QMB/SLMB APPLICATION

IMPORTANT!

DO NOT send this application back to SHIP

This will delay the processing.

Find your zip code on the next page and mail your completed application to the appropriate Montgomery County Income Supports Office.

To schedule an appointment to discuss your eligibility and other financial assistance programs call:

Montgomery County

Department of Health and Human Services (DHHS)

240-777-3000

Or Montgomery County SHIP

301 -255-4250

7921

Made possible with a grant from the U.S. Administrator for Community Living through the State of Maryland and Montgomery County.

QMB/SLMB DOCUMENTATION REMINDER

- **Along with my application, I need to mail copies of proof of income, assets (savings and checking accounts, life insurance, etc.) and health insurance listed on my application.**
- **If I cannot send the papers now, I will mail them at a later date. However, I understand that my eligibility for the QMB/SLMB Programs cannot be decided until I send all information. I understand that the local department of social services may ask me to submit more information.**

Please be sure to include a copy of all that apply to you. Do not send original records. They will not be returned to you.

Place a √ beside each item that you must send with your application	What
	Health Insurance Card(s) – front and back (not your Medicare card)
	Lawful Permanent Resident form, I-94 Card, or other forms from Immigration and Naturalization Services (Department of Homeland Security)
	Checking Account Statement – last 3 statements
	Savings Book/Statement showing the balance at the first of this month
	Divorce/Separation Papers
	Alimony Papers
	If employed, pay stubs for last month or 4 weeks, W-2, or letter from employer or proof of self-employment income (quarterly tax forms, receipts)
	Retirement / Pension Verification of gross income you get (before taxes, etc. are deducted)
	Life Insurance Policy (copy of original policy)
	Whole Life Insurance (cash value table from the life insurance policy or cash value letter from insurance carrier)
	Social Security Award Letter
	Veterans Administration Award Letter
	Civil Service Annuity Award Letter
	Stock, bonds, 401-Ks, etc.– statements for last 3 months
	Trust Fund document(s) for trusts you have had in the last 60 months (copy of trust & last 3 statements)
	Burial or Funeral Account, Fund, or Plan Statement
	Mortgage Contract for rental or business property for which you are the lender or are receiving money
	Rental/Lease Income Statements for property you rent or lease to someone else
	IRA or Keogh – last statement
	Annuities- copy of annuity & last 3 statements
	Copy of letter or statement showing amount for any other income or asset.

Keep this page for your records

OVER →

If you live in any of these zip codes, send your application to the Silver Spring Office.
Income Supports/Attention: Clerical Supervisor
8818 Georgia Avenue
Silver Spring, Maryland 20910
240-777-3100

20866	20903	20907	20912	20916
20868	20904	20910	20914	20918
20901	20905	20911	20915	20783

If you live in any of these zip codes, send your application to the Rockville Office.
Income Supports/Attention: Clerical Supervisor
1301 Piccard Drive, 2nd floor
Rockville, Maryland 20850
240-777-4600

20812	20818	20848	20854	20896
20813	20824	20849	20856	20902
20814	20827	20850	20860	20906
20815	20830	20851	20861	
20816	20832	20852	20862	
20817	20833	20853	20895	

If you live in any of these zip codes, send your application to the Germantown Office.
Income Supports/Attention: Clerical Supervisor
12900 Middlebrook Road, 2nd floor
Germantown, Maryland 20874
240-777-3420

20837	20842	20874	20878	20884
20838	20855	20875	20879	20885
20839	20871	20876	20880	20886
20841	20872	20877	20882	21771

State of Maryland
Department of Human Services

Mail-In Application for Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary (SLMB) Programs

Dear Applicant:

In this packet is the mail-in application to apply for the Qualified Medicare Beneficiary (QMB) and the Specified Low-Income Medicare Beneficiary (SLMB) Programs. To apply for these benefits, you will need to do the following things:

- Fill out this form
- Mail pages 1, 2, 3, and 4 of your completed form to the local department of social services in the county (or Baltimore City) where you live. You will find their addresses on the inside back cover.

