for this person?	How is this person related?	Disabled	Gender	Birth Date	Social Security Number	Medicaid State ID Number (if known)	Birth State	U.S. Citizen?	If Alien, Status	Ethnicity*	Race**	If a child, is a parent <u>NOT</u> living with them?	Currently on Medicaid?	Other health insurance available?
	<input type="checkbox"/> Yes <input type="checkbox"/> No	SELF	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Male <input type="checkbox"/> Female					<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Male <input type="checkbox"/> Female					<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Male <input type="checkbox"/> Female					<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Male <input type="checkbox"/> Female					<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Male <input type="checkbox"/> Female					<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

We have to ask your ethnicity and race, but you don't have to answer. Your answer won't affect how much you get or how soon. If you answer, use the following coding:

* Ethnicity: H = Hispanic or Latino; N = Not Hispanic or Latino

** Race (Choose all that apply): W = White; B = Black or African American; A = Asian; I = American Indian or Alaskan Native; N = Native Hawaiian or other Pacific Islander.

Did anyone receive medical care in the past three months? Yes No Who? _____ What months? _____

List anyone who is in the military, a veteran, or a spouse of a veteran: _____

Is anyone fleeing to avoid prosecution, custody, or jail for a felony crime? Yes No Is anyone violating a condition of probation or parole? Yes No

Is anyone in or expecting to go to jail or prison? Yes No

List pregnant persons who live in your home _____ Due Date (MMDDYY) _____

List the name of your health insurance provider _____

INCOME: List all income the people living in your home get. Include income from work, self-employment, Social Security, Veteran's Benefits, unemployment insurance, child support, worker's compensation, railroad retirement, IPERS, pensions, civil service, cash from friends or relatives, and any other income you get.

Person who received money	Employer or income source	Amount before taxes or deductions	How often is this amount paid?	Is this income expected to continue? If 'NO,' explain:
			<input type="checkbox"/> Weekly <input type="checkbox"/> Every other week <input type="checkbox"/> Monthly <input type="checkbox"/> Twice a month <input type="checkbox"/> Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Weekly <input type="checkbox"/> Every other week <input type="checkbox"/> Monthly <input type="checkbox"/> Twice a month <input type="checkbox"/> Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Weekly <input type="checkbox"/> Every other week <input type="checkbox"/> Monthly <input type="checkbox"/> Twice a month <input type="checkbox"/> Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Weekly <input type="checkbox"/> Every other week <input type="checkbox"/> Monthly <input type="checkbox"/> Twice a month <input type="checkbox"/> Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

RESOURCES: A resource is cash or anything that can be changed to cash. List all resources and the amount or value. Include cash on hand, checking accounts, vehicles, life insurance, stocks, bonds, certificates of deposits (CDs), trust funds, retirement accounts, burial contracts, burial spaces, annuities, etc. If only applying for medical coverage for a child, resources may not be counted.

Person with Resource	Type of Resource	Amount or Value	Location (bank's name and address, home, etc.)

Did anyone in your home sell or give away anything of value for less than its value within the last five years? Yes No

Does anyone in your home pay child support or alimony for a person who does not live with you? Yes No

If yes, who pays? _____ Amount? _____

Does anyone in your home pay for someone to care for a child or disabled adult? Yes No

If yes, how much is paid? _____ How often? _____ To whom? _____

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)

