Social Security Administration
Important Information

Our records show you may be eligible to get extra help paying for your prescription drugs.

Soon, a new Medicare Prescription Drug program will take effect. The new program will give you a choice of prescription plans that offer various types of coverage.

You may be able to get extra help to pay for the annual deductible, premiums and co-payments related to the new Medicare Prescription Drug program—an average of $2,100 in extra help.

But before we can help you, **you must fill out the application, put it in the enclosed envelope, and mail it today.** Or you may complete an online application at **www.socialsecurity.gov** beginning July 1, 2005. We will review your application and send you a letter to let you know if you qualify for extra help. We also will send you information about the Medicare Prescription Drug program and tell you what you should do next.

If you need help completing the application, call Social Security at **1-800-772-1213** (TTY **1-800-325-0778**). You can find more information at **www.socialsecurity.gov**.

If you need information about the new Medicare Prescription Drug program, call 1-800-MEDICARE (TTY 1-877-486-2048) or visit **www.medicare.gov**.

Mailing your application today will allow us to give you a quicker decision about whether you qualify for the extra help.

Jo Anne B. Barnhart

Jo Anne B. Barnhart
Commissioner

General Instructions for Completing the Application for Help with Medicare Prescription Drug Plan Costs

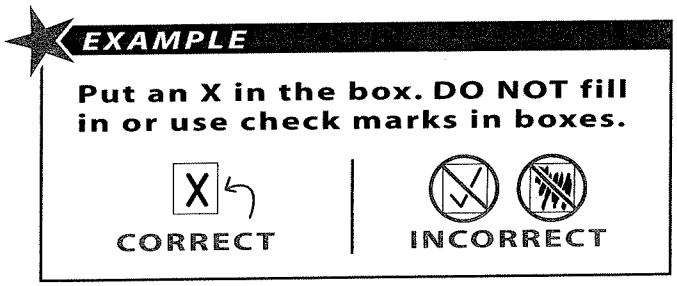
To Provide Extra Help in Paying for Your Drug Expenses

Do you (or the person you are helping apply) have Medicare and Supplemental Security Income (SSI) or Medicare and Medicaid or does your state pay your Medicare premiums?

If the answer is **YES, do not complete this application because you automatically will get the extra help**. You will receive another letter about how you will receive the extra help. If the answer is NO or NOT SURE, please complete this application. Please read the following instructions and guidelines before completing this application. Complete all questions unless otherwise noted.

How To Complete This Application

- Use **BLACK INK** or a **#2 pencil**;
- Keep your numbers, letters and Xs inside the boxes;
- Do not use dollar signs when entering money amounts. The dollar sign is preprinted; and
- Cents can be rounded to the nearest whole dollar.



If You Are Assisting Someone Else With This Application

Answer the questions as if that person were completing the application. You must know that person's Social Security number and financial information. Also, complete Section B on page 6.

Completing Your Application

You may complete the online application at **www.socialsecurity.gov** or use the enclosed pre-addressed stamped envelope to return your completed and signed application to:

Social Security Administration
Wilkes-Barre Data Operations Center
P.O. Box 1020
Wilkes-Barre, PA 18767-1020

Return the entire package in the enclosed envelope. Do not include any attachments. If we need more information, such as statements from financial institutions, we will contact you.

If You Have Questions Or Need Help Completing This Application

You may call us toll-free at **1-800-772-1213**, or if you are deaf or hard of hearing, you may call our TTY number, **1-800-325-0778**.

Form Approved
OMB No. 0960-0696

Application for Help with Medicare Prescription Drug Plan Costs

THIS DOES NOT ENROLL YOU IN THE MEDICARE PRESCRIPTION DRUG PROGRAM.

FOR OFFICIAL USE ONLY

State code: ☐☐ WBDOC Exception: ☐

EXAMPLE
Use capital letters when entering answers A B C D

1. Applicant's Name (Print each letter in a separate box.)

FIRST NAME **MI**

LAST NAME **SUFFIX (Jr., Sr., etc.)**

Applicant's Social Security Number

SOCIAL SECURITY NUMBER EXAMPLE
1 2 3 — 4 5 — 6 7 8 9

2. If you are single, divorced, a widow(er) or your spouse does not live with you, skip to question 3. If you are married and living with your spouse, please put an ☒ in one of the boxes below to indicate who is applying:

☐ Only you are applying. ☐ Both you and your spouse have Medicare and are applying on this application.

