Washington State Health Care Authority

Washington State Department of Social & Health Services

Transforming lives

Application for Medicare Savings Programs

Read the following before completing the application.

Depending on your income the Medicare Savings (MSP) can help pay your Medicare premiums or other costs not paid by Medicare including deductibles, coinsurance, and copayments.

There are five ways to submit this application:

- **Mail:**
  DSHS
  CSD Customer Service Center
  PO Box 11699
  Tacoma, WA 98411-6699
- **Fax:** 1-888-338-7410
- **Online: washingtonconnection.org**
- **Phone:** 1-877-501-2233
- **In person:** Find a drop box at your local Community Services Office at **dshs.wa.gov/office-locations**

1 Applicant name and contact information

First name (Self) | M.I. | Last name and Suffix

Client ID number (if applicable)

Address where you live | City | State | Zip Code

Check this box if you do not have a physical address

Mailing address (if different) | City | State | Zip Code

Primary phone number | Secondary phone number

Will you or anyone you're applying for need an interpreter or to receive documents in another language? No Yes

If yes, what language or alternative format do you need? List all that apply:

2 Authorized representative information

An authorized representative is any adult who is aware of the household circumstances and is authorized by the household to act on behalf of the household for eligibility purposes.

By designating an authorized representative, you are giving permission for your authorized representative to:

- Sign the application on your behalf;
- Receive notices related to your application and account; and
- Act on your behalf for all matters related to the application and account.

1. Are you designating an authorized representative? No Yes
2. Do you want your authorized representative to receive notices related to your application and account? No Yes
3. Does this authorized representative have legal guardianship? No Yes If yes, who: ________________
4. Does this authorized representative have power of attorney? No Yes If yes, who: ________________

Authorized Representative Name / Organization ________________ Phone number ________________

Mailing Address of Authorized Representative ________________ E-mail Address ________________

3 Information about you and your family

List yourself, spouse, and dependents living with you even if you are not applying for them (attach additional sheets, if necessary).

Name (First, Middle, Last) ________ Sex assigned at birth ________ Relation to you? **SELF** Date of birth ________

Social Security number (SSN)* ________ Do you want coverage for this person? No Yes

Citizen or non-citizen status: **(check one)**

U.S. citizen No Yes Washington resident No Yes

Are you Hispanic, Latino, or Spanish origin? (OPTIONAL)

Cuban | Mexican/Mexican American/Chicano | Not Spanish/Hispanic
Other Spanish/Hispanic | Puerto Rican

Race (OPTIONAL – select up to five that apply)

American Indian or Alaska Native	Chinese	Korean	Thai
Asian	Filipino	Laotian	Vietnamese
Asian Indian	Guamanian	Other Pacific Islander	White
Black or African American	Hawaiian	Other Race	
Cambodian	Japanese	Samoan	

Why we collect this – We use this information to help improve health equity and increase access to health care for all individuals. The information you provide will not affect your eligibility for health care coverage.

Name (First, Middle, Last) Sex assigned at birth Relation to you (e.g. spouse, child) Date of birth

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Black or African American Hawaiian Other Race

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Black or African American	Hawaiian	Other Race	
Cambodian	Japanese	Samoan	

Why we collect this – We use this information to help improve health equity and increase access to health care for all individuals. The information you provide will not affect your eligibility for health care coverage.

***HCA does not share this information with any immigration agency for immigration enforcement purposes. Leave this blank if you do not have an SSN.**

4 Medical coverage information

Eligible for or receiving: Medicare Part A
Check which applies.

Self No Yes Medicare number ______________________

Spouse No Yes Medicare number ______________________

Other No Yes Medicare number ______________________

Eligible for or receiving: Medicare Part B
Check which applies.

Self No Yes Medicare number ______________________

Spouse No Yes Medicare number ______________________

Other No Yes Medicare number ______________________

I/we have other medical coverage No Yes

____
If yes, what insurance and whom does it cover?

Did you pay Medicare premiums for Medicare Part A or Part B in the last 3 months? No Yes

If yes, tell us which months

5 Income

List the income for you and your spouse living with you (if applicable). List the income amount before deductions (such as taxes or insurance) are taken out. Income includes but is not limited to:

- Wages
- Self-employment
- Commissions
- Room and Board/Rent
- Railroad Benefits
- Social Security Benefits
- Veterans Benefits
- Alimony Benefits
- Unemployment or Worker Compensation
- Tribal Income*
- SSI/Public Assistance
- Pensions/Retirement
- Dividends and Interest
- Other

*View the Tribal income desk aid to learn if your tribal income is countable: **hca.wa.gov/assets/free-or-low-cost/tribal-income-desk-aid.pdf**

Name	Employer or source of income	Amount before deductions	How often received?

6 Voter registration

The Department offers voter registration services, including automatic voter registration.

Applying to register or declining to register to vote will not affect the services or amount of benefits that you may receive from this agency. If you would like help filling out the voter registration form, we will help you. The decision whether to seek or accept help is yours. You may fill out the voter registration form in private. 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 your own political party or other political preference, you may file a complaint with the

Washington State Election Division, PO Box 40229, Olympia, WA 98504, email **elections@sos.wa.gov**, or call 1-800-448-4881.

Do you want to register to vote or update your voter registration? No Yes

If you do not check either box, we will consider you to have decided not to register to vote at this time, unless you are eligible for, and do not decline, automatic voter registration.

Unless you checked "No" above, you may be eligible for automatic voter registration. You are eligible for automatic voter registration if you will be at least 18 years old by the next election, you are a citizen of the United States of America, and DSHS has your name, residential and mailing address, date of birth, verification of citizenship information, and your signature attesting to the truth of the information provided on this application.

Do you want to be automatically registered to vote? No Yes

If you checked the box marked "Yes," or do not check either box and you meet automatic voter registration eligibility requirements, DSHS will send your information to the Office of the Secretary of State and you will be automatically registered to vote.

7 Read carefully before signing

I understand that:

- I must report immediately to the agency or the agency's designee, in writing, or by telephone, any changes in my situation. Late reporting may cause incorrect benefits.
- My situation is subject to verification by the agency or other state or federal agencies.
- To receive help, I must provide proof when asked. The agency or the agency's designee may help me obtain the proof or contact other persons or agencies for it.
- By asking for and receiving medical care benefits, I assign to the state of Washington all rights to any medical support, and to any third-party payments for medical care.

To share comments or include more information, attach an additional sheet.

8 Declaration and signature(s)

I have read and understood the information in this application. I declare, under penalty of perjury, the information I have given in this application is true, correct, and complete to the best of my knowledge.

Signature of applicant ______ Date ______

Signature of person assisting applicant (If applicable) ______ Organization ______ Date ______

HCA and DSHS comply with all applicable federal and Washington state civil rights laws and are committed to providing equal access to our services. If you need an accommodation, or require documents in another format or language, please call 1-877-501-2233.