

**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 1 <sup>st</sup> 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 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

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**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	Southwest Center 1223 W. Pratt Street Baltimore, MD 21223 (443) 423-7800	Carroll County DSS 1232 Tech Court, Ste.1 Westminster, MD 21157 (410) 386-3300	Montgomery County DHHS 1301 Piccard Drive Rockville, MD 20850 (240) 777-4600
Anne Arundel County DSS Annapolis District 80 West Street Annapolis, MD 21401-2478 (410) 269-4500	Baltimore County DSS Catonsville District 746 Frederick Road, Catonsville, MD 21228 (410) 853-3450	Cecil County DSS P.O. Box 1160 Elkton, MD 21922 (410) 996-0100	Prince George's Co. DSS 805 Brightseat Road Landover, MD 20785 (301) 909-6066
Glen Burnie District 7500 Ritchie Highway Glen Burnie, MD 21061 (410) 421-8539	Dundalk District 1400 Merritt Blvd, Ste. C Baltimore, MD 21222 (410) 853-3400	Charles County DSS 200 Kent Avenue LaPlata, MD 20646 (301) 392-6400	Queen Anne's County DSS 125 Comet Drive Centreville, MD 21617 (410) 758-8000
Baltimore City DSS North East Regional Office 2000 N. Broadway Street Baltimore, MD 21213 (443) 423-4600	Essex District 439 Eastern Avenue Baltimore, MD 21221 (410) 853-3800	Dorchester County DSS P.O. Box 217 Cambridge, MD 21613 (410) 901-4100	Somerset County DSS P.O. Box 369 Princess Anne, MD 21853 (410) 677-4200
Dunbar-Orangeville Center 2919 E. Biddle Street Baltimore, MD 21213 (443) 423-6400	Reisterstown District 130 Chartley Drive Reisterstown, MD 21136 (410) 853-3010	Frederick County DSS 1888 North Market Street Frederick, MD 21701 (301) 600-4555	St. Mary's County DSS PO Box 509 23110 Leonard Hall Drive Leonardtown, MD 20650 (240) 895-7000
Harbor View Center 18 Reedbird Ave Baltimore, MD 21225 (443) 423-4700	Towson District Drumcastle Center 6400 York Road Baltimore, MD 21212 (410) 853-3340	Garrett County DSS 12578 Garrett Highway Oakland MD 21550 (301) 533-3000	Talbot County DSS 301 Bay Street – Unit 5 Easton, MD 21601 (410) 770-4848
Hilton Heights Center 500 N. Hilton Street Baltimore, MD 21229 (443) 423-6400	Calvert County DSS 200 Duke Street Prince Frederick, MD 20678 (443) 550-6900	Harford County Department of Social Services Swan Creek Office 2029 Pulaski Highway Havre De Grace. Md 21078 (410) 836-4700	Washington County DSS 122 North Potomac Street Hagerstown, MD 21740 (240) 420-2100
Northwest Center 5818 Reisterstown Road Baltimore, MD 21215 (443) 378-4400	Caroline County DSS P.O. Box 400 Denton, MD 21629 (410) 819-4500	Howard County DSS 7121 Columbia Gateway Dr. Columbia, MD 21046 (410) 872-8700	Wicomico County DSS 201 Baptist Street – Ste. 27 Salisbury, MD 21801 (410) 713-3900
Penn-North Center 2500 Pennsylvania Ave Baltimore, MD 21217 (443) 423-7606		Kent County DSS P.O. Box 670 Chestertown, MD 21620 (410) 810-7600	Worcester County DSS P.O. Box 39 299 Commerce Street Snow Hill, MD 21863 (410) 677-6800

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## If you need help to complete your application

COUNTY	PHONE NUMBER
Allegany	(301) 777-5970 ext. 1710
Anne Arundel	(410) 269-4500
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

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