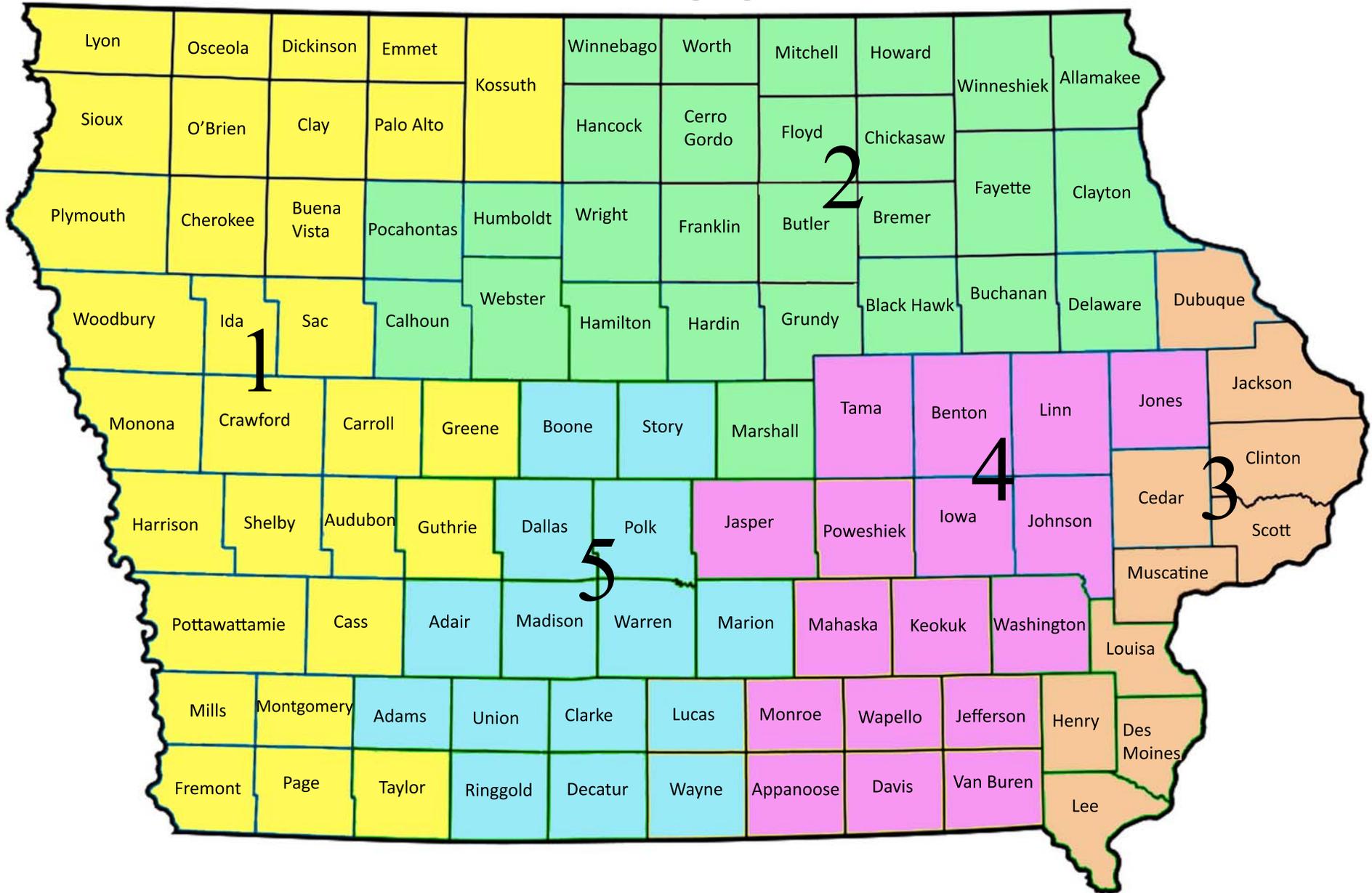
Signature or Mark

Signature or Mark

Date

Iowa Department of Human Services

Service Areas Imaging Centers



Imaging Center #1, 417 E. Kanessville Blvd, Council Bluffs, IA 51503 Email: Imagingcenter1@dhs.state.ia.us Fax: (515) 564-4014

Imaging Center #2, P.O. Box 11000, Waterloo, IA 50704 Email: Imagingcenter2@dhs.state.ia.us Fax: (515) 564-4015

Imaging Center #3, P.O. Box 8022, Davenport, IA 52808 Email: Imagingcenter3@dhs.state.ia.us Fax: (515) 564-4016

Imaging Center #4, P.O. Box 2027, Cedar Rapids, IA 52406 Email: Imagingcenter4@dhs.state.ia.us Fax: (515) 564-4017

Imaging Center #5, P.O. Box 41130, Des Moines, IA 50311-0503 Email: Imagingcenter5@dhs.state.ia.us Fax: (515) 564-4018