

Privacy Act / Paperwork Reduction Notice

Section 1860D-14 of the Social Security Act, as amended, allows us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from making a decision on your eligibility for a Medicare Part D subsidy.

We will use the information to obtain income and resource information to determine if you are eligible for a Medicare Part D subsidy. We may also share your information for the following purposes, called routine uses:

- 1. To applicants, claimants, prospective applicants or claimants (other than the data subjects and their authorized representatives) to the extent necessary for the purpose of pursuing Medicare Part D and Part D subsidy entitlement or appeal rights; and
- 2. To Federal, State, or local agencies (or agents on their behalf) for administering income maintenance or health maintenance programs (including programs under the Social Security Act).

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORN) 60-0090, entitled Master Beneficiary Record; and 60-0321, entitled Medicare Database File. Additional information and a full listing of all our SORNs are available on our website at https://www.ssa.gov/privacy/sorn.html.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the *Paperwork Reduction Act of 1995*. You do not need to answer these questions unless we display a valid Office of Management and Budget (OMB) control number. The OMB control number for this collection is 0960-0696. We estimate that it will take 30 minutes to read the instructions, gather the facts, and answer the questions. **Send only comments relating to our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.**

SEND THE COMPLETED FORM TO US AT THE ADDRESS SHOWN ON THE ENCLOSED PRE-ADDRESSED, POSTAGE-PAID ENVELOPE:

Social Security Administration Wilkes-Barre Direct Operations Center P.O. Box 1020 Wilkes-Barre, PA 18767-9910

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11. What do you expect your net earnings from self-employment to be **this calendar year?** Place an **X** in the **NONE** box if you are not self-employed and go to question 12.



| YOU: NONE | \$ |
|---|--|
| SPOUSE: NONE | \$ |
| Place an \mathbf{X} in the box(es) if you or your spouse expect a net loss. | YOU: SPOUSE: |
| 12. Have the amounts you included in questions 10 or 11 de | creased in the last two years? |
| | YES NO |
| 13. If you or your spouse pped working in 2020 or 2021 enter the month and year. | |
| Do NOT fill in the boxes next to SPOUSE if you did n | |
| EXAMPLE | YOU: 20 |
| For January – September, place a zero (0) in the | M M Y Y Y Y |
| first box. May 2021 | SPOUSE: 2 0 |
| should read: MM YYYY | M M Y Y Y Y |
| to question 14. Otherwise, skip to question 15 14. Do you or your spouse have to pay for things that enable | • |
| of your earnings toward the income limit if you work ar on a disability or blindness and you have work-related e Examples of such expenses are: the cost of medical trea depression or epilepsy; a wheelchair; personal attendant assistance or other special work-related transportation n guide dog expenses; sensory and visual aids; and Braille | and receive Social Security benefits based expenses for which you are not reimbursed. It ment and drugs for AIDS, cancer, at services; vehicle modifications, driver needs; work-related assistive technology; |
| Instructions; If NO, skip to question 15. If YES, place an | X in the YES box then go to question 15. |
| Do NOT fill in the boxes next to SPOUSE if you did not p | out spouse information in Question 2. |
| YOU: YES | SPOUSE: YES |
| 15. Information about Medicare Savings Programs: You with your Medicare costs under the Medicare Savings F for the Medicare Savings Programs, Social Security will State unless you tell us not to. If you want to get help f not complete this question. Just sign and date the appropriate the same of the same | Programs. To start your application process ll send information from this form to your from the Medicare Savings Programs, do |
| If you are not interested in filing for the Medicare Savir | ngs Programs, place an $\overline{\mathbf{X}}$ in the box below. |
| No, do not send the information of the information | mation to the State. |

Social Security Administration Important Information



You may be eligible to get Extra Help paying for your prescription drugs.