You can use this form if you are an individual or married couple who receives or has applied for Medicare benefits. Families with children that want to apply for Medical Assistance or Supplemental Nutrition Assistance Program must contact the local department of social services in their area.

There are instructions for each section of the application. If you want help, you may wish to ask a family member, friend, or neighbor. You may also call the State Health Insurance Assistance Program (SHIP) Coordinator for your area. Their phone numbers are on the last page of the document you keep for your records.

When you mail in this form, you are requesting QMB or SLMB benefits through the Maryland Medical Assistance Program. Once you are found eligible, **each year** your local department of social services will mail you a case information form (CIF) to be reviewed and returned so your eligibility for continued QMB/SLMB benefits can be redetermined. **If you do not return the form by the due date, your benefits will end.** Benefits for these programs are listed below.

Qualified Medicare Beneficiary Program (QMB)
The QMB Program helps eligible Maryland residents by paying the full amount of your monthly Medicare premiums and your Medicare co-pays and deductibles. You will receive a gray and white QMB card by mail.

Specified Low-Income Medicare Beneficiary Program (SLMB)
If you are eligible for SLMB, we will pay only your monthly Medicare Part B medical insurance premium. You will receive a letter to tell you if you are eligible, but you will not receive a card.

Keep this page for your records

RIGHTS and RESPONSIBILITIES

PRIVACY STATEMENT:

The Medical Assistance Program will use my personal information (Name, Address, Social Security Number, Date of Birth, Employment History, etc.) to see if I am eligible for benefits. If I do not provide the information, my application may be denied. I have the right to review, change, or correct any information. By law, the state may use my information only for purposes directly related to the administration of the programs for which I apply.

ASSIGNMENT OF RIGHTS OF PAYMENT FOR MEDICAL SUPPORT AND OTHER MEDICAL CARE:

As a condition of my eligibility, I assign to the state any rights to medical support and to payment for medical care from any third party. I agree to cooperate with the state in identifying and providing information to assist the state in pursuing any third party that may be liable to pay for my medical care and services. I understand that I must report to the local department of social services any payments received for medical care within 10 days.

REPORT CHANGES:

I understand that I must tell the local department of social services about any changes in my income, assets (savings and checking accounts, etc.), address, or living arrangements within 10 days after the change happens.

APPLICANT'S STATEMENT OF UNDERSTANDING AND AGREEMENT:

I agree to the release of my personal and financial information to any agent of the state who will evaluate and determine my eligibility for Medical Assistance benefits.

I understand that the state may verify all information on this form. Social Security Numbers will be used for identification to verify information for program reviews or audits and computer matches with other agencies, such as the Social Security Administration or the Internal Revenue Service.

I have the right to appeal any decision, action, or inaction made concerning my eligibility. I understand that my application will be considered without regard to race, color, sex, age, disability, religion, national origin, or political belief.

I certify that everyone requesting benefits on this application form is a U.S. citizen or lawfully admitted alien. Proof of lawful immigration status is required.

Keep this page for your records

Maryland Department of Human Services

Mail-In Application for Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary (SLMB) Programs

INSTRUCTIONS FOR COMPLETING APPLICATION

- **Read all instructions for each part before filling out. Print clearly. Answer all questions. Do not leave any blank spaces. Put "NA" in each space that does not apply.**
- **When finished, remove and mail the application (pages 1, 2, 3, and 4). Sign, date, and mail the application to the local department of social services in your area. A list of the social service offices is included.**

Section 1. Information about you.

Your Name: ____
First Middle Last

Address: ____
Street Address Apt. No.

