

The Low Income Subsidy

The Low Income Subsidy (LIS) is an extra benefit from Medicare for someone who has Medicare Part D. If you have Medicare and MSP you are automatically eligible for the LIS. With the LIS you can get:

- Help paying your Medicare Part D monthly premium.
- Help with your Medicare Part D yearly deductibles and,
- Help paying your Medicare Part D co-insurance and co-pays for drugs on your plan formulary. This does not start until Social Security receives notification that you are on MSP.

For more information about the LIS go to www.socialsecurity.gov, call 1-800-Medicare or for TTY call 1-800-325-0778.

How do I apply?

You can send your application to:

Senior Resources Agency on Aging
19 Ohio Avenue
Norwich, CT 06360

Or, you can speak to a representative at 2-1-1. Representatives are available 24 hours a day, seven days a week.

Or, telephone a CHOICES health insurance counselor at your Area Agency on Aging. They will answer your questions and send you an application and a return envelope. To reach a CHOICES counselor, call 1-800-994-9422.



The Medicare Savings Programs

You Can Save the Cost of Your Medicare Premium Every Month

This information is available in different formats.
Phone (800) 842-1508 or TDD/TTY (800) 842-4524.

Generally, if your monthly income is at or below these levels...	You may qualify for...
<p>\$ 2088.90 single</p> <p>\$ 2816.85 couple</p>	<p>QMB - This program is similar to a "Medigap" policy. It pays your Part B premium⁽¹⁾ and <u>all</u> Medicare deductibles⁽²⁾ and co-insurance.⁽³⁾</p> <p>(1) Your Medicare Part B covers Doctor costs, outpatient hospital and some preventive care.</p> <p>(2) The deductible is the amount that you pay for medical services before Medicare or any other insurance begins to pay. The amount changes every year.</p> <p>(3) Co-insurance is the portion of Medicare approved services that you are responsible for paying. This is usually 20% of the approved Medicare charge.</p>
<p>\$ 2286.90 single</p> <p>\$ 3083.85 couple</p>	<p>SLMB - This program pays for your Part B premium only.</p>
<p>\$ 2435.40 single</p> <p>\$ 3284.10 couple</p>	<p>ALMB - This program pays for your Part B premium only. This program is subject to available program funding. You are not eligible for this program if you receive Medicaid.</p>

The Medicare Savings Programs (MSP), also known as QMB (Qualified Medicare Beneficiary), SLMB (Specified Low Income Medicare Beneficiary) and ALMB (Additional Low Income Medicare Beneficiary), help pay for your Medicare premiums. QMB will also pay for your Medicare coinsurance and deductibles.

Who can apply for the Medicare Savings Programs?

A person who is eligible for Medicare Part A hospital coverage and who has income below the program limits may be eligible for one of the programs.

Most people become eligible for Medicare Part A when they turn 65 years old.

People who are between the ages of 18 and 65 can also receive Medicare Part A if they receive Social Security benefits and have been permanently disabled for at least two years.

How can I get back the amount of my Medicare premium each month?

If you have Medicare Part B (Part B pays for doctor bills, lab tests, x-rays, etc.), you pay for your premium each month. The premium comes out of your Social Security check. If you qualify for QMB, SLMB or ALMB, the State of Connecticut will pay the Part B premium for you. **You will then get more money in your Social Security check each month.**

What if I don't have Part A?

Some people choose not to take Part A when they become eligible for Medicare. They can change their minds later, but then the person has to pay the Part A premium instead of the federal government.

If you were eligible for Part A but did not take it at enrollment, **the State of Connecticut will pay the Part A premium for you under the QMB program.**

If you are not sure that you have Part A, check your Medicare card or call the Social Security Administration at 1-800-772-1213.

Are there other benefits?

Yes! If you qualify for QMB, we will pay your Medicare coinsurance (co-payments) and deductibles. We will pay up to the amount that Medicaid would pay for that service. These benefits could save you hundreds or even thousands of dollars each year!