The Medicare prescription drug program gives you a choice of prescription plans that offer various types of coverage. In addition, you may be able to get Extra Help (a Medicare Part D subsidy) to pay for monthly premiums, annual deductibles, and co-payments related to the the Medicare Prescription drug program.

Before we can help you, **you must fill out this application, put it in the enclosed envelope and mail it today, or** you may complete an online application at

www.ssa.gov/benefits/medicare/prescriptionhelp/. We will review your application and send you a letter to let you know if you qualify for Extra Help. To use the Extra Help, you must enroll in a Medicare prescription drug plan.

If you need help completing the application, call Social Security at 1-800-772-1213 (TTY 1-800-325-0778). You can find more information at ssa.gov.

You also may be able to get help from your State with other Medicare costs under the Medicare Savings Programs. By completing this form, you will start your application process for a Medicare Savings Program. We will send information to your State who will contact you to help you apply for a Medicare Savings Program unless you tell us not to by answering question 15 on this form.

If you need information about Medicare Savings Programs, Medicare prescription drug plans or how to enroll in a plan, call **1-800-MEDICARE** (**1-800-633-4227**; TTY **1-877-486-2048**) or visit **www.medicare.gov**. You also can request information about how to contact your State Health Insurance Counseling and Assistance Program (SHIP). The SHIP offers help with your Medicare questions.

Please mail your application today.

Social Security Administration

Form **SSA-1020-0CR-SM** (O1-2021) Recycle prior editions



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Form Approved OMB No. 0960-0696

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| | plication escripti | | | | | | Me | dica | re | FOR | OFFICIA | L USE ON | NLY |
| | | | | | | | | | DOES NOT RUG PLAN. | State Code: | | WBDOC Exception: | |
| 1. | Applicant | 's Nam | e: Prin | t name | as it aj | ppears | on yo | ur So | cial Security | card. Us | e one box | x for each | letter. |
| | | | | | | | | | | | | | |
| | FIRST N | AME | | | | | | | MI | | | | |
| | | | | | | | | | | | | | |
| | LAST NA | AME | | | | | | | | SU | FFIX (J | Jr., Sr., et | c.) |
| | | | | - | | | | | _ | | _ | | |
| | APPLIC | ANT'S | SOC | IAL S | ECUR | ITY N | [UM] | BER | APPLICA (M | NT'S DA 1M-DD- | | BIRTH | |
| ۷. | appears on your spouse's Social Security card. If you are not of your spouse or are widowed, skip to question 3 and do not include spouse on this application. | | | | | | ou are not cui | rrently m | arried, d | lo not live | with | | |
| | | | | | | | | | | | | | |
| | FIRST N | AME | | | | | | | MI | | | | |
| | | | | | | | | | | | | | |
| | LAST NA | AME | | | | | | | | SUF | FIX (Jr., | , Sr., etc.) | |
| | | | | - | | | | | | | _ | | |
| | SPOUSE | 'S SO | CIAL | SECU | RITY | NUM | BER | | | E'S DAT IM-DD- | | IRTH | |
| If y | our spouse | has M | ledicar | e, does | he or s | she also | wish | to ap | oly for the Ex | tra Help? | | YES | NO |
| 3. | | | | | | | | | ave savings, i | | | | |

YES

If you place an in the YES box, you are not eligible for the Extra Help. But, your State may be able to help you with your Medicare costs through their Medicare Savings Programs. To start the application process for Medicare Savings Programs,

\$14,790? Do NOT count your home, vehicles, personal possessions, life insurance, burial plots,

Savings Programs. To start the application process for Medicare Savings Programs, skip to page 6, sign this application and return it to us. If you are not interested in Medicare Savings Programs, skip to question 15 on page 5.

NO or

If you place an X in the NO or NOT SURE box, complete the rest of this

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NOT SURE

application and return it to us.

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General Instructions for Completing the Application for Extra Help with Medicare Prescription Drug Plan Costs



If You Are Assisting Someone Else With This Application

Answer the questions as if that person were completing the application. You must know that person's Social Security number and financial information. Also, complete Section B on page 6.

