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
- Collect and copy the documents that you need to provide as proof (see yellow page).
- Mail pages 1, 2, 3, and 4 of your completed form and the copies of your documents 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 eligible, each year your local department of social services will mail a case information form (CIF) to be reviewed and returned so your eligibility for continued benefits can be redetermined. 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, co-pays, and deductibles. If you are eligible for QMB, you are also eligible for the Maryland Pharmacy Assistance Program (MPAP). You will receive 2 cards by mail, a gray and white QMB card and a white and yellow MPAP card. Your pharmacy benefits will continue until your QMB eligibility ends.

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 not automatically receive a pharmacy assistance card if you are in SLMB. To apply for a pharmacy card, please call 1-800-226-2142.

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 care and services. I understand that I must report 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, life insurance policies, 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 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 an U.S. citizen or lawfully admitted alien. Proof of lawful immigration status is required.

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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. Use the yellow QMB/SLMB Documentation Reminder checklist to make sure you send all information that applies to you.**
- **Send copies of your records only. Original documents will not be returned.**
- **When finished, remove and mail the application (pages 1, 2, 3, and 4) and proofs. 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: (_____) _____ - _____**

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, 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, date of arrival in the U.S.: _____ INS ID Number _____

Which language do you speak the most? ☐ English ☐ Spanish ☐ Other_____

Section 3. Assets. To show proof of the assets listed below, send copies of all current statements for you and your spouse. See the yellow pullout page for copies needed.

Deleted:

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

Section 4. Income. **For your income listed below, send in proof of how much you and your spouse receive (example: Social Security and Veterans' benefits letters, 1 month's worth of your latest pay stubs).**

Type of 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 Income	$		☐	☐
Rental Income	$		☐	☐
Mortgage Income	$		☐	☐
Dividends or Investment 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. Life Insurance.

Do you or your spouse have a life insurance policy? ☐ Yes ☐ No If yes, please complete the following information and send a copy of your policy.

Policy Owner	Insurance Company	Policy Number	Original Face Value	Current Cash Value

Section 7. Other Health Insurance

Do you and your spouse have health insurance other than Medicare? ☐ Yes ☐ No If yes, complete the section below. Send a copy of the front and back of your health insurance card for you and your spouse. Do not write in your Medicare information.

Insured Person	Insurance Company	Policy Number

Section 8. Authorized Representative. This section is optional. Complete it only if you want someone else to handle your Medical Assistance Program application for the QMB/SLMB Programs for you.

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 card for me.

Section 9. 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 am eligible for the Maryland Pharmacy Assistance Program, the State may seek to take money from my estate, once deceased, if I was at least 55 years old, to repay pharmacy payments made on my behalf. The program may take the money only if I had no surviving spouse, unmarried child younger than 21, or blind or disabled child (married or unmarried) of any age.
- 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. I have provided proof of lawful immigration status.

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**

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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

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

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

Baltimore City DSS
c/o Edwin Dean
Central Medical Assistance
1920 N. Broadway
Baltimore, MD 21213
(443) 423-6100

Baltimore County DSS:

Catonsville District
c/o Melissa Caldwell
910 Frederick Road
Baltimore, MD. 21228
(410) 853-3475

Essex District
c/o Rose Cunningham
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 Shirlene Dodd
Drumcastle Center
6401 York Road
Baltimore, MD. 21212
(410) 853-3353

Calvert County DSS
200 Duke Street
Prince Frederick, MD.
20678 (410) 286-2100

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

Carroll County DSS
10 Distillery Drive
Suite 10
Westminster, MD 21157
(410) 386-3300

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

Charles County DSS
P.O. Box 1010
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
301-694-4555

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

Harford County DSS
2 S. Bond Street
Bel Air, MD. 21014
(410) 836-4949

Howard County DSS
7121 Columbia Gateway Drive
Columbia, MD. 21046
(410) 872-4200

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

Montgomery County DHHS
c/o Kate Garvey
401 Hungerford Road
5th Floor
Rockville, MD. 20850
(240) 777-1245

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
c/o Nicki Sacks
P.O. Box 509
Leonardtown, MD. 20650
(240) 895-7000

Somerset County DSS
P.O. Box 359
Princess Anne, MD.21853
(410) 677-2100

Talbot County DSS
P.O. Box 1479
Easton, MD. 21601
(410) 822-1612

Washington County DSS
122 N. Potomac Street
Hagerstown, MD. 21741
(240) 420-2100

Wicomico County DSS
201 Baptist Street
Suite 27
Salisbury, MD. 21601
(410) 543-6900

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

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TURN PAGE OVER

If you need help to complete your application, call the coordinator for the Senior Health Insurance Assistance Program (SHIP) in your area, listed below.

SHIP COORDINATORS

COUNTY	SHIP COORDINATOR	PHONE NUMBER
Allegany	Ms. Robbin Easton	(301) 777-5970 x 110
Anne Arundel	Mrs. Susan Knight	(410) 222-4464
Baltimore City	Ms. Susan Davis	(410) 396-2273
Baltimore County	Ms. Pat Venable	(410) 887-2059
Calvert	Ms. Mary Brown	(301) 855-1170 (410) 535-4606
Caroline	Ms. Irene Garrettson	(410) 479-2535
Carroll	Ms. Susan Cronin	(410) 876-3363
Charles	Ms. Theresa Mason	(301) 934-0118 (301) 870-3388 x 5118
Cecil	Mrs. Mary Kahoe	(410) 996-5295
Dorchester	Ms. Carol Humphrey	(410) 376-3662, x 106
Frederick	Ms. Sharon Lynn	(301) 631-3522
Garrett	Ms. Lynda Weeks	(301) 334-9431 1-888-877-8403
Harford	Ms. Janet Wright	(410) 638-3025
Howard	Ms. Jeanette Krapcho	(410) 313-7392
Kent	Ms. Kim Porter	(410) 778-2564
Montgomery	Ms. Leta Blank	(301) 590-2819
Prince George's	Ms. Julie Neal	(301) 265-8471
Queen Anne's	Ms. Kia Reed	(410) 758-0848
Somerset	Ms. Carol Humphrey	(410) 742-0505 x 106
St. Mary's	Ms. Debbie Barker	(301) 475-4444
Talbot	Ms. Peggy Vance	(410) 822-2869
Washington	Mrs. Katrina Eversole	(301) 790-0275 x 208
Wicomico	Ms. Carol Humphrey	(410) 742-0505, x 106
Worcester	Ms. Carol Humphrey	(410) 742-0505, x 106

Keep this page for your records

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
	Other:

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