We do not pay coinsurance or deductibles under the SLMB or ALMB programs.

Please note: We can only make the payment if the provider accepts Medicaid.

Will this cost me anything?

No. There is no charge to you for any of the benefits under these programs.

When can I expect to see an increase in My Social Security Check?

It can take up to 90 days before you see an increase in your Social Security check. However, you will receive reimbursement for the premiums that you paid during that time.

Is there an asset limit?

No. There is no asset limit for any of these programs

Is there an income limit?

Yes. The level of help that you receive depends on your income. The table on the back shows the benefits available at different income levels.

What is income?

Examples of income include Social Security, pensions, disability benefits, wages, alimony, rental income, interest and dividends.

Will I need to give you any documents?

All we need to get started is your completed application form. The Department will verify most of the information you provide on the form. We will let you know if we need anything else after we review your application.

We will also verify that you either have or are eligible for Medicare Part A coverage. (Part A pays for hospital care and other inpatient services.) In most cases, the federal government pays the premium for Part A, not the Medicare beneficiary.



W-1QMB
(Rev. 6/16)

State of Connecticut Department of Social Services Application for Medicare Savings Programs (QMB, SLMB, ALMB)

Use this form to **apply** for Medicare Savings Program benefits. If you currently receive these benefits, please renew using the Renewal Form for Medicare Savings Programs (W-1QMBR).

Do you need a reasonable accommodation or special help to complete your application because you have a disability? Yes No If yes, complete the next question and see page 3 about how we can help.

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

Tell us about yourself

First Name	Middle Name	Last Name	(Maiden Name)	Social Security #	Date of Birth
Home Street Address			City	State	Zip Code
Mailing Address (if different)			City	State	Zip Code
Best phone # to reach you		Marital Status (check one): <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
This application is for (check one): <input type="checkbox"/> Yourself only <input type="checkbox"/> Yourself and your spouse		Spouse's Name (first, middle, last)			
		Spouse's Social Security Number		Spouse's Date of Birth	

Title VI of the Civil Rights Act of 1964 allows us to ask for race and ethnic origin information. You do not have to give it to us. The information helps to make sure that we are following federal civil rights law. If you do not want to give us this information, it will not affect your application.

Are you of Hispanic, Latino/a, or Spanish origin? <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, check all that apply)
<input type="checkbox"/> Mexican, Mexican-American or Chicano/a <input type="checkbox"/> Cuban <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Other Hispanic, Latino/a or Spanish
Racial Heritage (check all that apply): <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Other Pacific Islander

Tell us about your citizenship status

	Are you a U.S. citizen? (check one)	If no, what is your non-citizen status? (refugee, entrant, permanent resident, etc.)	What is your alien registration number?	What is your country of origin?	What are the date and place that you came into the country?	What is your sponsor's name? (if applicable)
Yourself	<input type="checkbox"/> Yes <input type="checkbox"/> No					
Your Spouse	<input type="checkbox"/> Yes <input type="checkbox"/> No					



Tell us about your medical insurance

Do you or your spouse have insurance other than Medicare? Yes No (if you checked No, skip this section.)

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

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		
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 (employer name):	\$		Wages (employer name):	\$	
Interest:	\$		Interest:	\$	
Social Security (type):	\$		Social Security type):	\$	
Pension (company name):	\$		Pension (company name):	\$	
IRA (name of bank):	\$		IRA (name of bank):	\$	
Other (describe):	\$		Other (describe):	\$	



Important information for you to know about your application

- This application is a request for help from the Medicare Savings Programs only.
- 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.
- 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 application 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 4.

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 application, please identify the authorized individuals, agencies, or institutions that DSS may communicate with, and sign in the box:		
1	Name:	Phone #
	Address:	
2	Name:	Phone #
	Address:	
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>





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DO YOU WANT TO REGISTER TO VOTE?

Federal and state laws require the Department of Social Services (DSS) to give you the chance to register to vote. Please answer the questions below and print and sign your name in the space provided.