____
City State Zip Code

Daytime Telephone: (______) _______ - __________ Evening Telephone: (______) _______ - __________

E-mail address: ________________________________

Date of Birth: ____________________ **Sex:** ☐ **Male** ☐ **Female** **Race (optional):** ____________________

Your Social Security Number: __________ - __________ - __________

Your Medicare Number: __________ - __________ - __________ - __________

Marital Status: ☐ **Never Married** ☐ **Married and living with spouse** ☐ **Separated** ☐ **Divorced** ☐ **Widowed**

Are you a Maryland resident? ☐ **Yes** ☐ **No** **Are you a citizen of the U.S.?** ☐ **Yes** ☐ **No**

If not a citizen, most recent date of arrival in the U.S.: __________________ **INS ID Number** ____________________

Which language do you speak the most? ☐ **English** ☐ **Spanish** ☐ **Other:** _______

Section 2. Information about your spouse.

If you are living with your spouse, please complete the following information about him or her.

Name: ____
First Middle Last

Date of Birth: ____ **Race: (optional):** ____________________

Are you applying for QMB/SLMB benefits for this person? ☐ **Yes** ☐ **No** **If yes, complete the following:**

Social Security Number: __________ - _________ - ___________

Medicare Number: __________ - _________ - ___________ - __________

Citizenship: Is this person a citizen of the U.S.? ☐ **Yes** ☐ **No**

If not a citizen, most recent date of arrival in the U.S.: _________________ **INS ID Number** ____________________

Which language does your spouse speak the most? ☐ **English** ☐ **Spanish** ☐ **Other**____________________

Section 3. Assets

Type of Assets	Current Value (as of the 1st day of this month)	Owner: Applicant	Owner: Spouse	Account Number	Name of bank, institution, or location
Savings	$	☐	☐		
Checking	$	☐	☐		
Stock Certificates	$	☐	☐		
Certificates of Deposit (CD's) or Money Market					
Bonds	$	☐	☐		
Real Estate (except where you live)	$	☐	☐		
Trust Fund	$	☐	☐		
IRA, Keogh, 401-K,	$	☐	☐		
Cash	$	☐	☐		
Other:	$	☐	☐		

Section 4. Income

	Amount (before taxes and other deductions)	**How Often?** (monthly, weekly, bi-weekly)**?**	**Received by:** Applicant	**Received by:** Spouse
Social Security	$		☐	☐
Social Security Disability	$		☐	☐
Supplemental Security Income (SSI)	$		☐	☐
Veterans' Benefits	$		☐	☐
Railroad Retirement	$		☐	☐
Civil Service Annuity	$		☐	☐
Pension, Retirement, or Disability Income	$		☐	☐
Rental Income	$		☐	☐
Mortgage Income	$		☐	☐
Dividends or Interest Earnings	$		☐	☐
Job Earnings (Last 4 Weeks)	$		☐	☐
Alimony	$		☐	☐
Self Employment Income	$		☐	☐
Unemployment	$		☐	☐
Worker's Compensation	$		☐	☐
Annuity Income	$		☐	☐
Other:	$		☐	☐

Section 5. Vehicles. List any boats, airplanes, or other recreational vehicles that you own.

Type of Vehicle	Make	Year	Model

Section 6. Other Health Insurance

Do you and your spouse have health insurance other than Medicare? ☐ Yes ☐ No If yes, complete the section below.

Insured Person	Insurance Company	Policy Number

Section 7. Authorized Representative. This section is optional. Complete it only if you want someone else to represent you in your application process for the QMB/SLMB Programs.

You may have another person, such as a relative, friend, or attorney represent you in your application for benefits. If you would like that person to speak to the Department about your case and receive copies of all letters about your eligibility, please fill in the following:

Name of representative: ____

Address of representative: ____

____

Daytime telephone: (____) ______ - ______ Evening telephone: (____) ______ - _______

Representative's relationship to you: ____

would like the representative above to: (check all that apply)

☐ Receive copies of all letters about my eligibility and discuss my eligibility with the Local Department of Social Services and the Department of Health and Mental Hygiene.

☐ Receive and complete my yearly applications for me.

☐ Receive my identification cards for me.

