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 Stamps 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 Senior 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 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 1st day of this month)	Owner: Applicant	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	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: _____

I 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

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
P.O. Box 1420
Cumberland, MD.
21502-1420
(301) 784-7000

Anne Arundel County DSS
Annapolis District
c/o Karen Gaines
80 West Street
Annapolis, MD. 21401
(410) 269-4500

Glen Burnie District
c/o Janice Hudson
7500 Ritchie Highway
Glen Burnie, Md. 21061
(410) 421-8501

Baltimore City DSS
c/o Zerita Singleton
Central Medical Assistance
1920 N. Broadway
Baltimore, MD 21213
(443) 423-6017

Baltimore County DSS
Catonsville District
c/o Chanda Jessup
910 Frederick Road
Baltimore, MD. 21228
(410) 853-3475

Dundalk District
c/o Cynthia Hurst
1400 Merritt Blvd. Suite C
Baltimore, Md. 21222
(410) 853-3406

Essex District
c/o Sharon Baxter
439 Eastern Avenue
Baltimore, MD. 21221
(410) 853-3806

Reistertown District
c/o Betty Foster
130 Chartley Drive
Reisterstown, MD. 21136
(410) 853-3050

Towson District
c/o Cynthia McNeill
Drumcastle Center
6400 York Road
Baltimore, MD. 21212
(410) 853-3350

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

Caroline County DSS
P.O. Box 100
Denton, MD. 21629
(410) 819-4500

Carroll County DSS
10 Distillery Drive
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 21613-0217
(410) 901-4100

Frederick County DSS
P.O. Box 237
Frederick, MD. 21705
(301) 600-4555

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

Harford County DSS
2 S. Bond Street
Bel Air, MD. 21014
(410) 836-4700

Howard County DSS
c/o R. Small
7121 Columbia Gateway Dr.
Columbia, MD. 21046
(410) 872-8263

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

Montgomery County DHHS
c/o Sue Gordon
7300 Calhoun Place
Suite 700
Rockville, MD. 20850
(240) 777-4087

Prince George's Co. DSS
805 Brightseat Road
Landover, MD. 20875
(301) 909-7000

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

Saint Mary's County DSS
P.O. Box 509
Leonardtown, MD. 20650
(240) 895-7000

Somerset County DSS
c/o Beverly Mills
P.O. Box 369
Princess Anne, MD.21853
(410) 677-4200

Talbot County DSS
P.O. Box 1479
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
Suite 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. 110
Anne Arundel	(410) 222-4464
Baltimore City	(410) 396-2273
Baltimore County	(410) 887-2059
Calvert	(301) 855-1170 or (410) 535-4606 ext. 131
Caroline	(410) 479-2535
Carroll	(410) 386-3806 or 1-888-302-8978 ext. 3806
Charles	(301) 934-0118 or (301) 870-3388 ext. 5118
Cecil	(410) 996-5295
Dorchester	(410) 376-3662 ext. 106
Frederick	(301) 600-3522
Garrett	(301) 334-9431 or 1-888-877-8403
Harford	(410) 638-3025
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

Keep this page for your records