- Are you registered to vote? Yes, I am already registered No
- If you are not registered to vote where you live now, would you like to apply to register to vote here today? Yes No

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

You can register online at <https://voterregistration.ct.gov/OLVR>, or you can complete a paper voter registration application form and leave it at DSS or mail it in. The form is included with DSS applications and renewals that we mail to you, and you can also get one at all DSS offices. You can mail your completed form to DSS in the enclosed envelope or send it directly to your Town Hall. If you need help, please call 1-855-626-6632.

Print Your Name	Sign Here	Date
Your Address (#, Street, Apt #)	City	State
		Zip Code

For Worker's Use Only	
Date _____	<input type="checkbox"/> No boxes checked <input type="checkbox"/> Voter Registration Card Sent
Worker Name _____	Worker Number _____

(Tear Here and Keep)

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose you own political party or other political preferences, you may file a complaint with: State Elections Enforcement Commission, 20 Trinity Street, Hartford, CT 06106; 860-256-2940, toll-free 866-733-2463, TDD: 1-800-842-9710; SEEC@ct.gov

You completed an application for the Medicare Savings Program, Now What?

After mailing your application to the Connecticut Department of Social Services, this is a timeline of events:

1. It takes approximately **45-60** days for the State to process the application. Please do not call any entities prior to that date to check the status of your application.
2. After the state processes the application, you will receive a letter from the **Connecticut Department of Social Services**.
3. This letter will state if you have been approved for the Medicare Savings Program or denied.
4. **If approved**, from the **date of the letter**, it will take approximately **2 – 3 months** before you see the change in your Social Security Benefit. Meaning when the State of CT begins to pay your monthly Medicare Part B premium.
 - a. You will also receive any retro-payment from Social Security for premiums paid after the State determined your eligibility.
 - b. You are NOT eligible the month you applied to MSP. For example, if you mailed your application during the month of February, your start date will be March. **YOU WILL NOT RECEIVE ANY ASSISTANCE FOR THE MONTH OF FEBRUARY.**
5. **If approved**, it will take **2-4 weeks** before you start paying the lower copays at the pharmacy counter for your prescription medications (if you have a current Medicare Prescription Drug Plan or a Medicare Advantage Plan with drug coverage)
 - a. Keep receipts of prescriptions paid at the pharmacy counter
 - b. Keep receipts of premiums paid to your Part D plan
6. The Medicare Savings Program must be renewed on a yearly basis. You will receive a letter from the CT Department of Social Services along with the application to renew.

FAQ's

What if I do not receive a letter from DSS within 60 days? Call the DSS Benefits Center at 1-855-626-6632 to speak with an eligibility worker about the status of your application.

What if after 3 months I do not receive my retro-payment for Medicare Part B premiums? Call the DSS Benefits Center at 1-855-626-6632 to check the status of your Medicare Part B Buy-in.

Why should I keep copies of receipts? For premiums paid and copays paid. The month you are approved for MSP, you are automatically enrolled into the Low Income Subsidy (Extra Help). Your prescription drug plan will need to reimburse you for premiums paid (either in full or partially) from the date you became eligible for Extra Help – as long as you actually paid your premiums. Your drug plan will need to reimburse you for copays paid at the pharmacy counter. **CALL YOUR DRUG PLAN TO REQUEST INSTRUCTIONS ON HOW TO BE REIMBURSED.**

What if I do not complete my yearly renewal? This will be financially devastating for some. Since it takes time for State and Federal computer systems to "talk", (approximately 3 months), when DSS discontinues the program for failure to renew, you will owe your Medicare Part B premiums from the date you were discontinued. Therefore, you will find your next social security benefit check less approximately \$314, and at the end of the year, you will no longer be eligible for the Extra Help with your drug plan.

Please call the CHOICES Program at your local Area Agency on Aging and ask to speak with a CHOICES Counselor for further questions about the Medicare Savings Program at 1-800-994-9422

You Have
CHOICES