Do you have Medicare and Supplemental Security Income (SSI) or Medicare and Medicaid?

If the answer is YES, do not complete this application because you automatically will get the Extra Help.

Does your State Medicaid program pay your Medicare premiums because you belong to a **Medicare Savings Program?**

If the answer is YES, contact your State Medicaid office for more information. You could get the Extra Help automatically and may not need to complete this application.

How To Complete This Application

- Use **BLACK INK** only.
- Keep your numbers, letters and Xs inside the boxes; use only CAPITAL letters.
- Do not add any handwritten comments on the application.
- Do not use dollar signs when entering money amounts.
- Cents can be rounded to the nearest whole dollar.





Completing Your Application

You may complete the online application at **ssa.gov** or use the enclosed pre-addressed stamped envelope to return your completed and signed application to:

Social Security Administration Wilkes-Barre Direct Operations Center P.O. Box 1020 Wilkes-Barre, PA 18767-9910

Return this application package in the enclosed envelope. Do not include anything else in the envelope. If we need more information, we will contact you.

NOTE: To apply, you must live in one of the 50 States or the District of Columbia.

If You Have Questions Or Need Help Completing This Application

You can call us toll-free at 1-800-772-1213, or if you are deaf or hard of hearing, you may call our TTY number, 1-800-325-0778.

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If you placed an \overline{\Sigma} in the NO or NOT SURE box in question 3, answer all of the following questions. If you are married and living with your spouse, you must answer all of the questions for both of you.

Enter below money amounts of all bank accounts, investments or cash that you, your spouse, if married and living together, or both of you own. Also include items that either of you own with another person. Include only dollar figures not account numbers. If you or your spouse do not own any item listed, alone or with another person, place an X in the NONE box. Do NOT include a back payment from Social Security or SSI received in the last 10 months.

| | Combined total of all bank accounts (checking, savings and certificates of deposit) | NONE | \$ |
|----|---|----------------------|--|
| | Combined total of all stocks, bonds, savings bonds, mutual funds, Individual Retirement Accounts or other similar investments | NONE | \$ |
| | Any other cash at home or anywhere else | NONE | \$ |
| ·- | Will some money from the sources listed | l in question 4 be u | used to pay for funeral or burial expenses |

Instructions: If YES, skip to question 6.

If **NO**, place an $\overline{\mathbf{X}}$ in the **NO** box, then go to question 6.

Do **NOT** place an $\overline{\mathbf{X}}$ in the spouse **NO** box if you did not provide spouse information in Question 2.

YOU: NO **SPOUSE:**

6. Other than your home and the property on which it is located, do you or your spouse, if married and living together, own any real estate? Examples of other real estate are summer homes, rental properties or undeveloped land you own which is separate from your home.

| YES | NO | | |
|--------------------------|----------------|----------------------|--|
| omeone related to you by | blood adoption | or marriage (but not | |

7. For this question, a relative is someone related to you by blood, adoption, or marriage (but not including your spouse). How many relatives live with you and depend on you or your spouse for at **least one-half** of their financial support?

Please do not include yourself or your spouse in the number you enter. If your household consists only of you or you and your spouse, place an \mathbf{X} in the ZERO box. Place an \mathbf{X} in only one box.

| ZERO | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 or more |
|-------------|---|---|---|---|---|---|---|---|-----------|
| | | | | | | | | | |

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Signatures IMPORTANT INFORMATION - PLEASE READ CAREFULLY

I/We understand that the Social Security Administration (SSA) will check my/our statements and compare its records with records from Federal, State, and local government agencies, including the Internal Revenue Service (IRS) to make sure the determination is correct.

