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

4308

LTC Card Sponsored Medicare Transitional Assistance Program

First Name | MI | Last Name

Residence Address (including apartment number)

City | State | Zip Code

Date of Birth (MM/DD/YYYY) | Telephone Number

Gender ○ Male ○ Female

Social Security Number | Medicare ID Number

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

Income $.

Marital Status
○ Single, Widowed, or Divorced
○ Married

If married, please include your spouse's Social Security

Spouse's Social Security Number (if married)

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)

This section to be completed by nursing facility only.

Nursing Facility

Nursing Facility Contact Name

Facility Telephone Number

Facility Fax Number

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

4308

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

CMS Approval Date 05/03/2004

ACS-LTCPA v1.0 5-17-04

Print Reset