Section 8. Signature Section

- I have received a copy of my rights and responsibilities. I understand my responsibilities and agree to cooperate with the State as required.
- I understand that if I need help with other medical expenses, or if I need to apply for SNAP, I must file a separate application at the Local Department of Social Services in my area.
- I certify that everyone requesting benefits on this application form is a U.S. citizen or lawfully admitted alien.

By signing this application form, I certify under penalty of perjury that everything on the form is the truth, as best I know it. State and Federal law provide for fine, imprisonment, or both for any person who withholds or gives false information to obtain assistance to which he or she is not entitled.

______________________________________ Signature of Applicant

____________________ Date

______________________________________ Signature of Applicant's Spouse

____________________ Date

RIGHTS and RESPONSIBILITIES

PRIVACY STATEMENT:

The Medical Assistance Program will use my personal information (Name, Address, Social Security Number, Date of Birth, Employment History, etc.) to see if I am eligible for benefits. If I do not provide the information, my application may be denied. I have the right to review, change, or correct any information. By law, the state may use my information only for purposes directly related to the administration of the programs for which I apply.

ASSIGNMENT OF RIGHTS OF PAYMENT FOR MEDICAL SUPPORT AND OTHER MEDICAL CARE:

As a condition of my eligibility, I assign to the state any rights to medical support and to payment for medical care from any third party. I agree to cooperate with the state in identifying and providing information to assist the state in pursuing any third party that may be liable to pay for my medical care and services. I understand that I must report to the local department of social services any payments received for medical care within 10 days.

REPORT CHANGES:

I understand that I must tell the local department of social services about any changes in my income, assets (savings and checking accounts, etc.), address, or living arrangements within 10 days after the change happens.

APPLICANT'S STATEMENT OF UNDERSTANDING AND AGREEMENT:

I agree to the release of my personal and financial information to any agent of the state who will evaluate and determine my eligibility for Medical Assistance benefits.

I understand that the state may verify all information on this form. Social Security Numbers will be used for identification to verify information for program reviews or audits and computer matches with other agencies, such as the Social Security Administration or the Internal Revenue Service.

I have the right to appeal any decision, action, or inaction made concerning my eligibility. I understand that my application will be considered without regard to race, color, sex, age, disability, religion, national origin, or political belief.

I certify that everyone requesting benefits on this application form is a U.S. citizen or lawfully admitted alien. Proof of lawful immigration status is required.

When you finish filling in this application, mail pages 1, 2, 3, and 4 to the Local Department of Social Services for your area, listed below. Complete the following and keep this page for your records:

I mailed my application form on:

____
(Date)

Circle the office where you mailed your application.

LOCAL DEPARTMENTS OF SOCIAL SERVICES

Allegany County DSS
1 Frederick Street
Cumberland, MD 21502
(301) 784-7000

Anne Arundel County DSS
Annapolis District
80 West Street
Annapolis, MD 21401
(410) 269-4500

Glen Burnie District
7500 Ritchie Highway
Glen Burnie, MD 21061
(410) 421-8539

Baltimore City DSS
North East Regional Office
2000 N. Broadway Street
Baltimore, MD 21213
(443) 423-4600

Dunbar-Orangeville Center
2919 E. Biddle Street
Baltimore, MD 21213
(443) 423-6400

Harbor View Center
18 Reedbird Ave
Baltimore, MD 21225
(443) 423-4700

Hilton Heights Center
500 N. Hilton Street
Baltimore, MD 21229
(443) 423-6400

Northwest Center
5818 Reisterstown Road
Baltimore, MD 21215
(443) 378-4400

Penn-North Center
2500 Pennsylvania Ave
Baltimore, MD 21217
(443) 423-7606

Southwest Center
1223 W. Pratt Street
Baltimore, MD 21223
(443) 423-7800

Baltimore County DSS
Catonsville District
746 Frederick Road,
Catonsville, MD 21228
(410) 853-3450