By submitting this application, I am/we are authorizing SSA to obtain and disclose information related to my/our income, resources, and assets, foreign and domestic, consistent with applicable privacy laws. This information may include, but is not limited to, information about my/our wages, account balances, investments, benefits, and pensions. Unless I/we answered "No" to Question 15, I am/we are authorizing SSA to disclose to the State the financial information listed above and other individually identifiable information from my/our file, such as my/our name(s), date of birth, gender and Social Security number(s) to start the application process for Medicare Savings Programs.

| | | Sec | ction A | | | | |
|--|---|---|---|--|--|---|---|
| Your Signature: | | | Date: | | Phone (| Numbe | er: — |
| Spouse's Signature: | | | Date: | | | / | |
| Your Mailing Address | SS: | | | | | | Apt. #: |
| City: | | | | State: | | Zip Co | ode: |
| f you changed your m | ailing address | within the last t | three months, j | place an $\overline{\mathbf{X}}$ | here: | | |
| f you would prefer the person's name and a d | | | we have addit | tional ques | tions, j | please p | rovide the |
| Print First Name: | | Print Last Na | me: | | Phone (| Number | er: |
| | | Sec | ction B | | | | |
| If someone assisted your information requested | | in the box that | describes that | t person ar | nd prov | ride the | rest of the |
| Family Member | Attorney | | Other Advocate | | her ecify: | | |
| Friend | Agency | S | ocial Worker | | | | |
| Print First Name: | | Print Last Na | me: | | Phone (| Numbe | er: |
| Address: | | | | | | | Apt. #: |
| City: | | | | Sta | ate: | | Zip Code: |
| Form SSA-1020- | OCR-SM (D1-7 | 2021) P | age L | | | | |
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| OAL SECUR | | | | | | | |
| USA | | | | | | | |
| SAN ISTRACE | | | | | | | |
| S If you or your st | ouse if marri | ed and living to | | e income t | from a | ny of th | e sources liste |
| 8. If you or your sp below, you must each month. If t enter the average and list wages are | answer the que he amount change monthly income. | estions for both anges from mocome for the p | h of you. Pleas onth to month ast year for e | se enter the n or you do ach type i | total a not r n the a | amount receive i appropri | you receive t every mont ate boxes. Do |
| below, you must each month. If t enter the avera not list wages ar foster care paym | answer the quenche amount change monthly industrial self-employments here. If you | estions for both anges from mo come for the p ment, interest in ou or your spou | h of you. Pleas onth to month ast year for e ncome, public | se enter the or you do ach type i assistance | total and not return the and t | amount receive i appropri cal reim | you receive t every mont ate boxes. Do abursements of |
| below, you must each month. If t enter the average not list wages ar | answer the quenche amount change monthly industrial self-employments here. If you | estions for both anges from mo come for the p ment, interest in ou or your spou | h of you. Pleas onth to month ast year for e ncome, public | se enter the or you do ach type i assistance | e total a o not r n the a e, medi e from | amount receive i appropri cal reim | you receive t every mont ate boxes. Do abursements o e listed below |

| 7 | | Monthly Benefit |
|--|------|-----------------|
| Social Security benefits before deductions | NONE | \$ |
| Railroad Retirement benefits before deductions | NONE | \$ |
| Veterans benefits before deductions | NONE | \$ |
| Other pensions or annuities before deductions. Do not include money you receive from any item you included in question 4. | NONE | \$ |
| Other income not listed above, including alimony, net rental income, workers compensation, unemployment, private or State disability payments, etc. (Specify): | NONE | \$ |

| If you have worked in the last two years, you need to answer questions 10-14. I | [f |
|---|----|
| you are married and living with your spouse and either one of you has worked | l |
| in the last two years, you need to answer questions 10-14. Otherwise, skip to | |
| question 15. | |

| | | _ |
|-----|---|---|
| 10. | What do you expect to earn in wages before taxes and deductions this calendar year ? | |

YES

| YOU: | NONE | \$ |
|---------|------|----|
| SPOUSE: | NONE | \$ |

NO

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