

Low Income Premium Program Supplemental Application Medicare Carveout



govmembersupport@benefitmanagementllc.com

www.nmmip.org

PO Box 1090

Great Bend, KS 67530

1-844-728-7896

TTY 1-844-728-7897

Fax: 620-793-1199

The Low Income Premium Program (LIPP) is designed to help persons who qualify for NMMIP coverage remain on Pool coverage by offering a reduced premium.

Income does not determine pool eligibility. You must meet the eligibility requirements on the NMMIP application to be eligible for coverage.

To find out if you should apply for LIPP, find your household size and the corresponding yearly income amount in the table below. If:

- You are currently enrolled or apply and meet all eligibility requirements for the Pool **and**
- You or someone in your family will pay your monthly premium **and**
- Your total household income is within the amounts listed in the table below you may qualify for a reduced premium and should complete this application.

If you have questions or need assistance completing this application, contact us at 844-728-7896 or govmembersupport@benefitmanagementllc.com

Qualifying Income Guidelines Effective 01/01/2023 - 12/31/2023

Household Size	0-199% of 2023 HHS Poverty Guidelines 75% Premium Reduction	200-299% of 2023 HHS Poverty Guidelines 50% Premium Reduction	300-399% of 2023 HHS Poverty Guidelines 25% Premium Reduction
1	\$0 - \$27,044	\$27,045 - \$40,634	\$40,635 - \$54,224
2	\$0 - \$36,437	\$36,438 - \$54,747	\$54,748 - \$73,057
3	\$0 - \$45,830	\$45,831 - \$68,860	\$68,861 - \$91,890
4	\$0 - \$49,253	\$49,254 - \$74,003	\$74,004 - \$98,753
5	\$0 - \$64,615	\$64,616 - \$97,085	\$97,086 - \$129,555
6	\$0 - \$74,008	\$74,009 - \$111,198	\$111,199 - \$148,388
7	\$0 - \$83,401	\$83,402 - \$125,311	\$125,312 - \$167,221
8	\$0 - \$92,794	\$92,795 - \$139,424	\$139,425 - \$186,054

Applicant Information: Last name		First name	MI	ID Number
Address		City	State NM	Zip

Premium Payment Certification

I, _____ (name) certify that I, or a member of my family, will be paying my premiums.

Please note: If your premium is being paid by a third party who is not a family member, STOP. You are not eligible to participate in the Low Income Premium Program (LIPP).

Household Size

In order to determine if you qualify for a reduced premium, we need information about your household size and last year's total combined income for all persons in your household over age 18. Even if only one person is enrolled in the Pool, we still need information on the *entire* household, since the premium reduction eligibility is based on total household income.

List all the people in your household. Use additional sheets, if needed, for more household members.

Name	Relationship	Date of Birth

Household Income Information and Verification

NOTE: You do not need to include income information or verification for any member of your household whose income is from Supplementary Security Income (SSI) and/or Temporary Assistance for Needy Families (TANF) **ONLY**.

List total annual income amount for adults in your household *except as excluded above* (from Federal Tax Form: Line 7b of Form 1040)_____.

In addition,

1. Attach a copy of the previous year's Federal Income Tax forms filed (include certification form if filed electronically) by each household member who had income, *except as excluded above*, and complete and sign the **Federal Tax Form Affidavit** (Affidavit A) portion of this application – **AND/OR** –
2. If any adult in your household had income, *except as excluded above*, but were not required to file a Federal Income Tax form, they must complete, sign, and **notarize the Affidavit B - Other Income Source Affidavit** page 2 of this application.

Affidavit A - Federal Tax Form Affidavit *(Make copies for other household members, if necessary)* **Not Required to be Notarized.**

I, _____ (name), swear or affirm that the attached tax form is a true reflection of my income for calendar year 20____, and is a correct copy of the form provided to the Internal Revenue Service (IRS). I CERTIFY that the foregoing answers are true and accurate to the best of my knowledge and belief. I also acknowledge that the Pool may verify this information with state agencies or other sources.

Signature of applicant

Date

Signature of parent or legal guardian if applicant is under age 18, or legally incompetent

Affidavit B - Other Income Source Affidavit *(Make copies for other household members, if necessary)* **Must be Notarized.**

To be completed by any adult in the household who had non-excluded income, but is not required to file a Federal Income Tax Form.

I, _____ (name), hereby swear or affirm that I am not required to file a Federal Income Tax return for calendar year 20____, and that my income for this same calendar year was \$_____. My sources of income were:

Income Source Description	Income Amount
Total:	

Signature Printed name

Home phone Work phone Cell or message phone E-mail address

Subscribed and sworn before me this ____ day of _____, _____ by _____
(name)

My commission expires: _____
Notary Public