Household Number: CAT1 Budget Group Number: CAT2 Budget Group Number:
PI Recipient Number: Spouse's Recipient Number: Worker ID:

# South Carolina Department of Health and Human Services
# Addendum for Medicare Savings Programs

CLEAR FORM

**This addendum is developed specifically for the following Medicare Savings Programs (MSP):**
**Aged Blind Disabled/Qualified Medicare Beneficiaries (ABD/QMB); Specified Low Income Beneficiaries (SLMB); and Qualifying Individuals (QI)**

You recently applied for the Low-Income Subsidy with the Social Security Administration (SSA). When you applied, you also asked for SSA to send your application to the South Carolina Department of Health and Human Services to see if you may be eligible for a Medicare Savings Program (MSP). If approved for an MSP, you will get help to pay your Medicare Part B premium and you may get help to pay your Medicare co-insurance and deductible. We have your application from SSA and need some other information to see if we can help. Please answer all of the questions below and return this form by _____. We may also ask for proof of income and resources. If you have any questions about this form or the proof we are asking for, please call 1-888-549-0820 (TTY 888-842-3620). The address to return the form and any information is:

If we do not hear from you by_____, we will think you do not want us to see if you are eligible, and you will get a letter to let you know that we have denied your application.

## 1. Please check the information shown below about you. Make any corrections and fill in any missing information.

| **First Name** | **Middle Name** | **Last Name** | **Suffix** | |
|---|---|---|---|---|
| **Social Security Number** XXX – XX - | **Health Insurance Claim Number** | **Date of Birth** | **Gender** | **County** |

**Race:** ☐White/Caucasian ☐Black/African American ☐Hispanic ☐ Asian ☐Alaska Native ☐Multi Race
☐Federally Recognized Native American* ☐Other Native American ☐Native Hawaiian/Pacific Islander ☐Other/Unknown
* You must provide proof to be considered a member of a Federally Recognized Native American tribe

| **Mailing Address** | **Street Address** |
|---|---|
| **City:** **STATE:**<br>**ZIP:** **Phone Number:** | |

## 2. Please check the information shown below about your spouse. Make any corrections as needed and fill in any missing information.

| **First Name** | **Middle Name** | **Last Name** | **Suffix** |
|---|---|---|---|
| **Social Security Number** XXX – XX - | **Health Insurance Claim Number** | **Date of Birth** | **Gender** |

**Race:** ☐White/Caucasian ☐Black/African American ☐Hispanic ☐ Asian ☐Alaska Native ☐Multi Race
☐Federally Recognized Native American* ☐Other Native American ☐Native Hawaiian/Pacific Islander ☐Other/Unknown

## 3. Please tell us about any natural, adopted, or step children under age 22 that live with you.

| **Name** | **Relationship** | **Birthday** *(Mo/Day/Yr)* | **Sex** | **Race** | **SC Resident** | **Social Security Number** *(Optional)* | **Is this child a full-time student** |
|---|---|---|---|---|---|---|---|
| | | | | | | | ☐ Yes ☐ No |
| | | | | | | | ☐ Yes ☐ No |

***** Race Codes:** **01** White/Caucasian **02** Black/African American **03** Multi Race **04** Federally Recognized Native American **05** Other Native American
**06** Alaska Native **07** Asian **08** Other/Unknown **09** Native Hawaiian/Pacific Islander **10** Hispanic

**4. Do you or anyone in your home receive, or have applied for, any other income?** ☐ **Yes** ☐ **No**

**If Yes, check all boxes that apply and complete the table below**

☐ Social Security benefits (RSDI) ☐ Supplemental Security Income (SSI) ☐ Disability benefits
☐ Pension/retirement benefits ☐ Veterans benefits ☐ Unemployment benefits
☐ Wages/Earned Income/Self-Employment ☐ Rental Income
☐ Land contract, mortgage or other notes payable to a household member (Please provide a copy of the contract, mortgage, note or other agreement)
☐ Other (Please be specific): _____

| Person receiving/expecting money | Income source/type | How often received | Amount received | Comments |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

***Except for your Social Security, please send proof of all the income you get each month.***

**5. Are you or your spouse a Veteran?** ☐ **Yes** ☐ **No**

**6. Do you or your spouse have any of the following?** ☐ **Yes** ☐ **No**

**If Yes, check all boxes that apply and complete the table below.**

***When we start working on your application, we may ask you to send in proof of the resources you tell us about.***

☐ Bank Checking Account ☐ Bank Savings Account ☐ Certificate of Deposit
☐ Trust Fund or Trust Account ☐ Safe Deposit Box (Include a list of the contents) ☐ Car, Truck, Van
☐ Annuity (If Yes, provide a copy) ☐ Stocks, Bonds, or Mutual Funds ☐ Motorcycle, Boat, Camper
☐ Farm Machinery or Business Equipment ☐ 401K, IRA or other Retirement Account ☐ Cash on Hand
☐ Life Insurance ☐ Pre Need Burial Contract ☐ Cemetery Burial Space
☐ Money Set Aside for Burial ☐ Homestead Property ☐ Non-Homestead Property
☐ Other (Please be specific): _____

| Owned By | Type of Account - or - Type of Asset | Account Number - or - Asset Description | Current Value or Balance | Name of Institution |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**7. Do you or your spouse have any other health insurance?** (If Yes, send a copy of your card(s)) ☐ **Yes** ☐ **No**

**8. Did you or your spouse receive medical services in the previous three (3) months?** ☐ **Yes** ☐ **No**

| **Signature of applicant:** | **Date:** |
|---|---|
| | |

**9. Do you want to name someone as your Authorized Representative? This is someone we will contact if we have any questions about your application. We will also send letters and notices to this person.** ☐ **Yes** ☐ **No**

| **Name of Authorized Representative:** (Please Print) | **Signature of Authorized Representative:** | **Relationship:** |
|---|---|---|
| | | |
| **Address of Authorized Representative:** | **Telephone:** | **Date:** |
| | | |

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

# Notice of Non-Discrimination

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SCDHHS provides free aids and services to people with disabilities, such as qualified sign language interpreters and written information in other formats (large print, braille, audio, accessible electronic formats, other formats). We provide free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, please contact the Americans with Disabilities Act (ADA)/Civil Rights Official by mail at: PO Box 8206, Columbia, SC 29202-8206, by phone at: 1-888-549-0820 (TTY: 1-888-842-3620), or by email at: civilrights@scdhhs.gov.

If you believe SCDHHS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Civil Rights Official using the contact information provided above. You can file a grievance in person, by mail, or via email. If you need help filing a grievance, we are available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201 or by phone at: 800-368- 1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html