

Assistance with Medicare Costs

Medicare Savings (also known as Buy-In) Programs

Please note that this application is for the Medicare Savings (Buy-In) Programs only and will not be used to determine eligibility for other MassHealth programs.

What are the Medicare Savings (Buy-In) programs?

The MassHealth Medicare Savings (Buy-In) programs help pay some of the out-of-pocket costs of Medicare. The Buy-In programs can also help get Medicare Part B for people who only have Medicare Part A. If you are in a Buy-In program, you will also be automatically enrolled in the Medicare Part D Extra Help program, which can help with pharmacy costs.

How much can I have in income and assets?

For INDIVIDUALS IF your assets are at or below \$15,720	
AND Your monthly income before taxes and deductibles is below...	THEN You will be eligible for...
\$1,374	Senior Buy-In
\$1,738	Buy-In
For a MARRIED COUPLE who live together IF your assets are at or below \$23,600	
AND Your monthly income before taxes and deductibles is below...	THEN You will be eligible for...
\$1,852	Senior Buy-In
\$2,346	Buy-In

The income limit amounts may change March 1, 2020.

The asset limit amounts may change January 1, 2021.

For the most updated information about income and asset limits, go to www.mass.gov/service-details/program-financial-guidelines-for-certain-masshealth-applicants-and-members.

Medicare Savings (Buy-In) Program Benefits

MassHealth Senior Buy-In

MassHealth Senior Buy-In may pay for Part B Medicare premiums (and for Part A premiums for those who have one) and for the deductibles and coinsurance under Part A and Part B.

MassHealth Buy-In

MassHealth Buy-In may pay for the Medicare Part B premium.

If I am eligible for one of the Medicare Savings (Buy-In) programs, how do I get paid?

If MassHealth finds that you are eligible for payment of your Medicare Part B premium, we will tell Medicare.

If your Medicare Part B premium is deducted from your social security benefit, your monthly benefit will be adjusted so that your Medicare premium is no longer deducted. This means that the amount of your social security benefit will increase by the amount that had been deducted to pay for your Medicare Part B premium.

If you are eligible for, but not yet getting Medicare Part B, or if you are paying your Medicare Part B premium in some other way, such as getting a quarterly bill from Medicare, MassHealth will start paying this bill for you.

It will take several months to adjust your social security benefit or to pay your bill. However, you will get a refund for the amount you paid for your Medicare Part B premium back to the month you became eligible for MassHealth Buy-In or Senior Buy-In. You will get this refund in the same way as you now get your social security benefits.

When does coverage begin?

If you are eligible for **MassHealth Senior Buy-In**, your coverage begins in the month after we process your application. If you are eligible for **Buy-In**, in most cases the coverage begins as early as three months before your application month.

You will get a written notice that tells you about your coverage and when it starts. If you are not eligible, the notice will give you the reason(s) you are not eligible. If you think the decision is wrong, you have the right to appeal it. Information about how to appeal is on the back of the written notice.

How we use your social security number

Unless one of the exceptions listed below applies, you must give us a social security number (SSN) or proof that one has been applied for, for every household member who is applying.

Exceptions

- You or any household member has a religious exemption as described in federal law.
- You or any household member is eligible only for a nonwork SSN.
- You or any household member is not eligible for an SSN.

We use SSNs to check information you have given us. We also use them to detect fraud, to see if anyone is getting duplicate benefits, or to see if others (a “third party”) should be paying for services.

We may match the SSN of anyone in your household who is applying and anyone who has or who can get health insurance for any such persons with the files of agencies, including the following:

- Internal Revenue Service
- Social Security Administration
- Systematic Alien Verification for Entitlements
- Centers for Medicare & Medicaid Services
- Registry of Motor Vehicles
- Department of Revenue
- Department of Transitional Assistance
- Department of Industrial Accidents
- Division of Unemployment Assistance
- Department of Veterans’ Services, Human Resource Division
- Bureau of Special Investigations
- Bureau of Vital Statistics (Department of Public Health)
- Banks
- Other financial institutions

Files may also be matched with social service agencies in this state and other states, and computer files of insurance companies, employers, and managed care organizations. Additionally, MassHealth may obtain your financial records (and, if applicable, those of your household members) from banks and other financial institutions in order to verify your financial resources and otherwise determine your eligibility while you are a MassHealth member.

Privacy and Confidentiality

MassHealth is committed to keeping the personal information we have about you confidential. All personal information we have about any applicant or member, including medical data, health status, and the personal information you give us during your application for and receipt of benefits, is confidential. This information may not be used or released for purposes not related to the administration of MassHealth without your permission unless required by law or a court order.

