



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 \$45.00 per person.

How many are applying for SPC: _____ **SPC ID NUMBER** _____

Name: _____ **DOB:** _____
Last First MI

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


Spouse: _____ **DOB:** _____
Last First MI



SELF: _____

Medicare Claim Number: OK to use your new 11-digit Medicare ID number or original SSA #. **(include letter, usually "A", that follows your SSA number)**

Part A Effective Date: _____



SPOUSE: _____

Medicare Claim Number: OK to use your new 11-digit Medicare ID number or original SSA#. **(include letter, usually "A", that follows your SSA number)**

Part A Effective Date: _____

Address: _____ **Apt:** _____ **Phone:** (____) _____
City: _____ **County:** _____ **State:** _____ **Zip:** _____
E-mail address: _____

Emergency or Alternate Contact: _____
Phone number: (____) _____ **Relationship:** _____

How did you hear about Senior Partners Care: (check one)

- | | | |
|--|--|--|
| <input type="checkbox"/> Friend/relative | <input type="checkbox"/> Healthcare provider | <input type="checkbox"/> HOME referral |
| <input type="checkbox"/> City/county worker | <input type="checkbox"/> Senior Linkage Line | <input type="checkbox"/> Senior Center |
| <input type="checkbox"/> SCS website or newsletter | <input type="checkbox"/> Returning client | <input type="checkbox"/> Other (please describe) |

Name of clinic you usually use: _____

Name of Hospital you usually use: _____

1. Do you or your spouse (if applying) have health insurance besides Medicare? (Exclude a Part D drug only policy). If Yes, describe:	Yes	No
2. Do you or your spouse (if applying) have Medical Assistance, even with a spenddown, from your County? If Yes, describe:	Yes	No
3. Do you have SLMB or QI-1 paying for your Medicare Premiums? SLMB _____ QI-1 _____	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. Attach a complete copy (all pages) of your verification documents.

Current Senior Partners Care Guidelines

MAXIMUM GROSS Household Income:

- **Single individual: \$2,082.00 (\$24,780/year)**
- **Married couple: \$2,818.00 (\$3,820/year)**

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

MAXIMUM Household Assets

- **(EXCLUDES your home; one car; personal property)**
- **\$51,500.00 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)		
Indicate -0- if you have none	Self	Spouse	Indicate -0- if you have none	Self	Spouse
Social Security Attach 2019 SS Award Letter(s)	\$	\$	Cash; Saving; and/ or Money Market Attach Bank Statements**		\$
Pension(s) Attach Stub, Letter or Statement	\$	\$	Checking Accounts; Debit Cards Attach Debit Card Print Out or Bank Statements**	\$	\$
Monthly retirement fund withdrawal or monthly Interest/Dividends rec. Attach a company/brokerage statement	\$	\$	IRAs; Stocks; Bonds; CDs; Trusts; Annuities, 401k's, 403b's etc. Attach brokerage statements	\$	\$
Employment Income Attach 3 months of Pay Stubs	\$	\$	<u>Non-Homestead property</u> - Land you do not live on Attach Tax Statement	\$	\$
Self-Employment – NET PROFIT Copy of IRS 1040 Schedule C	\$	\$	<u>Additional Licensed vehicles:</u> If you only have one vehicle, write N/A. If more than one, provide make, model, year, mileage for the additional vehicles.	\$	\$
Rental <u>Income you receive</u> – NET Copy of IRS 1040 Schedule E	\$	\$	Boats, RVs, 4- wheeler, etc. Provide VIN and mileage /hours for each	\$	\$
Spousal Maintenance (Alimony): Copy of Checks, Bank Statement, or Order	\$	\$	Rental Units you own 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	\$	

** Include ALL household bank accounts including Direct Express or other debit card accounts where your Social Security is deposited. **SHOW ONE MONTH'S DEPOSITS in each, explain any deposits that are not your Social Security, pension or wages.**

STATEMENT OF UNDERSTANDING

(Please read and sign. The signatures of the applicant and spouse are required.)

You understand that Senior Partners Care is a community service program; it is **not** health 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.

You have listed your choice of Health Care Provider(s) and understand that not all Health Care Providers participate in this program.

You understand that Senior Partners Care **does not** provide a waiver for **all** health care expenses. You will be responsible for paying for services not covered by Medicare (i.e. routine annual physical) and services from Health Care Provider(s) who do not participate in Senior Partners Care.

You understand that you are not required to provide the personal, medical and financial information requested. However, failure to provide the information will result in failure to qualify for Senior Partners Care.

You understand Senior Community Services will keep your medical, personal and financial data private and will only use such data as necessary for the operation of the Senior Partners Care program. Information about eligibility for Senior Partners Care may be share with Health Care Providers who participate in the Senior Partners Care Program.

You certify with your signature below that you have read this entire application and that the personal and financial information provided here is complete and accurate to the best of your knowledge.

You grant permission to Senior Partners Care to contact your emergency contact, if necessary.

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 \$45.00 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 \$45 per person payable to Senior Partners Care with your application and verifications to:**

**Senior Partners Care
10201 Wayzata Blvd, Suite 335
Minnetonka, MN 55305
r.jordan@seniorcommunity.org**

Call with questions: 952/767-0665; 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.

FOR OFFICE USE ONLY

Approval/Disapproval date: _____

New Renewal Denial

Accepted Effective Date: _____

Fee Paid \$45 \$90

Qualify/Denial Reason: _____

Member ID _____

Spouse ID _____

Hospital Coordinator _____

Copy sent
SPC Rep initials _____

Notes:

Key Metro Area SPC Providers

- Fairview Health System*
- HealthEast System
- Hennepin County Medical Center
- Minnesota Oncology
- Noran Neurological Clinic
- North Memorial Hospital and Clinics
- Park Nicollet/Methodist Hospital
- United Family Medicine
- University of MN and Physicians
- Ridgeview Hospital and Clinics, Waconia area
- Lakeview Hospital and Stillwater Medical Group

Specifically NOT included:

- Allina facilities
- HealthPartners clinics
- Regions Hospital
- Lakeview Clinics: Waconia, Chaska, Watertown and Norwood
- Entira Clinics do not accept new SPC participants

*Fairview RIDGES Specialty Clinics/Ambulatory Surgery and Fairview Maple Grove Ambulatory Surgery are NOT participants nor is Fairview Home Care and Hospice

PLEASE PROVIDE YOUR 2019 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. Under My Home/ Replacement Documents. Go to the Medicare Card to Need Proof. Click and print a Benefit Verification Letter.
- If you have Direct Express, get a printout from your ATM or a statement. It must have your name, account number, etc.