Social Security Administration
Important Information

Name
Address
City, ST 99999

Would you like some financial help to pay for some of the out-of-pocket expenses under the new Medicare Prescription Drug Program? Our records show you may qualify for this assistance.

To apply you will need to do two things:

1. **You will need to complete the form on the Internet at www.socialsecurity.gov or, if you prefer, fill out and return the enclosed application. The sooner you apply, the sooner we can tell you if you are eligible for this extra help.**
2. **You will need to enroll in the Medicare Prescription Drug Program between November 15, 2005, and May 15, 2006, by contacting a company that is an authorized prescription drug plan provider. For names of providers in your area, call the Medicare and Medicaid Services at 1-800-MEDICARE.**

Here is some background information about the Medicare Prescription Drug Program

Beginning in January 2006, Medicare will offer a voluntary prescription drug benefit for all Medicare beneficiaries. To be eligible, you must enroll in this prescription drug program with an approved company. The drug benefit is in addition to current Medicare benefits. To get this new coverage, beneficiaries may need to pay a monthly premium, an annual deductible and co-payments. However, if you have limited income and assets, you may be able to receive extra financial help to meet some of these costs. This extra help is known as the Medicare Prescription Drug Cost-Sharing Subsidy.

Please remember that the enclosed application is not an application to enroll in the Medicare Prescription Drug Program. To do that, you must contact a company that is an authorized prescription drug plan provider in your area.

On the other side is important information about the application process.

How Do I Qualify for the Extra Help?

To qualify, your income and assets must be below certain limits. If you are married and you and your spouse live at the same address, your combined income and assets must be below certain limits. If your spouse lives at a different address, such as a nursing home, we do not count your spouse's income or the things your spouse owns when we determine your eligibility for the extra help.

Social Security determines whether you are eligible for the extra help based on the answers that you provide on the application. You have the right to appeal our decision, if you disagree.

What Kinds of Questions Will I Be Asked?

- We will ask about your and your spouse's income;
- We will ask about the things that you and your spouse own (such as bank accounts or investment accounts); and
- We will ask how many people are in your household.

Can My Spouse and I Use the Same Application?

Yes. Complete only one application if you both want the extra help. However, you and your spouse must sign it.

Completing Your Application

You may complete the application by visiting our Internet site at www.socialsecurity.gov.

Or, you may complete the enclosed application and return it to:

Social Security Administration
Wilkes-Barre Data Operations Center
P.O. Box
Wilkes-Barre, PA 12345-6789

After we receive your completed application, we will send you a letter informing you whether you qualify for the extra help. When we process your application, we will also check to see if you may be eligible for Supplemental Security Income (SSI) benefits.

Paperwork/Privacy Act Notice

Section 1860D-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 a premium subsidy under Medicare Part D. 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 Part D subsidy 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 subsidy 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: SSA, 1338 Annex Building, Baltimore, MD 21235-6401. **Send only 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 SELF-ADDRESSED ENVELOPE:

Social Security Administration
Wilkes-Barre Data Operations Center
P.O. Box
Wilkes-Barre, PA 12345-6789

Application for Medicare Prescription Drug Cost-Sharing Subsidy

To Provide Extra Help in Paying for Your Drug Expenses

If you receive Supplemental Security Income (SSI) or Medicaid, you do not need to complete this application. Contact your local Medicaid office about your eligibility for the subsidy. For the location of your local Medicaid office, call 1-800-MEDICARE.

General Instructions for Completing 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**
- **Do not show cents when filling out dollar amounts. Round to the nearest whole dollar.**

EXAMPLE
show $416.25 as
$,4 1 6

If You are Completing the Application for Someone Else

Answer the questions as if that person were completing the application. You must know about that person's income and assets.

Completing Your Application

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

Social Security Administration
Wilkes-Barre Data Operations Center
P.O. Box
Wilkes-Barre, PA 12345-6789

Return only the completed application in the enclosed envelope. Do not include any attachments. You may want to keep a copy for your records. If we need more information, we will contact you.

If You Have Questions or Need Help Completing this Application

You may call us at 1-800-772-1213 (for the deaf or hard of hearing, call our TTY number, 1-800-325-0778) or visit our website at www.socialsecurity.gov for general information about Social Security.

Signature of Applicant

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 on any accompanying statements or forms, 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.

X _____ X _____

Your Signature *Your Spouse's Signature*

Phone Number: (_____) _____ — _____

If you are signing on your own behalf and would prefer that we contact someone else if we have additional questions, please provide the person's name and a daytime phone number.

_____ _____

First Name *Last Name*

Phone Number: (_____) _____ — _____

Applicant's Home Address

_____ _____

Street Address *Apt. #*

_____ _____ _____

City *State* *Zip Code*

Applicant's Mailing Address (if different from above address)

_____ _____

Street Address *Apt. #*

_____ _____ _____

City *State* *Zip Code*

If you are signing on behalf of someone else, place an [X] in the box that describes your relationship to the person for whom you completed the application and provide your daytime phone number and address.

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

☐ Friend ☐ Agency ☐ Social Worker _____

_____ _____

First Name *Last Name*

Phone Number: (_____) _____ — _____

_____ _____

Street Address *Apt. #*

_____ _____ _____

City *State* *Zip Code*

Application for Medicare Prescription Drug Cost-Sharing Subsidy

FOR OFFICIAL USE ONLY

State code: ____ ____

THIS IS NOT AN APPLICATION FOR THE MEDICARE PRESCRIPTION DRUG PROGRAM.

1.

