State of Connecticut
Department of Social Services

W-1QMB
(Rev. 10/09)

Medicare Savings Programs Application/Redetermination (QMB, SLMB, ALMB)

Do you need a reasonable accommodation or special help to complete your application/redetermination because you have a disability? ☐ Yes ☐ No If you checked yes, please see page 3 about how we can help.
If you need a reasonable accommodation or special help, what kind of help do you need?

_____

Please give us the following information about you:

Your Name: _____
First M.I. Last

Your Address: _____

Your Mailing Address (if different): _____

Your Telephone Number: _____ A Message Number: _____

Your Marital Status: ☐ Never Married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

This application is for ☐ Yourself only ☐ Yourself and your spouse

Your Spouse's Name: _____
First M.I. Last

	Date of Birth	Place of Birth	Social Security Number	Sex	Do you have Medicare? Part A? (check one)	Part B? (check one)
Yourself					☐ Yes ☐ No	☐ Yes ☐ No
Your Spouse					☐ Yes ☐ No	☐ Yes ☐ No

You are not required to provide race or ethnic origin information, however, your cooperation will help determine compliance with the federal civil rights law. If you do not wish to give this information, it will in no way affect consideration of your application. We are authorized to ask for this information under Title VI of the Civil Rights Act of 1964.

Are you Hispanic or Latino? ☐ Yes ☐ No

What is your racial origin? (check all that apply) ☐ White ☐ Black or African Descent

☐ Native American or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander

Please give us information about your citizenship:

	Are you a U.S. citizen? (check one)	If no, what is your non-citizen status? (refugee, 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 appropriate)
Yourself	☐ Yes ☐ No					
Your Spouse	☐ Yes ☐ No					

Please give us information about your Income:

Please list all income that you and your spouse receive. Please 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		
Name and Address of Employer, if any:			Name and Address of Employer, if any:		
Name of Pension Company:			Name of Pension Company:		
Where does the money come from?	How much do you receive?	How often do you receive it? (Weekly, Monthly or Quarterly)	Where does the money come from?	How much do you receive?	How often do you receive it? (Weekly, Monthly or Quarterly)
Social Security	$		Social Security	$	
SSI	$		SSI	$	
Pension	$		Pension	$	
Wages	$		Wages	$	
Other (describe):	$		Other (describe):	$	
Other (describe):	$		Other (describe):	$	

I authorize the Department of Social Services to verify any information regarding anyone's non-citizen status with the United States Citizenship and Immigration Services (USCIS). I understand that the department will not share the information given on this form with USCIS. I also understand that USCIS cannot use this application to deny admission to the U.S., harm permanent resident status or deport me.

I give the Department of Social Services permission to share my name and other information with programs that help with energy costs for my home. These programs will use this information only to decide if I qualify for these benefits and to offer me the benefits.

I certify that all the statements made on this form are true and complete to the best of my knowledge. If I have knowingly given incorrect information, I may be subject to the penalties for false statements as specified in Connecticut General Statute Sections 53a-157b and 17b-97 and to penalties for larceny as specified in sections 53a-122 and 53a-123. I may also be subject to penalties for perjury under federal law.

Signature of Applicant Date

Signature of Spouse Date

Signature of Conservator or Other Representative Date

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

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. We can use different methods to complete your application or redetermination. For example, we may be able to complete your application or redetermination over the telephone if you cannot come into the office, we may be able to help you get certain proofs, or give you extra time to provide information. Contact your local regional office to request a reasonable accommodation or special help. If we do not agree to give you a reasonable accommodation or special help, you can complain to the department's Americans with Disabilities Act (ADA) coordinator. See the bottom of this page for how to make a complaint.

Important information for you to know about your application/redetermination:

- This application/redetermination 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 except for certain exceptions.
- The Social Security numbers of everyone receiving or requesting assistance will be used to verify identity and eligibility. Social Security numbers will also be matched against federal, state and local government files by computer. The department is allowed to request Social Security numbers based on the following statutes: for Medicaid, 42 USC sections 1320b-7(a)(1), (b)(2) and Connecticut General Statutes section 17b-77.
- The department will request information through the Income and Eligibility Verification System (IEVS). The information will be used to process this application/redetermination. Information will come from certain State and Federal agencies when allowed by law. We may directly verify information we receive with other sources such as banks and employers. Results from such verification may affect eligibility.

In accordance with Federal law and U.S. Department of Health and Human Services (HHS) policy, the Department of Social Services is prohibited from discriminating on the basis of race, color, national origin, sex, age or disability. To file a complaint of discrimination, write HHS, Director, Office for Civil Rights, 200 Independence Avenue, S.W., Room 509-F, HHH Building, Washington, D.C. 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TTY).

Under state law you have the right to make a discrimination complaint if you think we have taken actions against you because of your race, color, religious creed, sex, marital status, age, national origin, ancestry, criminal record, political beliefs, sexual orientation, mental retardation, mental disability, learning disability or physical disability, including but not limited to blindness. You or someone representing you may write to or call one or more of these agencies to make a discrimination complaint: **Commissioner of the Department of Social Services, Attention Affirmative Action Division Director/ADA Coordinator, 25 Sigourney Street, Hartford, CT 06106-5033**, or call 1-860-424-5040 (TDD: 1-800-842-4524); **Connecticut Commission on Human Rights and Opportunities, 21 Grand Street, Hartford, CT 06106**, or call 1-860-541-3400 (TDD: 1-860-541-3459).