CNS Paragraph Form

Date: 11.28.05

Program Area	**03**	**(01=PA, 02=FS, 03=MA, 04=HP)**
Paragraph Number	**R9005**	
Version Number	**0001**	
Effective Date	**2005**	**(YYMMDD)**
Title	**QI-1 Re-Enrollment Form**	
Comment		
Reason Code		

PLEASE COMPLETE, SIGN, AND RETURN THIS FORM TO CONTINUE YOUR PARTICIPATION IN THE MEDICARE SAVINGS PROGRAM.
FAILURE TO RETURN THIS FORM MAY CAUSE PAYMENT OF YOUR PREMIUM TO END

□ Married □ Single CIN# Social Security Number _____

Has your marital status changed since you originally applied for this program? □Yes □No

If Yes, how has it changed? _____

Do you or your spouse pay any health insurance premiums other than Medicare?

Yes_____ **No**_____ **Monthly Amount $**_____

MONTHLY INCOME

- *If you are married, report the joint income for you and your spouse*
- *Fill in each line. Where you do not have income, check the* NONE *box.*
- *Report all income including Social Security, pensions, interest from savings, rental income, etc.*

	YOUR INCOME	**NONE**	**SPOUSE'S INCOME**	**NONE**
1. Social Security and/or Railroad Retirement Benefits	$_____	□	$_____	□
2. Pensions and Annuities	$_____	□	$_____	□
3. Earned income (wages, business income, self employment income)	$_____	□	$_____	□
4. Other income (IRA, rental income, Capital gains, Etc.)	$_____	□	$_____	□
5. Interest and dividends	$_____	□	$_____	□
TOTAL MONTHLY INCOME	**$**_____		**$**_____	

CONSENT: I understand that by signing this application/certification form I agree to any investigation made by the Department of Social Services to verify or confirm the information I have given or any other investigation made by them in connection with my request for help paying my Medicare premium. If additional information is requested, I will provide it.

Applicant/Representative Signature_____ Date_____