Senior Partners Care Program Application

Administered by Senior Community Services

Please fill in all questions on this application. If a question does not apply, please write "N/A". Please print. Return the application with all proofs of income and assets together with a check made payable to "Senior Partners Care" in the amount of $42.00 per person.

How many are applying for SPC: _____

Name: _____ DOB: _____
Last First MI

Medicare ID: _____ Part A Effective: _____ Part B Effective: _____
SS# & Letter Exact Date Exact Date

Spouse: _____ DOB: _____
Last First MI

Medicare ID: _____ Part A Effective: _____ Part B Effective: _____
SS# & Letter Exact Date Exact Date

Address: _____ Apt: _____ Phone: (____) _____

City: _____ County: _____ State: _____ Zip: _____

Marital Status of Applicant (Circle): Married – Single - Divorced - Widowed - Legally Separated

Emergency or Alternate Contact: _____

Phone number: (_____) _____ Relationship: _____

Name of clinic you usually use: _____

Name of Hospital you usually use: _____

1. **Do you or your spouse have health insurance besides Medicare?** Besides Part D May be called "Advantage Plan" or "Medigap" or "Supplemental"? **If Yes, describe below:**	**Yes**	**No**
2. **Do you or your spouse have Medical Assistance, even with a spenddown, from your County? If Yes, describe:**	**Yes**	**No**

If applicant answers yes to questions 1 or 2 above, applicant is not eligible for Senior Partners Care.

FINANCIAL INFORMATION

You *must* provide copies of proof of income and assets from the past 30 days. That includes Social Security Verification of Income Letters, Letters from the County for assistance, Pension stubs/statement, bank statements, etc. Proof of assets include: a complete copy (All pages) of your checking and savings account statements showing all deposits, CDs, stocks, bonds, copy of cash value of life insurance, etc.

Senior Partners Care Guidelines

***MAXIMUM GROSS* Household Income**:

- Single individual: $2,010 ($24,120/year)
- Married couple: $2,707 ($32,480/year)

Based on 200% of Federal Poverty Guidelines
These amounts change annually.

MAXIMUM Household Assets
(***EXCLUDES your home; one car; personal property***)

- $49,200.00 in total value

Based on 200% FPG for family of four.

Your Current GROSS MONTHLY INCOME for all individuals (ATTACH PROOF)				**Your Current Assets in Value for all individuals (ATTACH PROOF)**		
	Self	**Spouse**			**Self**	**Spouse**
Social Security **Attach 2017 SS Award Letter, (see example)**	$	$		Cash; Saving; and/ or Money Market **Attach Bank Statement ***	$	$
Pension(s) **Attach Stub, Letter or Statement**	$	$		Checking Accounts; Debit Cards **Attach Bank Statement ***	$	$
Interest/Dividends **Attach a Company Statement**	$	$		Stocks; Bonds; CDs, Annuities, Trusts, 401K, etc. **Attach Statements**	$	$
Employment Income **Attach 3 months of Pay Stubs**	$	$		***Non-Homestead property*** - Land you do not live on **Attach Tax Statement**	$	$
Self-Employment – NET **Copy of IRS 1040 Schedule C**	$	$		***ADDITIONAL Licensed*** vehicles: **Provide Make, Model and Year**	$	$
Rental Income – NET **Copy of IRS 1040 Schedule E**	$	$		Boats, RVs, 4-wheeler, etc. **Provide model, year and mileage/hours for each**	$	$
Spousal Maintenance (Alimony): **Copy of Checks, Bank Statement, Order**	$	$		**Rental Units** **Taxable Market Value Statement**	$	$
Other Income:	$	$		Life/Burial Insurance **Attach Face Page with Cash Value or Letter**	$	$
				Other:	$	$
Total Monthly Income	**$**	**$**		**Total Assets**	**$**	**$**
GRAND TOTAL	**$**			**GRAND TOTAL**	**$**	

* **Show one month's deposits, explain any deposits that are not Social Security, pension or wages.**

STATEMENT OF UNDERSTANDING

(Please read and sign. Your signature is required.)

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

You understand that enrollment in Senior Partners Care may be denied if:

- *You* 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
- *You* currently receive Medical Assistance or Qualified Medicare Beneficiary (QMB) program benefits through the county where you 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. *You* have reviewed the "*Instructions for Senior Partners Care application"* (both sides).

To be eligible for the benefits of this program, all health care services must be provided by a Senior Partners Care participating health care provider:

- *You* have been informed that you 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.
- *You* understand that this information may be shared with health care providers. *You* also understand that Senior Partners Care will not share this information with any unauthorized persons.
- *You* grant permission to Senior Partners Care to contact your emergency contact, if necessary.
- *You* certify that the information you have provided (including financial information) is complete and accurate to the best of your knowledge.
- *You* will contact the Senior Partners Care if your insurance or Medical Assistance status changes.

If married, both partners must sign, even if only one partner is applying.