You can give us your written permission to use your personal health information for a specific purpose or to share it with a specific person or organization. You can also give us your permission to share your personal information with your authorized representative, Certified Application Counselor (CAC), or Navigator, if you have one, by filling out an Authorized Representative Designation Form, a Certified Application Counselor Designation Form, or a Navigator Designation Form.

For more information about how MassHealth may use and share your information and what your rights are about your information, please review the MassHealth Notice of Privacy Practices. You can get a copy by calling (800) 841-2900, TTY: (800) 497-4648, or by visiting www.mass.gov/masshealth.

Authorized Representative

An authorized representative is someone you choose to help you get health care coverage through programs offered by MassHealth. You can do this by filling out the Authorized Representative Designation Form (ARD). An authorized representative may fill out your application or eligibility review forms, give proof of information given on these eligibility forms, report changes in your income, address, or other circumstances, get copies of all MassHealth eligibility notices sent to you, and act on your behalf in all other matters with MassHealth.

An authorized representative can be a friend, family member, relative, or other person or organization of your choosing who agrees to help you. It is up to you to choose an authorized representative, if you want one. MassHealth will not choose an authorized representative for you.

You must designate in writing on the Authorized Representative Designation Form the person or organization you want to be your authorized representative. This form is included in the application packet. In most cases, your authorized representative must also fill out this form. Please see the instructions on the form for more details.

An authorized representative can also be someone who is acting responsibly on your behalf if you cannot designate an authorized representative in writing because of a mental or physical condition, or has been appointed by law to act on your behalf or on behalf of your estate. This person must fill out the applicable parts of the Authorized Representative Designation Form. If this person has been appointed by law to represent you, either you or this person must also submit to MassHealth a copy of the applicable legal document stating that this person is lawfully representing you or your estate. This person may be a legal guardian, conservator, holder of power of attorney, or health care proxy, or if the applicant or member has died, the estate's administrator or executor.

Permission to Share Information

If you want us to share your personal health information, including sending copies of your eligibility notices, with someone who is not your authorized representative, you can do this by giving us written permission. We have forms you can use to do this. You can call us or visit www.mass.gov/masshealth to get a copy of the right form.

Reporting Changes

If there are any changes in your living situation, including but not limited to income, assets, address, health insurance, immigration status, or disability status, you must tell us within 10 calendar days of the changes or as soon as possible. If you do not tell us about these changes, you may lose your benefits. You can tell us about any changes by calling (800) 841-2900, TTY: (800) 497-4648 for people who are deaf, hard of hearing, or speech disabled.

Other benefits

MassHealth offers other health care benefits that pay for medical services directly, and may also pay your Medicare copayments and deductibles. You may be eligible for these benefits if your income and assets are under certain amounts, or if you are disabled and younger than 65. Call us at (800) 841-2900, TTY: (800) 497-4648 to learn about these benefits. You should also call this number if you have any questions about the MassHealth Buy-In programs.

Most **Medicare** members on MassHealth or the Buy-In programs can get help with prescription drug costs through Medicare. To get more information, call Medicare at (800) 633-4227, TTY: (877) 486-2048, or visit www.medicare.gov.

Prescription Advantage offers help with prescription drug costs. To learn more about these benefits, call the Executive Office of Elder Affairs toll free at (800) 243-4636, TTY: (877) 610-0241.

How do I apply for the Medicare Savings (Buy-In) programs?

1. To apply for the MassHealth Buy-In programs, fill out the attached application. Include information about your spouse too, if he or she lives with you.
2. Sign the filled-out application, and
send it to: **MassHealth Enrollment Center**
P.O. Box 290794
Charlestown, MA 02129-0214
or fax it to: **(857) 323-8300.**
3. When we get the application, we will review it for completeness. If we need more information, we will write to you or call. Once we get all information, we will decide if you are eligible. We will also decide if your spouse is eligible.
4. A voter registration form is included with your application. (You do not need to register to vote to get a MassHealth Buy-In program.)
5. If you want someone to act on your behalf as your authorized representative, use the enclosed Authorized Representative Designation Form to tell us.

Please note that this application is for the MassHealth Buy-In programs only. If you would like to apply for all MassHealth programs (including the Buy-In programs) though a single application, contact MassHealth at the number above to request a full application.



Medicare Savings (Buy-In) Programs Application

for people who are eligible for Medicare

Who can use this application?

