



State Health Insurance Assistance Program (SHIP)

www.medicareabcd.org ♦ 301-255-4250 ♦ SHIP@AccessJCA.org

SLMB/QMB APPLICATION

Where to Mail Your SLMB/QMB Application

IMPORTANT!

DO NOT send this application 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 State Health Insurance Assistance Program (SHIP)
301-255-4250**

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 <input type="checkbox"/> beside each item that you must send with your application	<u>What</u>
	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.

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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 Resources

**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 Food Supplement 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.

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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 Resources
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 1 st day of this month)	Owner:		Account Number	Name of bank, institution, or location
		Applicant	Spouse		
Savings	\$	<input type="checkbox"/>	<input type="checkbox"/>		
Checking	\$	<input type="checkbox"/>	<input type="checkbox"/>		
Stock Certificates	\$	<input type="checkbox"/>	<input type="checkbox"/>		
Certificates of Deposit (CD's) or Money Market					
Bonds	\$	<input type="checkbox"/>	<input type="checkbox"/>		
Real Estate (except where you live)	\$	<input type="checkbox"/>	<input type="checkbox"/>		
Trust Fund	\$	<input type="checkbox"/>	<input type="checkbox"/>		
IRA, Keogh, 401-K,	\$	<input type="checkbox"/>	<input type="checkbox"/>		
Cash	\$	<input type="checkbox"/>	<input type="checkbox"/>		
Other:	\$	<input type="checkbox"/>	<input type="checkbox"/>		

Section 4. Income

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

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 food stamps, 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

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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.

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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

<p>Allegany County DSS 1 Frederick Street Cumberland, MD 21502 (301) 784-7000</p>	<p>Southwest Center 1223 W. Pratt Street Baltimore, MD 21223 (443) 423-7800</p>	<p>Carroll County DSS 1232 Tech Court, Ste. 1 Wesminster, MD 21157 (410) 386-3300</p>	<p>Montgomery County DHHS 7300 Calhoun Place Suite 700 Rockville, MD 20850 (240) 777-4087</p>
<p>Anne Arundel County DSS Annapolis District c/o John Lamb 80 West Street Annapolis, MD 21401 (410) 269-4596</p>	<p>Baltimore County DSS Catonsville District c/o Anne Cox 746 Frederick Road, Catonsville, MD 21228 (410) 853-3475</p>	<p>Cecil County DSS P.O. Box 1160 Elkton, MD 21922 (410) 996-0100</p>	<p>Prince George's Co. DSS 805 Brightseat Road Landover, MD 20785 (301) 909-7000</p>
<p>Glen Burnie District c/o John Lamb 7500 Ritchie Highway Glen Burnie, MD 21061 (410) 421-8501</p>	<p>Dundalk District c/o Charlene Jones 1400 Merritt Blvd – Ste. C Baltimore, MD 21222 (410) 853-3433</p>	<p>Charles County DSS 200 Kent Avenue LaPlata, MD 20646 (301) 392-6400</p>	<p>Queen Anne's County DSS 125 Comet Drive Centreville, MD 21617 (410) 758-8000</p>
<p>Baltimore City DSS North East Regional Office 2000 N. Broadway Street Baltimore, MD 21213 (443) 423-6400</p>	<p>Essex District c/o Sharon Baxter 439 Eastern Avenue Baltimore, MD 21221 (410) 853-3806</p>	<p>Dorchester County DSS P.O. Box 217 Cambridge, MD 21613-0217 (410) 901-4100</p>	<p>St. Mary's County DSS PO Box 509 23110 Leonard Hall Drive Leonardtwn, MD 20650 (240) 895-7000</p>
<p>Dunbar-Orangeville Center 2919 E. Biddle Street Baltimore, MD 21213 (443) 423-5100</p>	<p>Reisterstown District c/o Betty Foster 130 Chartley Drive Reisterstown, MD 21136 (410) 853-3050</p>	<p>Frederick County DSS 100 East All Saints Street Frederick, MD 21701 (301) 600-4575</p>	<p>Somerset County DSS P.O. Box 369 Princess Anne, MD 21853 (410) 677-4200</p>
<p>Harbor View Center 18 Reedbird Ave Baltimore, MD 21225 (443) 423-4700</p>	<p>Towson District c/o Cynthia McNeill Drumcastle Center 6400 York Road Baltimore, MD 21212 (410) 853-3350</p>	<p>Garrett County DSS 12578 Garrett Highway Oakland MD 21550 (301) 533-3000</p>	<p>Talbot County DSS 301 Bay Street – Unit 5 Easton, MD 21601 (410) 770-4848</p>
<p>Hilton Heights Center 500 N. Hilton Street Baltimore, MD 21229 (443) 423-4800</p>	<p>Calvert County DSS c/o Cheryl Harms 200 Duke Street Prince Frederick, MD 20678 (443) 550-6923</p>	<p>Harford County DSS 2 S. Bond Street – Ste. 300 Bel Air, MD 21014 (410) 836-4700</p>	<p>Washington County DSS P.O. Box 1419 Hagerstown, MD 21741 (240) 420-2100</p>
<p>Northwest Center 5818 Reisterstown Road Baltimore, MD 21215 (443) 378-4400</p>	<p>Caroline County DSS P.O. Box 400 Denton, MD 21629 (410) 819-4500</p>	<p>Howard County DSS c/o R. Small 7121 Columbia Gateway Dr. Columbia, MD 21046 (410) 872-8263</p>	<p>Wicomico County DSS 201 Baptist Street – Ste. 27 Salisbury, MD 21801 (410) 713-3900</p>
<p>Penn-North Center 2500 Pennsylvania Avenue Baltimore, MD 21217 (443) 423-7606</p>		<p>Kent County DSS P.O. Box 670 Chestertown, MD 21620 (410) 810-7600</p>	<p>Worcester County DSS P.O. Box 39 299 Commerce Street Snow Hill, MD 21863 (410) 677-6800</p>

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TURN PAGE OVER

If you need help to complete your application

COUNTY	PHONE NUMBER
Allegany	(301) 777-5970 ext. 1710
Anne Arundel	(410) 222-4358
Baltimore City	(410) 396-2273
Baltimore County	(410) 887-2059
Calvert	(301) 855-1170 or (410) 535-4606 ext. 131
Caroline	(410) 479-2093
Carroll	(410) 386-3800
Charles	(301) 934-9305 or (301) 870-3388 ext. 5118
Cecil	(410) 996-8174
Dorchester	(410) 742-0505 ext. 106
Frederick	(301) 600-1605
Garrett	(301) 334-9431 or 1-888-877-8403
Harford	(410) 638-3577 ext. 2238
Howard	(410) 313-7392
Kent	(410) 778-2564
Montgomery	(301) 590-2819
Prince George's	(301) 265-8471
Queen Anne's	(410) 758-0848
Somerset	(410) 742-0505 ext. 106
St. Mary's	(301) 475-4200 ext. 1064
Talbot	(410) 822-2869
Washington	(301) 790-0275 ext. 208
Wicomico	(410) 742-0505 ext. 106
Worcester	(410) 742-0505 ext. 106

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