Senior Partners Care Program Application

Administered by Senior Community Services

Note: To avoid a delay in processing your application, complete pages 1 and 2 and provide proof of income and assets: sign page 3 and include a check or money order for $40 per person with your application to cover the application processing fee. If a question does not apply, please write "N/A". ***Please print.***

Name: ____ **DOB:** ______________

Last First MI

Medicare ID: __________________ **Part A Effective:** __________ **Part B Eff:** __________

Spouse: ____ **DOB:**______________

Last First MI

Medicare ID: __________________ **Part A Effective:** __________ **Part B Eff:** __________

Address: __________________________ **Apt:** _______ **Phone:** (____)_______________

City: _______________________ **State:** _____ **Zip:** ________**County:**____________

If married, are both applying for SPC? ☐ **Yes, both.** ☐ **No, husband only** ☐ **no, wife only**

Emergency Contact: ___________________ **Their phone number:** (_____)____________

Relationship:_________________________

Name of clinic you usually use: ____________________________

Name of Hospital you usually use: ________________________________

Do you receive Medical Assistance from the County? ☐ **Yes** ☐ **No**

If yes, what benefit do you receive? ___________________________

You cannot have Senior Partners Care if you are on Medical Assistance unless it is SLMB or QI-1.

Do you currently have health coverage besides Medicare? ☐ **Yes** ☐ **No**

If yes, is this a Medicare Advantage Plan? ☐ Yes ☐ No

Name of Insurance Company: ____________________________

Note: You cannot have Senior Partners Care if you are on a Medicare Advantage Plan.

Senior Partners Care is not insurance so there are no monthly premiums. However, there is a $40 application processing fee per person. *This fee must accompany the application in order to be considered.* If you do not qualify for the program, your application fee will be refunded. **Please submit a check or money order for $40 per person payable to Senior Community Services with your application.**

FINANCIAL INFORMATION

You must provide copies of proof of income and assets from the past 30 days. That must include your current Social Security Award letter, Pension stubs/statement, bank statements, etc. Proof of assets can include: checking and savings accounts statements, CDs, stocks, bonds, copy of cash value of life insurance, etc.

Senior Partners Care Guidelines

MAXIMUM Household Income:

- Single individual: $1,945 ($23,340/year)
- Married couple: $2,622 ($31,460/year)

Based on 200% of Federal Poverty Guidelines

MAXIMUM Household Assets
(EXCLUDES your home, one car and personal property.)

- $47,700 in total value

Based on 200% FPG for family of four.

These amounts change annually.

Your Current MONTHLY INCOME **(attach proof)**			**Your Current Assets in Value** **(attach proof)**	
Social Security	$		Cash/Savings/Money Market	$
Spouse's Social Security	$		Checking Accounts	$
Pension(s)	$		Stocks/Bonds/CDs/Trusts	$
Interest/Dividends	$		Land you do not live on	$
Employment Income	$		Additional Licensed vehicles	$
Other:	$		Life Insurance (cash value)	$
			Other:	$
Total Monthly Income =	**$**		**Total Assets =**	**$**

STATEMENT OF UNDERSTANDING

(Please read and sign, your signature is required.)

Senior Partners Care is a community service program. It is not insurance.

I/We understand that enrollment in Senior Partners Care may be denied if:

- *I/We* do not meet the income and/or asset guidelines for the program; or
- Information furnished on (or attached to) this application is found to be inaccurate; or
- *I/We* currently receive Medical Assistance or Qualified Medicare Beneficiary (QMB) program benefits through the county where *I/We* reside and/or the Minnesota Department of Human Services.

Under the Senior Partners Care Program, the decision to waive a deductible or co-payment is made by the Health Care Provider based on an individualized determination of the enrollee's financial need. The program does not provide a waiver for ***all*** healthcare expenses (i.e. nursing home, ambulance) or any services not covered by Medicare. *I/We* have reviewed the "*Instructions for Senior Partners Care application*" (both sides).

In order to be eligible for the benefits of this program, all health care services must be provided by a SPC participating health care provider. *I/We* have been informed that *I/We* are not required by law to provide the personal, medical and financial information requested. However, failure to provide such information will result in not qualifying for participation in this program.

I/We understand that this information may be shared with health care providers. *I/We* also understand that Senior Community Services will not share this information with any unauthorized persons. *I/We* certify that the information *I/We* have provided (including financial information) is complete and accurate to the best of my/our knowledge.

Applicant ____ Date _____________
(Written Signature)

Spouse ____ Date ______________
(Written Signature)

Please return this application (all 3 pages), proof of income and assets and $40 per person processing fee to:

Senior Partners Care
Senior Community Services
10201 Wayzata Blvd, Suite 335
Minnetonka, MN 55305

Please call: 1-888-541-5488 or 952-767-0665 with questions.

Please be advised that within 30 days of receipt of your application, the Senior Partners Care program will notify you of acceptance or denial into the program. This period will be extended if additional information is required from the applicant.

FOR OFFICE USE ONLY

Approval/disapproval date _________________ ☐ New ☐ Renewal ☐ Denial

Reason ____________________________________ ☐ D Help needed ☐ Fee Paid ☐ $40 ☐ $80

Denial Reason ______________________________________

Accepted Effective Date:________________________________ SCS Rep initials ___________

Hospital Coordinator ____________________________ ☐ Copy sent Member ID _________