



LTC Card Sponsored Medicare Transitional Assistance Program

Dear Applicant: Please read all the information below regarding the enrollment process and then complete all the information fields on the attached enrollment form. Your signature is required for processing. If you have any problems completing the form, please call the LTCPA Call Center at 1-866-490-1863. The TTY phone number is 1-888-816-7874. Visit www.ltcpa.org to download this application. **Once you have completed your application, please fax it to 1-866-213-6066.**

Release of Information: By applying for enrollment in this company's Medicare-approved discount card, I allow the Centers for Medicare & Medicaid Services (CMS) to give information to the company of the Medicare-approved drug discount card. The information will say whether I have Medicare Hospital Insurance Benefits (Part A) and/or Supplementary Medical Insurance Benefits (Part B). I also allow the State Medicaid Program, Social Security Administration, and Internal Revenue Service, or any other agency with relevant information about me to give CMS or CMS's agents the information needed to determine if I am eligible for the Medicare-approved prescription drug card and, if applying, for a credit of up to \$600 toward prescription drugs.

Review of Eligibility: I understand that my application will be considered without regard to race, color, sex, age, handicap, religion, national origin, or political belief. I also understand that by signing this application I am agreeing to a full investigation or review of my eligibility by states, federal agencies, or their contractors and, if requested, I agree to provide the documents necessary to confirm the accuracy and completeness of the information provided in this application. If documents aren't available, I agree to give the name of the person or organization that can provide and release this necessary information.

Upon approval, CMS is authorized to disenroll the applicant from the current sponsor program and enroll the applicant in the LTCPA program. Federal law provides for fine or imprisonment, or both for any person who withholds or gives false information to obtain assistance to which (s)he is not entitled. I understand the questions on this application and I certify, under penalty of perjury, that the information given by me is correct and complete to the best of my knowledge.

Income requirements: CMS has established income requirements that all applicants must meet in order to qualify for the Transitional Assistance benefits. These requirements are based on your state of residence. Listed below are the state-based income ranges. The corresponding co-payment that will be payable at the pharmacy is listed in parentheses.

Alaska residents

Single: \$15,701 - \$11,630 (10%)	Married: \$21,074 - \$15,610 (10%)
Single: Less than \$11,630 (5%)	Married: \$15,610 (5%)

Hawaii residents

Single: \$14,445 - \$10,700 (10%)	Married: \$19,386 - \$14,360 (10%)
Single: Less than \$10,700 (5%)	Married: Less than \$14,360 (5%)

All other state residents

Single: \$12,569 - \$9,310 (10%)	Married: \$16,862 - \$12,490 (10%)
Single: Less than \$9,310 (5%)	Married: Less than \$12,490 (5%)

If you are unable to fax this application, please mail to:

LTC Card, PO Box 502368, Atlanta, GA 31150

LTC Card Assistance Program, 365 Northridge Road, Suite 400, Atlanta, GA 30350



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First Name	MI	Last Name
<input type="text"/>	<input type="text"/>	<input type="text"/>

Residence Address (including apartment number)

City	State	Zip Code
<input type="text"/>	<input type="text"/>	<input type="text"/>

Date of Birth (MM/DD/YYYY)	Telephone Number	Gender
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="radio"/> Male <input type="radio"/> Female

Social Security Number	Medicare ID Number
<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="text"/>

Please indicate your total annual income in the field to the right.

Income \$.

Marital Status	If married, please include your spouse's Social Security	Spouse's Social Security Number (if married)
<input type="radio"/> Single, Widowed, or Divorced <input type="radio"/> Married	<input type="text"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>

Have you recently (within the last 2 years) retired or been widowed or divorced? Yes No

Do you have Medicare Part A or Medicare Part B? Yes No

Do you have outpatient prescription drug benefits under your State Medicaid Program? Yes No

Do you have TRICARE (military health insurance)? Yes No

Do you have Federal employee or retiree health insurance (FEHBP)? Yes No

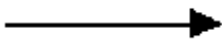
Does your state help you pay your Medicare part A or part B premiums? Yes No

Do you have other health coverage that includes outpatient prescription drugs, such as VA pharmacy benefits, employer or retiree plans? Note: If your health coverage is through a Medicare Managed Care Organization or Medigap plan, answer "No" to this question. Yes No

Upon approval, CMS is authorized to disenroll the applicant from the current sponsor program and enroll the applicant in the LTCPA program. By signing below, you certify that you have read and understand the information on this entire enrollment application. If you can't sign, a representative may sign for you.

Your enrollment application is not complete unless all fields are completed and it is signed.

PLEASE SIGN



Applicant's Signature or Authorized Representative

Date of Application (MM/DD/YYYY)

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This section to be completed by nursing facility only.

Nursing Facility

Nursing Facility Contact Name

Facility Telephone Number	Facility Fax Number
<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>

Please fax your completed enrollment application toll free to 866-213-6066.

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If you have questions or require assistance in completing this application please call toll free 866-490-1863

CMS Approval Date 05/03/2004