Even if your spouse is not applying, we need all of the questions answered and signatures for both of you if you live together.

Spouse's Name (if you are married and living together)

FIRST NAME **MI**

LAST NAME **SUFFIX (Jr., Sr., etc.)**

Spouse's Social Security Number

3. If you are single, a widow(er) or your spouse does not live with you, are your savings, investments and real estate (other than your home) worth more than $11,500? If you are married and living together, are they worth more than $23,000? (These limits will be higher after 2006.) Include the things you own by yourself, with your spouse or with someone else. **Do not include your home, vehicles, burial plots or personal possessions.**

☐ **YES** ☐ **NO** ☐ **NOT SURE**

If you put an ☒ in the **YES** box, you are not eligible for the extra help and you do not need to complete the rest of this application. You may still be eligible through your state Medicaid agency. However, if you want a decision, put an ☒ in the **NOT SURE** box. If you put an ☒ in either the **NO** or **NOT SURE** box, complete the rest of this application.

4. Please enter the money amounts of bank accounts, investments or cash that either you, your spouse (if married and living together) or both of you own in the boxes below. Include items that either of you own with another person. (Include only the dollar figures, not the account number.) If you or your spouse (if married and living together) do not own an item listed, either separately, jointly or with another person, place an ☒ in the **NONE** box.

• Bank accounts (checking, savings and certificates of deposit)	☐ **NONE**	$ ☐☐ , ☐☐☐ . ☐☐
• Stocks, bonds, savings bonds, mutual funds, Individual Retirement Accounts or other similar investments	☐ **NONE**	$ ☐☐ , ☐☐☐ . ☐☐
• Any other cash at home or anywhere else	☐ **NONE**	$ ☐☐ , ☐☐☐ . ☐☐

5. Do you (or your spouse, if married and living together) own life insurance policies with a total face value of $1,500 or more? Answer for you and for your spouse if your spouse lives with you. If you answered **NO** for both you and your spouse, go to question 6.

YOU: ☐ **YES** ☐ **NO**

SPOUSE (if living together): ☐ **YES** ☐ **NO**

If the answer for either you or your spouse is **YES**, how much money would you get if you turned in your insurance policies for cash right now? (This is not the face value of your policies. You may need to call your insurance company to help answer this question.) Enter the amount.

$ ☐☐ , ☐☐☐ . ☐☐

6. Do you expect to use money from any of the sources listed in questions 4 or 5 to pay for funeral or burial expenses for yourself (or your spouse, if married and living together)?

YOU: ☐ **YES** ☐ **NO**

SPOUSE (if living together): ☐ **YES** ☐ **NO**

7. 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?

☐ **YES** ☐ **NO**

8. Your living situation may affect the amount of help you can get. Therefore, we need to know how many relatives who live with you (and your spouse, if married and living together) depend on you or your spouse to provide at least one-half of their financial support. Relatives may include anyone related to you by blood, marriage or adoption.

How many relatives who live with you and your spouse depend on you or your spouse to provide at least one-half of their financial support? **Do not include yourself or your spouse in this number.** (Place an ☒ in only one box.)

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
NONE	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9 or more**

9. If you (or your spouse, if married and living together) receive income from any of the sources listed below, please enter the **total monthly income**. **If the amount changes from month to 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 any of the sources listed below, place an ☒ in the **NONE** box.

• Social Security	We will use the amount in our records.	
• Railroad Retirement	☐ **NONE**	$ ☐☐ , ☐☐☐ . ☐☐
• Veterans	☐ **NONE**	$ ☐☐ , ☐☐☐ . ☐☐
• Other pensions or annuities (Do not include money you receive from any item you included in question 4.)	☐ **NONE**	$ ☐☐ , ☐☐☐ . ☐☐
• Other income not listed above, including alimony, net rental income, workers' compensation (Specify):_____ _____	☐ **NONE**	$ ☐☐ , ☐☐☐ . ☐☐

10. Have any of the amounts you included in question 9 decreased during the last two years?

☐ **YES** ☐ **NO**

11. Does anyone provide or help you (or your spouse, if married and living together) pay for any of the following household expenses — food, mortgage, rent, heating fuel or gas, electricity, water and property taxes? (Do not include food stamps, house repairs, help from a housing agency, an energy assistance program, Meals on Wheels, or help with medical treatment and drugs.)

