Senior Partners Care - Program Application

*Administered in your area by the **Seven County Senior Federation.***

Please print answers to all questions on this four-page application. If a question does not apply, write "N/A". Return completed application to the Seven County Senior Federation with your financial documents & the annual application fee.

Household Size: _____ **How many people in your household are applying for SPC?** _____

Your Name: _____ **Birthdate:** _____
Last First MI

Medicare ID: _____ **Part A Effective:** _____ **Part B Effective:** _____
SS# & Letter mm/dd/year mm/dd/year

Marital Status of Applicant *(circle)*: Married – Single - Divorced - Widowed - Legally Separated

Spouse: _____ **Birthdate:** _____
Last First MI

Medicare ID: _____ **Part A Effective:** _____ **Part B Effective:** _____
SS# & Letter mm/dd/year mm/dd/year

Mailing Address: _____ **Apt:** _____ **Phone:** (____) _____

City: _____ **County:** _____ **State:** _____ **Zip:** _____

Emergency or Alternate Contact: _____

Phone number: (_____) _____ **Relationship to you:** _____

Name of clinic(s) you usually use: _____

Name of hospital(s) you usually use: _____

1. Do you or your spouse have a health plan or insurance* besides Medicare? If Yes, describe:	**Yes**	**No**
2. Do you or your spouse have Medical Assistance (*or* "M.A. with a spenddown") from your county? If Yes, describe:	**Yes**	**No**

***Having a stand-alone Part D prescription drug plan is compatible with Senior Partners Care.**

If the answers to questions 1 and 2 is No, please continue to the next page.

FINANCIAL INFORMATION

Please provide a document verifying each source of income and/or asset that you list here. A complete copy (all pages) of your checking and savings accounts statements from the past 30 days, CDs, stocks, bonds, copy of cash value of life insurance, etc. We can copy and return original documents to you.

Senior Partners Care 2017 Eligibility Guidelines

MAXIMUM GROSS Household Income:
- Single individual: **$2,010 ($24,120/year)**
- Married couple: **$2,707 ($32,480/year)**

For larger households: please call us for the guideline.

Based on 200% of Federal Poverty Guidelines

MAXIMUM Household Assets
(EXCLUDES your home*; one car[1]; the personal property of the household)
- **$49,200** in total value

Based on 200% FPG for family of four.

Show current GROSS MONTHLY INCOME** for all individuals in the household (ATTACH PROOF)				**Show current value of ASSETS** for all individuals in the household (ATTACH PROOF)		
	Self	**Spouse**			**Self**	**Spouse**
Social Security *Attach 2017 SS Award Letter*	$	$		Savings Account or Money Market *Attach bank statement*	$	$
Pension(s) *Attach paystub or statement*	$	$		Checking Account or Debit Card Account *Attach bank statements*	$	$
Interest/Dividends *Attach a dated statement*	$	$		Stocks; Bonds; CDs, Annuities, Trusts, etc. *Attach statement or trust*	$	$
Employment Income *Attach 3 months of paystubs*	$	$		*Non-Homestead property - Land you do not live on *Attach tax statement*	$	$
Self-Employment -**net *Attach IRS 1040 Schedule C*	$	$		[1]Additional Licensed Vehicles *Provide year/make/model & Mileage for each*	$	$
Rental Income – **net *Attach IRS 1040 Schedule E*	$	$		Boats, RVs, ORVs *Provide year/make/model & Mileage for each*	$	$
Spousal Maintenance (Alimony): *Attach check, bank statement or court order*	$	$		Rental Units *Attach taxable market value statement*	$	$
Other Income:	$	$		Life/Burial Insurance *Attach letter or face page if it has a cash value*	$	$
				Other:	$	$
Total Monthly Income	**$**	**$**		**Total Assets**	**$**	**$**
GRAND TOTAL	**$**			**GRAND TOTAL**	**$**	

STATEMENT OF UNDERSTANDING

Please read. The signatures of the applicant and spouse are required.

You understand that Senior Partners Care is a community service program; it is ***not*** health insurance.

You understand that enrollment in Senior Partners Care may be denied if:

- You do not meet the income and/or asset guidelines for the program; or
- The information furnished on (or attached to) this application is found to be inaccurate; or
- You currently receive Medical Assistance or Qualified Medicare Beneficiary (QMB) program benefits through the county where you reside and/or the MN Department of Human Services.

You have listed your choice of health care provider(s) and understand that not all health care providers participate in this program.

You understand that Senior Partners Care does not provide a waiver for **all** health care expenses. You will be responsible for paying for services not covered by Medicare (i.e. routine annual physical) and services from health care provider(s) who do not participate in Senior Partners Care.

You understand that you are not required to provide the personal, medical and financial information requested. However, failure to provide the information will result in a failure to qualify for SPC.

You understand that the Seven County Senior Federation will keep your medical, personal and financial data private and will only use such data as necessary for the operation of the SPC program. Information about eligibility for SPC may be shared with health care providers who participate in the SPC program.

You certify with your signature below that you have read this entire application and that the personal and financial information provided here is complete and accurate to the best of your knowledge.

X_____ Date _____

Applicant Signature

X _____ Date _____

Spouse Signature If married, both partners must sign, even if only one partner is applying.

Senior Partners Care has no monthly premium, but there is an annual application fee. Please select a choice below. We take credit or debit cards by phone. Or submit check/money order payable to "SCSF."

☐ Single Membership (SCSF)
Including one SPC applicant **$35**

☐ Household Membership (SCSF)
Including one SPC applicant **$50**

☐ Household Membership (SCSF)
Including two SPC applicants **$65**

☐ Non-member SPC applicant
$40 each

Membership in the SCSF is for twelve months, concurrent with Senior Partners Care, if you are found eligible for SPC. Benefits include the Echoes newspaper & discounted fees.

SPC enrollment is for twelve months.

Please return this completed application, your proof documents and the annual application fee to:

Seven County Senior Federation - SPC
47 Park Street N, Suite 7
Mora, MN 55051

Questions? Call us at **1(866) 679-4700** or **(320) 679-4700.** Fax (320) 679-4703**.**

Approximately 30 days after receipt of your application, Senior Partners Care program will notify you of acceptance or denial. This period will be extended if additional information is required from the applicant.

FOR OFFICE USE ONLY
Approval/disapproval date _____ □ Enrolled □ Denied Initial Approval _____
Reason _____ SPC Expiration _____ SCSF initials _____

☐ Member ☐ New Member ☐ Non-Member ☐Fee paid Amount _____

WEBSITE APPLICATION