Applicant _____ Date _____
(Written Signature)

Spouse _____ Date _____
(Written Signature)

Senior Partners Care is **not** insurance so there are no monthly premiums. **The yearly application processing fee is $42.00 per person. *This fee must accompany the application.*** If you do not qualify for the program, the application fee will be refunded. **Submit a check/money order for $42 per person payable to Senior Partners Care with your application and verifications to:**

Senior Community Services - SPC
10201 Wayzata Blvd, Suite 335
Minnetonka, MN 55305

Call 952/767-0665 with questions. Fax: 952/541-0841

Approximately 30 days after of receipt of your application, Senior Partners Care will notify you of acceptance or denial into the program. This period will be extended if additional information is required from the applicant. Avoid using staples on your documents.

FOR OFFICE USE ONLY

Approval/Disapproval date: _____ ☐ New ☐ Renewal ☐ Denial

Accepted Effective Date: _____ ☐ Fee Paid ☐ $42 ☐ $84

Check Number _____

Qualify/Denial Reason: _____

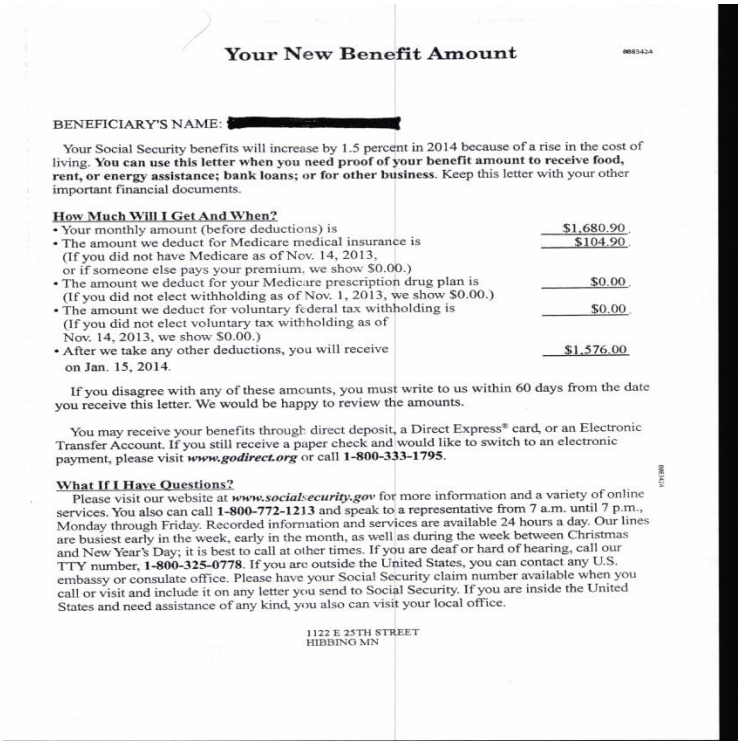
SPC Rep initials _____

Hospital Coordinator _____ ☐ Copy sent Member ID _____

Member ID _____

Notes:

EXAMPLE OF A SS AWARD LETTER



Your New Benefit Amount

BENEFICIARY'S NAME: [redacted]

Your Social Security benefits will increase by 1.5 percent in 2014 because of a rise in the cost of living. **You can use this letter when you need proof of your benefit amount to receive food, rent, or energy assistance; bank loans; or for other business**. Keep this letter with your other important financial documents.

How Much Will I Get And When?

- Your monthly amount (before deductions) is $1,680.90.
- The amount we deduct for Medicare medical insurance is $104.90.
  (If you did not have Medicare as of Nov. 14, 2013, or if someone else pays your premium, we show $0.00.)
- The amount we deduct for your Medicare prescription drug plan is $0.00.
  (If you did not elect withholding as of Nov. 1, 2013, we show $0.00.)
- The amount we deduct for voluntary federal tax withholding is $0.00.
  (If you did not elect voluntary tax withholding as of Nov. 14, 2013, we show $0.00.)
- After we take any other deductions, you will receive on Jan. 15, 2014. $1,576.00

If you disagree with any of these amounts, you must write to us within 60 days from the date you receive this letter. We would be happy to review the amounts.

You may receive your benefits through direct deposit, a Direct Express® card, or an Electronic Transfer Account. If you still receive a paper check and would like to switch to an electronic payment, please visit ***www.godirect.org*** or call **1-800-333-1795**.

What If I Have Questions?

Please visit our website at ***www.socialsecurity.gov*** for more information and a variety of online services. You also can call **1-800-772-1213** and speak to a representative from 7 a.m. until 7 p.m., Monday through Friday. Recorded information and services are available 24 hours a day. Our lines are busiest early in the week, early in the month, as well as during the week between Christmas and New Year's Day; it is best to call at other times. If you are deaf or hard of hearing, call our TTY number, **1-800-325-0778**. If you are outside the United States, you can contact any U.S. embassy or consulate office. Please have your Social Security claim number available when you call or visit and include it on any letter you send to Social Security. If you are inside the United States and need assistance of any kind, you also can visit your local office.

1122 E 25TH STREET
HIBBING MN

PLEASE PROVIDE YOUR 2017 SOCIAL SECURITY AWARD LETTER. IT IS REQUIRED.

- We no longer accept Social Security direct deposit line item entries on your bank statement or Form SSA-1099 as proof of income.
- Call Social Security at 1-800-772-1213 to request a copy. OR
  Go to www.socialsecurity.gov to print a copy. Navigate to mySocialSecurity → Sign in or create an account → Get a Benefit Verification Letter. Click and print the letter.
- If you have Direct Express, get a printout from your ATM. It must have your name, account number, etc.