☐ **YES** ☐ **NO**

If you put an ☒ in the **YES** box, enter the monthly amount, or if the amount changes from month to month, enter the average monthly amount for the past year.

$ ☐☐ , ☐☐☐ . ☐☐

- **If you are single, divorced, separated or a widow(er) and have not worked in the last two years, skip questions 12 – 16 and go to page 6.**
- **If you are married and living with your spouse and neither of you have worked in the last two years, skip questions 12 – 16 and go to page 6.**

12. What do you expect to earn in wages before taxes **this year**?

YOU: ☐ **NONE** $ ☐☐ , ☐☐☐ . ☐☐

SPOUSE (if living together): ☐ **NONE** $ ☐☐ , ☐☐☐ . ☐☐

13. If self-employed, what do you expect your net earnings or loss to be **this year**?

YOU: ☐ **NONE** $ ☐☐ , ☐☐☐ . ☐☐

SPOUSE (if living together): ☐ **NONE** $ ☐☐ , ☐☐☐ . ☐☐

Put an ☒ here if you or your spouse expect a net loss. **YOU:** ☐ **SPOUSE (if living together):** ☐

14. Have the amounts you included in questions 12 or 13 decreased in the last two years?

☐ **YES** ☐ **NO**

15. If you (or your spouse, if married and living together) recently stopped working or plan to stop working, enter the month and year.

EXAMPLE

For January – September, put a zero (0) in the first box. May 2006 should read: 0 5 (M M) 2 0 0 6 (Y Y Y Y)

YOU: ☐☐ (M M) 2 0 ☐☐ (Y Y Y Y)

SPOUSE : (if living together) ☐☐ (M M) 2 0 ☐☐ (Y Y Y Y)

- **If you are single, divorced, separated or a widow(er) and 65 or older, skip question 16 and go to page 6.**
- **If you are married and living with your spouse and both you and your spouse are 65 or older, skip question 16 and go to page 6.**

16. Do you (or your spouse, if married and living together) 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 (if living together):** ☐ **YES** ☐ **NO**

Signatures

I/We understand that by submitting this application I am/we are declaring 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. I/We understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison or may face other penalties, or both. 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 to make sure the determination is correct. By submitting this application 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, insurance policies, benefits, and pensions. **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:	Your Spouse's Signature:	Phone Number: ( ) –

Your Home Street Address:	Apt. #:

City:	State:	Zip Code:

Your Mailing Street Address (if different from home address):	Apt. #:

City:	State:	Zip Code:

If you recently changed your address, put 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: ( ) –

SECTION B

If you are assisting someone else, place an ☒ in the box that describes who you are and provide your daytime phone number and address.

☐ Family Member ☐ Attorney ☐ Other Advocate ☐ Other Specify: _____

☐ Friend ☐ Agency ☐ Social Worker _____

Print First Name:	Print Last Name:	Phone Number: ( ) –

Street Address:	Apt. #:

City:	State:	Zip Code:

Privacy Act / Paperwork Reduction Notice

Section 1860 D-14 of the *Social Security Act* authorizes the collection of information requested on this form. The information you provide will be used to enable the Social Security Administration to determine if you are eligible for help paying your share of the cost of a Medicare Prescription Drug Plan. You do not have to give us the information requested. However, if you do not provide the information, we will be unable to make an accurate and timely decision on your application. We may provide information collected on this form to another Federal, State, or local government agency to assist us in determining your eligibility for the extra help or if a Federal law requires the release of information.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it. Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

Paperwork Reduction Act Statement — This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the *Paperwork Reduction Act of 1995*. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 35 minutes to read the instructions, gather the facts, and answer the questions. You may send comments on our time estimate above to: Social Security Administration, 1338 Annex Building, Baltimore, MD 21235-6401. **Send <u>only</u> comments relating to our time estimate to this address, not the completed form.**

SEND THE COMPLETED FORM TO US AT THE ADDRESS SHOWN ON THE ENCLOSED PRE-ADDRESSED ENVELOPE:

Social Security Administration
Wilkes-Barre Data Operations Center
P.O. Box 1020
Wilkes-Barre, PA 18767-9910