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

FIRST | MIDDLE INITIAL | LAST

EXAMPLE

If the claim number on the Medicare card is 000-00-0000A

show 0 0 0 – 0 0 – 0 0 0 0 – A

Applicant's Social Security Number | *Applicant's Medicare Claim Number*

2.

If you are married, please put an X in one of the boxes below to indicate who is applying:

☐ *You are applying.* ☐ *Both you and your spouse are applying on this application.*

Spouse's Name (if you are married and your spouse lives with you)

FIRST | MIDDLE INITIAL | LAST

Spouse's Social Security Number | *Spouse's Medicare Claim Number*

3.

Do you own assets that are worth more than $11,500 (or more than $23,000, if you are married and living with your spouse)? Assets include: bank accounts, stocks, bonds, savings bonds, mutual funds or other investments, Individual Retirement Accounts, 401(k) plans, Keogh plans, or similar assets and any real estate (other than your home). This includes assets that you or your spouse co-own with another person. Assets do not include your home, vehicle or personal possessions.

If you are unsure, put an X in the NO box.

☐ **YES** ☐ **NO**

If you put an X in the **YES** box, you are **not** eligible for the subsidy and you do not need to complete this application. However, if you want a formal decision, please continue to the next page.

If you have not worked in the last two years, skip questions 13 – 15.

13.

What are your **average monthly** gross wages (before taxes) and net earnings from self-employment? If you are married and your spouse lives with you, include both your wages and your spouse's wages and net earnings from self-employment. *If you and your spouse do not work now, place an* **X** *in the* **NONE** *box; otherwise, print the dollar amount.*

☐ **NONE** $ ☐☐,☐☐☐

14.

Has the amount of your and your spouse's gross wages (before taxes) or net earnings from self-employment decreased in the last two years?

☐ **YES** ☐ **NO**

If you are age 65 or older, skip question 15.

15.

Do you or your spouse (if your spouse lives with you) 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 medicines and medical treatment 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.

☐ **YES** ☐ **NO**

4.

Please print the value of each asset that either you, your spouse or both of you own (include items that either of you co-own with another person) in the boxes below. If you or your spouse (if your spouse lives with you) do not own an asset listed, either separately, jointly or with another person, place an X in the **NONE** box.

IF THE VALUE IS GREATER THAN $99,999
show $ 99,999

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

5.

Do you or your spouse (if your spouse lives with you) own any life insurance policies with a total face value of $1,500 or more? *Answer both if your spouse lives with you.*

YOU: ☐ **YES** ☐ **NO**

SPOUSE: ☐ **YES** ☐ **NO**

If you answered **NO** for both you and your spouse, go to question 6.

IF the answer for either you or your spouse is **YES**, what is the total cash surrender value of these life insurance policies? *Enter the dollar amount.* $ ☐☐,☐☐☐

6.

Have you or your spouse (if your spouse lives with you) set aside any money for burial expenses?

☐ **YES** ☐ **NO**

7.

Do you own any real estate other than your home and the property on which it is located?

☐ **YES** ☐ **NO**

8.

Have you or your spouse (if your spouse lives with you) transferred or given away any assets since November 2004?
(Do not include your home, vehicles or household items.)

☐ **YES** ☐ **NO**

DO NOT WRITE IN THIS AREA
DO NOT WRITE IN THIS AREA

9.

Your living situation may affect the amount of help you can get. Therefore, we need to know how many relatives live with you and your spouse for whom you or your spouse provide at least one-half of their financial support. Relatives include: your parents, your children, grandchildren, great grandchildren or step children and their spouses, your brothers or sisters and their spouses, nieces and nephews, your aunts, uncles or cousins or your in-laws.

How many relatives who live with you and your spouse depend on you or your spouse to provide at least 1/2 of their financial support? *(Place an X in only one box.)*

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

10.

If you or your spouse receive income from any of the sources listed below, please print the **average monthly income** (excluding wage and self-employment income) in the appropriate boxes. If you or your spouse do not receive income from any of the sources listed below, place an X in the **NONE** box.

If you received this application in the mail, we may have pre-filled some of the amounts based on information in our records. The amount shown will be the amount you actually receive, but we will add the amount of your Medicare Part B premium to figure your income. If you believe the amounts shown are wrong, cross them out and print the correct amount.

Social Security or Railroad Retirement benefits	☐ **NONE**	$ ☐☐,☐☐☐
Veterans' pension or compensation benefits	☐ **NONE**	$ ☐☐,☐☐☐
Pensions or annuities (Do not include payments from an IRA, 401(k), Keogh or similar plans)	☐ **NONE**	$ ☐☐,☐☐☐
Other income not listed above, including alimony, net rental income, workers' compensation *Specify:* _____ _____	☐ **NONE**	$ ☐☐,☐☐☐

11.

Have any of the amounts in question 10 decreased during the last two years? ☐ **YES** ☐ **NO**

12.

Does anyone provide, or help you or your spouse (if your spouse lives with you) pay for, any of the following household expenses? (*For example, food, mortgage, rent, heating fuel or gas, electricity, water and property tax. Do not include help from a housing agency, energy assistance program, Meals on Wheels or food stamps you receive.)*

☐ **YES** ☐ **NO**

If someone other than your spouse (if your spouse lives with you) pays for any of your food or housing costs each month (for example, rent, mortgage, gas or electric) or provides food or housing to you, enter the amount.

If **YES**, how much do they pay each month? **Print the dollar amount.** $ ☐☐,☐☐☐

DO NOT WRITE IN THIS AREA

DO NOT WRITE IN THIS AREA