Individuals of any age who are receiving Medicare and are only seeking help with payment of their Medicare premiums and cost sharing.

If you want to apply for other MassHealth benefits, (as well as assistance with Medicare costs), call MassHealth Customer Service at (800) 841-2900, TTY: (800) 497-4648 for people who are deaf, hard of hearing, or speech disabled for a different application.

Please print clearly and fill out all sections.

General Information

Who is applying? you you and your spouse

If you and your spouse live together, you must also give us information about your spouse even if he or she is not applying for benefits.

You Last name _____ First name _____ MI _____

Street address _____ City _____ State _____ Zip _____

Mailing address (if different from above) homeless
 _____ City _____ State _____ Zip _____

Date of birth / / Gender M F Telephone number () _____

Preferred spoken language _____ Preferred written language _____

Social security number _____ Medicare claim number _____

Your Spouse Last name _____ First name _____ MI _____

Date of birth / / Gender M F Telephone number () _____

Preferred spoken language _____ Preferred written language _____

Social security number _____ Medicare claim number _____

Income

Fill out this section for you and your spouse. List the gross monthly income (before taxes and other deductions, such as the Medicare Part B premium).

Source of income	Gross monthly income before taxes and deductions.	
Social security	Your \$ _____	Your spouse's \$ _____
Pensions	Your \$ _____	Your spouse's \$ _____
Federal veterans' benefits	Your \$ _____	Your spouse's \$ _____
Annuities or trusts	Your \$ _____	Your spouse's \$ _____
Dividends and/or interest	Your \$ _____	Your spouse's \$ _____
Income from a job (before deductions)	Your \$ _____	Your spouse's \$ _____
Rental income (after expenses)	Your \$ _____	Your spouse's \$ _____
Other (please specify) _____	Your \$ _____	Your spouse's \$ _____

Assets

Source	Your \$ _____	Your spouse's \$ _____	You and your spouse \$ _____
Savings accounts	Your \$ _____	Your spouse's \$ _____	You and your spouse \$ _____
Checking accounts	Your \$ _____	Your spouse's \$ _____	You and your spouse \$ _____
Second car (first car is noncountable)	Your \$ _____	Your spouse's \$ _____	You and your spouse \$ _____
Certificates of deposit	Your \$ _____	Your spouse's \$ _____	You and your spouse \$ _____
Stocks	Your \$ _____	Your spouse's \$ _____	You and your spouse \$ _____
Bonds	Your \$ _____	Your spouse's \$ _____	You and your spouse \$ _____
Mutual funds	Your \$ _____	Your spouse's \$ _____	You and your spouse \$ _____
Other (please specify) _____	Your \$ _____	Your spouse's \$ _____	You and your spouse \$ _____
Total assets	Your \$ _____	Your spouse's \$ _____	You and your spouse \$ _____

Signature

Please read the following carefully. Then sign and date the bottom of this page. Both you and your spouse must sign if your spouse lives with you. By signing, you agree to and understand the following.

You give permission to MassHealth to get any records or data to prove any information given on this application. You understand that you must tell MassHealth of any changes in information you gave on this application. You further certify under the penalty of perjury that the information on this application is correct and complete to the best of your knowledge.

If you are acting on behalf of someone in filling out this application, the enclosed Authorized Representative Designation Form must also be filled out and sent back with this application. Your signature on this application as an authorized representative certifies that the information on this application is correct and complete to the best of your knowledge.

If you think MassHealth's decision about whether you are eligible is wrong, you have the right to appeal. If you are denied benefits, you will get information on how to appeal.

MassHealth will obtain from your current and former health insurers all information about health insurance coverage for you and your spouse. This includes, but is not limited to, information about policies, premiums, coinsurance, deductibles, and covered benefits that are, may be, or should have been available to you and your spouse.

MassHealth may get records or data about you and your spouse listed on this application from federal and state data sources and programs, such as the Social Security Administration, the Internal Revenue Service, the Department of Homeland Security, the Department of Revenue, and the Registry of Motor Vehicles, as well as private data sources including financial institutions, 1) to prove any information given on this application and any supplements, or other information given once you or your spouse becomes a member, 2) to document medical services claimed or provided to you or your spouse, and 3) to support continued eligibility.

X _____
Signature of applicant or authorized representative Print name Date

X _____
Signature of applicant's spouse or authorized representative Print name Date

Voter registration information is enclosed in this packet.

Once you have filled out and signed this form, send it to:

**MassHealth Enrollment Center
P.O. Box 290794
Charlestown, MA 02129-0214**

OR

fax it to: (857) 323-8300