Dundalk District
1400 Merritt Blvd, Ste. C
Baltimore, MD 21222
(410) 853-3400

Essex District
439 Eastern Avenue
Baltimore, MD 21221
(410) 853-3800

Reisterstown District
130 Chartley Drive
Reisterstown, MD 21136
(410) 853-3010

Towson District
Drumcastle Center
6400 York Road
Baltimore, MD 21212
(410) 853-3340

Calvert County DSS
200 Duke Street
Prince Frederick, MD
20678 (443) 550-6900

Caroline County DSS
P.O. Box 400
Denton, MD 21629
(410) 819-4500

Carroll County DSS
1232 Tech Court, Ste.1
Westminster, MD 21157
(410) 386-3300

Cecil County DSS
P.O. Box 1160
Elkton, MD 21922
(410) 996-0100

Charles County DSS
200 Kent Avenue
LaPlata, MD 20646
(301) 392-6400

Dorchester County DSS
P.O. Box 217
Cambridge, MD 21613
(410) 901-4100

Frederick County DSS
1888 North Market Street
Frederick, MD 21701
(301) 600-4555

Garrett County DSS
12578 Garrett Highway
Oakland MD 21550
(301) 533-3000

Harford County Department
of Social Services
Swan Creek Office
2029 Pulaski Highway
Havre De Grace. Md 21078
(410) 836-4700

Howard County DSS
7121 Columbia Gateway Dr.
Columbia, MD 21046
(410) 872-8700

Kent County DSS
P.O. Box 670
Chestertown, MD 21620
(410) 810-7600

Montgomery County DHHS
1301 Piccard Drive
Rockville, MD 20850
(240) 777-4600

Prince George's Co. DSS
805 Brightseat Road
Landover, MD 20785
(301) 909-6066

Queen Anne's County DSS
125 Comet Drive
Centreville, MD 21617
(410) 758-8000

Somerset County DSS
P.O. Box 369
Princess Anne, MD 21853
(410) 677-4200

St. Mary's County DSS
PO Box 509
23110 Leonard Hall Drive
Leonardtown, MD 20650
(240) 895-7000

Talbot County DSS
301 Bay Street – Unit 5
Easton, MD 21601
(410) 770-4848

Washington County DSS
P.O. Box 1419
Hagerstown, MD 21741
(240) 420-2100

Wicomico County DSS
201 Baptist Street – Ste. 27
Salisbury, MD 21801
(410) 713-3900

Worcester County DSS
P.O. Box 39
299 Commerce Street
Snow Hill, MD 21863
(410) 677-6800

Keep this page for your records **TURN PAGE OVER**

If you need help to complete your application

COUNTY	PHONE NUMBER
Allegany	(301) 777-5970 ext. 1710
Anne Arundel	(410) 222-4464 ext. 4076
Baltimore City	(410) 396-2273
Baltimore County	(410) 887-2059
Calvert	(301) 855-1170 or (410) 535-4606 ext. 132 / ext. 138
Caroline	(410) 479-2535 ext. 8009
Carroll	(410) 386-3800 or 1 (888) 302-8978 ext. 3806
Charles	(301) 934-0118 or (301) 870-3388 ext. 5118
Cecil	(410) 996-5295 or (410) 996-8174 Main #
Dorchester	(410) 742-0505 ext. 120
Frederick	(301) 600-1604 option 1
Garrett	(301) 334-9431 ext. 6140 or 1 (888) 877-8403 Main #
Harford	(410) 638-3025 ext. 2238
Howard	(410) 313-7392
Kent	(410) 778-2571
Montgomery	(301) 590-2819
Prince George’s	(301) 265-8471
Queen Anne’s	(410) 758-0848 ext. 2712 / ext. 2724
Somerset	(410) 742-0505 ext. 120
St. Mary’s	(301) 475-4200 ext. 1064
Talbot	(410) 822-2869 ext. 231
Washington	(301) 790-0275 ext. 221
Wicomico	(410) 742-0505 ext. 120

Keep this page for your records